A Comparative Study of Physician-Writers' Representations of What Makes a Good Doctor

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A thesis submitted in fulfilment of the requirements for the degree of Doctor of Philosophy in Comparative Literature, The University of Auckland, 2015.

Abstract

This thesis draws on the work of the Narrative Medicine movement and offers for the first time a comparative study of the creative representations of what makes a good doctor by eight physician-writers from a range of cultural backgrounds. What makes a good doctor is one of the central concerns in medical practice, especially as medicine is increasingly criticised for being practised too scientifically and technically and with insufficient artistry and humanity. Creative works by the eight doctor-writers offer readers a much more human understanding of the challenges involved in being a good doctor, compared with more serious and less accessible scholarly and academic writings. The eight doctor-writers chosen for this study represent those most quoted with respect to questions of medical ethics in their own time and place. The study takes an innovative comparative approach that lifts the question of the literary treatment of what constitutes good medical practice beyond the context of a single author or cultural context to enable the illumination of this question from multiple perspectives. The comparative reading of these works not only reveals the extent to which each doctor's representation of the good doctor is influenced by such specificities as the form of writing, the doctor's gender and specialty and the socio-cultural contexts on which the work is written, but also shows a remarkable commonality of concerns that transcends these specificities. The study is primarily carried out in Western cultural and medical contexts, although a Chinese physician-writer is introduced for comparison so as to add a valuable extra dimension to the discussion of what makes a good doctor. In the field of medical humanities, this research provides a complementary literary approach to current studies in medical education; meanwhile in the field of comparative literature, it provides the first systematic study of "doctors who write creatively".

Keywords

comparative literature, physician-writers, creative writing, what makes a good doctor, medicine and literature, Narrative Medicine

Acknowledgment

I would like to extend my sincere gratitude to my supervisors, Dr Hilary Chung and Associate Professor Michael Hanne for their supervision, support, motivation and expertise in the past four years of my PhD study. My thanks first go to Dr Hilary Chung, who has offered me this wonderful opportunity to undertake my PhD journey in such a beautiful university. She has made great contributions particularly to my discussions on modern Chinese culture and literature. She has offered valuable advice with regard to gender criticism, too. She has been training me to maintain a strong argumentation and kept reminding me to stay focused in my thesis writing. My special thanks go to Associate Professor Mike Hanne. Despite the fact that he is my second supervisor, he has worked very closely with me all through my PhD years. He has commented in great detail, on every piece of my writing, and his immense knowledge in Narrative and Metaphor has consistently offered me inspiration. His coordinated medical humanities course titled "Unexamined Metaphors, Uncharted Stories", in particular, broadened my scope and enriched my knowledge in medical humanities. I cannot image a PhD journey without his generous help and encouragement.

I owe Dr Peter Goldsworthy a big thank you for sparing me the time for an interview. I was impressed by his erudition in medicine, literature, ethics, and politics and so on. The conversation with him was extremely illuminating and helpful for my thesis writing. I also appreciate the interesting talks I had with participants in "The Examined Life Conference" at the University of Iowa. Their reading and sharing have greatly widened my understanding on physician-writers' writing. I also thank our subject librarians Lin Haiqing, Mark Hangartner and Chie Emslie for their kind assistance during my library research.

Finally, I would like to express my gratitude for the Chinese Scholarship Council for funding this research. I also want to thank my family and friends for being there at my most vulnerable moments and leading me through difficult times with their love and accompany. The end of this thesis represents the beginning of a new exploration, study and journey. It concludes the research in this thesis, but anticipates future work and more possibilities.

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Chapter 1: Introduction

Doctors who have written creatively for publication have increased greatly in number in recent years. Creative writing by doctors refers to such literary forms as novels, short stories, poetry, essays, memoirs and so on, which can be easily distinguished from doctors' technical or academic writing normally published in medical journals. "A Roster of Twentieth-Century Physicians Writing in English" shows that an estimated one hundred and seventy-three physicians-writers have published at least one literary work since 1900 (Bryant, 1994, p. 285). The roster, as Daniel Bryant admits, is not complete, and could never be, in that the number of potential physician-writers is still rocketing; besides, it does not include physicians who have written in languages other than English. In addition to the sheer number, published physicians have mushroomed into a considerable and legitimate community. With the foundation of the World Union of Physician Writers in 1973,[1] a successor to the former International Federation of Societies of Physician-Writers founded in 1955, writing creatively as a physician is not an individual act anymore; and the creative works by physicians have come more and more to be studied in an academic context.

Doctors have written creatively about a wide range of subject matter, for a variety of motives. They may have written about medical practice so as to release pressure at work; to depict, often critically or satirically, hospitals and other medical institutions; to make amends for errors they have made during practice; to justify their proper function and roles; to seek understanding and empathy among the public; to test the public response to certain ethical issues. They may also have written on themes independent of medicine to make sense of the wider world. They may have written for fame or fun, or to stay away from medicine, temporarily or permanently.

Creative writing by doctors not only enjoys great popularity among the wider public, but also whets the research appetite of professional critics. The popularity can be ascribed to the fact

[1] Or "Union Mondiale des Écrivains Médécins". It is an umbrella organisation that subsumes physician-writer groups in Brazil, France, Germany and eleven other countries.

that people are often fascinated by doctors' unique position in storytelling: they are believed to have a privileged access to the secret areas of the human body and mind; they are seen as bearing witness and offering help for patients at their most vulnerable moments. The popularity can also be ascribed to a common recognition that doctor-writers, at least good ones, manage to bring into their writing first-hand clinical raw materials, sharpened observations and insights, "cut-in" and "suturing" writing techniques, and more importantly, humane and moral concerns.

Of all the medicine-themed topics they have dwelt on, many doctor-writers base their writing on the broad ethical question of what makes a good doctor. The reason may lie in the fact that "what makes a good doctor" is supposed to be a priority in medical practice, also a key concern for doctors who cure and care. Especially in recent years, in the light of the fact that doctors nowadays have more advanced scientific methods and high technology to rely on for treating patients, they have been criticised for practising too "scientifically" but not artistically enough; too technically with regard to certain diseases but without sufficient humanity in relation to the patient; too specifically with regard to certain parts of the body but not holistically enough with respect to the organic whole. In response, physicians and medical scholars have begun to turn to the arts and humanities for solutions. On the one hand, scholars from such medical humanities programmes as Narrative Medicine advocate the practical use of literature as a solution to issues in the highly scientific and dehumanised modern medical practice. On the other hand, a group of physicians have participated in improving the practice of modern medicine by writing creatively about medical ethics. Both inside and outside the medical world, the question of what makes a good doctor is discussed and the effectiveness of healing is reviewed; and doctor-writers, with backgrounds and perceptions from both medicine and literature, may serve as the most promising commentators.

There has previously been little systematic comparative study on physician-writers' creative writing, and this project involves a comparative study of creative writing by eight physician-writers of the contemporary period. How insightfully but diversely these

physician-writers represent the topic of "what makes a good doctor" will be studied, in terms of the form of writing, the specialty of each doctor, the linguistic and cultural contexts each doctor has written in, the doctor-writer's gender and so on. Seven of them are from such Western countries as Australia, the UK, New Zealand and the US, and the study is carried out primarily in Western linguistic and cultural contexts. However, in an in-depth case study of two doctor-writers in Chapter Three, I shall introduce in more detail a Chinese doctor-writer, the study of whose works, in comparison with an Australian doctor-writer, will add a valuable dimension to the discussion of doctors' representations of what makes a good doctor.

1-1: Why Do Doctors Write?

Doctors' creative writing refers to such writing as memoirs, essays, autobiography, fiction, poetry and so on, which distinguish themselves from doctors' technical reports, academic writings, research papers and so on. One of the most commonly asked questions about doctors' creative writing is: what motivates doctors to write? Scholars from both medicine and literature, as well as doctor-writers themselves, have offered a number of explanations. Tony Miksanek, a family doctor and co-editor of the blog *Literature, Arts and Medicine*, in his "Seven Reasons Why Doctors Write" offers such reasons as therapy, exploration, sharing, joy, honour, atonement and notoriety, listed from the most important to the least (2009). It is especially noteworthy that, in Miksanek's summary of physicians' motives for writing creative works, "therapy" was put at the top of the list. In fact, Miksanek is not alone in recognising the significance of "writing as therapy". Many scholars and physicians have concurred in viewing physicians' primary motive as "writing to heal". What is more, the priority of the so-called "writing therapy" is surprisingly laid on physicians rather than on patients in the first instance, especially by published physicians themselves. John Stone, an American physician-poet and essayist, has conducted writing workshops for medical students for years. He is one of those who have faith in the power of writing to heal medical workers (Jones, 1997, p. 278). Glenn Colquhoun, a New Zealand general practitioner and poet, in his poetry collection expresses his gratitude to patients, "you [referring to patients] have no idea how many times you have healed me" (2002, p. 8). Given that they work professionally as

healers, why do so many physicians call for a self-healing and attach great importance to it? Physicians' medicine-related writings may shed some light on their need for self-healing. Physician-writers have explained that need in a variety of ways.

Firstly, they have written about the toughness of medical study and the transformation they undergo from interns to qualified doctors, so as to release their repressed emotions. In almost every country, medical schools only recruit students with the highest marks. Even after the best of the best students manage to squeeze into the medical world, a great number of them may tumble along the path in transforming themselves from being an intern to a qualified doctor. Samuel Shem, for example, reflects the ridiculous pressures associated with internship in his novel *The House of God* – to share with his fellow interns what he sees as "the worst year" of interns' lives, for the purpose of "catharsis" (Shem, 2010, p. 392).

Secondly, they have dealt with the treatment and avoidance of "medical error", in order to make amends to their patients or to remind themselves and their colleagues of the failure of interventions. As when Jerome Groopman comments on a misdiagnosis, "I have never forgotten my mistake, or forgiven myself" (2007, p. 35), there are moments that doctors may regret, mourn or confess, in the course of medical practice. Therefore, a doctor-writer such as Kate Scannell has written about her regrets for not having provided enough morphine to enable an AIDS victim to die a peaceful death in an essay "Death of the Good Doctor"; Gabriel Weston also confesses to having failed to comfort a lonely dying child in her essay "Children".

Thirdly, they have referred to the frustrations and negativity the profession may produce, to gain some sense of control over things they feel uncertain or insecure about. This is because medicine is where medical workers are forced to face the negative and frustrating side of human life – the weakness and helplessness of human creatures, the dysfunction of human organs and the disorder of human minds, as well as the brevity and transience of human life. Glenn Colquhoun in his poem "Today I do not want to be a doctor", for example, vividly presents his frustration when patients' conditions deteriorate.

Fourthly, they have dwelt on expectations for physicians to be infinitely knowledgeable, rational, almighty, and able to prevent people from dying, so as to justify their roles as healers. Physicians are often assumed to be much more knowledgeable than ordinary people with respect to the human body and mind; they are assumed to manage emotions triggered by disease or even death more rationally; they are assumed to be almighty and able to cure every patient; they are even assumed to have the responsibility to prevent people from dying. All these expectations become a source of anxiety. Susan Onthank Mates, for example, describes the fear of not being able to reach patients' expectations, and of not deserving patients' trust in her short story "Laundry".

In short, the nature of medicine determines that doctors must work with all sorts of pressure at almost every stage of their career. This gives physicians the urge to tell stories, about their patients, their colleagues, as well as themselves. Writing creatively in such circumstances serves as a way of self-healing, which Miksanek calls "therapy". Different views exist though, regarding the idea of "writing as therapy". Peter Goldsworthy, an Australian doctor-poet and novelist, suggests, "I'm very suspicious of writing as therapy. It's very good for some people ... the problem is – and I'm struggling at present with it – writing can be torture. It can be very emotionally draining" (Guo Yan, personal communication, December 1, 2013). Goldsworthy's comment more or less echoes Zhang Yu, a Chinese gynaecological oncologist and columnist, that "although at times writing in response to the force of inspiration has brought me surprising and inexpressible pleasure, it did not take me long to discover what hard labour writing is" (Zhang Yu, 2013, Preface).

Nevertheless, for many doctors, writing does become an effective outlet, keeping them refreshed from their stressful work, as Lynn Neary comments, in an American National Public Radio programme titled "Story Specialists: Doctors Who Write":

> In a hospital, routine can quickly become a matter of life or death, and there is precious little time to sift through the events of the day to uncover what it all means. Perhaps, then, it's little wonder that some doctors would turn to that most contemplative of arts, writing, where they can be alone with their thoughts, searching for just the right words to find release or understanding. (2009)

But examples show that doctors do not only write for their own benefit. First of all, many of them write about human bodies and minds, diseases and symptoms, to educate, share and lead readers into specialised medical fields that they might otherwise be unable to access. For example, using exquisite language, Richard Selzer in the essay "Liver" explains to readers the functions and characteristics of the liver; with a number of clinical examples, Oliver Sacks, British neurologist, in his essay collection *The Man Who Mistook His Wife for a Hat* introduces readers to the fascinating world of patients who suffer from different sorts of neurological disorder; Zhang Yu in her essay collection Only Doctors Know (《只有医生知道》)[2] promotes obstetric and gynaecological knowledge and better prenatal and postnatal care with a great sense of humour. Such writing becomes a vivid, entertaining and lively way of educating.

In addition, some doctors write about their encounters with patients to honour the trust and the privilege of their access to the intimate areas of patients' lives. These stories often feature "a fictionalized version of a character or an amalgamation of a few people" (Miksanek, 2009). William Carlos Williams in his *The Doctor Stories* for example includes a number of stories and anecdotes about patients. Rather than boasting of the privilege of controlling patients' lives, he takes the opportunity of retelling their stories as a way to honour the authority given by patients (Williams and Coles, 1984, p. xiii). Abraham Verghese, an Ethiopian-born Indian specialist in AIDS, advocates that more doctors should write about patients, since doctors are "allowed into part of people's lives that they often don't share with their spouses or their preachers" (Klass, 1994). Verghese's honouring of patients' stories is well reflected in *My Own Country*, a memoir recording his interaction with patients with AIDS. What is more, they may write about controversial ethical issues, and creative writing in such a circumstance offers doctors a relatively safe stage to perform their discussion on, and to test the public responses to, certain controversial issues. In the short story "Mercy" by Richard Selzer, for example, while the doctor fails to provide enough morphine and the patient does not die an easy death, the patient's mother gently accuses the doctor of not being ready for the idea of euthanasia. Through the mother's mouth, Richard Selzer actually attempts to raise the idea of

[2] Most titles of Chinese works are translated by the writer of this thesis, thus are not in italics.

euthanasia to see whether the general public is ready for it.

Last but not least, they may write to reveal institutional problems, to make sense of medicine, or to promote a better art of healing among doctors, or better understanding for the medical community among the public. Gabriel Weston refers to issues such as the hierarchy system and gender discrimination in her essay collection *Direct Red*. Oliver Sacks explores the moral, spiritual, and philosophical aspects of medicine and attempts to promote them in his memoir *A Leg to Stand On*, in response to today's medicine that features an increase in the contribution of science but a decrease in humanity. Zhang Yu intends to promote a healthy, friendly and understanding doctor-patient environment in Only Doctors Know. "When readers realise that a doctor also has emotions, has to eat, has to experience birth, aging, sickness and death, no different from other human beings," the author anticipates, "the public may know better how to communicate with the doctor more effectively" (Zhang Yu, 2013, Preface).

In a word, doctors may write for a variety of altruistic reasons. As they write to share their medical knowledge and experience of doctoring, their interaction with patients, their thoughts on ethical issues, institutions or medical practice in general, they entrust themselves to a wide readership. In reward for opening up to readers through writing, doctors may earn understanding and empathy from readers, which, in return, contributes to doctors' self-healing process.

But this is not the whole picture. In addition to medicine-themed writings, many doctors choose to represent the world in a larger perspective, and their works in this context are not necessarily related to medicine. Some of them are still based on their experience and speculations as doctors; some others may be totally independent of medicine in their themes. An excellent example is the Russian writer Anton Chekhov, who is known for such medicine-themed works as "Ward Number Six" and such non-medicine-themed work as "A Chameleon". In the course of practising medicine, doctors, at least those who cure and care, may have encountered confusions about medical ethics and humanity, different world views and philosophies, complicated human emotions and perceptions, and existential mysteries

around life and death. These puzzles can hardly be settled in the limited time usually allotted for diagnosis, treatment and contact with patients and colleagues. A sense of dissatisfaction thus may emerge. With the assistance of writing, doctors are able to search for answers to bigger questions that are generated by medicine but may go beyond the medical realm. This is because creative writing is a way of making sense of the world, and it offers the "licence to take up aspects of medicine that were not yet fully appreciated or understood" (McLellan, 1997, p. 564).

Many doctors rely on writing to make sense of life, whether on a vocational, emotional, moral or spiritual level. Chinese internist, psychiatrist and novelist Bi Shumin attempts to unravel the puzzle about people's capacity for self-destruction in A Red Prescription (《红处方》), a novel representing the world of drug addiction and its rehabilitation (Wang Xiaoshan, 1998, p. 30). Peter Goldsworthy explores the complexity of human emotions, and some of the existential mysteries around life and death, as well as Australian Aboriginal culture in the novel *Three Dog Night*. Abraham Verghese records his life experience when he first came to the US, as both migrant and doctor, in his essay "The Cowpath to America". With stories about people from all walks of life, Susan Mates in *The Good Doctor* strives to inquire into "the goal of being good" (Gentry, 1996, p. 427).

Though with the assistance of writing doctors may extend their interest beyond their vocational concern, medicine may still serve as a starting point for their literary experimentation (McLellan, 1997, p. 564), and their writing more or less bears the "special imprint peculiar to those who have felt, smelled, and cured among fevers, madness, blood and abscesses" (Pellegrino, 1982, p. 20). Many doctors' writings on non-medical topics are still read by critics as being associated with the theme of "healing", perhaps because of their role as a healer, or the solicitude for humanity which the profession demands. When asked to comment on her motives for writing, Bi Shumin, for example, responds that the impulse that drives her to write is "an interest in the workings of people's souls and a desire to help them" (Chinaculture, 2005). Anne Jones, Professor in the Humanities in Medicine, makes a similar observation that both medical and literary practitioners can be healers, sharing "a common

goal in their efforts to maintain light and order against the chaos of darkness and disease, and to create and restore the beauty and harmony of health", while medicine serves the body, literary writing [poetry is what she originally referred to] serves the spirit (Jones, 1997, p. 275). In addition, it is worth mentioning that the writer of this thesis had a chance to talk to some physicians about what motivates them to write, at a conference "The Examined Life: Writing, Humanities, and the Art of Medicine" at University of Iowa, which I shall refer to further. A physician kindly shared a very private life story that he started writing because of his daughter, who has suffered from five different diseases. After a period of time of questioning "why me", he turned to writing to make sense of life. He said now he can view many things from patients' perspectives, thanks to his writing about his daughter. By writing to heal himself, the physician finds a way to offer better healing to patients.

On the individual level, doctors' motives for writing are not always as glorious as "educating or honouring patients", "atoning for medical errors", "healing the repressed self" or "making sense of life", since some write, as they openly admit, for fame or fun. Some others may write simply to stay away from medicine, temporarily or permanently. Junichi Watanabe, a Japanese surgeon and writer, criticised his hospital for undertaking heart transplant surgery in a novel and was forced to abandon his medical career for writing (Watanabe, 2003, Postscript).[3] The Chinese doctor Yu Hua, however, abandoned his medical career when he was sick of his job and turned to a career that better activated his imagination (Yu, 2007, p. 34-35). Though these two doctors never looked back after devoting themselves to the world of literature, many more doctors have managed to balance their dual careers and benefited from both – while medicine provides rich material for their writing, writing helps them make peace with medicine. Glenn Colquhoun, for example, took poetry as a temporary break from his "dry" scientific routine. As his experience as a doctor illuminates the path of poetry, the doctor-poet declares, writing, in return, enabled him to review his medical position, and thanks to writing, he fell in love with medicine all over again (Colquhoun, guest speech, May 19, 2011).

[3] He criticised the surgery because he believed that the donor's brain was not dead when the transplant was undertaken. According to Yuichi Iwaki, Watanabe did not oppose organ transplantation in principle (Iwaki, 2014).

1-2: Doctors as Competent Storytellers

While doctors write creatively for many different reasons, these reasons more or less show doctors' desire to tell stories, and to communicate with the wider public. While many doctors say they have a strong desire, even a need, to write creatively, that, in itself, does not guarantee that they will all be competent writers. Peter Rowland, for example, is sceptical of doctors' literary competency in general:

> With a few notable exceptions, such as Conan Doyle and Somerset Maugham, [and Abraham Verghese as the reviewer adds later on] doctors do not usually make good authors. The daily grind of letters, reports, and endless clinical notes seems to kill in utero whatever literary urges may be stirring within. (1994, p.1169)

Nevertheless, in the current literary world, a surprisingly large number of creative works by doctors have been well received by readers and reviewers. "When faced with the opportunity to read a book by someone who isn't by profession a writer, I always go for the doctor", Stephen J. Dubner comments (2007), which to a certain degree accords with Miksanek's argument that as a profession, "physicians are a remarkable group of writers ... Their literary accomplishments are even more impressive given a lack of formal training in the art of writing" (2009).

What makes many physicians acute observers and interpreters of human beings has been extensively discussed by scholars, reviewers and doctor-writers themselves. It has been argued that medicine puts physicians in a unique position to observe, record and create stories. This uniqueness results from the sensitivity and accuracy of observation physicians gain from their training in medicine; their ability to narrate benefits from a constant making sense of patients' stories which are gathered in the course of their medical practice. What is more, the frequent contact with patients and disease and treatment itself provides physicians with rich sources and inspirations for writing. Besides, it has been widely suggested that medical training and practice equip doctor-writers with a unique clinical gaze and writing techniques, distinctive aestheticism and concern for humanity.

First of all, physicians are granted access to a huge number of stories that other writers may be unable to access. The "daily witness to such matters at the heart of human experience as pain, suffering, joy and transcendence" (McLellan, 1997, p. 565) provides physicians with a myriad of sources and inspiration for writing. For many doctor-writers, all the elements of a story – plot, protagonist, antagonist, setting, dialogue, and theme – seems to be "readily available", as Miksanek points out:

> Physicians witness struggle – disease, death, and suffering – all the time. Writers call it conflict. Physicians regularly observe cures, acts of heroism, and even miracles. Writers refer to it as denouement. Doctor-writers have oodles of experience to tap from. They have a rich pipeline of poignant images, unforgettable language, colorful characters, and vexing irony in any single day. In addition, physicians get plenty of practice writing and editing office notes, consultations, and histories and physicals. (2009)

The privileged experience of studying or practising medicine, however, only offers physicians the raw materials for writing. To translate these raw materials into interesting pieces of literary work, physicians need to be able to select, extract and process the raw materials. It is often suggested that, ideally speaking, doctor-writers are able to bring into their writing acute observation and physicians' insights. For example, M. Faith McLellan suggests that experiences with patients provide "insight", at least for doctors of sensitivity (McLellan, 1997, p. 565). Susan Mates, for another example, is believed to have brought to her writing an anatomist's eye, "loving but distant" (Wellbery, 1998, p. 918).

In addition, doctors' writing techniques are also believed to be reflective of their medical training and experience, or to be more specific, their specialties. For example, Bi Shumin's literary works often consist of large paragraphs of conversations, as well as the retelling of stories, which reflect her specialty as a psychiatrist to a certain extent, since the job involves mainly consultations with patients in conversation form. The surgeon-writer Richard Selzer's comments on his writing technique reflect his medical specialty, too, as Peter Josyph quotes:

> I loved learning how to cut and stitch and clamp. The technical side of it thrilled me. Similarly, when I

> first began to learn to write, it was the suturing together of words into sentences, the selection of these words, the scattering of them on the page, that delighted me. The language was and still is the most important part of my writing. (as cited in McLellan, 1997, p. 566)

Moreover, medicine endows physicians' works with special aesthetic insights, referring to the unique aesthetic standards physicians employ. In some practising physicians' hands, "even the lugubrious details of anatomy and pathology become instruments of poetry or evocations of the joy and peril of human embodiment" (Pellegrino, 1982, p. 20). For example, in Rae Varcoe's poem "The Cancer Cells Sum Up", scary cancer cells are transformed into an exotic beauty in the poet's eye. In Richard Selzer's "Liver", the organ is so exquisitely and vividly represented that it seems to be given a personality. Growing up in a surgeon's family, Yu Hua in his stories often offers unreserved depictions of blood, bones, flesh – this or that kind of medical violence. Both Gabriel Weston's and Bi Shumin's short stories about surgeons or surgery seem to brim with such colours as blue and purple, red and white, which may reflect colours surgeons commonly see during operations – white gowns, red blood, purple-blue veins and so on.

Furthermore, works by doctors, especially those about issues of life and death, are often read as bringing warmth and tenderness to people and touching human hearts, as many scholars argue. However, different opinions do exist, critiquing doctors' writing for being too clinical, too careless or dark. Peter Goldsworthy's works are critiqued by a reviewer as feeding readers' bloodlust (Stretton, 1988, p. 80). Yu Hua's earlier short stories about surgery are critiqued as taking violent narrative to its extreme and revealing the physician's necrophiliac complex (Sun Fei, 2007, p. 19). The fictional representations of the treatment of patients by such doctors as Shem and Colquhoun, for example, are by contrast criticised by some reviewers as being too careless and playful, and somewhat disrespectful to patients.[4]

On the other hand, rather than focusing on how physicians' medical experience equips them

[4] In the interval during the MBCHB 311 medical humanities class taught at the Medical School of the University of Auckland on April 4, 2013, the writer talked to some students about Colquhoun's poems. One student said she was slightly annoyed by some of the poems about patients, feeling that the poet is making fun of his patient.

to become competent storytellers, some critics attempt to examine the issue of what makes doctors competent storytellers by observing the commonalities between the two professions. It is widely argued that the practice of medicine and the practice of literature share common ground, with regard to their narrative nature, their techniques as well as their concern for humanity. The "most compelling link" between the medical and writing professions is "the construction of narrative," as McLellan accurately states. He further suggests that practitioners of both arts share a great number of "fundamental values and interests": curiosity about other people's lives, the need and desire to communicate, engagement in the process of "identification with and detachment from subjects", involvement in making sense of experience, formulating narrative tasks such as intuition and interpretation and so on (1997, p. 566). McLellan's view to a certain degree echoes Goldsworthy's that the two careers relate intimately to each other: on the one hand, like writing, medicine is a highly verbal art, "a matter of listening and talking, especially listening"; on the other hand, like diagnosis in medical practice, writing is a matter of decision-making and problem-solving (Marshall, 2007, p. 161). In addition to the narrative construction of the two, it is suggested that the practices of medicine and literature rely on the same techniques to get to the essence:

> So why do these doctors write so well, and so much better (to my mind, at least) than other non-writers? Perhaps there are elements of doctoring that lie in harmony with writing: peeling back the layers to get to the core of an issue; confronting the obvious but being willing to look beyond it; learning where to "cut in," of course; and, more than anything, recognizing that this object before you – in one case a human body, in the other a manuscript – is on a certain level a miraculous object with the power to astound, and on another level is a complex, dynamic system which can (and must be) reduced to a schematic, laid out on paper or x-ray film. (Dubner, 2007)

Last but not least, it is widely accepted that the same solicitude for humanity grounds the "natural affinity" between medical practice and literary practice. In the past few decades, medicine and literature have increasingly been understood to be closely related on the grounds that both are the study of human beings, and both strive "to reveal and to make sense of what it is to be human, offering insight on the human condition" (Killick, 2009, p. 526),

although their approaches differ, as many scholars have pointed out. For example, commenting on the two professions' attempts to reveal the existential mysteries of human beings, Jones suggests that doctors "have a special vantage point on that mystery, but it takes a poet to express it so perfectly and poignantly" (Jones, 1997, p. 277). Jones' comments echo Groopman's suggestion that while medicine attempts to unravel such life mysteries as "the miraculous moment of birth, the jarring exit at death, the struggle to find meaning in suffering", it is literature that "most vividly grapples with such mysteries, and with the character of physician and patient" (Groopman, 2007, p. 35).

In short, either from the perspective of how medicine influences the way doctors write or the perspective of how the practice of medicine and the practice of literature share common ground, many doctors' published creative writing is applauded for its rich first-hand clinical subject matter, acute observation and delicate depiction, distinctive technique and aesthetic standards, as well as its profundity and concern for humanity. For all these reasons, a remarkable number of published physicians are regarded as competent storytellers about human beings, and their creative writing has proved popular with the wider public.

In recent decades, "physicians' creative writing" seems to have evolved into a cultural and literary phenomenon that arouses the attention of, and discussions amongst, scholars. In such journals as *The Lancet*, *Literature and Medicine* and *Journal of the American Medical Association* for example, book reviews of, or scholarly articles on, physician-writers' creative writing have been consistently published, and physician-writers have been studied more and more as being distinct from other writer-groups.

Doctors who write creatively have come to be studied as a "breed" that is differentiated from doctors who write technologically or academically. This reflects the tendency in the modern era to divide writing by doctors' into two rather separate categories: one is technical and professional writing concerning research and medical practice, which is published in medical journals and textbooks, and the other is such 'creative writing' as novels, essays and poetry, which may or may not treat medicine as a central subject. So how have doctors who write

creatively emerged as a distinct group and how has creative writing by doctors flourished over the last hundred years?

1-3: Creative Doctor-writers as a Phenomenon

The *modern* concept of "creative writing" by doctors emerged when Western medicine became dominant and medicine began to be practised more as a science than as an art. There was, however, a long period of time when medicine did not entirely separate itself from such disciplines as religion and theology, or chemistry and biology, or ethics and philosophy, and when physicians' writing brimmed with the so-called creative components by today's standards. In pre-modern times, writing by physicians was made up for many centuries by several interwoven strands: philosophical reflection (Patwardhan, 2005, p. 466; Drizis, 2008, p. 334), empirical testing and observation (Ross, 1964, p. 680), records of herbal medicines and collections of remedies (Crellin, 1997, p. 70; Yan, Qing & Sang, Aiye, 2011, p. 38-40), reproduction or correction of earlier medical "classics" (Crellin, 1997, p. 71; Saad, 2005, p. 476), creative application of medical knowledge and methods to other fields (Cameron, 2012, p. 44), reflections on doctor-patient interactions, discussions of medical ethics, e.g. the Hippocratic Oath (Yapijakis, 2009, p. 507), and so on. At different periods, the strands were interwoven in somewhat different ways.

Nevertheless, physicians' writing has gradually diverged into distinctive directions, in accordance with the evolution of traditional medicine into modern medicine. In the fifteenth and sixteenth centuries in the West, physicians' writing reached a crucial point of transformation, echoing that of medicine. This was a time when the West witnessed an intellectual renaissance. Breakthroughs in anatomical theory and practice were first made as bans on dissection were lessened in the sixteenth century, and physicians' writing on medicine began to bring in ideas which challenged tradition, deriving from their practical observations, experience, and empirical analysis (Drucker, 2008, p. 200). Belgian anatomist Andreas Vesalius‘ (1514-1564) *On the Structure of the Human Body* (1543), for example, is based on his direct observations and discoveries in dissection. French surgeon Ambroise Paré's (1517-1590) *The Method of Curing Wounds Caused by Arquebus and Firearms* (1545),

for another example, is based on his discoveries in anatomy and surgical practice. From the seventeenth century onward, physicians' writings on medicine evolved more and more from speculative or deductive to observational or inductive. The English physician William Harvey's (1578-1657) "On the Motion of the Heart and Blood" (1628) records his discovery concerning the circulation of blood and marks the foundation of modern medical science (Cule, 1997, p. 31); the English physician Thomas Sydenham (1624-1689) in *The Methods of Curing Fevers* (1666) published his study on the natural history of disease, which represents the beginning of modern clinical medicine (Dewhurst, 1962, p. 114). With more and more experimental or observational writings by physicians published, scientific attitudes overtaking classical philosophy finally prevailed towards the end of the seventeenth century.

From the nineteenth century onward, medical practice came to be based more and more on developments in biology, chemistry, and physiology. In particular, infectious diseases were for the first time studied under a microscope in the laboratory using scientific methods. Accordingly, physicians' writings deriving from scientific investigation and about scientific discoveries were on the rise. Based on close observation, scientific experimentation and inductive reasoning, physicians' writing began to adopt a succinct language style, and an informative, explanatory or illustrative function, more and more distinguished from writings in literary form featuring rhetoric. Examples include "The Physiological Theory of Fermentation" by French microbiologist Louis Pasteur (1822-1895), who introduced the germ theory of disease to the public; and "On a New Method of Treating Compound Fracture, Abscess, &c., with Observations on the Conditions of Suppuration" by British surgeon Joseph Lister (1827-1912), who introduced antisepsis to surgery, ensuring a clean and safe environment in hospitals. Meanwhile, Western knowledge began to infiltrate such eastern countries as China and Japan from the seventeenth century, and from the mid-nineteenth century Western science and advanced technology were adopted on an unprecedented scale, which brought about a chain of social, political, economic, cultural transformations (Saks, 1997, p. 200). Numerous missionary hospitals were built, bringing the knowledge of modern Western medicine. From the nineteenth century onward modern Western medicine has increasingly come to be practised nearly all over the world, though traditional herbal

medicine and home remedies and therapy may have been preserved, in different degree, in medical practice in China, India and some Arab countries such as Morocco, Yemen, Egypt and so on (Patwardhan, 2005, p. 465; Saad, 2005, p. 478).

When the world entered the twentieth century, Western medicine came to be almost universally studied and practised in terms of science and high technology. Countless innovations and revolutionary insights have taken place, such as X-ray and CAT scanning, the application of antibiotics to treat infection, the decoding of DNA and so on. In consequence, doctors have had a much wider range of resources to rely on and many more opportunities to cure their patients of many diseases. Meanwhile, a series of standardisations and classifications were carried out in medicine and medical-care service. As the institutionalisation of medicine has occurred, including hospitals affiliated to universities in many countries, medical study has come to be viewed more and more as a form of higher scientific education; and the status of doctors (especially of surgeons, who were considered manual craftsmen for a long time) has risen to that of social elites almost universally (Dally, 1997, p. 49). University education has encouraged physicians to publish and circulate their experimental research, discoveries and new ideas on medicine, and this promoted physicians' writing of a scientific and technical kind in articles, textbooks and so on as "academic writing". For publication, physicians needed to follow a specific format, wording, and style, and this helped regulate physicians' academic writing to a great extent.

As the strand of physicians' technical, scientific and academic writing came to develop separately, it became appropriate for doctor-writers to identify and develop a distinct area of creative writing about medical topics. From the nineteenth century onward, an increasing number of doctors have written creatively about medical practice from the perspectives of technical competence, the human interaction with patients, as well as ethical issues in medical practice and so on. Distinguishing themselves from publications in a scientific or academic manner, these writings have adopted a wide range of forms such as novels, short stories, essays, memoirs, poetry and so on, so-called "creative writing" in the modern sense. Anton Chekhov and William Carlos Williams, in particular, offer excellent examples of

doctors' creative writing about the daily experience of medical practice. Meanwhile creative works by doctors independent of the theme of medicine increased, too. In addition to Chekhov and W. C. Williams, who also wrote about non-medical topics, other celebrated names in the nineteenth and early twentieth centuries included Arthur Conan Doyle (1859-1930), noted Scottish detective-story writer, famous for the Sherlock Holmes stories; Lu Xun (鲁迅1881-1936) and Guo Moruo (郭沫若1892-1978), two of the most important writers of the New Culture Movement in modern China; Mori Ōgai (森鷗外1862-1922) and Mokichi Saitō (斎藤茂吉1882-1953), leading figures in the world of Japanese literature during the Meiji Period and the Taishō Period respectively. All of these writers received a medical education of Western style, though some of them quit medicine, or rather, did not take up medical practice.

With the blooming of the publishing industry, physicians' publications, both academic and literary, multiplied significantly from the mid-twentieth century onward. As a result, the term "physicians' writing" in the modern sense not only refers to physicians who have produced academic writings in terms of scientific research and practical operations, but also refers to those who have written creatively, whose subjects are either about or independent of the practice of medicine. It is "physician-writers" in contemporary times, who have practised medicine and written creatively, and particularly about medical practice and medical ethics, that constitute the main topic of this thesis.

1-4: The Affinity between Medicine and Literature in Contemporary Era

In contemporary times, a great number of doctor-writers have offered critical thinking and reflection on the effectiveness of modern medicine, as well as ethical issues generated in the course of medical practice, in a variety of literary forms. Some of the central concerns in their creative writing include the doctor-patient relationship, the proper exercise of power and care, traditional and modern ideals of healing and so on. This is because, as the world has come more and more to depend on scientific medicine, the idea of "scientific medicine" has begun to be widely challenged and physicians' authority has begun to be questioned. The most common criticism are that the art of treating patients has come to be gradually overshadowed

by the scientific technology of treating diseases; and that medicine has come, increasingly, to be conceived of, and practised primarily as, a scientific discipline, leaving its connections to the arts and humanities far behind (Porter, 1997, Forward).

For example, the classification of medical specialties triggered a systematic categorisation within the medical career, and as a result, medicine is practised day to day in an increasingly specialised way. As a result, doctors become expert in treating one disease rather than the patient as an organic whole (Dally, 1997, p. 46). For another example, with the medicalisation of health and disease, diagnosis and treatment, childbirth and death, patients have found themselves, from the very first day of their life to the end, largely subject to medical power, which leads to the problems of some doctors' abuse of power (Dally, 1997, p. 66-67). In addition, there has also been criticism regarding the isolated forms of treatment methods, abuse of pharmaceuticals (e.g. antibiotics), as well as the lack of humanity in medical practice and so on (Saks, 1997, p. 202). As a result, "despite its ever-increasing efficacy ... both patients and physicians voice increasing dissatisfaction with the practice of mainstream medicine" (Thernstrom, 2004, p. 42). Many patients have begun to seek alternative medicine, to cure, or to prevent disease and maintain health; scholars and physicians themselves have begun to re-examine the effectiveness of healing and promote a better medicine, too (Saks, 1997, p. 208-213).

Doctor-writers, who have a background and perceptions deriving from both medicine and literature, are some of the most promising examiners of the effectiveness of modern medicine. Actively, they have striven to express their own critical thinking to colleagues, patients and the wider public. The desire to communicate, however, is easily frustrated in reality. For instance, doctors are forbidden from circulating stories about patients or other medical workers, otherwise they may violate the principle of the privacy of their patients. Similarly, they may find it risky to talk about the institutions they are working in, or pointless to complain about the medical system they are bound to. Even if their voice can be heard, it may only reach a limited audience. Writing in such circumstances provides an ideal solution for doctors under constraints. Especially such creative writings as poetry, drama and novels, as

published doctors may find, are a more satisfying and productive means of sharing and communicating, in comparison with medical journals piled with lifeless jargon and dry records.

As these physician-writers turn to literature for help, a group of medical scholars have called for other ways in which medical practice may benefit from the use of literature. The so-called Narrative Medicine movement offers one of the best examples. It is a programme first defined in 2001 by Rita Charon, physician and Professor of Clinical Medicine at Columbia University in the US. Narrative Medicine offers a "literary cure" to the problem that "in growing as a science, medicine has forgotten that it is an art":

> The goals of narrative medicine are similar to those of other medical movements that have focused on communication and treating ''the whole person'' instead of the disease alone, like biopsychosocial medicine, patient-centered care, relationship-centered care, the primary care movement and others. But while other movements have used psychological and spiritual terms, narrative medicine uses literary one. (Thernstrom, 2004, p. 43)

First coined in "Narrative Medicine: Form, Function, and Ethics" in 2001, an article published in the Annals of Internal Medicine (Thernstrom, 2004, p. 43), the idea of Narrative Medicine has been further defined and developed by Charon in a series of later publications such as "Narrative Medicine: A Model for Empathy, Reflection, Profession, and Trust" (2001), "Narrative Medicine: Attention, Representation, Affiliation" (2005), *Narrative Medicine: Honoring the Stories of Illness* (2008), and so on. By introducing the concept of "Narrative Medicine", Charon encouraged medical practitioners not only to write creatively alongside their professional works, but to read creative works by patients and others relating to sickness, and to employ concepts such as narrative and metaphor, borrowed from literary study, in their interactions with patients. Charon's proposal is based on the belief that narrative competence is instrumental for physicians to build a better physician-patient relationship, to make better sense of treatment and therapy, and in the end to help promote a kind of medicine that is practised with "empathy, reflection, professionalism and trustworthiness" (Charon, 2001, p. 1897). Narrative Medicine has had a great impact on

medical practice and medical ethics in the US and other parts of the world. Ever since the programme was established, there has been "an explosion of writing about illness by both physicians and patients" who have attempted to "restore a sense of meaning and healing to counter the dehumanizing effects of technological explosion" (Thernstrom, 2004, p. 43). In 2009, Columbia University, where Charon started the Narrative Medicine programme, became the first University to offer a Master's Degree in Narrative Medicine.

In fact, before Charon, the idea was raised of borrowing literary concepts for use in medical practice and in the discussion of medical humanities. Edmund D. Pellegrino in "To look Feelingly – the Affinities of Medicine and Literature", for example, ambitiously predicted that the medical use of literature and the literary uses of medicine may "enhance human beings' capacity to heal themselves in spirit and body" (1982, p. 23). Anne Jones also suggests in her study of physician-poets that "when the power of medicine and writing [poetry] are combined in the same person, the potential for healing may be greatly enhanced" (1997, p. 275). In "Narrative in Medical Ethics" published two years later, Jones highlights the importance of narrative in medical ethics, as offering case examples for teaching ethics, as moral guides to living a good life, and as a re-examination of accepted ethical precepts (1999, p. 254). Jerome Groopman and Abraham Verghese are both "preoccupied with the same issues that Narrative Medicine purports to address", although in rather different ways from Charon's. When he was working at the University of Texas, Verghese offered a programme which he describes as "literature at the bedside" to provide emotional or spiritual support to medical students. Groopman was an adviser in a similar programme at Harvard University for medical students so as to develop in young physicians ''the ability to bear their patient's suffering'' through reading and writing (Thernstrom, 2004, p. 44-46).

Although the use of literature in medicine is not Charon's invention, she is one of the first that has confirmed a *practical* use of literature in the practice of medicine, and added a new perspective on the affinity between medicine and literature in the new era. Before Charon, the medical humanities programmes were always "institutionally marginalized" and were perceived as "offering mere enrichment rather than vital skill", whereas Charon managed to

move literature "from the margin to the center of medical education" (Thernstrom, 2004, p. 44). In Charon's own words, she has striven to create practical skills that "will allow for more efficacy" rather than ''civilizing veneer – how cute, a doctor who writes poetry" (Thernstrom, 2004, p. 44).

More or less influenced by Charon's Narrative Medicine Programme, many medical students and practitioners began to actively participate in the programme, either in an organised way or voluntarily. In April 11-13, 2013, the writer of this thesis attended a Conference titled "The Examined Life: Writing, Humanities, and the Art of Medicine" at the University of Iowa in the US. It is an annual gathering for medical practitioners, medical scholars, students, therapists, clinicians and so on who have a passion for writing and have faith in writing as a way to promote a better medical practice. At the workshops, discussion panels and presentations, I was amazed by participants' willingness to share their ideas and by how writing helped them open up. When asked to produce a piece of writing at the workshops, for example, the participants always ended up sharing very personal experiences. In addition, in different presentations and panel discussions at the conference, I noticed that a large number of universities worldwide have added courses such as literature appreciation and creative writing to their curriculum. The programme at the University of Ohio, for example, was first initiated by medical students who could not handle the pressure of study and sought literature as a relief. What is more, in many other medical institutions and private clinics, similar workshops, poetry readings as well as other related programmes are widely practised.

In fact, apart from American hospitals and universities, Narrative Medicine and other medical humanities programmes have been offered in many medical institutions and universities all over the world. At the University of Auckland, for example, the author of this thesis participated in a medical humanities course titled "Unexamined Metaphors, Uncharted Stories", which has been offered to its third-year medical students for the last seven years, where they are not only asked to read literary works by physicians but also encouraged to write their own poetry, so as to make better sense of the narrative and metaphor components in the doctor-patient interaction and medical practice.

1-5: Research Focus

Whether in the syllabus of medical humanities courses, or in the broad discussion of medical ethics, the eight doctor-writers to be discussed in this thesis are some of the most influential contributors. They include Samuel Shem, an American psychiatrist, author of the novel *The House of God*; Oliver Sacks, a British-born practising neurologist and author of the essay collection *The Man Who Mistook His Wife for a Hat*; Abraham Verghese, an Indian-American specialist in AIDS and author of *My Own Country*; Susan Mates, an American practising physician, author of the collection of short fiction *The Good Doctor*; Gabriel Weston, a British surgeon and author of an essay collection *Direct Red*; Glenn Colquhoun, a New Zealand general practitioner and poet best known for his poetry collection *Playing God*; Peter Goldsworthy, an Australian general practitioner and author of the novel *Three Dog Night*; and Bi Shumin, a Chinese female surgeon and psychiatrist, author of the novel A Red Prescription. These doctor-writers' works have been well received and are relatively more high profile in their respective linguistic and cultural contexts; the six writers to be discussed in Chapter Two are among the most frequently critiqued and quoted writers in such journals as *The Lancet*, *Narrative Medicine*, *Medicine and Literature* that have contributed to the discussion of medical ethics. They have actively taken part in the discussion and promotion of more effective healing and more human and holistic medicine in the worlds of both literature and medicine. It is in these contexts that I place these eight doctor-writers as the centre of the comparative study in this thesis.

Of all the topics explored by these doctor-writers that are related to medical practice and ethics, a favourite is "what makes a good doctor". That is because this issue is a central concern for medical practitioners and scholars, at least for those who care. A great number of physicians have offered their critical thinking on what makes a good doctor. Although opinions may vary, there are two common approaches to defining a good doctor. One involves clinical competence and the other involves such non-clinical aspects as empathy, care, honesty, communication skills and so on.

For example, Brian Hurwitz, Professor of Medicine and the Arts in the School of Humanities at King's College in London, defines the good doctor as one who combines "individual clinical expertise" with such qualities as "truthfulness and a reflective turn of mind open to audit and to learning from mistakes" (2002, p. 667). Richard Conti, a cardiologist practising in the US, regards a good doctor as the one with "procedural skills", the most important being "cognitive knowledge that, in the long term, insures optimal patient care" (Conti, 2005, p. 496). In a long list of what he regards as making a good doctor, some points more or less echo the Narrative Medicine movement. A good doctor, Conti suggests, should let the patient relate what is going on when taking a history (p. 497); talk with, and not at, the patient; not be afraid "to change a diagnosis if facts learned later in the evaluation are not consistent with the initial impression" (p. 498). "Great physicians base their professional practice on a threshold of scientific knowledge they have acquired throughout their career. Upon this foundation they build an artistic display of communication, compassion, empathy, and judgment" suggests Donald Barr, an America physician in a paediatric department (2010, p. 679); Mandy Fletcher, an American advanced trainee in paediatrics, defines the good doctor as the one who is able to integrate into his or her clinical practice such non-clinical aspects of medicine as leadership, clinical practice improvement, quality and safety, communication, ethics and cultural competency (Fletcher, 2013, p. 26).

In one way or another, these physicians have offered the observation that nowadays emphasis is laid more on the "clinical aspects of medicine" (Fletcher, 2013, p. 26). To make a good doctor, these physicians have argued, a combination of clinical and non-clinical aspects should be achieved, with the effort coming from the medicos themselves, medical education, the selection system and the government. Luke O'Neil, President of the Medical Students' Association of the University of Notre Dame, Australia, criticises medical students for their examination-focused mentality and calls for more emphasis by students on "developing themselves to become good doctors and more of a focus on educating themselves for their future patients, not for their future exams" (2010, p. 31). Regarding the term "good" in the definition of "the good doctor' as increasingly "a descriptive label that denotes having met certain tests of competency", Hurwitz calls for a medical education that can "marry the skills

and sensitivities of the applied scientist to the reflective capabilities of the medical humanist" (2002, p. 667). In addition, while Barr criticises the current selection system for being scientifically-biased and proposes a selection system at medical schools that values equally the scientific and artistic factors in a doctor (2010, p. 679); a British GP Gopi Patel calls for an effort from the policy makers in the UK to offer a more supportive policy for doctors rather than "turning them into tick-box doctors instead of what they really aim to be — 'good doctors'" (Patel, 2007, p. 244).

Largely echoing these physicians and medical scholars' viewpoints, the eight writers to be discussed in this thesis offer their reflection on what makes a good doctor from a variety of perspectives, too. In the following chapters, I shall first offer a comparative study of creative works which touch on the question of "what makes a good doctor" by six physicians: Shem, Sacks, Verghese, Mates, Weston and Colquhoun. Their works will be assessed comparatively, in terms of the form of writing, specialism, gender and cultural context – to show how differently and analogically "the good doctor" is represented in each work. After a study of the spectrum of doctor-writers from English-speaking countries, it is valuable to introduce an extremely different case – that of Bi Shumin, a Chinese doctor-writer, whose literary works add valuable insights to the discussion of what makes a good doctor from a relatively different cultural, social and medical perspective. Therefore in Chapter Three, I will narrow the comparative study down to an in-depth reading of Peter Goldsworthy's *Three Dog Night* and Bi Shumin's A Red Prescription. Both novels unravel a story about the "death of the good doctor", and trigger, in extreme and oblique ways, a wide range of complicated discussions around the topic of "what makes a good doctor", a comparative reading of which offers interesting and valuable insights into the central concern of this thesis. To conclude the comparative study of doctor-writers' creative representations of what makes a good doctor, I shall offer my personal opinion on "what makes a good physician-writer".

A number of scholarly works have been published on each writer; nevertheless, most of these have been limited to studies of single authors or, at most, doctor-writers from single countries or cultures. There has been very little scholarly work on broad issues associated with doctors'

writing, and very little has been of a comparative nature. Due to the originality of the topic and the paucity of the scholarship, in addition to currently available academic printed works, resources have been obtained from a vast range of media, such as radio broadcasts, webpages, blogs written by medical scholars and so on. Even though many of these references are readers' comments that have not been peer reviewed, these readers' response are very important in that my subject is not just creative writing by doctors but a consideration of doctors writing and readers reading in conjunction. This lies at the heart of narrative medicine – the exchange of narrative between doctors and patients during medical practice to make sense of illness and symptoms, and the interaction between authors and readers to make sense of the text. Moreover, in terms of reader response theory, it is very important to have access to unmediated responses from readers and this thesis brings much of this material into an academic context for the first time.

In order to collect first-hand materials on the key authors in this thesis – Peter Goldsworthy and Bi Shumin, I also attempted to contact these two writers for interviews. Although Bi Shumin has not replied, in December 2013, I managed to interview Dr Peter Goldsworthy in Melbourne, Australia. Some of the conversations with him will be quoted for analyses and discussions in this thesis.

By choosing the eight writers and their works, I attempt to cover a wide spectrum of doctor-writers from both genders, who have different specialties, and have written in different literary forms and cultural contexts. In spite of the different backgrounds, the eight writers have written more or less in the modern context of medical humanities, although they may not necessarily have written in direct response to the Narrative Medicine movement. Sacks and Shem, for instance, wrote prior to the time when the Narrative Medicine movement was founded. Although Verghese has written almost in parallel with the programme, he has taken a relatively different approach. Though having heard of the programme and attended narrative-medicine-themed discussions or conferences, Goldsworthy and Colquhoun have not written under its direct influence. Bi Shumin who comes from a totally different language and cultural background may not have heard of the programme. There was not sufficient evidence

to show Mates and Weston's direct involvement in the Narrative Medicine programme, either. Nevertheless, these physician-writers have actively participated in the promotion of a better practice of medicine and a more effective healing for patients, and in this sense, they more or less anticipate, reflect or create an atmosphere for the establishment and development of the Narrative Medicine programme and other medical humanities programmes.

Chapter 2: A Comparative Reading of Six Writers' Representations of What Makes a Good Doctor

In this chapter, I shall undertake a comparative study of the creative writing of six writers who, in one way or another, treat the question of what makes a good doctor. These writers have written in different times, cultural contexts, forms, and from the perspective of different medical specialties. By choosing the six writers, I demonstrate a spectrum of doctors' representations of what makes a good doctor. The works to be discussed include the novel *The House of God* by Samuel Shem; a series of case studies *The Man Who Mistook His Wife for a Hat* and a clinical memoir *A Leg to Stand On* by Oliver Sacks; a memoir *My Own Country* by Abraham Verghese; three short stories from the collection *The Good Doctor* by Susan Mates; an essay collection *Direct Red* by Gabriel Weston; and a poetry collection *Playing God* by Glenn Colquhoun.

These doctor-writers offer an array of critical thinking on the practice of modern medicine, regarding the limits of medication, the incapacity of doctors, the inefficiency of institutional systems, the boundaries of professionalism, and examining the issue of what makes a good doctor from a medical professional's perspective. At the same time, these doctors represent the balance between career and family, doctors who deal with incurable situations, who face their own mortality, and confront such challenges as the practice of palliative care and euthanasia. By so doing they illuminate the question of what makes a good doctor from personal, ethical, philosophical, and socio-cultural perspectives. In spite of their diverse subject matter and complex perspectives, these works largely inform the doctor-writers' definition of what makes a good doctor, and jointly promote a patient-centred, holistic medical practice. In this sense, even though these writers may not have written in the context, or under the influence, of Narrative Medicine, their critical thinking and the principles of healing embedded in their creative writing either anticipate, or contribute to, the emergence and formation of the Narrative Medicine movement to a certain extent.

These works demonstrate a great diversity in terms of the socio-cultural contexts in which they are situated, their perspectives with respect to gender and specialty, the form of writing employed, as well as the groups of readers to which they are directed. In terms of the socio-cultural contexts for example, Shem wrote in a time and place when the issue of the internship system in the USA was still considered as a taboo, whereas Weston has written in a more tolerant context in the UK where doctors are allowed to admit to their limits. In terms of specialties for another example, Sacks centres his book on the case studies of patients with neurological disorders, whereas Verghese centres his book on his experience as a doctor treating AIDS. In addition, in terms of gender, while Colquhoun's poems offer a portrayal of the doctor as a young man, the three short stories by Mates trigger discussion on the good doctor particularly from a woman doctor's perspective. These differences anticipate how each doctor distinguishes him/herself as a writer, and at the same time determine, to a considerable extent, how their works are received by readers.

Furthermore, there is a mix of genres in these writers' works. These creative works by doctors are based on, or draw from, their own life experience as a doctor – their medical practice, encounters with patients, and clinical observations and so on. But at the same time, they are artistically processed and recreated in one way or another. They may involve a fictionalised or metaphorical interpretation of real life events; they may involve case studies of a patient who is in fact a synthesis of several patients; they may include research notes, empirical observations, personal reflections, philosophical thinking, moral values all at the same time. The mix of genres leads to a differentiation of reviewers' reading from the writer's own perception of the genres they write in. For example, although Weston describes her first book *Direct Red* as not being literally true, most reviewers tend to read the book as the author's surgical memoir, and some of the reviewers who seem to be her colleagues even identify the characters and events mentioned in the book (Craft, 2009, p. 123). On the other hand, while reviewers read the novel *The House of God* as fiction, or satire, its author Shem does not agree with this genre classification, insisting that almost everything in the novel is based on his real-life experience during his internship year (as cited in Wear, 2002, 498).

In the following sections, I shall make a comparative study of the six writers' representations of what makes a good doctor. I shall first briefly introduce each work or selection of works in terms of how distinctively the question of what makes a good doctor is treated; then I shall offer a brief biography and background information about each writer, including the socio-cultural contexts for their publication, the writer's writing principle or their view of themselves as a doctor-writer, and reviewers' responses to their writing. The six writers will be introduced in rough chronological order in terms of when their works were published.

2-1: A Psychiatrist's Fictional Resistance against Inhumanity

The House of God (1978) is Samuel Shem the psychiatrist's resistance through fiction against inhumanity in medical practice in the US in the late 1970s. It examines what makes a good doctor from the perspective of the American internship system. In this novel, he traces an intern's emotional and psychological fluctuations during his training days and his attempts to make sense of his role as a doctor. From the intern's perspective, and with such devices as sarcasm and black humour, ethical issues are triggered concerning how patients should be treated, how interns should be treated, and what kind of role model senior doctors should set up for interns. The form of fiction offers an ideal stage for the discussion, even though the author suggests that the novel is based on solid facts.

Samuel Shem, the pen-name of Stephen Bergman, is an American psychiatrist and novelist. As a graduate of Harvard College and Medical School, Shem has been a practising physician for about forty years, and most recently worked as a professor of psychiatry at Harvard Medical School in the division of addictions (Worldwide Speakers Group, 2012). Though he loved surgery, Shem chose psychiatry as his specialty since the "stories of the psychiatric patients were outrageous and astonishing"; in addition, psychiatry promised some time for writing, and a better knowledge and understanding of people, suffering and healing (Shem, 2002, p. 934).

Unlike such writers as Abraham Verghese and Peter Goldsworthy to be discussed later, Shem views himself as primarily as a writer, and only secondarily as a doctor. Comparing medicine

to his “meal ticket”, Shem describes writing as his passion, solace, and a way to perceive the world, in a certain way echoing Chekhov’s declaration that “Medicine is my lawful wife”, and “literature is my mistress” (Chekhov, 2004, p. 62):

> I was a writer before I was a doctor. From an early age I was concerned with suffering and understanding, and I often turned to stories for solace. I loved stories long before I knew they were an essence of good doctoring—shared stories that bring solace, understanding, and healing to others. (Shem, 2002, p. 934)

When he graduated from medical school, though it was not compulsory, Shem volunteered to do a medical internship, so as to learn “how to really take care of people.” These experiences lit “a fire” in Shem to write his first novel, *The House of God* (Shem, 2002, p. 934). Since its first publication in 1978, millions of copies have been sold and it is now regarded as a classic by readers both inside and outside the medical world. “*The House of God* could probably not be written now, at least so unabashedly”, John Updike comments, in that “its lavish use of freewheeling, multi-ethnic caricature would be inhibited by the current terms ‘racist’, ‘sexist’, and ‘ageist’” (Shem, 2010, p. xv). Indeed, *The House of God* was a product of its time and place. The book was published in a period in the US when “medicine had achieved feats” and “the science of medicine had so distorted the art of practice that both patients and doctors ha[d] become victims of the technological imperative gone wild” (Jones, 1996, p. 735). These comments somewhat echo Shem’s view of himself and his fellow interns as being “products of the 1960s” – a generation which was “brought up on the civil rights movements and the Vietnam War”, who would take action to change things for the better if they saw an injustice, and *The House of God* is precisely Shem’s act of resistance, to “the brutality and inhumanity”, “isolation and disconnection” in medical practice, through fiction (Shem, 2002, p. 935).

Patterning the story on his own experience as an intern at the Beth Israel Hospital in Boston, the author offers a close-to-reality picture of the American medical internship system. By collecting a series of moments that may be “unjust, cruel, militaristic, or simply not right”, and moments that “came so fast and furious in the internship” that they “could neither be ignored nor passed by” (Shem, 2002, p. 934), Shem offers a critical reflection on a

dysfunctional medical institution and a negative picture of the way in which the profit-motivation of American hospitals had distorted hospital practice. Moreover, influenced by Chekhov, Shem takes "Life as it should be in addition to life as it is" as his motor for writing (Shem, 2010, p. 392), and the book involves not only the author's reflections on what the problem is but also his reflections on how to improve the problematic situation. Furthermore, the book in many ways reflects the author's serious and critical thinking on what makes a good doctor in the context of a medical institution. Like other doctor-writers to be discussed, Shem's critical thinking on the "good doctor" is closely related to his specialty – psychiatry, although the storytelling does not take off from psychiatry but ends with it, a point which I shall develop further shortly.

Thirty-five years have passed since its first publication, yet "it is far too soon to put *The House of God* in the back shelves of the library and declare the task over" (Brody, 2011, p. 502). The strength of Shem's book is largely in its timelessness, which is proved in recurring comments on the book. Updike in his introduction to the 1995 edition of the novel affirms that the novel is "more timely than ever, as the American health-care system approaches crisis condition – ever more overused, overworked, expensive, and beset by bad publicity" (Shem, 2010, p. xvi); Delese Wear also reads the novel as a "more important book for medical students and residents to read now than it was when first published" because of the "timeless questions" raised in the novel such as what it means for doctors to ''be with'' patients (2002, p. 500). By the end of the 2000s, the novel was still considered as illuminating, not only in relation to internship training itself – "over the years, it has served as a required guidebook for medical neophytes and a clarion call for the old guard to make striking changes in the way we train young physicians" (Markel, 2009) – but doctors' self-reflection: "there is still room for change in how residency training makes us feel about ourselves, our patients, and our choices" (Kusin, 2009, p. 566). Indeed, despite the fact that things have changed dramatically in medical institutions, the novel has been and will keep offering insights in the examination of the modern medical system and doctors' role in it. Shem regards "the good doctor" as the one who can transform his/her role from "power-over" to "power-with" (patients, colleagues etc.) (Shem, 2010, p. 396). He applies this notion to his writing, too. Taking the composition

of the novel as a means to survive the internship, Shem also powers-with his readers by sharing his personal feelings and critical thinking, and more importantly, by showing them – today's interns for example – "Writing this is a way to survive, and to heal" (Shem, 2010, p. 397). Shem's idea more or less anticipates the emergence of Narrative Medicine which stresses the therapeutic function of reflective writing for medical practitioners.

Having simply intended to "tell the truth with some art", Shem could hardly foresee how "radical my novel was and the backlash it would create" (Shem, 2010, p. 935). This is because Shem touched a taboo that had seldom been touched before: "Shem has done what few in American medicine have dared to do. That is to share an unpolished, unglorified, and amazingly unegotistical experience of that revered institution, the internship" (Gillette, 1981, p. 1288), and the problematic institutional system based on the internship system. This is also because Shem presented it in a way that had rarely been presented before: "It is like caricature, distorted but truer than reality, because it distils the qualities that no one ever dared depict in quite this way before" (K. Hunter, 1983, p. 144). With the notion that the only way anyone would want to read what is awful and brutal is via humour, Shem relates "the worst year" in interns' lives in such a way that almost every page of the novel brims with black humour and satire:

> Shem does not position himself as a[n] objective essayist who chronicled the events of his internship year. Instead, he wrote a novel, using very specific rhetorical devices that signal satirical intent — to ridicule or criticize long-standing practices in academic medicine, derisively at times, ironically at others, often with great humor. (Wear, 2002, p. 499)

His "humorous treatment of sacrosanct medical phenomena" is so intense and outrageous that it caused "initial uproar and continues to evoke strong responses" (Wear, 2002, p. 498). Therefore *The House of God* does for medical training "what Catch-22 did for the military life", and is perhaps "more outrageous", as Updike puts it (Shem, 2010, p. xiii). Though the novel is commonly read as satire, the author does not quite agree with the categorisation. In his introduction to the 1988 edition of the novel, Shem insists that almost all of his novel is as close a description of the reality of that year as possible, while satire may indicate

"exaggeration in the service of polemic" (as cited in Wear, 2002, 498). Indeed, *The House of God*, as I read it, is an autobiographical fiction that is dressed up in the form of satire. It contains, as Wear describes it, "elements of all these genres, blurring the ever-disappearing line between so-called fact and fiction" (Wear, 2002, p. 497).

The novel is narrated in the first person by protagonist Roy Basch. Roy is a medical intern who has just finished his first-year internship. In flashback, Roy recollects the physical, emotional and psychological damage the internship caused to interns like him. The storytelling is divided into three chapters by geographical location. "France", "The House of God" and "The Wing of Zock", which at the same time mark the psychological and emotional turning points of Roy's internship journey. The story first locates readers in France, where Roy is on a vacation with his girlfriend Berry, at the conclusion of his medical internship. In spite of his struggle to rest and Berry's effort to call him back from his recollections, Roy keeps being haunted by his days at the "House of God", a nickname for the hospital where Roy has received his training. In free association, Roy's mind travels back and forth, and accordingly, the narration switches between the past tense and the present tense. The first chapter ends with an intense fantasy: in spite of the best efforts of doctors and nurses' rescue, a young patient does not survive cardiac arrest and dies a violent death, after which all of the rescue team end up "consoling [themselves] in sex on the blood-slippery floor, singing as [they] rocket toward orgasm …" (Shem, 2010, p. 9). The scene is both comical and disturbing, setting up the basic tone of the storytelling. Meanwhile, the overlapping of the death scene and the sex scene reveals two most important tools for interns to overcome their difficult times at the House of God, "cynical sex" and black humour.

In retrospect, Roy relates his rotations at "Gomer City",[5] Emergency Ward and the Medical Intensive Care Unit, respectively. Starting his journey as a proud and ambitious intern, Roy undergoes a gradual emotional and psychological degradation; meanwhile, his relationship with his girlfriend Berry is "on the rocks". Gradually, he is deprived of the ability to socialise, to feel and to love, and is evolving into a disillusioned "machine" (Shem, 2010, p. 317). At

[5] A nickname for a medical department where the elderly are tended.

the end of the first-year internship, Roy is on the edge of collapse. It is noteworthy that in relating his internship journey, Roy becomes more and more cynical and emotionally unstable, and his narration becomes more and more ridiculous and untrustworthy. In the end when Roy suffers from a total emotional and psychological breakdown, he becomes an unreliable narrator. At Gomer City and Emergency Ward, for example, Roy protests from time to time about the ridiculousness of his job; but by the time he is rotated to the Intensive Care Unit, he begins to feel good about what he is doing, "The thrill of handling the complexity of disease, of running the show well and with power, on top of the pile, the elite of the profession. I was king" (Shem, 2010, p. 308), which ridicules the situation rather than indicating how Roy really feels. In addition, at the beginning of his internship whenever Berry criticises him for joking about patients, Roy always apologizes for his insensitivity; but when she accuses him of turning into a machine after working for some time at the Unit, Roy is in denial at her accusation, "She was wrong. I was not a machine. I was not dead. I was alive. I was doing extremely well. My life was full" (Shem, 2010, p. 319), which again foreshadows Roy's emotional breakdown. Both examples demonstrate the inconsistency of Roy's behaviour and psychological state, which conveys to readers Roy's unstable state as a protagonist, and his unreliability as a narrator.

To supplement Roy's narrative, therefore, Berry's comments and analysis accompany Roy's storytelling throughout. Berry is a psychiatrist who has been offering help and comfort all through Roy's internship. Berry is regarded by some reviewers as "one of the book's failures" in that she "embodies the satiric norm of psychological and social (as well as sexual) health by which we and the hero are to judge his aberrant year" and that she offers "incessant explication of the psychological principles governing the interns' behavior" (K. Hunter, 1983, p. 143). Personally, I do not quite agree with this review. Together with Roy, Berry contributes to the analysis and critique of the internship system, in the sense that readers are offered two voices at the same time, one from Roy that seems to ridicule the situation, and the other from Berry that keeps reminding readers of Roy's irony. For example, as Roy makes jokes about patients, Berry comments that laughing at patients is sick; when Roy talks and acts like a machine, Berry points out that this strange behavior is a Freudian defence; when

Roy shows no sign of mourning after a fellow intern's death, Berry warns of the danger of the attempt to forget what has happened. In other words, both voices serve the same purpose – a critique of the internship system – except that one is presented in the form of farce while the other is presented as a normative criticism. With the two voices developing side by side, the author attempts to remind readers that what looks like a farce or a comedy is in fact a tragedy. It is by forming a sharp contrast between the comedy – how the story is delivered – and the tragedy – what the story is really about – that an effective critique of the internship experience is achieved. The two voices contrast with and confront each other all the way through the storytelling and merge into one in the last chapter "The Wing of Zock". The chapter title in Roy's vocabulary represents "hope" and marks Roy's emotional awakening. Under Berry's direction, Roy is "kidnapped" by his friends to a theatre and forced to watch mime Marcel Marceau. Thanks to the humane power of the performance, Roy's senses are suddenly turned on and what has died in him is brought back to life. Emotionally alive and psychologically healthy again, Roy's narration joins Berry's explication in commenting on the devastation inflicted by the internship experience on the interns' "creativity", "humanness" and "passion" (Shem, 2010, p. 316).

That the novel is narrated from an intern's perspective is significant in that it ensures an effective critique of both the institutional system and the issue of "the good doctor": on the one hand, interns are at the bottom of the medical hierarchy, which makes them pertinent and persuasive in revealing what works and what does not work in a medical institution; on the other hand, interns are in the course of becoming doctors, which ensures them a good position to measure what makes a good doctor and what prevents one from becoming a good one. From the intern Roy's perspective, other interns such as Chuck, Runt, Potts, Eddie, Howie and Hooper are depicted as having a difficult time in the course of becoming a doctor, too. Like Roy, they are caught between the different philosophies of healing proposed by the Fat Man and Jo, a male and a female second-year resident, respectively, who directly supervise them; they are frustrated by the paradox that while "gomers" – which is an acronym for "Get out of my emergency room", referring to elderly patients who are always in hospitalisation – never seem to die, younger patients die with little chance of being saved;

they struggle with their professional conscience and their physical, emotional and psychological limits. Disillusioned, outraged and repressed, they turn to different things for comfort – while Roy turns to cynicism, Chuck turns to alcohol, Runt to sex, Howie to drugs, Hopper and Eddie to the absurd competition for the ridiculous Black Crow Award.[6]

As morbid as it is, interns' behaviour seems to be justified through Berry's comments that they do strange things to rid themselves of rage and repression. Without developing a "hobby", to release the repression and to protect themselves, as is argued in the novel, interns may not be able to go through the internship, as is exempflied by the case of Potts. Eaten by the guilt of not having made the right decision in attempting to save a patient and burdened by the attempt to do everything for patients, Potts becomes more and more withdrawn from the company of friends, and ends up throwing himself off the top of the building and smashing onto the parking lot. Potts' tragedy highlights the importance for a doctor to be capable of self-rescue, which lays a foundation for the discussion about the "good doctor" in this novel. Echoing what the Fat Man suggests, "At a cardiac arrest, the first procedure is to take your own pulse" (Shem, 2010, p. 177), Shem suggests that doctors should know how to protect themselves, to stay healthy, both physically and mentally, before they can possibly become good doctors. This is a very important ethical issue in medical practice, which has been frequently dwelt on by the other doctor-writers and represented in extreme forms in Bi Shumin's A Red Prescription and Peter Goldsworthy's *Three Dog Night*, which I shall examine in the next chapter.

In the novel, Pott's suicide rings a bell for the interns and triggers their introspection – "*how can we care for patients if'n nobody cares for us*?" (Shem, 2010, p. 364).[7] As they actively reflect on what leads to Potts' and their own tragedy, the layers of the medical institution are peeled away one-by-one till the hidden problems are exposed. First of all, the tragedy is partially caused by the interns themselves, as Roy and other interns realise, in the sense that they do not care for each other, nor do they know how to care for themselves. Moreover,

[6] This is an award invented by the Chief of Medicine to encourage interns to get as many permissions for carrying out autopsies from dying patients or their family as possible.

[7] The "if'n" here is not a typo; here the author is representing character's accent.

without effective communication, interns are very much isolated, and as a result, whenever frustrated and repressed, they may tend to think "I am crazy" rather than "This is crazy". What is even worse than being in isolation, however, is their unawareness of isolation. On the orientation day, when the House psychiatrist tries to warn interns of the high suicide rate at medical school, his speech is interrupted by the Fish, Chief Resident; and, as Roy tries to communicate with the Leggo, Chief of Medicine, about interns' problems, the Chief does not seem to "have a clue" (Shem, 1978, p. 360). Neither the Fish nor the Leggo seems to notice, or care about, what is going wrong. This ignorance at the highest level of the hierarchical system leads to what seems to be the key problem for the interns – the lack of a role model: "What we're saying is that the real problem this year … [is] that we didn't have anyone to look up to", as Roy speaks for his fellow interns in a direct confrontation with the Leggo (Shem, 2010, p. 362).

In addition to the Fish and the Leggo, who are portrayed as shallow and inhuman, more interested in "slurping" their way up to the higher levels of the hierarchy, the residents Jo and the Fat Man are the ones the interns look up to most frequently and directly. In Roy's depiction, Jo is compared to a "walking textbook devoid of feeling" (K. Hunter, 1983, p. 138); the Fat Man, on the other hand, is portrayed as practical, cynical but humorous. With the contrasting portrayals of Jo and the Fat Man, two confronting healing philosophies form: on the one hand, Jo proposes to do "anything for patients" and suggests treating patients "aggressively, objectively, completely" and "never give up" (Shem, 2010, p. 162); on the other hand, the Fat Man is suspicious of doctors' ability to cure, "So maybe we do make diagnoses; big deal. We hardly ever cure." The cure, according to the Fat Man, is the disease: "The main source of illness in this world is the doctor's own illness: his compulsion to try to cure and his fraudulent belief that he can" (Shem, 2010, pp. 192-193). On the surface, it seems that Jo's opinion stands for the normative view of a doctor's function in modern medicine and makes more sense, whereas the Fat Man's philosophy and behaviour may sound absurd, insulting or even crazy. The irony is that to Roy's great surprise, while Jo offers everything to keep patients alive, patients only get worse; under the Fat Man's principle of doing nothing medical, patients more often get better. The irony is less a denial of

doctors' importance than a reminder of the limits of their ability. The author seems to warn that Jo's obsession with "winning the war against death" can be devastating to both doctors and patients, and the effort to treat patients "aggressively, objectively, completely" itself is inhumane. In fact, though the Fat Man plays at being a cynic, makes jokes about patients, and invents such disturbing rules as doing nothing medical for patients, he is depicted as hiding his human side as a form of self-protection, as is revealed later in Roy's conversation with him:

> "Well, I found you out," I said. "Your indifference is all an act. You care about everything you do."
>
> "'course I care."
>
> "Why do you pretend that you don't ?"
>
> "On the street, it's the only way to be … Being cool is the only way of stayin' alive". (Shem, 2010, pp. 101-102)

What is more, in teaching interns when to laugh, the Fat Man also teaches them when to cry – as he demonstrates for the interns how to use cynicism to protect themselves, he also shows how to feel empathy for patients and make them feel cared for. In spite of nicknaming the old patients who never seem to die as "gomers", the Fat Man teaches his interns to "learn from the gomers so that when some young person comes into the House of God dying, you know what to do, you do good, and you save them" (Shem, 2010, p. 76). Similarly, though his "Laws of the House of God" are "still outrageous", they are from the Fat Man's "fund of clinical experience" and "make sense" (K. Hunter, 1983, p. 139), since these laws offer a better knowledge of the gomers, a summary of the nature of the job, and his advice for the interns to go through the tough situation. In short, though the Fat Man is depicted as a rarity in the hierarchy, he is regarded as "a human-being doctor" (Shem, 2010, p. 363), a good doctor in an unconventional sense and a role model by Roy and other interns – "a wizard, not only brilliantly proficient technically but deeply compassionate and caring towards his patients. He models the ideal of high mastery of both scientific medicine and the art of practice" (Jones, 1996, p. 735). The portrayal of the Fat Man as an ideal example of "the good doctor" offers a valuable perspective for exploring the question of what makes a good

doctor.

Furthermore, though the Fat Man may do little medical for patients, he offers far more than what medicine can do. What a doctor can really do for the patient is one of the issues frequently explored by doctor-writers. In this novel, the answer is offered through Roy, based on what he has learnt from the Fat Man – that even though doctors may not be able to cure, they can heal simply by *being with* the patient. After informing a patient that she is dying, for example, the Fat Man holds the patient's hands and spends the tough hours with her; he tries his best both to let the dying die a peaceful death and to save those who are not supposed to die. This idea of healing is reinforced in the dramatic encounter between Roy and Dr Sanders, Roy's patient who is a doctor himself. During his last conversations with Roy, Dr Sanders shares his opinions on the doctor's role in curing, which, again, is less scepticism about doctors' capacity than a re-emphasis of the importance of accompanying patients and offering empathy:

> "No, we don't cure. I never bought that either. I went through the same cynicism – all that training, and then this helplessness. And yet, in spite of all our doubt, we can give something. Not cure. No. What sustains us is when we find a way to be compassionate, to love. And the most loving thing we do is to be with a patient, like you are being with me." (Shem, 2010, p. 156)

Influenced by such "human-being doctors" as the Fat Man, Berry and Dr Sanders, and having examined the different functions a doctor may perform – a provider of hospice-like care as in Gomer City, a purveyor of speedy and effective treatment in the Emergency Ward, a technician counting on high-tech and the power of machines to cure as in the Intensive Care Unit – Roy realises that his real interest lies in "being with patients", what Berry describes as "the essence of psychiatry" (Shem, 2010, p. 340). Together with other interns, Roy decides to leave physical medicine for psychiatry.[8] This plot is significant in the sense that it represents not only the interns' rebellion against the internship system but also the author's views on what makes a good doctor, which are closely related to his specialty.

[8] Roy's experience as a psychiatrist is extended in Shem's another novel titled *Mount Misery*, sequel to *House of God*.

Also worthy of note are the two policemen who are always on a patrol around the House, friends to Roy and other interns. They decide to become amateur psychiatrists, too. They are portrayed as having built a better knowledge base about care and healing than such professionals as the Fish, the Leggo, and Jo. This plot deployment further extends the idea of the good "doctor" to the good "healer". It seems to suggest that a good healer may not necessarily be professional; anyone has the potential, as long as they are able to offer care and empathy. This resonates with Shem's summary of Roy's internship journey: "Wanting to become a doctor, he becomes a healer" (Shem, 2010, p. 397). The deliberate distinguishing of "the healer" from "the doctor" once again highlights what Shem values more in a doctor and reflects what he sees in his specialty – psychiatry – to offer empathy, care and a medicine that is "human-to-human" (Shem, 2010, p. 193). The novel itself is the author's act of resistance against the inhumanity of the system. It largely anticipates the Narrative Medicine Programme that takes reflective writing as an important means to advocate for an empathetic and humane medical practice.

2-2: A Neurologist's Spiritual Drama on a Neurological Basis[9]

Unlike Shem and other doctor-writers, Sacks in his "neurography" *A Leg to Stand On* (1984) and his collection of case studies *The Man Who Mistook His Wife for a Hat* (1985) has explored what it means to be a patient with a serious neurological disorder, the former being based on his own experience as a patient, and the latter being based on the case histories of his patients. In the former case, Sacks is depicted as a patient who experiences an unsatisfying encounter with an arrogant and ignorant surgeon who does not bother to listen; in the latter case, Sacks presents himself as an idealised image of a doctor who is helpful, heroic and values patients' narratives. The two works by Sacks offer a negative and a positive portrait relevant to the question of what makes a good doctor.

[9] In Sacks' summary of his experience of injury and recovery as a patient with the disturbance of body-image, he compares his emotional and existential experience to "the journey of a soul into the underworld and back, a spiritual drama – on a neurological basis." Hence the title of this section, referring to his examination of patients' conditions as not only pathology but also "existential experience" and a "spiritual journey" in many of his works.

Oliver Sacks was born in 1933 and grew up in a family of physicians. He received a medical degree from Queen's College, Oxford University and has practised neurology in New York since 1965. From 2007 to 2012 he worked as Professor of Neurology and Psychiatry at Columbia University, where he was appointed the first "Columbia University Artist" (Rich, 2007). Now he is serving as Professor of Neurology at the School of Medicine in New York University (Sacks, 2014). So far he has published twelve books, most of which are based on the case histories of patients with neurological disorders. Each work introduces readers to a different type of neurology-related disease such as body-image disturbance, colour-blindness, hallucination and so on.

Sacks is one of the most widely read physician-writers in English-speaking countries, and his works such as *Awakenings* and *The Man Who Mistook His Wife for a Hat* have been translated into many other languages. Yet he is one of the most controversial physician-writers of the twentieth century. On the one hand, Sacks' books are considered as opening a window for readers onto the world of neurological disorder; on the other hand, since Sacks' works are primarily based on patients' pathological conditions, the doctor-writer is bitterly criticised by some reviewers as exploiting patients and invading their privacy, and given the title "the man who mistook his patients for a literary career" by British sociologist Tom Shakespeare (1996, p. 137). What makes Sacks controversial is not only the subject matter itself, but also the genre he writes in. Sacks' works defy the conventional categories of genre: unlike many medical scholars who base their medical writing on scientific research and experiments, and unlike Shem and other creative physician-writers who have written out of the discipline of medicine in fictional form, Sacks' case studies on patients very much blur the boundary between medical writing and literary writing. If *Migraine*, Sacks' first book, was still "well within the established medical 'canon'" (Sacks, 1983, p. 1968), from his second book *Awakenings* onward, he abandoned the conventional format of medical writing and "took off in all directions – with allegory, philosophy, poetry" (Sacks, 2003).

Most of Sacks' writings are in the form of essays, using the language of both medicine and literature, combining both technical descriptions and scientific definitions, and literary narrations and poetic reflections. This writing style reflects how Sacks defines his specialty

and what he sees as missing in the study of neurology of his times. According to Sacks, he received orthodox training in neurology and had a good knowledge of what he thought of as an advanced form, neuropsychology. While acknowledging the "enduring importance" (Sacks, 1984, p. 165) of both classical neurology and neuropsychology, Sacks reveals what he thinks is lacking:

> Neuropsychology, like classical neurology, aims to be entirely objective, and its great power, its advances, come from just this. But a living creature, and especially a human being, is first and last active – a subject, not an object. It is precisely the subject, the living 'I', which is being excluded. (Sacks, 1984, p. 164)

As a result, Sacks proposes an even more advanced neurology – "a neurology of self, of identity" (Sacks, 1984, p. 165), what Russian neurologist A. R. Luria – whom Sacks considers as his mentor and the "pioneer of a new and deeper medicine" – would call "romantic science" and Sacks himself defines as "clinical ontology" or "existential neurology" (Sacks, 1984, p. 166). Correspondingly, a new type of writing is required. While previous writing on neurology excluded the "psyche", the experiencing, active, living "I", as is suggested by Luria, this new form of writing allows the neurologist to "move beyond a purely quantitative analysis of the brain to a fuller consideration of the mind as it consciously and unconsciously responds to experience" (Journet, 1990, p. 194). In a letter to Sacks, Luria reveals the fact that he feels compelled to write two sorts of books – alongside the "systematic" books he has always written, he also attempts to write about patients as "the suffering, acting 'I'" in the form of neurological biographies or novels (Sacks, 1984, p. 164). Unlike Luria, who feels the urge to write "two sorts of books", it seems that Sacks aspires rather to write one book, or to write two books in one. Meanwhile he notes that Luria's later works "go beyond the 'veterinary' approach" more and more, and "enter fully into the actual experience of the patient" while there is no "sacrifice of objectivity and accuracy" (Sacks, 1984, p. 164). Luria's writing style seems to set up an ideal model for Sacks. This partially explains why Sacks' works on neurological disorders position themselves somewhere between biology and biography, and between science and the humanities.

Sacks' style has been shaped not only by how he intended to write, but also how he has been received. Take *Awakenings* for example. The book records the life story of a group of patients who had become institutionalised since the great epidemic of encephalitis lethargica (so-called sleepy sickness) and were "awakened" after being treated with the drug L-DOPA. Before the publication of the book, however, Sacks originally attempted to have his findings published in such medical journals as *JAMA*, but was rejected. Two years later, he was invited to write an article for *The Listener* and "The Great Awakening" was published in 1972. It aroused "a wave of interest" among non-medical readers, which finally led to the publication of *Awakenings*, a complete collection of case histories, in 1973. To Sacks' disappointment, *Awakenings* (1973) "met the same cold reception from the profession as my articles had done earlier. There was not a single medical notice or review, only a disapproving or uncomprehending silence", except for one "brave editor" who made the book his "editor's choice" of that year (Sacks, 1983, p. 1969). Contrary to the cold reception received from the discipline of medicine, however, the book intrigued many non-medical readers. Besides, it has been extensively quoted in studies of anthropology, social psychology, nursing science, as well as English literature and language, and is considered as exemplary in bringing humanity to the discourse of medical science or as humanising the practice of neurology. Therefore, from the publication of *Awakenings* onward, Sacks' works have been more and more labelled as popular science, both referring to and reflecting the fact that, firstly, his works are more widely read and better received among the non-medical audience; and, secondly, that his works illuminate the public perception of the study and practice of neurology in one way or another. In a broad sense, Sacks is believed to exemplify "the bridging of the two cultures, scientific and artistic, to the advancement of both" (Wasserstein, 1988, p. 444), and his examination of patients' pathology and the advice he gives for treatment, in particular, illuminate critical thinking on the issues of illness and identity, the doctor-patient relationship, and a holistic approach to healing.

The Man Who Mistook His Wife for a Hat (hereafter referred to as *Hat*) offers an excellent example of this praxis. *Hat* is an essay collection based on the author's clinical observation of a group of patients who suffer from the disturbance of body-image and body-ego. Published

in 1985, the book "hit some nerve in the reading public, and became an instant best-seller" (Sacks, 2003). The author's interest in this odd neurological syndrome and its related identity crisis derives from one of his personal experiences of becoming a patient. Once while hiking, Sacks injured his leg and experienced the disturbance of his own body-image. The process from injury to recovery offered him an entirely new perspective for viewing neurological practice, and opened up to him an entirely new field of interest. This special experience and its significance are vividly recorded in his clinical autobiography *A Leg to Stand On* (hereafter referred to as *Leg*), which was published in 1984, ten years after the accident. *Leg* reads both as a medical study of the disturbance of body-image and as a literary reflection on the significance of becoming a patient, what Sacks defines as "neurography", referring to the fact that it is "rooted in personal experience and neurological fact" (Sacks, 1984, p. viii). The neurological autobiography is narrated in the first person by Sacks, who is set up to play a dual role; on the one hand, the narrator is a victim of the accident, which endows his storytelling with a patient's subjectivity and an insider's perspective; on the other hand, the narrator is a researcher on his injury and recovery, which endows his analysis with a doctor's expertise and professionalism. This unusual position enables the author to pursue a range of preoccupations the findings of which are applied to a group of patients later in *Hat*:

> The specific neuropsychological and existential phenomena associated with my injury and recovery; the business of being a patient and of returning later to the outside world; the complexities of the doctor-patient relationship and the difficulties of dialogue between them, especially in a matter which is puzzling to both; the application of my findings to a large group of patients, and the pondering of their implication and meaning … (Sacks, 1984, p. viii)

Chronologically and thematically related to each other, the two books, in many ways, lay the foundation for a critique of "current neurological medicine", which Sacks hoped to undertake, and "to a vision of what may be the neurological medicine of the future" (Sacks, 1984, p. viii). Reading one book alongside the other helps lend insight into the discussion of what makes a good doctor, or to be more specific, what makes a good neurologist. While in *Leg*, what makes a good doctor is examined through the author's criticism of his surgeons, in *Hat*, the issue is largely illuminated in the author's proposal for a holistic medicine and a holistic

healer.

In *Leg*, the image of a good neurologist is not directly portrayed; rather, it is very much implied in the portrayal of "the surgeons" by the narrator Sacks, who turns from a powerful doctor into a helpless patient. A series of dramatic conflicts between the surgeons and Sacks the patient are presented to assist the portrayal. First of all, at the time when Sacks is admitted to the hospital, the Surgical Houseman and Registrar come to take "the history". While Sacks the patient wants to tell them "everything – the entire story", the surgeons seem to be only interested in "salient facts" (Sacks, 1984, p. 29). By criticising the fact that patients' narratives are not paid enough attention, Sacks the narrator creates an image of the surgeons as the ones who do not bother to listen. Then before the surgery, Swan the chief surgeon pays a "lightning visit" and offers very brief information about the surgery, "We reconnect it. Restore continuity. That's all there is to it … nothing at all" (Sacks, 1984, p. 30). Swan's oversimplified monologue frustrates Sacks the patient's expectation that he will have a dialogue with the doctor and be provided with ample information about his condition. Here the surgeon is depicted as a doctor who is – like his name "Swan" – overconfident, self-important and superior. In addition to a criticism of the surgeons from his own perspective as an upset patient, Sacks launches a further critique of the surgeons from the mouth of his physiotherapist, which more contemporary readers would recognise as a cliché nowadays: "I'm not saying anything against the orthopods – they do a wonderful job – but they never seem to think of movement and posture – how you *do* things once the anatomy's been put right" (Sacks, 1984, p. 40). These words from the physiotherapist effectively assist in portraying the surgeons as having limited knowledge of body function, in spite of their excellent surgical craft. The climax occurs during the Grand Rounds after what the chief surgeon claims to have been a "successful" surgery. The narrator complains to Swan that he has "difficulty locating the position of the leg", though "surgically speaking" the leg seems fine. To the patient's surprise, his complaints are taken by the chief surgeon as "nonsense", "nothing to be worried about" (Sacks, 1984, pp. 72-73). Although the narrator attempts to be fair by offering an afterthought that in such a circumstance as the Grand Round, Swan is forced to play the expected role as the all-knowing authority and Sacks has to take the

inferior role of the know-nothing patient (Sacks, 1985, p. 73), yet the portrayal of Swan makes a strong impression on readers, as not simply indifferent or overconfident, but rude, arrogant and ignorant, the kind of doctor who "never listens to, never learns from, his patients" and who "dismisses" and "despises" patients, and "regards them as nothing" (Sacks, 1984, pp. 72-73).

The dramatic conflicts between Sacks and his surgeons not only serve as a critique of traditional conceptions of the doctor-patient relationship, but also as a negotiation between different medical professionals on the idea of illness and healing. This is because the patient is a medical specialist himself. In other words, most of Sacks' complaints are launched not only from the perspective of a patient, but from a medical professional who assumes that he knows no less than his surgeons about the human body and its functions. By contrast with the doctor-doctor encounter between Roy and Dr Sanders in *The House of God*, which is peaceful and inspiring, brimming with mutual respect and understanding, the confrontation between Sacks and Swan is intense and aggressive. All through the narrator's portrayal, there is a strong sense of "the surgeons" as "the other": they are portrayed as paying little attention to patients' feelings, failing to value patients' narratives and treating them as a subject of anatomy rather than the subject of healing. In other words, it is more or less implied that the surgeons have little understanding, or less understanding than Sacks the neurologist, of the idea of healing. Though his judgment of "the other" may not be completely justified, it is from what he regards as a problematic doctor that Sacks brings to light the holistic philosophy of healing and the principles of practising medicine, and all of them outline his ideal model of "the good doctor". In this sense, the experience of becoming a patient recorded in *Leg* not only becomes an incentive for further investigation of the issue of body-image, but also turns into a "special qualification for the task":

> I could now open myself fully to the experiences of my patients, enter imaginatively into their experiences and be accessible and 'hospitable' in these regions of dread. I would listen to my patients as never before … as they journey through a region I knew so well myself. (Sacks, 1984, p. 157)

The importance of valuing, listening to and preserving patients' narrative highlighted in *Leg*

becomes a guiding principle for Sacks' consultation with patients, which is carried out in his case studies of patients in *Hat*. What is also apparent to *Hat* is a strong narrative of all-knowing. This book triggers the discussion of the good doctor with the author's self-image as a doctor who values patients' narratives and who promotes a holistic approach to healing, and who claims to know the field "so well". This tension between empathy on the one hand and narratorial self-aggrandisement and paternalism on the other – while a product of its time – is also the source of potential readerly ambivalence. The book is arranged into a "four-part journey, each segment focused on a 'presenting feature' of neurological disorder (Howarth, 1990, p. 113): Losses, Excesses, Transports, and The World of the Simple. Each part includes a series of cases that are examined in the form of a medical study but deepened to become "a narrative or tale", so as to present "a real person, a patient, in relation to disease", reflecting the author's belief that "the study of disease and of identity cannot be disjoined" (Sacks, 1984, p. viii). Nevertheless, "a real person" in the case of *Hat* involves the blending of several patients rather than one actual patient. "Losses" probes case histories both clinically and metaphorically related to a loss of functions such as proprioception; cases in "Excesses" are caused by the "excess or superabundance of function" rather than deficits (Sacks, 1985, p. 87); "Transports" examines "the power of imagery and memory to 'transport' a person as a result of abnormal stimulation of the temporal lobes and limbic system of the brain" (Sacks, 1985, p. 131); "The World of the Simple" investigates the world of the mentally disabled who lose the "abstract-categorical attitude" or "propositional thought" (Sacks, 1985, p. 174).

In retelling patients' stories of illness, Sacks portrays the image of a doctor who, unlike the surgeons in *Leg*, respects and values the patient's voice in the doctor-patient interaction: the doctor encourages patients to look for solutions by themselves, and preserves a large portion of his patients' own interpretation of their conditions. In this sense, both *Leg* and *Hat* seem to examine the issue of "the good doctor" in the context of the doctor's role in the narrative of illness and healing. While *Leg* emphasises the importance of valuing and preserving patients' narratives, *Hat* stresses that doctors need to take an active role in interpreting. Here Sacks in fact touches upon the key concern in the Narrative Medicine movement. In this sense,

although he has written very much prior to the development of the programme, and only became actively involved in related discussions quite late in his career, Sacks' view anticipates the formation of Narrative Medicine.[10] In relating case narratives about patients, the doctor-narrator in *Hat* very much idealises his self-image as a skilful listener, a well-trained transcriber, and an interpreter of patients' case stories, who possesses what Charon describes as "narrative competence", "the ability to acknowledge, absorb, interpret, and act on the stories and plights of others" that will encourage efficacy of medical practice (Charon, 2001, p. 1897). As a listener to patients' stories, the doctor is depicted as having acute narrative consciousness – for instance, he is sensitive enough to notice the change of tense in his patients' storytelling (Sacks, 1985, p. 24). When patients are unable to complete a story about their own condition – because they lose memory or senses or awareness and their ability to connect, a key feature of narration – it is Sacks the doctor who helps transcribe patients' stories. In addition to the transcription of patients' stories, the doctor actively adds his "notes", what he describes as "a strange mixture of facts and observations, carefully noted and itemised, with irrepressible meditations on what such problems might 'mean'" (Sacks, 1985, p. 29). It is the writer's *meditations* on the *significance* of these facts and observations that make him an active interpreter of patients' stories rather than a mechanical transcriber.

The interaction between Sacks and his patients involves not only the exchange of narratives but also metaphors. Once again, Sacks portrays himself as a well-trained transcriber and interpreter of these metaphors, who is not only able to record, but also help modify, patients' use of metaphors, to help them achieve a better understanding of illness and healing. In "The Disembodied Lady", for example, the patient loses her proprioception, the ability to experience her body as being her own "property". Metaphorically, the patient describes her own situation as if the body "can't 'see' itself as if it's lost its eyes." To follow up the body-as-eye metaphor, she even offers a possible solution, which is "to watch it (her body)" and "be its eyes". While preserving patients' metaphorical interpretation of their own

[10] For example, he offered lectures for the Narrative Medicine Rounds at the Columbia University in 2009. He also gave a speech titled "Narrative and Medicine: The Importance of the Case History" at a conference at the University of Warwick in 2013.

condition, the doctor offers his professional interpretation, too. Noticeably, rather than using such strong terms as “blindness” and “deafness” (of the body), the doctor describes the condition as “sensory darkness/ silence”. With his careful choice of metaphors, for one thing, Sacks the doctor helps revise patients’ perception of diseases, turning the negative into positive. In another example “Hands”, the patient has been taken care of ever since she was born, thus has been deprived of the chance to develop the functioning of her hands. As a consequence, she underestimates the capability of her hands and comes to a negative conclusion about them, “[My hands] are useless godforsaken lumps of dough”. By strategically replacing the tangible image of “dough” with an abstract concept “deficit”, and promising to help patients “remember what has been ‘forgotten’, or ‘dissociated’, or ‘inactivated’”, the doctor helps increase the patient’s confidence concerning her own recovery and creates a friendly atmosphere for implementation of the physiotherapy that may follow. Sacks also alludes to the way that in modern medicine, medical professionals tend to classify diseases before they can possibly understand and accept them. In the case of *Hat*, however, many patients’ syndromes are too odd to even have proper names. Therefore even in the patient community, Sacks’ patients are threatened by a variety of losses, live in some kind of nothingness, and suffer from a kind of identity crisis. With his careful choice of metaphors, Sacks the narrator also manages to make what might have been complicated concepts of diseases and syndromes easy to understand for readers, which helps patients earn attention and understanding from the public.

What Sacks the doctor-narrator attempts to win for patients, however, is empathy rather than sympathy. Sacks believes that “we paid far too much attention to the defects of our patients, … and far too little to what was intact or preserved” (Sacks, 1985, p. 183). Therefore, rather than focusing on defect, disability and dysfunction, the doctor proposes concentrating on patients’ ability and strength. For example, as opposed to such depressing expressions as “helpless, demented, confused and disoriented” as is shown on his patients’ transfer notes from other hospitals (Sacks, 1985, p. 24), the doctor tends to describe his patients as individuals who simply experience some sorts of “losses” or “excesses”, “reminiscence” or “concreteness”. In addition, patients are always portrayed as being

"spiritually a full and complete being",[11] despite the fact that they may be labelled as "freaks" and the tests on them may show nothing but deficits. The section "The World of the Simple" records a group of patients whom Sacks terms as "intellectually cripple[s]" but have displayed great talents in acting, music, art or mathematics. The case story "A Walking Grove", for example, narrates the case of Martin, a Parkinsonian who showed the syndromes of "retardation, impulsiveness, seizures, and some spasticity on one side". Yet, he has amazing musical memory and when he was singing, or "in communion with music", he seems like a "transformed" person. It is the same with the other cases when Rebecca acted, or Jose drew, or the Twins were in their "strange numerical communion", when "all that was defective or pathological fell away, and one saw only absorption and animation, wholeness and health" (Sacks, 1985, p. 192). In these cases, Sacks seems to argue that even the mentally disabled may be "truly and creatively intelligent" in some specific realms, and their intelligence, "albeit in a special and narrow area", "must be recognised and nurtured" (Sacks, 1985, p. 194). The proposal for the acknowledgment of "what was intact and preserved" over "the defects" of patients once again reinforces the ideal doctor-image in this book, in the sense that the doctor needs to be able to pick up beauty and creativity out of patients' defects and help them discover, define or develop their talents, as is shown in the case stories in the section "The world of the simple".

Problematically, while these case studies reveal overriding empathy with patients, Sacks engages in the issue of empathy by using the kind of terminology that downgrades his empathy. In his narration about the patients with mental disabilities, Sacks frequently uses such terms as "retardate", "retardation", "cripple" and "idiot-savant". This type of terminology is utterly inappropriate today, and has been replaced by less offensive terms such as Intellectual disability (ID), intellectual development disorder (IDD), savant syndrome and so on. Even though it is apparent that Sacks used such terms without offensive intention – these were accepted terminologies in medicine when the book was written – this example shows exactly how prejudice is constructed as a social norm. Sacks is a product of his times,

[11] There are a few exceptions, such as Mr Thompson, who has difficulty remembering and recognising people and whom the doctor-writer describes as having had his soul scooped out by his illness.

and his use of this terminology reflects the constructed social value of his time.

What makes *Hat* even more problematic, however, is the fact that although the book primarily consists of patients' stories, the centre of interest is the most dominant figure in the book, who is not one of the patients, that is "the perceived", but Oliver Sacks "the perceiver" (Kusnetz, 1992, p. 186; W. Hunter, 1995, p. 100). In spite of the perceiver's attempt to promote empathy, both Sacks' selection of case studies and the way he interprets these cases lead to the criticism that he is exploitative and manipulative. For example, William Hunter observes that "none of his patients really seem to suffer. They work, they question, they adapt, but they all overcome", and this, according to Hunter, can be ascribed to the author's selection of patients "who are strong enough to deal with their problems", in order to downplay "his failures in returning his patients to normal" (1995, pp. 99-100). Indeed, few of Sacks' portrayals of patients engage with recovery. Most of them are described as accommodating their conditions and some even "find their true nobility only after having developed the disease" (W. Hunter, 1995, p. 99). Nevertheless, I argue that the approach to treating such patients in Sacks' cases is precisely not to seek to cure, but to cope with, these neurological deficits. In this sense, even though Sacks' may be manipulative in his selection and interpretation of patients' cases, his work significantly illuminates the discussion of what a doctor can do for patients when medical treatment reaches its limits. Like Shem's "being with patients" but from a slightly different perspective, Sacks' answer to the question is to be a holistic healer and to practise holistic medicine. By quoting Luria, Sacks suggests that a person "has feeling, will, sensibility, moral being ...", and it is from here that "... you may touch him, and see a profound change" (Sacks, 1985, p. 38). Since the subject of healing is the "experiencing, active, living" patient, it is very important for the doctor to view the patient not as a container of pathologies, but as an individual human being, as a live history, a complete narrative and a holistic identity. A holistic view of patients leads to a holistic understanding of illness – what being a patient means. In *Le*g, the author points out that being a patient means not only being physically weak and an invalid but also morally passive, reduced, dependent on his doctor (Sacks, 1984, p. 98). Therefore he suggests that there should be an agent, such as the convalescent, that helps bridge "the abyss between sickness

and health", which illuminates the role a doctor should play in a patient's recovery. A holistic understanding of patients and illness leads to holistic healing advice which in Sacks' view may not be purely medical. In *Leg*, for example, music and dancing are the key to Sacks' recovery. As Sacks the patient is forced to join the rhythm produced by a melody or a dance, he is delighted to find that his injured limb spontaneously "remembers" how to move and function, as a normal limb. In addition to the artistic approach, Sacks proposes spiritual, philosophical, moral or religious approaches that can also be applied to patients with different needs. These approaches require that the doctor should be a holistic healer, and a master of many things.

It is noteworthy that Sacks' representations of what a good doctor should look like more or less echoes Sacks' self-portrait – a caring and fatherly doctor, which itself becomes problematic: "in the very same stories in which he glorifies his patients, [he] is constructing a matrix in which he maintains all power and authority" (W. Hunter, 1995, p. 93). It is the doctor who has control over discourse and interpretation. Hunter believes that Sacks' writing demonstrates the current split perception on doctors:

> While voices both inside and outside of the field have called for a greater sense of humanity in the treatment of patients, at the same time, medical training and the responsibilities of practice have required a strong commitment to distant objectivity and complete authority. (1995, p. 101)

The issue of power-over and empowering patients is frequently visited by doctor-writers, Weston and Colquhoun to be discussed below offering good examples. It reinforces my argument that literature is an effective medium to negotiate these uncertainties and controversies in medical practice. Compared with Weston and Colquhoun who both critique on the importance for a doctor of displaying proper power for patients' interest, Sacks seems to lack the vision to criticise his demonstration of power and paternity over patients. This may explain the controversy Sacks' work evokes. In this sense, as is with the case of Shem, reading Sacks' works from today's perspective can help us trace the evolution of social attitudes towards patients with disabilities, and offers insights to our discussion about medical ethics in a new era.

To sum up, in spite of his use of outdated terminology, his problematic interpretation of patients' stories, as well as his idealised self-image as a good doctor, the characteristics Sacks regards as essential to the good doctor do add more possibilities to the definition of what makes a good doctor and set up such standards for the good doctoring – one who is observant and creative, caring, loving and understanding; one who is a skilled transcriber and interpreter of patients' narrative and metaphor; and one who is a qualified scientist, philosopher, humanist and artist rolled into one.

2-3: A Specialist's Reflection on the Immigration of AIDS and Himself

My Own Country (1994) by Abraham Verghese is a memoir based on the author's four-year experience in Johnson City, Tennessee, as a specialist in infectious diseases, as much as an ordinary person whose family life is greatly influenced by his specialty, and as an Indian immigrant to America who seeks to establish himself and gain a sense of belonging. The book is framed by the overarching metaphor of "immigration" – the doctor's immigration to the US which was in parallel with the "immigration" of AIDS to the country. The issue of what makes a good doctor is examined not only from the specialist's attempts to justify his role as a healer, but as an immigrant who searches for a sense of "home", and also an ordinary person who searches for a sense of accomplishment and inner peace.

Abraham Verghese was born in 1955 in Ethiopia and migrated to America in 1980. After his medical internship and residency in Johnson City, Verghese was offered a fellowship at Boston University School of Medicine and trained as a specialist in infectious diseases. In 1985, he returned to Johnson City and worked in the rural hinterland for four years, during which time his job evolved more and more exclusively into the treatment of patients with HIV. Five years later, "overwhelmed by the experience of treating AIDS patients, Verghese decided to pursue his writing dreams" (Oder, 1994, p. 30). He moved to Iowa for a job at the University of Iowa outpatient AIDS clinic, and meanwhile studied at, and graduated from, the Iowa Writers' Workshop. So far he has published three bestsellers – two memoirs and a novel. Now he is the Senior Associate Chair for the Theory and Practice of Medicine at Stanford University. Having achieved much as a writer, Verghese regards himself first and foremost as

a doctor, and views his first career as inspiring his second career as a writer:

> I think I came to medicine with a strong sense of medicine being a romantic pursuit, a calling. And I am still really very much in love with medicine, and I love what I do. And I often think the writing emanates from that stance of being a physician. And I worry that I would become mute if I ever left medicine and tried to write. (Neary, 2009)

The predominant subject matter of Verghese's earlier writing derives from his specialty, "Everything I've written – fiction and nonfiction – has been about AIDS" (Klass, 1994), although his later work moves further afield. Following a similar trajectory to Sacks, who first attempted to write about patients with sleepy sickness in a conventional academic context, Verghese wrote about this "previously undocumented epidemiology" in an academic paper in the first place. But he soon realised that a scientific account could not fully convey the whole picture since "it neglected the stories", not just of patients, but his own transformation from being someone who was "homo-ignorant" (Klass, 1994). This view largely resonates with Charon's suggestion that "a scientifically competent medicine alone cannot help a patient grapple with the loss of health or finding meaning in suffering" (2001, p. 1897). "Along with scientific ability", Charon suggests, "physicians need the ability to listen to the narratives of the patient, grasp and honour their meanings, and be moved to act on the patient's behalf" (2001, p. 1897). Although Verghese denies that he has written under the influence of Charon, and he indeed has a slightly different approach from Charon – he values the medical content more and regards the use of literature in medicine as offering a support for isolated, overwhelmed medicos rather than teaching narrative competence (Thernstrom, 2004, p. 44-45) – this is exactly what Verghese has done. Like Sacks, and the other doctor-writers to be discussed in this thesis, in 1994, five years after his departure from Johnson City, Verghese channelled his experience as a specialist in infectious disease into the "compelling" book *My Own Country*, when "his frustration with the limits of modern medicine [was] still raw" (Ingrassia, 1994, p. 62).

Since the identification of AIDS in the 1980s, a plethora of general books has been written by patients or their survivors (Davenport-Hines, 1996, p. 606), but *My Own Country* is "the first

extended and frank testimony by a physician about his work with AIDS patients and about the profound changes that brought about in his professional and personal lives" (Cady, 1996, p. 278). Compared with writing in the form of pure academic study or reportage, a work that mixes genre has the potential to offer a more vivid picture of the epidemic and is regarded as being easier to relate to, by both lay people and medical professionals: "Every reader will be provoked to rethink old assumptions by this gently challenging and finely observed book. Every patient faced with serious illness will hope to have a physician like Verghese" (Davenport-Hines, 1996, p. 606). Peter Rowland, a pioneer in the treatment of AIDS himself, made a similar comment:

> Those of us who work with patients with AIDS will clearly see our own lives mirrored in his [...] some of his anecdotes are so uncannily my own that it is almost unbelievable that he is in Johnson City, East Tennessee, and I am in Canberra, Australia. (Rowland, 1994, p. 1169)

In the book Verghese places himself as doctor and, more broadly, as a human being, at the centre of the work. He links moments of personal significance to the time points of significance in the history of the AIDS epidemic in America – his internship and residency, his return and settlement, his marriage and the birth of his son, in parallel with the landing of HIV virus in the country, the emergence of the first case in rural Tennessee, and the discovery of the HIV virus as the cause of AIDS. By making an analogy between the "immigration" and development of the AIDS epidemic and his own immigration and settlement in the country, the narrator builds into the book knowledge of AIDS and case studies of patients, reflections on what makes a good doctor, as well as an immigrant's experience of a new country.

To be more specific, on the one hand, the doctor-narrator explores the definitions and essence of AIDS, investigates its social, moral and human implications, traces its historical background and tracks updates on the trials of treatment. In this sense, the book forms almost a research report on AIDS, not only from the medical point of view, but touching on such issues as "medical practice, spiritual need, social justice and sexual conduct" (Davenport-Hines, 1996, p. 606). On the other hand, as he searches for what AIDS means and implies, the narrator explores what it is to be a doctor of AIDS, and in this regard, the book

seems to become a dissertation on what makes a good doctor. “The book is one of the first to describe the experience of the care giver in the age of AIDS [...] it captures the maelstrom of excitement, fatigue, tragedy, and ultimate gratification that AIDS care givers feel” (Wachter, 1994, p. 1100). What is more, in the course of making sense of his professional life, the doctor keeps exploring how his role as specialist in AIDS has shaped his personal life. In this sense, the book reads as a research report, a dissertation and a memoir all at the same time. “The greatest strength of this eloquently written book is its ability to weave together all those separate strands” (Klass,1994).

In relating his personal story alongside practice as a doctor of AIDS, Verghese strategically links his “foreignness” regarding his immigration experience to the sense of isolation that AIDS victims experience, which illuminates readers’ thinking on “otherness” and alienation. In his earlier contact with patients, the doctor is very much aware of his foreignness. He describes the paradox of himself as a new immigrant caring for American veterans, including veterans’ diatribes about the foreigners making money off those who fought for their country; and conflict with the local hospital staff who may sometimes lose patience with the foreign physicians (Verghese, 1995, p. 43). This foreignness allows the author to compare the marginalisation he faces as an immigrant doctor who is treating AIDS to the social marginalisation his patients suffer. Moreover, foreignness, as the doctor later learns, offers a position of exceptional insight. “The tantalizing and fascinating paradox of *My Own Country* is its suggestion that sometimes to be the ethnic or racial outsider is to be the supreme insider” (Srikanth, 2004, p. 436). Indeed, on the one hand, the doctor’s foreignness seems to train him to be more sensitive, understanding and empathetic, making it easier for him to connect with patients’ alienation from the local community; on the other hand, it makes him more approachable. The fact that the doctor is an “outsider”, who is assumed to be less judgmental, seems to endow the doctor with the privilege of a preacher, towards whom patients tend to be less alarmed and more willing to open up (Verghese, 1995, p. 117). In this sense, his foreignness seems to enable a “doctor-patient bond” (Ingrassia, 1994, p. 62).

This doctor-patient bond is how the doctor begins his “research report” on AIDS. In this report, the doctor employs a “research method” that involves humanity as much as science:

he carries out "experiments" through human contact; he conducts "field research" by practising bedside medicine; and he collects "data" from the patients' case histories. Stories are what Verghese values most during his encounters with patients. "Narrative is huge in medicine" (Neary, 2009), so Verghese comments when talking about his consultation with patients in a radio interview. Valuing patients' narratives, faithfully Verghese records these stories:

> I was also interested in the patients' stories for their own sake. I was fascinated by the voyage that had brought them to my clinic door. The anecdotes they told me lingered in my mind and became the way I identified them. Most of these stories I kept in my head. Some I recorded in a journal that I kept faithfully and that became very important to me as time went on. (Verghese, 1995, p. 126)

Similarly to Sacks' narratives in *The Man Who Mistook His Wife for a Hat*, the doctor-narrator in *My Own Country* describes himself as not only valuing patients' narratives but also a skilled listener and transcriber of patients' narratives, although Verghese makes himself much more visible than Sacks. Before a conversation, the doctor prefers not to be offered any information about the patient, "I wanted my first impression to be unsullied, I wanted it to be pure like a well-struck note – I wanted to hear every quaver and intonation. My ear must not be biased" (Verghese, 1995, p. 111); once the patient starts talking, the doctor seldom interrupts, only making comments when necessary. Moreover, during the conversation with patients, the doctor-narrator records not only the main plot and anecdotes during his encounter with patients, but "the whole package" of narratives, including such small details as the sequence of their storytelling, their use of pet phrases and body language. Even their dress style, their companions, and the scent of the room seem to be taken into serious account, as if every element forms a different feature in the narrative of patients. Verghese's approach resonates with Charon's description of a consultation with a patient, which she often quotes to explain the essence of Narrative Medicine:

> I listen not only for the content of his narrative but for its form – its temporal course, its images, its associated subplots, its silence, where he chooses to begin in telling of himself, how he sequences symptoms with other life events. (2008, p. 23)

What Charon suggests here is that, as listeners to patients' narrative, physicians do not only follow the "narrative thread", but also imagine the situation of the teller, recognise "the multiple and often contradictory meanings of the words used and the events described, and in some way enter into and are moved by the narrative world of the patient" (Charon, 2001, p. 1898). Interestingly, this comment was made based on readings of both Jerome Groopman's *The Measure of Our Days* and Verghese's *My Own Country.*

By portraying himself as a doctor who respects and values patients' narratives and a skilful listener and transcriber of patients' stories, the narrator not only explains how he builds up his knowledge regarding these patients' personalities, their special vocabulary and signals and their inner worlds, but also reveals his opinion on what makes a good doctor. Interestingly, the doctor describes himself as becoming an AIDS expert "in name only", since when he started practising, "there was no AIDS to see" (Ingrassia, 1994, p. 62). It is during the collecting of patients' stories that the doctor accumulates knowledge about AIDS, and becomes a real expert on it. Therefore, while it incorporates many case stories of patients, the book is "primarily the story of a doctor and his very personal journey" (Fitzgerald, 2001). Like Oliver Sacks, Verghese chooses patients' stories carefully. He draws readers' attention not only to patients that are gay, but a larger community of patients who are infected by other means. Each case study illuminates a different aspect relating to social attitudes toward, and ethical issues about, patients with AIDS.

In his storytelling about patients who are gay, Verghese chooses examples that highlight their humanity, creativity and value to counter the prejudice against them. Take his encounters with Gordon and Fred, for example. Gordon was the doctor's first case in Tennessee, and is described as having developed a colourful inner world and displaying an extraordinary talent for drawing. Fred is depicted as being intelligent, passionate and eloquent, and as having rich life experiences – he worked as a home manager at a learning-centre, taught at a community college and he now works as an accountant. Besides, he has a degree in psychology and participates actively in a support group for patients with AIDS. With both examples, Verghese argues that gay people have the same humour and creativity as others, and are just as engaging, when they do not need to hide their homosexuality from the outside world (1995,

p. 92), and they should be treated without prejudice as human beings. In a similar approach to Sacks' *The Man Who Mistook His Wife for a Hat*, the doctor in these case stories promotes a more understanding and tolerant social environment for the gay community, because "[t]he treatment meted out to gay men with AIDS, especially in small rural areas apparently the world over, can be compared only to medieval witch burnings" (Rowland, 1994, p. 1169). It is noteworthy that Verghese is so eager to challenge the social attitudes towards gay people that he poses the thesis that gay men may be "more representative of men than *heterosexual* men":

> … with gay men you are looking at men without the confounding influence of women to deal with. You are looking at the behavior of men left to themselves … meaning perhaps, some of the sexual activity of gay men, their sexual drive, the number and variety of partners, the ready possibility of anonymous sex, might present what all men want, except that they can't get women to agree. (Verghese, 1995, p. 143)

This extraordinarily problematic statement can be understood in similar terms to Sacks' use of terminology which is no longer acceptable. Verghese's clumsy attempt to valorise non-heterosexual male identity appears to be an attempt to critique prevailing expectations of masculine behaviour, particularly in the Southern United States, without the benefit of the critical discourse of queer theory which emerged later, and which he anticipates. Verghese and Sacks are similarly products of the own time and place in their use of language and/or ideas which are unsustainable when read by contemporary readers.

In addition, Verghese includes some case studies of patients who are non-heterosexual. The diversity of infected patients brings the doctor's understanding of AIDS to a different level. This type of patient self-identifies as being relatively "innocent", and with this portrayal, Verghese raises another important issue regarding patients with AIDS, namely that discrimination exists not only from outsiders, mostly uninfected people, but also from the HIV infected community – while most patients are discriminated against by society, some may at the same time discriminate against others, in particular, patients who are gay. For example, Vickie is infected because her husband had unprotected sex with other men. As she

recalls her first experience at the support group for AIDS patients, she says to herself "what in the world are you doing with a bunch of queers?" The word "queer" refers to gender minorities that are neither heterosexual nor cisgender.[12] Even though the term has significant and accepted currency in academic and political contexts today, it was a derogatory term at the time the book was written. The use of this word reflects attitudes expressed by patients like Vickie toward patients who are gay. In the second case, Verghese narrates a story about a patient called Will who is infected during a poorly-managed blood transfusion. Will not only asks the doctor to hide the nature of his disease from his family and friends, but also describes himself as being an "innocent victim". Will's case adds an interesting but perplexing dimension to the discussion about patients with AIDS. For one thing, Will's request for complete confidentiality indicates an existing discrimination within the world of disease: while a cancer patient can die as a hero fighting a battle, the HIV infected can only expect a death in indignity. Furthermore, as a target of discrimination, ironically, Will's self-description as an "innocent victim" also reflects discrimination, for the implication would be that patients who did not get the virus through a blood transfusion are "guilty" (Verghese, 1995, p. 250).

Compared with the time when the book was first published, there is much more tolerance in western countries towards those with AIDS, regardless of sexual orientation; nevertheless, it is worth stressing the value of Verghese's writing in the sense that he was one of those who first used creative writing to challenge the bias and discrimination against patients with AIDS both outside and within the community of the infected. In this sense, the book itself breaks cultural taboos of the author's time and place - the Southern United States in the 80s and 90s. Although many of the issues he raises have been commonly debated and some have become truisms for today's readers, the book not only offers an account of the attitudinal change in western societies toward patients with AIDS, but also offers illumination in other cultures where these battles have yet to be won, as Verghese comments in an article written twenty-five years after the break of the epidemic:

[12] Cisgender refers to those whose experience with gender accords with the sex they were assigned when they were born, as opposed to transgender.

> ... I watched with awe as politics eclipsed science and as gay activists rattled the cages of stodgy government entities like the Food and Drug Administration, and got results.
>
> ... Today I see so many of us who came of age at the same time now have one foot in Africa or Asia, as if we need the kind of challenge we once faced here. It is as if we have carried the lessons of the AIDS protest group Act Up abroad, to prove that one can make a difference even in a poor country, one can find ways to pay for and distribute drugs, one can make an impact on transmission from mother to child. (2006)

Alongside his practice and encounter with AIDS patients, the doctor keeps revising and re-defining his role as a specialist in infectious disease. When he first started practising, AIDS was still considered as a city disease, from which the rural area where Verghese lived was thought to be immune. Upon an activist's invitation, Verghese approached a local gay bar to publicise knowledge about the disease and the doctor adds the role of a public educator to his professional profile. In response to his health education and public speaking efforts to counter the public of ignorance about AIDS, his personal contact with the infected patients increased. As more patients came to share their private stories, the doctor began to function as an internist, a listener, a provider of services which "blossomed with the illness" such as referring patients to the support group, or even an assistant in such trivial things as helping patients get their insurance and handicapped parking stickers (Verghese, 1995, p. 185). To be more specific, as a *rural* doctor of AIDS, who practises in an area where ignorance and discrimination dominated and most AIDS victims were still in hiding, the doctor needed to act as the patients' surrogate activist and link to a larger consciousness of AIDS (Verghese, 1995, p. 276). In short, what the doctor deals with is not simply disease or patients, but "the moral, ethical and social subtleties that were so much part of this disease" (Verghese, 1995, p. 380). A big irony in the AIDS-clinic at his time of practice, however, lies in the fact that while there was a clear diagnosis, there was not yet an effective cure. This more or less echoes the situation the fictional character Roy faces when taking care of elderly patients in *The House of God*, and Sacks the neurologist faces in *The Man Who Mistook His Wife for a Hat*. Once again, the issue of what a doctor can do for patients is raised, and Verghese's opinion on the

issue is reflected in his adjustment of his role as a specialist on AIDS. He redefines his role as a practitioner of bedside medicine, and a provider of "the non-technological kind of medicine such as hand-holding and family visits", although neither does his training prepare him, nor does the medical system pay him, to be this kind of doctor (1995, p. 272). If he has been practising this type of medicine unconsciously before, the suicide of a patient helps him conceptualize his role:

> In the absence of a magic potion to cure AIDS, my job was to minister to the patient's soul, his psyche, pay attention to his family and his social situation. I would have to make some more home visits, make more attempts to understand the person I saw in the clinic, be sure I understood the family dynamics by meeting all its members. Some of this I was already doing as a matter of interest. I would now have to do it out of necessity. (Verghese, 1995, p. 272)

In addition, the doctor seems to suggest that even the smallest gesture of encouragement and comfort, factual or metaphorical, can convey the most powerful empathy. Like Sacks who delivers positive messages with the use of positive metaphor, the doctor-narrator in *My Own Country* offers a therapeutic handshake, as Norman, a patient who always maintained his dignity and courage, for the first time reveals his helplessness. By offering the "soul shake", the doctor successfully conveys how much the doctor thinks the patient is him, and him the patient (Verghese, 1995, p. 341). What is more, the doctor tries to offer what the Fat Man teaches Roy to do in *The House of God* – to be with patients. At the admission of a patient who has been turned down many times by many hospitals, for example, though without any therapy, the doctor-narrator offers a promise to take care of him, no matter what happens, which proves to be what the family want most (Verghese, 1995, p. 281). This "being with patients" is what Verghese regards as the "timelessness in the ever-changing medical field":

> When there is nothing more medically you can do for patients, remember it is just the beginning of everything you can do for your patients; you can still give them the best of you, which is your presence at their bedside.
>
> You can heal even when you cannot cure by that simple human act of being at the bedside – your

presence (Verghese, 2014).

Even when the doctor cannot be present, he tries his best to ensure that his patients are accompanied – he keeps referring patients to support groups so that patients do not to carry the disease alone. For example, Fred the gay man with a degree in psychology is actively involved in a support group for gay people. When realising Fred's activism is as therapeutic as being a physician is for the doctor himself, the doctor begins to refer more patients to the support group, and Vickie who has contracted the virus from her husband is one such referee. On her positive change, the doctor comments, "I believed laughter did a lot more than most things I prescribe" (Verghese, 1995, p. 413).

The most recent advances in drug treatment have tremendously slowed the degradation of AIDS patients' health; nevertheless in the year when the book was written, the doctor was confronted with the frustration that the essence of AIDS and the path it led to involved loss, degradation, and eventually death, even though he kept himself updated on every possible medical advance from the outside world and he encouraged patients to try new medication (Verghese, 1995, p. 281). Knowing that he is striving to cure what at the time was incurable – decaying physical condition and in the end death, the doctor still tries his best to make each diagnosis as if it is a "ritual of the examination", a "dance of a Western shaman", and a celebration of the music of the human body (Verghese, 1995, p. 424). In addition, the doctor further specifies his function as a provider of hospice services. Especially after a patient's violent death in hospital, the doctor reflects on what he could have done – diminishing the patients' suffering with large doses of morphine and easing their anxiety and fear with consoling words at their deathbed. From then on he keeps searching for ways to accomplish a good death, "If I could do little else, perhaps I could lead them to a proper end, the right punctuation to close a life" (Verghese, 1995, p. 371). In the whole process of readjusting his roles as a doctor treating AIDS, Verghese articulates what Shem, Sacks and other writers have continued to emphasise, "the secret in the care of the patient is caring for the patient" (Verghese, 2006).

In the course of making sense of AIDS and justifying his role as a specialist in infectious

diseases, the doctor-narrator explores how his personal life keeps being shaped and re-shaped by his job. From the beginning of his life journey, there is a strong sense of being unsettled and of unrest, a sense of foreignness and alienation. Even though he reasons his way to overcome the literal "foreignness", the doctor still suffers from a metaphorical sense of "foreignness", referring to the sense of isolation he suffers at work and at home. Starting as an AIDS specialist feeling proud, ambitious and self-important, the doctor finds himself becoming "a family doctor in the (possibly idealized) nineteenth-century style" (Adams, 1994, p. 136). Or in Tom De Haven's words, "he became far more than a doctor". But "practicing this kind of old-fashioned, folksy medicine exacted its price" (1994, p. 53). The fact that he is a country doctor of AIDS puts him into a position "of greater medical isolation" (Klass, 1994). He begins to feel more and more alienation from society: "By taking up the cause of AIDS, I had become tainted, the associations of this word had tarnished me, I often felt as 'guilty' as the kind of people I cared for" (Verghese, 1995, p. 253). What is worse, pressure comes also from his family. Here Verghese skilfully employs a set of metaphors to show how the job he takes on makes him a "foreigner" to his family, his shelter from the exhausting job in the past (1995, p. 167): the job is first compared to a "wild friend" that he indulges but no longer brings to the family (1995, p. 171), and then into "a mistress" that keeps him away from home and that he dare not introduce into conversation at home (1995, p. 288), till in the end, into a total taboo and an abyss that cannot be bridged (1995, p. 310). Even more frustratingly, the lack of understanding and support is not only from the non-medical world. Even in his hospital, AIDS becomes a "litmus test" for the nurses and physicians (Verghese, 1995, p. 105): the medical team have a debate about whether or not the AIDS patients are worthy of their effort; those who work with AIDS may be homophobic (Verghese, 1995, p. 184); the administration blames the AIDS clinic for not being profitable. The narrator sums up all the frustrating situations he faces as a doctor – the lack of remedies, family understanding, institutional support or social empathy, which offers an important insight into what makes a good doctor – a doctor can only function properly in an effectively run medical system. A similar kind of argument is raised in Samuel Shem's *The House of God*, and Bi Shumin's A Red Prescription, which I shall explore further in the next chapter.

The end of his research on AIDS represents the beginning of a new life. After the doctor submitted his findings to the *Journal of Infectious Diseases*, he was invited to add in anecdotes and individual case studies, which is how the book came into being. Soon he was offered a job in Iowa, and decided it was time to move on. It is during the constant readjustment and readaptation, as an immigrant, a specialist of infectious disease, and a family person, that the narrator searches for the sense of existence and belonging:

> From the time I was born I lacked a country I could speak of as home. My survival had depended on a chameleon-like adaptability, taking on the rituals of the place I found myself to be in: Africa, India, Boston, Johnson City. I felt as if I was always reinventing myself, discovering who I was. (Verghese, 1995, p. 58)

As a migrant, Verghese keeps searching for a sense of home; as a doctor, he keeps defining his functions in caring for AIDS patients; as a family man, he keeps justifying his roles as a husband and a father; as an ordinary person, he keeps exploring the meaning of life. Each settlement represents a new discovery and a new iteration; each move represents the start of a fresh journey, in search of a place where his restless heart can settle and where his disturbed mind is in peace. Although the three-in-one book – the research report on AIDS, the dissertation on what makes a good doctor, as well as the memoir of an immigrant – comes to an end, the doctor's research on infectious disease and reflection on what makes a good doctor, as well as the journey of home-searching, sense-making, is still on-going.

The following discussion examines the work of two female doctors, Susan Mates and Gabriel Weston, both of whom build a gendered critique into their discussions on "the good doctor".

2-4: A Female Clinician's Fictional Chronicle of Three Female Doctors

The Good Doctor (1994) is a collection of short stories by Susan Mates, a contagious-disease specialist. The title directly echoes the topic of this thesis, even though not all twelve stories relate to medicine. Among the twelve short stories anthologised, three of them are dedicated particularly to female doctors and will be read analogically in this chapter. Though the three stories are not directly linked, they coincidentally represent images of female doctors at

different stages of their professional lives, and concur in revealing the theme that it is especially difficult for women to become good doctor since, in addition to handling of the emotional costs of being a doctor, as male doctors do, female doctors have to handle gender discrimination, stereotypical expectations, issues involving power and hierarchy, and so on.

Susan Onthank Mates was born in 1950 in America. She was a formerly a concert violinist and is a practising physician. She was trained in internal medicine and paediatrics before she joined Brown University, where she works as a clinical associate professor of medicine and a visiting member of the Literary Arts Programme.[13] Meanwhile she has worked part-time as a contagious disease specialist at the Rhode Island State Tuberculosis Clinic. So far she has published one short story collection *The Good Doctor*, which won the 1994 Iowa Writers' workshop John Simmons Short Fiction Award. The book anthologises twelve stories of ordinary people's everyday lives and their emotional worlds. From a variety of social, cultural and professional backgrounds, all characters seem to "struggle to fathom the meaning of their lives and their place in the world" (Miksanek, 1998, p. 1044). Mates makes the best use of the economy and power of the short story form, to capture a few moments that impact greatly on a person's life, from which she reflects on the complexity of human nature and the subtlety of human emotions. But in most of her stories, Mates leaves the answer to her inquiry open-ended, leaving room for debate. "Amply nourished by memory and mystery, these stories are as much about what they leave unsaid as what they say. Like the characters themselves, we must search out meaning, must make sense of a difficult world where explanation is lacking" (Wellbery, 1998, p. 918).

In spite of its wide range of subject matter, "an important pattern" in the book is "the creation of characters whom nobody can diagnose – or who inspire a new reading by every viewer" (Gentry, 1996, p. 427). There is no explicit link between the twelve stories, nevertheless, reviewers tend to treat them as dealing with a coherent theme, and loneliness, displacement, suffering and salvation, as well as the influence of the past are some of the themes most

[13] The biographical information about the author is retrieved from NYU Health Sciences Libraries, the websites of Brown University and University of Iowa Press.

commonly found in the twelve stories (Kirkus Reviews, 1994; Warwick, 1995, p. 135; Wellbery, 1998, p. 918). Though most stories in this book are not medicine-themed, a number of reviewers tend to view the book as reflecting Mates' background as a medical professional: "That their author is a doctor sort of matters, but this is no ordinary musing about medical practice" (Charon, 1995, p. 755). In terms of the perceptions and insights, it is suggested that Mates "uses her experience as a practising physician to make sensitive and insightful comment on the nature of healing" (Kirkus Reviews, 1994). With regard to the use of language, Rita Charon argues that "Mates makes odd and effective use of medical diction throughout the stories" (1995, p. 755). In addition, the fact that characters in Mates' stories are from multicultural backgrounds is considered as being related to hospital culture (Gentry, 1996, p. 427). Therefore, the fact that the collection is titled "The Good Doctor" is somewhat significant in the sense that in many different ways, the title indicates one of the central questions in this collection.

There is a great diversity in Mates' ways of storytelling. It is sometimes a rather traditional sequential narration in the third person; sometimes a stream of consciousness or flashback from a first-person perspective; and sometimes a series of addresses in the second-person mode. Because she previously worked as a concert violinist, Mates' works are also commonly acknowledged for their delicate use of language and even musicality. For example, Charon takes the collection of stories as "a serious attempt to reclaim a language – simultaneously poetic, empirical, private, and universal" (1995, p. 755), and Tony Miksanek concurs by suggesting that Mates' use of language "eloquently captures the melody of medicine and human interactions" (1998, p. 1044). Caroline Wellbery is unstinting in her admiration for the musicality of Mates' storytelling, too:

> Her talent is better described in musical terms. Her range and depth rank her as a true virtuoso of the page. I can think of no-one else who in such sparse words convenes such an array of cultures and memories, of dilemmas and dreams. These she bathes in a lyrical sadness leavened only occasionally by lighter tones. (1998, p. 918)

Of all the stories told about ordinary people's lives, several of them happen to be from the

perspective of a doctor, among which "Ambulance", "Laundry" and "The Good Doctor" are of special interest for the purpose of this study. Though not chronologically related, the three stories present different images of a female doctor at different stages of her medical career: a medical student who is experiencing her first ambulance ride and just begins to make a little sense of her role as a healer; a mother-doctor who is torn apart by her dual roles and "struggles with issues of boundaries and the meaning of care" (Wear & Nixon, 2002, p. 111); an unmarried-doctor who is a role model for her students and colleagues but ends up giving in to personal longings, "only to learn how costly her selfless devotion to her profession has been" (Charon, 1995, p. 756). All three characters are depicted as being stuck at a certain moment, the moment of self-examination of their roles as a medical professional and an ordinary human-being:

> In each of the stories told from a physician's point of view, we find a doctor trying to do good, to do the right thing, and in each case struggling with the personal consequences of his or her actions. Mates portrays doctors as human beings, as people with human hearts who try to do the best they can but often fall short by their own estimations as much or more than by the estimations of society. (Michaelson, 1995, p. 273)

It is from the representation of these doctors' struggles as human beings, whether it is emotional, moral or sexual, that the discussion of what makes a good doctor, or to be more specific, a good female doctor, is drawn. Although Mates does not directly engage with Narrative Medicine or other medical humanities programmes, her works, especially "Laundry", are frequently quoted by scholars for the discussion of ethical issues and in medical humanities, including Rita Charon, the founder of the Narrative Medicine Programme. In addition to her admiration for the musicality of Mates' work and its "astonishing and lasting power", Charon highlights the humanity of the book, "Dr. Mates has learned — from mothering, from music, and from medicine — what being human means" (Charon, 1995, p. 756). In certain ways, Mates may offer inspirations to Charon, and the way Mates "lets her medicine register in the deepest, most silent places of her writerly self" (Charon, 1995, p. 756) anticipates the formation of the Narrative Medicine programme that

bridges the two disciplines in a profound manner.

"Ambulance" is a medical student's narration of her first ambulance ride on the night of a massive knife fight in the emergency clinic. When the hospital runs out of doctors on duty, the narrator is entrusted by the chief resident to transfer a young man to another hospital, and her duty is to sit in the ambulance and try to keep the patient alive. In spite of her efforts, the patient dies, and she blames herself for having done little for him and is stuck at the moment of guilt. Like Shem's *The House of God*, this story invites readers to the very early stage of doctors' career. While Shem's novel reveals in a satirical way the emotional cost for interns, this story unfolds a literary "musical" of a medical student's emotional preparation for becoming a doctor.

The chaotic, violent and frustrating experience starts as a peaceful night: "I was putting my feet up with the evening shift nurse on the women's ward" (Mates, 1994, p. 64). The past continuous tense immediately brings readers into the slower pace of night duty. When the narrator is chatting with Marie, the evening shift nurse, about Marie's two sons and her expected grandchild, all of a sudden, the casual tone and tranquility are cut short "innocently", as the author beautifully puts it. Thanks to the author's vivid depictions of sounds and sights, readers become involved in the melodrama of an ambulance rescue. First comes the prelude: the paging begins, from the senior house surgeon, to all the senior doctors, and eventually to all doctors available, setting up a sense of escalating emergency. After a brief introduction, the theme music follows, when all the medical students, the narrator included, are summoned. With the narrator rushing to the emergency room, readers seem to be located in a theatre: "Solo yells and screams peaked over a general chaotic chorus, like some experimental war requiem" (Mates, 1994, p. 66). Standing paralysed amidst the chaos for a moment, where doctors are doing their professional work, patients are bleeding and families are sobbing, the narrator is assigned to ride an ambulance with a dying patient, so follows what seems to be a military march – the ambulance taking off violently, turning abruptly, the siren on and the patient falling to the ground, the air bag blocked and the narrator adopting an awkward mouth-to-mouth resuscitation.

Unfortunately, the protagonist's solo performance, against the background of the chaotic chorus, looks awkward and unsatisfying. What is worse, when she drops by at the hospital the next day, the narrator is informed that the patient may have died even before being properly admitted the previous night. The fruitless first ambulance ride offers an interesting perspective on the discussion about the good doctor: before learning how to save life, a doctor must learn how to handle death, emotionally. But the student seems to be too young and inexperienced to reach this conclusion on her own. As if compensating for the student's incapacity, two nurses seem to do what the Fat Man does for Roy in *The House of God*, by showing the female student the way to handle her emotions triggered by death. When the patient's death causes the narrator a strong sense of uselessness and disappointment, the head nurse stops the narrator in the hall and mildly criticises her for her self-accusation:

> …she suddenly frowned and grabbed me by the shoulders. "Do you think you should have saved him? Who do you think you are? Better than you tried to save that boy's life, not just in one minute in the end, but year after year after year, and you some white girl gonna come down here and make everything all right in a few minutes?" She herself was shaking now. (Mates, 1994, p. 71)

The black nurse is warning the young white doctor about the danger of expecting herself to act as a heroic figure and to solve every problem. In quite a different manner, Marie, the nurse the narrator was chatting with at the beginning of the story, comforts her by showing a photo of her newly-born grandson when they meet later that night:

> She fumbled in her pocket and pulled out some dog-eared Polaroids. "Here, let me show you something. My new grandbaby, just born last night. Isn't she beautiful?"
>
> She smiled like the moon breaking loose on a cloudy night. (Mates, 1994, p. 71)

Both nurses in fact try to teach the narrator the same thing – life continues while death frequently visits, and a doctor cannot expect to save every patient. Therefore it is very important for a doctor to stay positive and not let a patient's death get in the way of their self-assurance as a healer. What is more, both nurses demonstrate for the narrator what they regard as being professional, in their different ways. The head nurse warns of the risk of

mouth-to-mouth resuscitation and offers to show the narrator how to use the ambulance bag. Her gesture emphasises the importance of ensuring doctors' own safety, prior to their attempt to save patients' lives, which echoes Shem's suggestion that a doctor needs to ensure his or her own health so as to be able to take good care of patients. Marie, on the other hand, demonstrates a medical worker's obligation and care by smoothing patients' pillows, in spite of their being unconscious. Her sense of obligation echoes Verghese's effort to make each diagnosis a performance, despite the fact that he can offer little effective medication for AIDS victims. Rather than doing nothing, both nurses show how a medical practitioner is capable of doing something for patients – as is unanimously argued in Shem, Sacks and Verghese's works, and capable of doing something for doctors themselves, as Shem stresses in *The House of God*. In this sense, the fruitless experience of the ambulance ride is in fact fruitful, in terms of its impact on a medical student's understanding of her future career.

In contrast to "Ambulance", the stories "Laundry" and "The Good Doctor" offer much more complicated pictures of a female doctor's struggle with her professional self and personal self. Like Verghese's memoir, but in a very different manner, "Laundry" involves a doctor's, but this time, a female doctor's, self-justification of her role as a medical professional, and vividly captures the complicated emotions the doctor has developed during her encounter with a patient – frustration, anxiety, compassion and sympathy. The story is narrated in the first person by a mother-doctor. Once again, the use of the past continuous pins readers down to a certain moment, when the narrator is folding the baby's diapers and the telephone rings. The narrator does not pick up the phone until the end of the story, and what is depicted between the diaper-folding and the phone-answering is the doctor-narrator's reflection on caring for a dying patient during her pregnancy, interrupted from time to time by the narration about the nursing of her newly-born baby. The laundry serves as an indicator separating the present time from her reflection.

In flashback, the narrator recalls the last days of a patient named Mr Dantio, who is diagnosed as having cancer and in need of the doctor's advice about his treatment. The recollection is related in the second-person narrative mode, as if the narrator is addressing the

dying patient in person, although it is only the narrator's reflection on the patient's condition. This second-person narrative promotes an active interaction with readers: "I don't know Mr Dantio, the cancer is all over your lungs those cells are eating you, collapsing you, deflating you, your X-ray looks like a drowned man, and each breath drives a spike of pain through your chest" (Mates, 1994, p. 10). The narrator moves on to describe Mr Dantio's decaying condition, with a number of metaphors, reflecting on what was not said to the patient but the narrator knows must endure in her memory, "I'll watch when you scream and the water in your lungs bubbles up pink like cotton candy from your mouth and nostrils and I'll see the terror in your eyes as you try to pull a breath and your muscles contract and your ribs stand out like a skeleton and no air comes in ..." (Mates, 1994, p. 10). When the doctor and the patient exchange ideas about the necessity of taking a biopsy, what the narrator offers at first are results of studies that are "scientific and more systematic than just one doctor's experience"; but what Mr Dantio asks for is the doctor's honesty and empathy, "don't tell me about studies[;] tell me what you would do" (Mates, 1994, p. 12). But the decision is intricate. From a professional point of view, the narrator reckons that taking a biopsy may prolong Mr Dantio's life, but from her personal perspective, she perceives the treatment as involving torments and suffering. Therefore, to talk the patient into treatment means torturing him, but to ask him to give up treatment means declaring his death in advance. Here the doctor's "advice" is of great significance in that it "highlights the ambiguity and uncertainty many health care professionals experience when it comes to implementing the 'recommendation' component of the informed consent process"; moreover, the "advice" serves to test the boundary between the doctor's professional self and personal self (Martinez, 2002, p. 185). This example once again reinforces my argument that in real life, patients may tend to ask for certainty from doctors, and creative writing offers physician-writers an ideal platform to negotiate with patients about the uncertainty and ambivalence of medical practice. As a result of the inner struggle, the narrator suggests that "I would not do it, don't do it don't let them me do it to you no" (Mates, 1994, p. 12). The repeated use of negatives represents the doctor's sense of helplessness at the tension between her competing perspectives.

After advising the patient not to have the biopsy, however, the doctor-narrator cries right in

the middle of the hall, stuck in the helplessness of striving to become a good doctor. What is worse, she is challenged by a male surgeon for not having persuaded Mr Dantio to undergo the biopsy. The encounter between the two very much resembles that between Oliver Sacks the patient and Swan the surgeon in *A Leg to Stand On*. By contrast with Sacks who takes a quite masculine action by criticising the surgeon, the doctor-narrator in Mates' story makes a gesture of retreat by portraying herself as being distracted and inappropriate – her white coat split down the middle and belly stuck out, "a lost pregnant woman with greasy hair and a discharge in [her] pants because the baby is coming" (Mates, 1994, p. 13). Her self-portrayal forms a deliberate contrast to the image of the male surgeon, who is depicted as young, tall, energetic and clean shaven, with "clean white coat buttoned down his flat front and his neat black hair" (Mates, 1994, p. 12). Here the writer makes good use of irony. She portrays the female doctor as she is envisioned by the male surgeon – a stereotypically incompetent and unprofessional female doctor in the family way, despite the fact that the female doctor has greater insight.

When the narrator is on maternity leave, the patient dies anyway, without much dignity – he is jumped on, his chest is pounded and cut open, and his heart is squeezed, though "he never wanted all of that". As readers may be about to criticise the inhumane way Mr Dantio is treated, however, they soon find the irony – after Mr Dantio's death, infection is found in his lung, and the narrator begins to doubt her advice to him in the first place:

> …all I could think of was maybe I was wrong, maybe he could have lived longer if he'd had that biopsy, maybe I never learned this language right, medicine, I feel like I'm a visitor from some other world dressed up like a doctor but they can tell I'm not really one because in moments of great stress I revert to my native tongue. (Mates, 1994, pp. 13-14)

The "language" stands for the practice of medicine in a highly masculinised world. Throughout the storytelling, the narrator seems to have trouble identifying herself as a good doctor: when being addressed as doctor, she seems a bit confused over the phone, "yes I am Dr Martin, pointing to the name tag that says Dr Martin on the white coat that says doctor, doctor, doctor"; considering buying her daughters a new bicycle, the narrator seems to think

about other options, “maybe I should try to work another job, after all I am a doctor”; in response to Mr Dantio’s complaints, the narrator expresses her helplessness, “… I can’t win this battle, slay the dragon…”, “it wasn’t my decision, no one asked me should he live or die”; when confronted by the male surgeon, she directly denies her role as a doctor, “I’m no doctor, I never thickened and rooted and became ‘Doctor’”. The strong sense of denial is generated not only from the doctor’s confusion about what to do for the dying patient, but also from her self-identification as a woman and a mother whose perspective is marginalised in the masculinised world.

A pregnant woman doctor who is about to give birth offers a valid perspective for the discussion about what make a good female doctor, since she embodies “the gendered ambivalence of some women regarding medicine and motherhood” (Wear & Nixon, 2002, p. 112). On the one hand, the fact that women physicians may have access to the experience of birth may be the source of the stereotypical expectation for them to be more patient and motherly, with better nursing skills compared with male doctors. On the other hand, women physicians are expected to be tougher and stronger, acting against the stereotype for women doctors in some medical fields where competition is heated. For example, the narrator complains that as the only woman doctor in her hospital, while the wives of the doctors receive flowers when they have babies, no one has sent her flowers when she has her own baby. What is even worse, she is not given the full minimum maternity leave.

All through the storytelling, two existential themes are interwoven, one is life – the caring for the baby, and the other is death – the caring for a dying patient. It is noticeable that the way the narrator describes the baby’s crying, complaints and needs for milk forms an analogy to the patient’s complaints, depression and demands for help. The parallel storytelling about the baby and the patient not only represents a female doctor’s struggle between her role as a housewife and a doctor, but also highlights a female doctor’s role as a care-provider for both the newly-born and the dying. Rather than the conventional nurturing, loving and competent image, however, the care-provider presented in the story is portrayed as being messy and somewhat incompetent. Page-long paragraphs of stream-of-consciousness, dialogues without

quotation marks, and a natural switch between the fictional now and then produce an intense rhythm, which mimics the doctor-narrator's state of being chased, stressed and out of breath, as if the narrator strives to look after both the patient and the baby, but fails. In spite of the narrator's self-identification as a helpless, vulnerable and inept doctor over and over again, I would rather take this identification as a strategy. Unlike Sacks who fights back by writing to criticise the surgeons, Mates in this story makes concessions so as to earn space to advance. By making the female doctor admit that "I never learned this language right", the author earns herself room to challenge the "language", the way medicine has been practised; by admitting to vulnerability and helplessness, rather than playing tough or masculine, women doctors in effect reaffirm their gender and motherhood, which may earn them a valid and secure position in the male-dominant medical world. The reflection about Mr Dantio ends with a "neatly seamless and infinite circle of life" (Belling, 2008, p. 17), as the narrator bump into his wife and chats with her about Mr Dantio's death and the doctor's newly-born baby. What seems to be a philosophical ending joins the good doctor with the good mother in "life-affirming attentiveness" (Charon, 1995, p. 756), leading the storytelling to closure, but the discussion continues.

"The Good Doctor" involves a story about a much more mature female doctor and depicts the kind of doctor who is a highly devoted, almost a perfect role model to younger doctors but whose professionalism as a doctor gives way to her emotions as a woman. This kind of portrait is also seen in Peter Goldsworthy's portrayal of the female doctor Lucy in *Three Dog Night*, which will be examined later. While in *Three Dog Night*, the key concern is for the proper palliative care a female doctor should offer to her "patient", who is at the same time her husband's best friend, the discussion triggered in Mates' story involves issues not only around sex, as in *Three Dog Night*, but also around power.

The story records, in the third person, the experience of Helen, a middle-aged unmarried doctor who has returned from Africa and taken over the job at the medicine department at City Hospital. All through the storytelling, the African jungle seems to form an intriguing analogy to the urban jungle, whether it is the "cycle of life, death, and the changing seasons",

or the same *rule* that applies to both worlds (Miksanek, 1998, p. 1044). The frequent switches between the two worlds offer an effective context for the protagonist to make sense of her professional and personal life. Unlike the female doctor in "Laundry", who struggles with her role as a good doctor, it seems that Helen is already regarded as a perfect doctor: she is a missionary who has set up a small clinic in a remote area in Africa and devoted herself to the care of local people; she is a scholar who has achieved academic excellence in the field of virus study; she is head of the department who is considered as an authority by her colleagues, as "Sister" by staff members, and as role model by her medical students; she is a supervisor who encourages the devoted chief resident Diana to "fit practice around family" and teaches the careless medical student Mike to do as much as possible "for the patients' good". It is worth noticing that in spite of her unmarried status, the portrayal of Helen brims with a strong sense of motherhood. Having reaffirmed for herself that the job in the hospital is her life-mission, for example, Helen is depicted as taking on "a pregnant glow" and feeling "more content than she could remember in her life" (Mates, 1994, p. 37). The way Helen teaches and helps Diana more directly reflects her metaphorical motherhood: she takes Diana as her daughter from the first time they meet; she feels comforted in thinking of Diana as a daughter, married and a doctor herself; she suggests Diana spend more time with her husband and have children before she gets too old; she finds pleasure in helping Diana to become a good doctor, "after all the years of solitude". Therefore, motherhood in Helen's case is more a metaphor of the unreserved caring and devotion of a woman doctor to her job.

But the image of a perfect motherly doctor is suddenly deconstructed. After the death of a staff member, Mike the medical student suffers an emotional break down and turns to Helen for comfort. In spite of her resistance in the first place, Helen is seduced by Mike, who turns out to be attempting to bribe Helen with sex to let him pass his exam. The deconstruction of the perfect doctor invites a reconsideration of what makes a good female doctor in the most striking way. Erin McGraw suggests that the medical student's seduction of Helen is "predictable and fascinating, like a slow-motion train wreck" (1995, p. 546). It is predictable in the sense that it follows a recognisable pattern of behaviour, but striking and fascinating because the roles are reversed. It is this reversal that is central to Mates' critique since if Mike

had been a young woman and Helen a senior man, the scenario would be far less likely to elicit the same kind of readerly comment or excitement. While in the traditional medical system, the critique of the manipulation of power often involves a relationship between a senior male doctor and a junior female doctor, in Helen's case, it is the female doctor who has gained authority and power and struggled with the question of how not to abuse it. This configuration very much complicates the discussion of the "good female doctor".

At the same time, McGraw's comment is problematic in the sense that it neglects the fact that Helen's professional success is at great personal cost. Helen is unmarried, having prioritized her career over her personal life, yet her sexual desire is intensely portrayed. For example, the moment Helen's eyes set on Mike, the sexuality seems to intensify: "... Helen saw an extraordinarily beautiful young man with smooth, almost hairless golden skin, laughing and tossing his head. Like the African sun, thought Helen. Like sex" (Mates, 1994, p. 32). As she warns Diana about the issue of the abuse of power, Helen cannot help glancing at the student's tight buttocks, though she looks away quickly and with humiliation; even though she threatens to fail him, when she senses the student's flirting glance, she is immediately erotically charged. Nevertheless, Helen who desires for human love and comforts needs to choose her career over her emotional life, and her choice becomes part of this extended critique of the system. According to Jack Coulehan, who helps medical students explore the meaning of professionalism using such short stories as "The Good Doctor", medical students' responses to the story vary. While some students condemn the character and then "generalise to impugn the motivation for her life's work", the majority seem to take "a more nuanced approach" by agreeing that the fictional character "has generally been a good person and a good physician, but they struggle with the implications of her recent peccadillo" (Coulehan, 2007, p. 108). Doubtless, in a general sense, Helen is both a good physician and a good person. During her long struggle between professionalism and personal longings, professionalism has always had the upper hand. The days spent in Africa, as she later realises, offered an apprenticeship to prepare her for the life at the City Hospital, where she learns to subjugate her will, and dedicate herself unreservedly to her career. In this sense, her "peccadillo" is only a temporary manifestation of her long suppressed yearning for human affection or even family life, and

therefore the fall of the perfect doctor represents the rise of an ordinary woman.

Before readers may reason themselves into forgiving Helen's "peccadillo", however, they are greeted by another irony. At the end of the story, filled with shame and disgust, Helen decides to write a letter to the Dean about her affair with the medical student. But then she changes her mind and decides to forgive herself:

> Helen climbed down from the windowsill and sat at her desk. "The men," she said firmly, to herself, "do it all the time." She listened for a moment, for a rebuttal. Then she pulled on a white coat, to cover herself, and went out onto the wards. (Mates, 1994, p. 41)

Not that she feels unashamed of what she has done. Unlike many fictional unmarried female doctors who are either unaware of their problems or uncritical of themselves – such as Jo the resident in Shem's *The House of God* or Professor Jing in Bi Shumin's A Red Prescription – Helen is depicted as being self-reflective and self-critical. From time to time, she would reflect on her personal life and personal needs. When Mike says he wants to enjoy life rather than becoming a superdoctor, for example, Helen turns to a self-mockery of her devotion, "You are a fifty-year-old woman", and "You are inappropriate. You are disgusting" (Mates, 1994, p. 35). The extended critique of the system is expressed in the incompatibility between her masculine position of seniority and the power it potentially enacts and the femininity of her self-critique. Like "Laundry", "The Good Doctor" portrays a woman doctor's self-identification in the masculinised medical world. Unlike the mother-doctor in "Laundry", who uses her vulnerability and gesture of concession to launch a strategic critique on the male-dominant medical world and the masculine way of practice, the unmarried-doctor Helen seems to offer a little "fight back". Ironically, the issue of power is what she has warned Diana about before, in the teacher-student relationship:

> "you must be careful about personal relationships. There is the issue of abuse of power." She looked away quickly, and with humiliation.
>
> "Yes," said Diana. "But," she added, "the men do it all the time." (Mates, 1994, p. 34)

Helen who questioned the male-dominant system and warned her Chief against the danger of sex and power at work ends up becoming the subject of her own critique. What is highlighted is the inequality of behavioural expectations for senior men and women with respect to sexual relationships with their juniors. To conclude, issues raised in the three stories, especially the last two, are controversial, intriguing and thought-provoking in the medical profession because of the gender inequalities entangled with power. "Mates takes great risks in telling these stories, and she tells them for the sake of us doctors", so Rita Charon comments (1995, p. 756). By presenting three female doctors with the flaws and frustrations and struggling to make sense of their role as a care-provider, a mother, and essentially, a human being, Mates create a series of competing perspectives to demonstrate different sorts of challenges in being a woman doctor and offers a strong critique of the prevailing system of power. It is exactly ambiguity and uncertainty that invites and illuminates readers' thinking about the good female doctor, and in this lies the beauty of Mates' storytelling.

2-5: A Female Surgeon's "Poetic Reflection" on Her Maturity as a Doctor

In quite a different manner from Mates, Gabriel Weston in her essay collection *Direct Red* (2009) traces a female surgeon's physical and psychological journey towards maturity. With fourteen essays chronicling the doctor-narrator's transformation from an intern to a qualified doctor, the book raises the question "what makes a good female doctor" in a relatively more direct way than Mates' three stories about female doctors. The discussion of the "good doctor" is predominantly carried out within the field of surgery, where surgical qualities are carefully analysed, the doctor-patient relationship are vividly presented, and a wide range of issues around hospital practice are debated regarding power, responsibility, discrimination and so on.

Gabriel Weston was born in 1970. She received an MA degree in English at Edinburgh University before retraining as a medical doctor at King's College in London. She graduated as a doctor in 2000, and became a Member of the Royal College of Surgeons in 2003 and an ENT specialist in 2005. Now she works as a part-time surgeon at Frimley Park Hospital in Surrey, specialising in skin cancer. So far she has published an essay collection *Direct Red*

and a novel titled *Dirty Work*.

Published in 2009, *Direct Red: A Surgeon's Story* traces a female doctor's transformation from an intern to a qualified surgeon. Though the author describes her book as not being literally true, many reviewers tend to read the book as the author's surgical memoir. N. Craft, who seems to be Weston's colleague, claims to be able to identify some of the characters and events mentioned in the book (2009, p. 123), and this concurs with George Rousseau's suggestion that the book "reads like a memoir rather than a fiction" with "anecdotes" and "vignettes" (2010, p. 428). Nevertheless, Nadine De Alwis describes the book as "a collection of short stories detailing important lessons learnt throughout her medical career..." (2010, p. 193); whereas Elizabeth Day takes the book as a "compelling semi-fictionalised memoir" that explores the "intriguing conundrum" of medicine as a "combination of dispassionate abstraction and extreme human emotion" (2009). The ambiguity of genre can be ascribed to the fact that the narrator corresponds to a large extent with the author, in terms of occupation, voice and values. Nevertheless, there is no doubt that the writing itself draws largely from Weston's own experience as an intern and a practising surgeon. With "a mixture of things that have happened and things that might have happened", Weston attempts to achieve a sense of "authenticity", since, according to the author herself, "authenticity works and bullshit really doesn't" (Calkin, 2013).

Authenticity in Weston's context does not mean the factuality of her stories, but the sense of honesty the work produces to readers. To give the impression of honesty, Weston writes in a self-reflective tone. According to Weston, writing with honesty is made possible thanks to a series of revolutions in medical practice in recent decades. For example, the Patient's Charter of 1991 in the UK, as Weston mentions, revolutionised the doctor-patient relationship, granted patients more rights and dethroned doctors to some extent. As a result, the perception of what constitutes a perfect physician has changed, and doctors are encouraged to admit to and learn from their own mistakes; besides, communication skills have become a core subject in medical training and the importance of an open dialogue between medical professionals and patients is highlighted. It is in such an increasingly tolerant climate, according to the author, that *Direct Red* came into being (Weston, 2009a, p. 1411).

As the author hoped, the book successfully unfolds a convincing picture of the surgical world. It offers first-hand information about what it is like to be a surgeon; it reveals previously unrevealed scenes in the surgical theatre; it analyses the qualities that distinguish surgery from the other medical specialties. What is more remarkable, the author does not hold back the emotions that an intern and a surgeon may experience during their training and practice. A complicated combination of pride, frustration, awe, shame, dislike and sense of responsibility and so on is presented without reservation. Some of these, such as the impatience towards certain patients or dislike for certain colleagues, the sense of incapacity or the vanity of impressing a boss at the expense of the interests of patients, may look offensive or disturbing to the lay person's eye, but many doctor-readers find they are able to relate to them: "This honesty is far removed from the surgical corridors of television and fiction, where every patient teaches the doctor a valuable life lesson, and each death [is] a personal agonising moment of failure", comments Sarah Asbury, a doctor herself (2010, p. 40). Controversial as it may be, the author seems to believe that blunt honesty will not harm a doctor's trustworthiness. Quite the opposite, with honesty, she seems to suggest, a doctor is in a favourable position to justify his/her motives and experience. In "The Uncertainty of Medicine", Weston's book review of two doctors' literary works, the author openly admires the "growing canon of medical writing that represents the doctor as less than omniscient" (2009, 1412), and takes the honesty about the doctor's own uncertainty, mistakes, and true emotions as her writing principle. Weston's writing with honesty resonates with what Narrative Medicine proposes doctors should do, to write reflectively, so as to "achieve more accurate understanding of all the sequelae of illness, equipping them to better weather its tides", "through the narrative processes of reflection and self-examination" (Charon, 2001, p. 1899).

That the writer has received training in literature seems to set up high expectations from readers. Her work is described as having "accuracy and lyrical beauty" and as having "richness of language and imagery" (Dillner, 2009, p. 1214); it has been described as a book "too literary to be called an exposé" (Carpenter, 2009). Throughout the book the writer "uses her familiarity with English literature to bring a depth and poetry to her practice" (Asbury,

2010, p. 40), and the book is "a doctor's poetic reflections on her profession" (Shakespeare, 2009). The poetic reflections in this book, as I read it, are essentially dedicated to the discussion about what constitutes a good doctor, and on many occasions, particularly about what constitutes a good surgeon. Although the book is written from a female surgeon's perspective, which has the potential for strong gender critique since the field of surgery itself is very male-dominated, Weston chooses to deal with the issues of sex and power in a rather broad and self-reflective way. Some of the essays do involve a gender critique, but the gender critique in this book is less overriding compared with Mates' stories.

The essay collection is in narrative form and serves a reflective purpose. The experiences and events are narrated and examined retrospectively by a much more experienced female surgeon, compared with when she first started her training as an intern. It is divided into fourteen small sections based on themes, with a single-word title each, such as "Sex", "Death", "Hierarchy", and "Changes" and finally "Home", clear and powerful. They involve "common situations every trainee has been in" (Asbury, 2010, p. 40), or controversial issues generally discussed in medical practice. They do not simply embark on technical concerns in surgical practice, but, on more occasions, trigger emotional, moral, or even philosophical reflections on surgery as a distinguished medical specialty, medicine as a modern institutional system, and surgeons as a distinctive species. Perhaps this explains the fact that the book has been extensively read and reviewed by medicos, "...this is a surgical memoir, written for us in the profession to enjoy and perhaps allow remembrance of our own personal halls of medical fame" (Asbury, 2010, p. 40); and further recommended to future medical students, "... for those who are thinking of a career in medicine as it will paint a picture of what life was like and is often still like" (Challenor, 2010, p. 20).

In terms of structure, all fourteen thematically-divided sections are relatively independent and make a complete episode of their own; these independent episodes approach the discussion about the "good doctor" from a variety of perspectives. The structure of the sections vary from one to another, producing a sense of variety and flexibility: it can be from general to particular as in "Death"; several different examples may be integrated in one as in "Sex"; it can start from an argument but end with the opposite conclusion as in "Children". Various as it is, each

section is integrated in the broader structure of the book – the external exploration of what makes a good doctor is at the same time an inward search for home. While for Verghese, "home" stands for an immigrant's searching for a sense of belonging and an AIDS specialist's demand for understanding from the outside world, "home" in Weston's case represents a female doctor's moving towards maturity, and a more mature understanding of her life as a doctor, wife and mother.

The scenario opens right in the middle of a surgical operation. It offers a clue for readers' understanding of the title – *Direct Red* – the narrator's "reciting pathology slide stains in all colours of the rainbow (including direct red) to avoid an operating theatre vasovagal" (De Alwis, 2010, p. 193), and more importantly, it puts the enquiry about the "good surgeon" into action. In the first section titled "Speed", the idea of the "good surgeon" is examined with the number one technical quality in a surgeon – swiftness. Two slowly and inefficiently executed operations are narrated. The first one is performed by the narrator's "foolish boss" who is deliberately reluctant to act fast. His sluggishness proves to be fatally devastating when the patient dies of massive blood loss; the second one is carried out by the narrator herself who fails to make a fast, firm and unfussy cut as she intends to. What is worse, the pressure to please her "talented boss" with speed almost puts her patient's life at risk. Interestingly, the two cases narrated approach the discussion of "a good surgeon" as counter-arguments: the first one reinforces the argument that being swift and decisive, in decision-making, action-taking and performance of their crafts, makes a good surgeon; the second one deconstructs the argument, as the narrator realises that for an unskilled surgeon, what is more important than speed is the safety of the patient, "I do not yet know whether I will make a good surgeon, but the fact that I am slow at the moment doesn't make me a bad one" (Weston, 2009b, p. 9). While emphasising the "paramount value of a quick response", the narrator warns against the "absurdity and hubris" of her seduction by speed.

Like "Speed", most sections contain two or more case-stories, forming counter-arguments to each other. There are rounds of negotiation between the seemingly opposed arguments which achieve a comprehensive reflection on "what makes a good surgeon". For example, the surgical quality put up for discussion in "Children" is *roughness*, "an absolute requirement of a

surgeon", and the topic about treating the underaged sets up an ideal context. Two cases are narrated: in the first case, a child has fractured her femur. In order to prevent the soft tissue damage from getting worse, though she wants to comfort the screaming girl and to be on the good guys' team, the narrator has no choice but to assist in pushing the divorced pieces of bones back into unity, reducing the damage to minimum. The case echoes William Carlos William's "The Use of Force", in terms of the attempt to justify the necessary and proper use of force for the patient's benefit. In the second case, however, the argumentation is turned around: one night when she is on call, a child without a guardian complains about his headache. Feeling awkward at talking to children and also feeling sleepy, the narrator increases the dose of morphine before quickly returning to her room. Later that week, when the narrator knows that the child has died of a brain tumour, she cannot get rid of the unease of having offered a painkiller rather than human comfort to this lonely child at his last moments. Therefore in the second case, the narrator attempts to argue for the importance of replacing toughness with gentleness. Once again, the two opposing cass seem to suggest that a good doctor should know when to perform with brutality and when to offer human comfort.

Like Shem and Sacks, whose works reflect their pride in their own specialties, in Weston's representations of the surgical world and her critical thinking on the surgical specialty, there is a sense of surgery being "exalted and portrayed as the king of medicine" (Rousseau, 2010, p. 428). The "king of medicine", however, does not always make the narrator proud. On many occasions, a mixture of emotions towards surgery such as pride and shame, admiration and criticism set a complicated context for discussion about her specialty. "Beauty", for example, starts with the narrator's strong admiration for the beauty of surgery – the diagnostic definiteness, the combination of regularity with a magical artistry, the military adherence to the principle of order, the craft that is "repeatable, reliable and always dramatic", the choreography inside the theatre – all of which, at least for the narrator, makes surgery stand out within the ambiguous world of medicine. The "rosy", "controllable and pretty" picture of surgery is smashed as admiration gives way to the narration of a violent surgical scene. The author seems to portray two pictures of the same patient by deliberate choice, one in grace and peace and the other deprived of liberty and dignity. The patient is called Mr Cooke, a professor of English

literature. In the first scene, Mr Cooke, with whom the narrator engages in a pleasant conversation about literature, holds hands with his wife while they joke about their marriage-long dispute on different literary genres; in the second scene, Mr Cooke is wheeled into the theatre, pinned down and arms strapped in position, needled and sliced open, guts hoisted out. Unfortunately, he does not survive the surgery; what is worse, he is denied the opportunity to say a word of farewell to his wife. By contrasting the beauty of surgical craft and the violence it is attached to, the author attempts to weigh efficiency in surgery against the need to offer the patient dignity.

While in such stories as "Speed" and "Beauty" the issue of "the good doctor" is examined specifically as "the good surgeon", a single species having distinctive surgical qualities, the "good doctor" is also explored in a broad sense as a care-provider, no different from other medical specialists, and in this case, such factors as sex, competitiveness, power, and communication, that may get in the way of the "good doctor", are taken into account. First of all, the story "Sex" probes into one of the greatest challenges a female surgeon faces in a male-dominant specialty. Weston integrates in this essay three episodes of sexual tension – commonly experienced in a female doctor's workplace, though they are not closely-related to one another: the narrator's embarrassment when treating a male patient; sexual harassment by a male surgeon; as well as a romance between the narrator and her patient. By contrast with Mates, Weston skirts around the issue of power and offers broad advice that a good doctor in such a circumstance should learn to manage sexual matters in hospital life.

Secondly, in the opening paragraph of the story "Territory", the doctor-narrator admits that "success in a profession as competitive as surgery" requires "a strong sense of self". She demonstrates what it is like for many doctors when the tension arises between "what is best for a patient and what is best for one's career": to gain the reputation of "a no-nonsense young surgeon who didn't make unnecessary work for her bosses, who didn't create long ward rounds, who didn't display that worst of faults, sentiment", the narrator puts what is best for her career before what is best for her patients by successfully rebuffing patients that may need to be hospitalised, which could be identified by feminist commentators as a masculinised mode of behaviour. Only when she receives undeserved thanks for her vain

effort to save a patient, does she realise the error of her territorial perspective. Bravely confessing that she has often put herself before her patients in the earlier years of surgical training, the writer concludes with a reflection and meanwhile a piece of advice to medicos that, in spite of the competitiveness the specialty may require, "the single most important part of the job is protecting the interests of those you are lucky enough to be looking after" (Weston, 2009b, p. 90).

Thirdly, "Hierarchy" involves the discussion about *power* in a medical system. It briefly traces the narrator's emotional journey at different stages of the hierarchical system. The first case is at the early stage of training when the narrator still feels capable and cocky. She is eager to show off to her friends the skeleton model she has collected at the anatomy department. The self-congratulatory thrill of becoming a medical student, unfortunately, is soon frustrated by the sense of uselessness, as the narrator fails to save a man's life in a pub, due to her ignorance of primary first aid. In the second case, the narrator rises "significantly in the hierarchy and becomes a registrar". To perform in the "hierarchy", she has to keep reminding herself to "stand a little aloof and let [my] SHO do the chores" (Weston, 2009b, p. 72).[14] When an important diagnostic decision needs to be made and reported to a registrar, she realises she is the registrar on call. Here somewhat echoing what Mates does in "The Good Doctor", but from a rather different perspective, Weston adds another dimension to the issue of power: with greater hierarchical rank, comes not only greater power but also greater responsibility. Unlike Sacks, who is unaware of, or at least uncritical of, the doctor's demonstration of power over patients, Weston not only acknowledges its prevalence but argues for the necessity of exercising this kind of power and explores the possibility to make the best use of the power to fulfil his/her responsibility.

Last but not least, both "Voices" and "Help" suggest that effective communication makes a good doctor. In "Voices", two cases of ineffective communication are presented, which lead to the conclusion that, firstly, patients' voices are important for the examination and treatment process, and thus should be valued; secondly, efforts should be made on both patients' and

[14] SHO refers to the Senior House Officer.

doctors' sides, to ensure smooth communication. In "Help", the focus is switched to communication between doctors, "poor communication, not clinical error, is the main reason why doctors end up getting sued" (Weston, 2009b, p. 133). Both essays echo the central concern of the Narrative Medicine programme in the sense that they tackle two of the four narrative situations Charon regards as being central for practitioners: physician-patient, physician-colleague – the other two being physician-self, physician-society (2001, p. 1897), both vividly represented in Verghese's memoir *My Own Country.*

What makes a good doctor is explored from a variety of perspectives, either with a specific examination of the surgical specialty and its distinctive qualities, or in a more macroscopic context such as the gender realm, the specialty system, the hierarchical system, as well as doctor-patient and doctor-doctor relationships. Weston's reflection on what constitutes a good doctor is dialectic. She seems to be extremely careful not to value one factor more than the other: both swiftness and safety should be ensured; both refined craft and patients' dignity should be considered; both roughness and softness should be performed. The dialectical argumentation seems to endow the book with a didactic quality. The narrator's reflections on self-confidence and self-doubt offer a good example. In "Hierarchy", when the narrator's final decision saves the patient's life, now as a registrar, rather than boasting about the victory, the narrator indulges in a feeling of self-doubt. But according to the author, self-doubt is a positive part of training, since the "awareness of one's own limits may prove more life-saving than any knife" (Weston, 2009b, p. 80). In the case of "Help", however, self-confidence triumphs. When she feels incapable of handling the operation, the narrator admits to her incapacity and avoids no further damage. As she asks for help, however, she is told JFDI (just fucking do it) by a female senior she always looks up to. Fortunately, the rejection becomes a source of motivation. Pulling herself together, she finishes the operation by herself. Therefore the advice offered in "Help" turned out to be the knowledge of when not to ask for help. The author seems to suggest that both qualities, the decisiveness and the awareness of one's limits, are virtues, but they need to be performed in correct proportion.

The dialectical reflection may create a sense of uncertainty and ambiguity, as if suggesting that what makes a good doctor is hard to define since many criteria should be taken into

account. In this regard, *Direct Red* offers a relatively wider, not necessarily deeper, range of criteria for measuring what makes a good doctor than the previous doctor-writers. Meanwhile, the dialectical reflection ensures a comprehensive evaluation of the "good doctor", as if suggesting that the good doctor should be the one who can find a perfect balance, or at least one who cares to find a balance between those factors, just as the author summarises, "to be a good doctor, you have to master a paradoxical art" (Weston, 2009b, p. 10). Furthermore, the dialectical reflection encourages modesty and an open-mind: since there are limits in one's perception of what makes a good doctor, there should be room for uncertainty and debate. This kind of modesty and open-mindedness mark the maturing of a doctor, which is well displayed as the narrator's reflective journey draws to an end.

The last three sections, as I read them, represent the maturity of the female doctor, in terms of her change of perceptions in surgery and the role of a surgeon. The story "Appearance" seems to be a reflective preparation for big "Changes" – another story – to come. The narrator has always held that one form of surgery is more glorious and more moral than the other. After assisting in a beautifully performed example of cosmetic surgery, however, the narrator's eyes are opened: "surgical virtue or lack of it comes from who is holding the knife, not where it is put" (Weston, 2009b, p. 160). This change of opinion on cosmetic surgery represents a change in her perception of the profession as a whole. The story "Changes" stems from a critical review of surgery as expertise, but comes to focus on the specialisation system in modern medicine, preparing for the arrival of the last story "Home". While admitting to the advantage of specialisation, "once you know what disease or injury you have, you want to be treated by the person who knows the most about it", the narrator also points out that "as doctors, a preoccupation with our own specialty may lead us to overlook the wider clinical picture" (2009b, p. 161). Weston's view best summarises what has been frequently reflected in previous works – Shem deliberately differentiates the "healer" from the doctor; Sacks promotes the idea of the holistic healer and holistic medicine; and Verghese the AIDS specialist readjusts his role to that of a basic care or hospice care provider. Echoing the Dean's talk at Weston's graduation ceremony that "more fundamental than being a surgeon is being a doctor" (2009b, p. 90), these writers emphasise the doctor's role as a healer,

care-provider, while acknowledging the differences between specialties.

"Home" wraps up the reflective journey with the narrator's decision to give up her dream of becoming a consultant surgeon, and to step back to work part-time, so as to have more time for family. The decision has triggered some debate among reviewers. Some reviewers take the decision as a compromise for a female surgeon, "it seems a shame for such a sensitive and appealing young doctor as Weston, after humanising the experience of surgical training for us, to present her situation as a dichotomy between a fulfilling existence and a commitment to being a surgeon", and hopes that the "bittersweet note at the end will not be the taste that lingers in the mouth of those young trainees who read this book looking for inspiration" (Raizman, 2009, p. 998). Others seem to be more understanding about the decision: "One finishes *Direct Red* with the conviction that the qualities that promoted this choice are the very ones that will be valued by her children and patients alike" (Whitaker, 2009); "Only in stepping back was she able to make sense of what she had learned and done" (Shakespeare, 2009). Indeed, the narrator's decision to resign in this context echoes what has been constantly argued in *The House of God*, *My Own Country* and Colquhoun's poetry collection *Playing God* to be discussed below – "what matters more in a doctor than knowledge is knowledge of one's own limits" (Weston, 2009a, p. 1412). A good doctor knows his or her limits, and knows when to stop. Unlike Mates who uses the retreat as a way to critique the problematic power system in the medical world, I would rather read Weston's stepping-back as the triumph of an intern, who has seen, experienced, reflected, and in the end reached her epiphany and maturity.

2-6: An Ambivalent GP's Portrayal of an Ambivalent Doctor

Like Weston in *Direct Red*, Glenn Colquhoun the general practitioner in his poetry collection *Playing God* (2002) explores the issue of what makes a good doctor in the light of the doctor's making sense of life, both professional and private. As a GP, the poet introduces readers to a much broader range of diseases, symptoms and treatments in the form of narrative poetry, though less detailed than the portrayals by such specialists as Verghese and Sacks, or Weston the surgeon. In the course of making sense of patients, diseases, and

treatments, the doctor-poet depicts a doctor who has confidence and doubts, pride and fears – an ambivalent doctor who strives to manage what Weston describes as the "paradoxical art".

Glenn Colquhoun was born in 1964 in Auckland, New Zealand. He was trained as a doctor at the University of Auckland, where he also received a degree in English. Having worked for some time in a rural area of Northland, he now works as a part-time general practitioner on the Kapiti Coast, north of Wellington. So far he has published five poetry collections, one essay collection, and two picture books for children. His subject matter ranges from the peaceful clash of two cultures, to the bittersweet love people experience, to a poetic discussion on the concept of poetry. *Playing God: Poems about Medicine*, first published in 2002, comprises, like Colquhoun's other poetry collections, the poet's keen observations and deep reflection on his life, the focus being switched from the cultural and emotional dimensions to his occupational life as a medical doctor.

Echoing Chekhov's aphorism that medicine is his wife and literature is his mistress, Colquhoun describes literature as his love and medicine as the girl he got pregnant (Colquhoun, guest speech, May 19, 2011). To Colquhoun, poetry is not only a literary or medical tool of communication; it offers a way of perceiving, interpreting and expressing. For example, asked to do an assignment at medical school, Colquhoun the student ended up writing poems; invited to make a speech at a conference on Narrative and Metaphor in Medicine, Colquhoun the presenter ended up explaining his ideas on poetry with more poems shared. He tends to study, discuss and consult in the form of poetry. It seems that poetry becomes an effective thinking pattern or even habit that the poet can rely on to make sense of the world around him, especially in his medical practice.

In spite of his love for poetry, like the physician-writers already studied, Colquhoun is one of those who makes peace with medicine. According to the poet, medicine "pays well" and ensures him the time for his devotion to poetry. In addition, the experience of doctoring, especially being a GP, offers him "a wonderful platform from which to view the world", and provides him with "an intimate view of the complex web of human relationships, the whole tapestry of human emotion" (Quaintance, 2003, p. 64). What is more, medicine seems to help

him form a reader-friendly writing style. Described as exhibiting "wit, raw honesty, warm humanity, wonderful use of metaphor" (Davey, 2009, p. 59), Colquhoun's poetry is especially applauded for its accessibility. He has written in a language that communicates with a wide audience, and this reader-friendly writing style, according to Roger Steele, Colquhoun's publisher, has something to do with "the fact he is a hell of a good doctor": "He communicates well; he really does make an effort to get in touch with his audience". For such a reason, Steele describes Colquhoun as "a natural and worthy successor to the 'people's poet' Hone Tuwhare"[15] (Quaintance, 2003, p. 63). Kevin Ireland, elder statesman of New Zealand poetry, also praises Colquhoun for his "courage to say something directly and powerfully", compared with many writers of "academic poetry" (Quaintance, 2003, p. 62). According to the poet himself, he had played with codes and written obtuse poetry before he came to a turning point when he started writing "from the angle of what [he] would want to listen to or what did the people around me", so as to "catch" his audience, and then "connect to most people" (Clarke, 2004). This reader-friendly style, in return, helps him reach a large audience, ranging from medical workers to the wider public.

The book *Playing God* is a collection of the poet's keen observations and reflections on different components of his medical career, and at the same time, his attempt to try out the concept of poetry in a variety of ways. The section "Patients I Have Known", for example, records the poet's emotional responses to his everyday practice:

> He charts the world of human frailty, the optimism that is sometimes unwarranted, the physical assaults made on the body and the mind by a variety of serious illnesses, the agony of treating very ill children. He is unafraid of staring down death; he understands too well the ephemeral nature of life itself. (Bieder, 2003)

The section "Diseases I Have Known", for another example, offers a brief introduction to the pathological world. Compared with medical specialists who only invite readers to a specific, more detailed, field of medicine, Colquhoun the general practitioner presents to readers a

[15] Hone Tuwhare (1922-2008) was a noted Maori poet of New Zealand, whose masterpieces include *No Ordinary Sun* and *Piggy-Back Moon*.

larger world of medicine with a variety of diseases, symptoms and treatments. Moreover, the section "Spells", anthologising curses and haka[16] used to celebrate birth, prevent death, or mend broken bones or heart, is the poet's playful but humane representation of medical practice. Last but not least, the poet reflects on and critiques, in a more general way, the role of a medical professional in "A Portrait of the Doctor as a Young Man" and "Playing God".

In spite of this diversity, Colquhoun's poems are primarily in narrative form, presented by a doctor in the first person,[17] who we assume resembles the poet in his perceptions and values. These poems, according to the poet, are directly borrowed from or inspired by patients. The poetry collection is comparable to *The Man Who Mistook His Wife for a Hat* in the sense that the creative work can be taken as a joint composition by the doctor and the patient, reflecting their exchanges of narratives, or sometimes metaphors, during the consultation process. In a sense the author plays the key role in the creation process since he needs to be able to discover the significance of each interaction with patients, to find "beauty" in what may look ugly to an ordinary eye, for example, a disease or a decaying body (NZEPC, 2001), and to verbalise his observations in polished literary forms. Not only such poetic devices as metaphor and personification, but also special visual and sound effects are employed, to enable a vivid illustration of pathological conditions, diagnoses and treatments. Nevertheless, while Sacks in his book strives to make sense of illness and help patients live with their condition, if medication is ineffective, Colquhoun views his creative work as "a long conversation with my doubt, trying to work out the angst and finally coming to some peace with this old hag I've married" (Colquhoun, 2002, p. 8). In this sense, *Playing God* is, as *My Own Country* for Verghese and *Direct Red* for Weston, a book for himself rather than anyone else, as the poet himself claims – a collection of "accrued stories of me and my patients being human beings in the face of how things are perceived around us" (Moore, 2003, p. D12). Even though Colquhoun does not directly pose the question of what makes a good doctor, with the observations and reflections on different components of the profession, Colquhoun creates a vivid portrait of an ambivalent doctor-narrator, who is both amused by and

[16] This refers to traditional war dances performed by the Maori people of New Zealand.

[17] Such poems may be narrated by a patient as "A History" and "A Short Poem Dictated One Day by an Intubated Patient".

compassionate for patients' pathological condition; both awed and terrified by such existential puzzles as life and death; both honoured and frustrated by the privilege of being offered patients' secrets and personal stories; both ambitious to play god and aware of his limits. The image of the ambivalent doctor-narrator happens to resemble the poet's self-image:

> I am an ambivalent doctor. I think sometimes that the god of medicine is a cantankerous old bitch in the sky. At times she tries to woo me. She allows me the most intense and beautiful views of human life. At other times she terrifies me by revealing my limitations as well as her ability to deal so arbitrarily with our existence. (Colquhoun, 2002, p. 8)

It is with the portrayal of an ambivalent doctor that Colquhoun launches his discussion of what makes a good doctor. Like the other doctor-writers studied, Colquhoun's critical thinking is strongly related to the kind of medicine he is devoted to – general practice. To Colquhoun, the general practitioner, medicine is not "just about x-rays and ECGs", but involves conversations "about wayward husbands and depressed daughters and parties and hangovers" (Quaintance, 2003, p. 65). Like Verghese, Colquhoun very much values the process of consultation. While Verghese may value the consultation more for its "medical content" (Thernstrom, 2004, p. 46), the doctor-poet values it more for the beauty of narrative during the doctor-patient conversations:

> … the thing that fascinates me most about medicine is the consultation, that small altar that a doctor and a patient come to on a regular basis. It is in this place that we sit down and tell each other stories. It is a point of great frisson and intensity and beauty. (Colquhoun, 2011, p. 316)

A number of poems illustrate the process of consultation. Both "A History" and "A Mini Mental Status Examination", for example, show the key element in a consultation – narrative. "A Brief Format to Be Used When Consulting with Patients", for another example, emphasises the importance of the exchange of narratives during a consultation: both the patient and the doctor will talk; both will listen while the other is talking; both will think that their counterpart's words make sense; both will think that they can be properly understood;

and both the patient and the doctor seem so sure. The poet does not quite comment on the effectiveness of such a consulting format, but by ending the poem with a question "Shouldn't hurt a bit, should it?", it seems to suggest that it is often harder than it sounds to achieve. Nevertheless, what matters more for a consultation, at least in ideal circumstances, is to keep the narratives dynamic – both should speak and listen, trying to understand and be understood. In reality, however, the exchange of narratives between patients and doctors may not always be effective, and "She Asked Me If …" offers such an example:

> **She asked me if she took one pill for her**
> **heart and one pill for her hips and one pill**
> **for her chest and one pill for her blood**
> **how come they would all know which part**
> **of her body they should go to**
>
> I explained to her that active metabolites in each
> pharmaceutical would adopt a spatial configuration
> leading to an exact interface with receptor molecules
> on the cellular surfaces of the target structures
> involved.
>
> She told me not to bullshit her.
>
> I told her that each pill had a different shape and that
> each part of her body had a different shape and that
> her pills could only work when both these shapes could
> fit together.
>
> She said I had no right to talk about the shape of her
> body.
>
> I said that each pill was a key and that her body was
> ten thousand locks.
>
> She said she wasn't going to swallow that.
>
> I told her that they worked by magic.
>
> She asked me why I didn't say that in the first place. (Colquhoun, 2002, p. 14)

When the patient asks how different pills can automatically find their ways to cure different

parts of her body, the doctor tries his best to explain. The irony is, as he offers a scientific explanation piled with medical terms, the patient tells him "not to bullshit". So the doctor has to simplify his explanation until he "bullshits" about the magic of the pills. The poem, Colquhoun tells us, was "stolen" from a patient who questioned him after a speech he gave about iron deficiency in a rural kindergarten (Colquhoun, 2011, p. 318). Symbolically, it mimics the typical consultation process and more importantly, reveals the trickiest part of a consultation. First of all, a gap often occurs because of the differentiated knowledge and ways of thinking between the doctor and the patient. To achieve a common understanding, they always need to negotiate the meanings of diseases, symptoms and treatments. Only by reaching an agreement is the treatment plan able to be effectively carried out. Interestingly, the most convincing explanation for the patient is the simplest and least scientific one, which is the second challenge – the doctor does not need to be scientific, rational or logical all the time; sometimes he may need to be a little magical or almighty – which may symbolise a proper display of authority and power, in response to patients' expectations. Echoing Weston's discussion of the necessity of displaying power, Colquhoun seems to move a bit further by suggesting that in certain circumstance it is much more helpful that the doctor can play the role of a magician or even God in a sense the doctors' confidence and authority may offer patients the impression that they are in capable hands. Rather than promoting what Shem would describe as "power-with" patients, here in this particular poem, Colquhoun plays a write-back, advocating the "power-over", although a larger number of his poems in fact brim with a doctor's humility and willingness to "power-with" patients.

What makes a good doctor, these poems seem to indicate, at least for general practitioners, lies primarily in effective communication, which involves not only the art of listening to patients' stories, the ability to interpret and a flexible display of power. Though the poet admits that good communication skills are not always what patients require of doctors, at least in general practice, the poet seems to suggest, it is a skill that is essential to be a good doctor (Colquhoun, 2011, p. 316). This view echoes, even if it is not influenced by, Narrative Medicine, which emphasises the need for the doctor to possess narrative competence to achieve a more effective communication. In addition to the doctor's narrative competence,

effective consultation in Colquhoun's view is achieved also with the exchange of metaphors. Taking "She Asks Me If …" for example: in order to be understood, the doctor-narrator compares the effect of a pill to a key, and the body where the pill takes effect to a lock. On many occasions, a precise use of figurative languages such as metaphor and personification assists in better communication between the doctor and the patient. Colquhoun's representation of pathological conditions is rich in metaphor and personification. In "The Smell of a Stroke", the subject is compared to a spectrum of smells such as tea, old clothes, cardboard, farming and timber; in "Viruses", the subject is described, using personification, as the doctor's nephews, who "try to get into the cupboards", "bang pots and pans on the floor" and "run up and down" the inside of the narrator's head. Sometimes the use of metaphor and personification is combined in such a poem as "The Heart Attack", or rather, the poem consists of a series of denials of metaphors and personifications:

> The heart is not attacked
> by red Indians clinging underneath
> the bellies of their ponies.
>
> The heart is not attacked by
> kamikaze flying their exploding planes
> onto its burning decks
> …
> The heart is not squeezed like
> ripe lemons into a clean glass.
>
> The heart is not beaten by
> the arrangement of its soft belly
> around a hard fist like a glove
> …

After a series of denials, a metaphor is provided to describe what a heart attack really is:

> The heart stops simply like a blocked toilet
>
> While someone unsuspecting is opening the
> newspaper or reading poetry or staring quietly at
> the pictures in the calendar on the back of the door
> …
> (Colquhoun, 2002, p. 50)

All the signifiers chosen are images familiar to readers – red Indians clinging under their ponies – or everyday scenes – lemons squeezed into a glass, or the toilet blocked while someone sits on it. During the deconstruction and reconstruction of metaphors and personifications, the disease that may be unfamiliar and confusing to patients becomes tangible and understandable, and as a result, effective communication is achieved, either between a doctor and a patient, or between a poet and a reader.

In addition, Colquhoun represents pathological conditions in some alternative forms, which may be influenced by Erza Pound's idea that poems can be either a story, or a picture, or a song (Marshall, 2007, p. 150). While most of Colquhoun's poems tell stories, some of them turn into pictures and songs. For example, "Visual Acuity" adopts the form of an eye chart; "Lines Composed One Day underneath an Anaesthetic Machine" is purely graphical; "A Short Poem Dictated One Day by an Intubated Patient" mimics the way an intubated person speaks with each word split into letters; "Heart Sound" demonstrates different rhythms of heart beats corresponding to different heart diseases. What is more, poems such as "A Spell to Be Used When Addressing the Birth of A Child", "A Haka to Be Used When Reversing the Effects of a General Anaesthetic" and "A Spell to Be Cast Prior to Dying" offer an amusing introduction to the world of medical practice in the form of magical incantations. The application of audio-visual elements does not only make Colquhoun's poems "entertaining" and "palatable", as he intends (Marshall, 2007, p. 150), it reflects the poet's inclination to experiment in the writing of poetry. It reflects the doctor's keen observation and accurate knowledge of pathological conditions, in combination with a little imagination and creativity, and a sense of humour. What lies behind the "wry sense of humour", however, is the doctor-poet's "sense of compassion" (Sharp, 2003, p. C6). Like Shem and Goldsworthy, Colquhoun often uses humour to channel his sympathy for patients with diseases and awe towards such existential puzzles as life and death, although the New Zealand poet's use of humour is less dark, compared with his American and Australian counterparts.

Like the doctor-writers previously discussed and those to be studied later, Colquhoun dedicates some of his poems to the topic of dying and death. While many writers'

representations of death are primarily from the perspectives of hospital practice, Colquhoun's reflections on dying and death are more diverse. They can be both hospitalised and non-hospitalised, medical or philosophical. "An Examination of Her Body after Death" and "On the Death of My Grandmother" are two examples of a doctor's emotional response to the death of a patient (or family member in the second case). If the first is presented using the technical language of anatomy, the second is presented in the form of a narrative elegy to recall the life of the beloved:

> You are not her shoulders!/ There has been a mistake!/ The long, thick candles of Catholics/ hold clammy in my hands./ Where are the rubbery veins?/ These are made from brittle wax. ("An Examination of Her Body after Death")

> On the beach where I live, last Sunday/ three children built a man out of sand./ He lay on his back with his arms by his sides,/ his feet slightly spread as though he was asleep. ("On the Death of My Grandmother")

On the same topic of death, the poet sets up different tones. In the first poem about examining a patient's body after her death, the doctor is addressing the dead body directly in exclamatory mode to express the doctor's shock and frustration with the rawness of death; the second poem is written to honour the doctor's grandma who has passed away, by offering a peaceful and beautiful depiction of a man-shaped image built out of sand. Even though the grandma does not appear in the poem, except in the title, by depicting the forming and breaking of the sand image, the doctor expresses his awe for the calmness of death. The differences in tone reflect the doctor's ambiguous attitude towards the existential puzzle – his fear of and frustration over its rawness, versus his awe of and admiration for its beauty. The ambiguous attitude toward dying and death is reflected in another pair of poems. While in "An Attempt to Prevent the Death of an Old Woman" the narrator helplessly begs the old woman not to go, in "A Spell to Be Cast Prior to Dying" he wisely suggests "Die, go on, time's up, die". If the first poem presents a humane response to the death of a person, the second poem offers a philosophical approach to dying and death – when it is time to go, simply let it go. The two pairs of examples reflect the ambivalence of a medical professional's emotional world: he can be calm and rational, performing professionally; meanwhile he may be helpless and terrified, no different from a lay person. These

representations of ambivalence seem to echo what has been frequently highlighted in the work of the other five doctor-writers previously studied – that a doctor is a medical professional as much as a human being, the acknowledgment of which is extremely important for doctors to justify their role as healers and to recognise the boundary between career and private life. It again confirms Charon's suggestions that reflectively writing – poetry in Colquhoun's particular case – offers doctors an effective means to identify and interpret their own emotions towards patients, especially in facing sick and dying patients (Charon, 2001, p. 1899).

If the first three sections only offer a brief sketch of an ambivalent doctor, in the remaining two sections "A Portrait of the Doctor as a Young Man" and "Playing God", the image of an ambivalent doctor becomes more solid and three-dimensional. "Today I Do Not Want to Be a Doctor" and "Today I Want to Be a Doctor", a pair of poems in parallel narrative forms, offer the best example of all:

Today I do not want to be a doctor	Today I want to be a doctor
No one is getting any better.	Everyone seems to be getting better.
…	...
The lame want to walk.	The lame accept chairs.
The blind want to drive.	The blind ask for dogs.
The deaf are making too much noise.	The deaf are listening to music.
The depressed are not making enough.	The depressed are tapping their feet.
…	...
Disease will not listen to me.	Disease has gone weak at the knees.
Even when I shake my fist.	I expect him to make an appointment.

(Colquhoun, 2002, pp. 74-75)

The parallel narratives serve to illustrate the doctor's strongly mixed feelings towards his job: the sense of triumph versus defeat, powerfulness versus powerlessness. This pair of poems sets the tone for the portrayal of an ambivalent doctor. On the one hand, the medical profession is described as a profession with privilege, beauty and power, as is shown in "The View from the Ninth Floor of Auckland Public Hospital". The narrator starts with the sentence "From here I can …" and lists the many benefits offered by the profession: he has the privilege of listening to "stories of old people" and "the secrets of

love"; he is presented with the beauty of "the inside of bodies, their tangling of wires" and "what lies under skin"; he is granted the power of witnessing the birth of babies and the death of patients. On the other hand, from here, as the narrator realises at the end of the poem, he can "fall such a long way to the ground" (Colquhoun, 2002, p. 76). The last sentence breaks the fantasy and brings the other side of the story into discussion – this is a profession with doubts, challenges, and little romance, all which have been repeatedly referred to, in his other poems.

Firstly, the doctor may sometimes be deprived of beauty and romance, as is narrated in "The Morning after a Night Spent Taking Blood". After a night in which he has had to take many blood samples, what could have been a fantasy about a romance with a charming girl in a shop gives way to the "fantasy" about her vein – "She might have looked with/ warm brown eyes at me./ All I saw was the way one/ vein leapt like a taut fish/ from the soft slack sea in the crook of her arm" (Colquhoun, 2002, p. 79). Secondly, the doctor may face endless challenges in his attempt to cure human beings, as is described in "Creation". In discoveries in clinical practice and medical science, the doctor only discovers more threats to human lives – "bacteria were made resistant to antibiotics. New viruses were discovered in Africa. The drinking age was lowered … a large increase in deaths attributed to earthquakes, pestilence, lightning, famine and flood" (Colquhoun, 2002, p. 82). What is worse, the doctor may have doubts, as is admitted in "Myths": "It is not my intention/ to distress you/ but when I go home/ I do not live inside a bottle./ I do not sleep with a gun/ underneath my pillow…". After confessing that he is never a superhero, the narrator keeps presenting his clumsiness at being a doctor without reservation:

> …
> I am sorry to have to break
> this news but when I go home
> I have to look in books.
> I try hard to remember
> the pathways of arteries.
> I forget the names of bones.
> I get mixed up between

my right and my left.
I wish I had used a different drug.
I consider what would have happened if
I had put the needle in the other arm.
I wonder if you are alive or dead. (Colquhoun, 2002, p. 91)

At the end of "Myths", the narrator begs "If this is a cause of concern/ to you please do not try to/ hang me on a cross./ Contrary to popular opinion/ I cannot raise the dead." These verses create sharp contrasts with the image of the doctor as god or saviour, as is shown in the poems "Playing God" and "The Saviour". The contrasts present the biggest irony of the book: the doctor who attempts to play god, as is indicated in the title, turns out to be a humble doctor who may need to prescribe "a note of warning to patients when all else fails", as is shown in the last poem of the whole collection.

Compared with the writings by Weston, which depict her field of interest, surgery, as "the king of medicine", Colquhoun seems to be modest about his "specialty". This may be ascribed to the fact that general practice is more concerned with prevention, as opposed to the aggressive, active, and interventionist practice of surgery. In one of the poems, "When I Am in Doubt", the doctor-narrator turns to the surgeon for help, reflecting the relatively inferior position the poet sees himself as holding in the world of medicine, with regard to the possibility of intervention. Compared with such a specialist as Oliver Sacks who tends to idealise the doctor as a heroic, efficient and ambitious figure, Colquhoun is more willing to see the doctor's role as a humble healer:

> I am not a god able to fix everything I want to. I am a human being with a little bit of science and, a lot of doubt who relies greatly on three things: the body's ability to heal itself, my patients' belief in my profession and being polite to as many people as I can. (Colquhoun, 2002, p. 8)

As Mates does in her short story "Laundry", Colquhoun in his poems acknowledges the limit and vulnerability of a doctor. While Mates may use retreat and concession as a strategic critique of a masculinised medical practice and system, Colquhoun's humble attitude reflects his healing philosophy – the body has a healing power of itself, as is shown in the poem "Performing Miracles", "All miracles here/ are usually performed/ by

various members of/ the domestic staff" (Colquhoun, 2002, p. 84).

In a word, *Playing God* portrays an ambivalent doctor, who both loves and hates his job; who sees both beauty and stress in this profession, who attempts to play the role of a saviour but turns out to be one who is in need of help. Meanwhile, this is a doctor who listens and writes, valuing the importance of communication, practising "a little bit of science" but a lot of art and humanity. It seems to suggest that an ambivalent doctor can be a good one; a good doctor may on many occasions be ambivalent. More than once in his interviews, Colquhoun offered an example that had a great impact on him: a lecturer at the end of an anatomy class put up a poem to remind medical students that "there's more to life than medicine" (Quaintance, 2003, p. 61; Marshall, 2007, p. 133). It is with poetry writing that Colquhoun, the ambivalent doctor, seeks this "more to life" in his practice of medicine, and it is during his poetry writing – story-telling and sharing – that the ambivalent doctor makes peace with his profession.

To conclude, using different literary forms, the six writers studied have represented the issue of what makes a good doctor from a variety of perspectives: doctors as the healer of "a whole person" rather than a disease, doctors in complicated doctor-patient relationships, doctors as striving to balance their professional and personal lives, and doctors as experiencing subtle emotional and psychological fluctuations and confronting moral dilemmas. Although they have written in different times and socio-cultural backgrounds, from the perspectives of different specialties and both genders, they all have written, in one way or another, to promote a more effective, human, empathetic and holistic medical practice. Since the thesis discusses works written over a time span as long as thirty-one years – from Shem who published in 1978 to Weston who published in 2009 – reading these works comparatively offers an account of how medical practice and social attitudes toward certain ethical issues across cultures have evolved during the past three decades. These works not only offer insights into enduring questions of medical education and training; when read in new contexts, these works have the potential to transcend their original cultural context, in the sense that the issues described are being

experienced anew.

Even though none of these writers have composed directly in response to the Narrative Medicine Programme, the critical thinking, moral reflection, philosophical meditation reflected in their creative works either anticipate, or influence, or create a positive atmosphere for the establishment of the Narrative Medicine programme or other medical humanities programme. To be more specific, writing prior to the formation of the Narrative Medicine Programme, both Shem's comment on the therapeutic function of reflective writing for medical practitioners and Sacks' emphasis on the importance of the exchange of narrative and metaphor between doctors and patients in medical practice foresee the emergence of the programme. Aware of but denying direct influence of the programme on him, Verghese's recognition on the pivotal role of narrative in medicine, and the way he adopts narrative competence in his diagnosis and prognosis in many ways echoes what is called for in the Narrative Medicine Programme. Despite the fact that neither Mates nor Weston directly recognises the influence of the Narrative Medicine Programme on their literary and medical practice, Mates' work, especially "Laundry" and "The Good Doctor" are frequently quoted by scholars from Narrative Medicine and other medical humanities programmes such as Rita Charon and Catherine Belling; and Weston's work reflects what the programme advocates – to write reflectively so as to make sense of a doctor's own journey in medical practice, which is reflected in Colquhoun's poetry, too. In addition, Colquhoun's poetry reinforces what is argued in Narrative Medicine that the narrative competence assists in an effective doctor-patient communication and making sense of illness. All in all, the six writers' representations of what makes a good doctor themselves demonstrate what Charon highlights as the advantage of the kind of medicine that is practised with narrative competence:

> With narrative competence, physicians can reach and join their patients in illness, recognise their own personal journeys through medicine, acknowledge kinship with and duties toward other health care professionals, and inaugurate consequential discourse with the public about health care. By bridging the divides that separate physician from patients, themselves, colleagues, and

> society, narrative medicine offers fresh opportunities for respectful, empathic, and nourishing medical care. (Charon, 2001, p. 1897)

Despite the fact that these writers are from different backgrounds, they all have written in Western contexts, and the discussion about their representations of what makes a good doctor has been solely carried out in the context of Western socio-cultural backgrounds and among Western reader groups. It is both necessary and interesting to bring into discussion a rather different case – Bi Shumin, a Chinese doctor-writer, surgeon, internist and registered psychiatrist, whose literary works add valuable insights to the discussion of what makes a good doctor from relatively different cultural, social and medical perspectives. In the following chapter, I shall be introducing Bi Shumin and Peter Goldsworthy, an Australian writer and general practitioner, whose works have displayed great breadth and depth with regard to medical ethics. *Three Dog Night* by Goldsworthy and A Red Prescription (《红处方》) by Bi Shumin, in particular, offer extreme and extraordinary examples of, and important insights into, the exploration of what makes a good doctor.

Chapter 3: A Dialogue on What Makes a Good Doctor: Peter Goldsworthy and Bi Shumin, a Case Study

Peter Goldsworthy and Bi Shumin have dedicated a number of their literary works to the discussion of what makes a good doctor. The novels *Three Dog Night* by Goldsworthy and A Red Prescription by Bi Shumin, in particular, offer excellent and extreme examples of representations of "the good doctor". In this chapter, I shall firstly introduce Bi Shumin as having written in rather different language, socio-cultural and medical contexts from not only Goldsworthy but the six writers previously discussed. Then I shall offer an analogical introduction to the two writers' life experience and dual careers, and an exploration of how each doctor has written about such medicine-themed topics as dying and death, which I suggest best illustrate their distinctive writing styles. I shall narrow my discussion down to each writer's representations of doctors, and highlight the range of techniques employed by the two writers in their literary exploration of what makes a good doctor in their short fiction. The literary approaches and insights offered in their short stories, as I shall argue, are encapsulated in their lengthier and more serious novels *Three Dog Night* by Goldsworthy and A Red Prescription by Bi Shumin, both of which I read as setting the discussion of what makes a good doctor in extreme and extraordinary contexts. In the last section of this chapter, I shall explore in detail how similarly and differently the issue of the good doctor is represented in the two novels.

3-1: Introduction to the Chinese Physician-writer Bi Shumin

By contrast with Goldsworthy and the six writers discussed in the previous chapter, Bi Shumin has written in different language, socio-cultural and medical contexts. The addition of Bi Shumin will bring extra dimensions to the representation by physicians of what makes a good doctor. Bi Shumin published her first novella in 1987 and her first novel in 1997. This was a period when China was experiencing a series of significant socio-economic changes. Since the reform and opening-up policy were carried out in 1978, the market economy has progressively replaced the planned economy, stimulating

economic growth, and improving the average quality of life of its people. Meanwhile, however, from the 1990s onward, a series of problems were exposed such as the unequal social distribution of wealth, the disparity between rural and urban areas, the difficulty and ever-increasing costs of getting healthcare and education, and so on. Though Bi Shumin has seldom written directly in response to the socio-economic reforms – she is more interested in medical professionals and the physical and psychological health of ordinary people – the novels she published in the 1990s, including *An Appointment with Death* (《预约死亡》, 1994)[18] and A Red Prescription (《红处方》, 1997), indirectly reflect the social and economic changes during that time.

In addition, Bi Shumin was writing in a period when major reforms in the healthcare system were being undertaken. In academia, news reports, books and popular media, issues regarding medical ethics and healthcare have been more and more widely discussed. Especially in the past few years, the discussions about how to stimulate a better doctor-patient relationship have been on the rise in both the mass media and academic scholarship. In the mass media, such journalistic pieces as "The Doctor-Patient Relationship, What Can I Do about You?" (《拿什么来拯救你，医患关系？》) (Zhang Xuehua, 2011) and "The Chinese Doctor-Patient Relationship: Who Is the Victim?" (《中国医患关系总结：一笔糊涂帐 两个受害群》) (Zhuang Qinghong, 2013) both reveal the problematic doctor-patient relationship in today's medical practice.[19] In the scholarly domain, for example, Hu Ruxin has researched the construction of hospital culture from the perspective of the doctor-patient relationship (Hu Ruxin, 2009); Tang Pingping has proposed the building of a harmonious doctor-patient relationship from the angle of social work (Tang pingping, 2013). Bi Shumin is one of the first physician-writers,[20] and one of the most popular ones, to reflect on the doctor-patient relationship and other medical ethics, with her creative works.

[18] The novella was translated into English, thus the title is in italics here.

[19] Both English titles are translations by the writer of the thesis, thus not in quotation marks.

[20] Physician-writers in China do not constitute a big and organised community, although some scholarly articles can be found reviewing their creative works. The most frequently quoted names include Chi Li (池莉) and Feng Tang (冯唐), in addition to Yu Hua and Zhang Yu who have already been mentioned in Chapter One.

In terms of the medical context, unlike Goldsworthy and the other six Western doctor-writers, who have practised in a medical system that is dominated by Western medicine, Bi Shumin has been involved in a more dynamic context. Like elsewhere in the world, Western medicine is now practised in most hospitals and institutions in today's China. Nevertheless, China is one of the few countries where Traditional Chinese Medicine (TCM) has still been actively practised. Despite the fact that in the early twentieth century, debates were fiercely undertaken among scholars, physicians and revolutionists regarding the abolition of TCM (Yan Qing & Sang Aiye, 2011, p. 184), Western medicine and TCM are now practised side by side to meet the different needs of patients. "Scientific medicine is, on the whole, more efficient in dealing with acute illness" (Dally, 1997, p. 45). Chinese patients tend to go to Western medicine for acute diseases, surgery or when they expect quick and immediate treatment. But they prefer going to Traditional Chinese Medicine for chronic problems or disease prevention, or when they seek a more conservative and less intrusive treatment. In addition, TCM has widely permeated daily life as offering advice for people's health and nutrition, and embodies the major principle that the best treatment for a disease is to prevent it from happening; and that the best doctor is the one who is able to treat the "future/potential disease",[21] which in fact largely echoes what Western preventative public medicine holds: "Prevention is better than cure" (Dally, 1997, p. 45). Nowadays the two modes of medicine are not only practised as co-existing but increasingly influencing and supporting each other (Yan Qing & Sang Aiye, 2011, pp. 195-199).

Bi Shumin seems to be knowledgeable in both modes of medicine, and this is widely reflected in her medicine-themed works. On the one hand, the use of terms from TCM in

[21] The idea was first posed in the section titled "Su Wen" (《素问·四气调神大论》) in the Yellow Emperor's Inner Canon that the greatest doctors treat future disease ("是故圣人不治已病治未病". This idea was developed by such great physicians as Bian Que (扁鹊 407-310) in the Spring and Autumn Era and Sun Simiao (孙思邈 581-682) in Tang Dynasty, suggesting that the greatest doctors know how to prevent people from becoming sick (未病); the second greatest doctors treat people who are about to be sick (欲病); the average doctor treat people who are sick (已病).

her essays and novels reflects her knowledge of TCM, and some short stories depict the interaction between a medical student and a medical professor, reflecting the apprentice kind of medical training in typical TCM. On the other hand, stories set in medical institutions reflect her knowledge of the functioning of such modern institutions as hospices and rehabilitation centres; her novels published after 2002 reflect her training in psychiatry, which is a product of modern medicine. What is more, she seems to be open to both modes of practice and training, and able to absorb both sets of concepts and philosophies. For example, in many of her works, the idea of treating the patient as an organic entity rather than treating the disease may come from both the philosophical concept of healing in TCM and the influence of the medical humanities trend in the West which she may (or may not) have read about.

In terms of its cultural and literary context, China has a long tradition of using writing (referring to both creative and non-creative writing) as a means of education and promotion of morality and philosophy – "wen" (the business of writing) should "convey the Way" ("文以载道"). From the second decade of the twentieth century, many debates occurred in association with what became known as the New Culture Movement, and whether or not writing should shoulder the responsibility of didacticism was warmly discussed. For example, Mao Dun (茅盾) suggested distinguishing non-creative writing from the realm of "literature", along with such writers as Ye Shengtao (叶圣陶) and Lao She (老舍) proposing the independence of literature from the didactic function it had traditionally had (Wang Benzhao, 2010, p. 157). Nevertheless, from 1927, Guo Moruo (郭沫若), Cheng Fangwu (成仿吾) and some other writers wrote to propose the so-called "revolutionary literature", emphasising the socio-political function of literature. In 1942, at the Yan'an Talks, Mao Zedong called for a codified practice and function of literature at this time, and established what was to become national policy for literature until the 1980s, emphasising the political determination of artistic content (Chung & Falchikov, 1996, Introduction). From 1985 onward, the practice of literature as a means of promoting social responsibility and moral values seems to have been largely replaced by all sorts of avant-garde literary styles, influenced by modernist and postmodernist thinking in the

West. These experimental writings focused more on form than on storytelling, and were often obscure or even absurd in theme. They tended to deconstruct the heroism and sublimity that prevailed in the pre-revolutionary and revolutionary eras. On the other hand, a group of women writers in the 1990s began devoting themselves to so-called "Private Writing"(私人化写作), which was more or less influenced by Western Feminism. These "Private Writings" took sex and the body, as well as female psychological activities as major subject matter, to protest against patriarchal discourse and to make women's unique voice heard in literary circles. These avant-garde literatures were popular for a certain period of time – because they introduced Chinese readers to completely different literary concepts and approaches – but since much of these literary experimentations became pure form rather than "stories", they became less accessible for a general reader.

Bi Shumin's works stood out in such a context, in the sense that, first of all, compared with formalist writing or private writing, which seems to discard the traditional concept of storytelling, Bi Shumin utilizes conventional storytelling modes, using plain language and relatively conventional narrative devices and structure; secondly, from the viewpoint of a physician and psychiatrist, Bi Shumin has broken many cultural taboos introducing readers to new medical institutions, calling attention to the psychological health of ordinary people; triggering discussion on controversial issues in medical ethics and philosophical thinking on existential issues of human beings. All these topics are what readers became more and more interested in, as their material life remarkably improved in the 1990s. For such reasons, her works are described as an integration of sense and sensibility, medicine and aesthetics by some reviewers (Wang Meng, 1995; Zhang Deli, 2002, p. 100). For the same reason, however, some of Bi Shumin's works are criticised as being didactic (Liu Lili, 2000, p. 79), or even "narcissistic" (Guo Haiyu & Wang Zhiguo, 2008, p. 227). When asked whether she is afraid of being labelled as didactic, the author confesses that she would defend her personal values and beliefs, but she does not mind disagreements; an exchange of opinions is always warmly welcomed (Wu Fei, 2002). This open-mindedness is in fact widely reflected in her fictional works, where the author always tends to invite discussion by presenting ambiguity and dilemma for her readers,

rather than offering judgments of her own.

In short, Bi Shumin has written against a socio-economic, medical, cultural and literary background that is very different from the six writers discussed in the previous chapter and from Peter Goldsworthy. Although involving the Chinese doctor-writer by no means represents a fully developed comparison between the East and the West, or a comparison between Chinese writers and Australian writers or American writers, the introduction of Bi Shumin's works, in comparison with Goldsworthy's, can add a valuable range to the spectrum of doctor-writers' representations of what makes a good doctor.

3-2: The Portraits of Goldsworthy as a Scientist and Satirist and Bi Shumin as a Philosopher and "Reportage-writer"

Bi Shumin and Goldsworthy are comparable in a variety of ways. Both of them had a great interest in literature before they became doctors. Having chosen medicine as their first career, both writers reclaimed their passion for writing in the course of their medical practice. Both doctors spent ten years refining their skills and accumulating experience with shorter forms – poetry and short stories for Goldsworthy, and novellas and essays for Bi Shumin – before eventually embarking on full-length novels.

Goldsworthy was born in 1951 in Minlaton, South Australia. He grew up in various Australian country towns such as Penola and Darwin. According to Goldsworthy, his engagement with writing came slightly earlier than with medicine. Interested in science and describing himself as a "science nerd", Goldsworthy started writing science fiction at an early age. On finishing his schooling in Darwin, because of his forte in science and medicine and "a bit of pressure from parents", Goldsworthy chose medicine as his major and left Darwin for Adelaide to study medicine. At that time he also became interested in poetry, and kept writing poetry through his medical years, since there was not time for "anything more than a poem" alongside his studies (Marshall, 2007, p. 160; Goldsworthy, 1998, pp. 10-11).

After graduation from the University of Adelaide in 1974, he decided to work part-time so that he would be "left time to expand the literary side of things" (Marshall, 2007, p. 160). He worked in an alcohol-and-drug-dependence unit for five years, before eventually settling down as a family doctor in Adelaide. Alongside his medical practice, the doctor began producing short stories, a literary form Goldsworthy considers as being "near perfect." In an interview with the writer of this thesis, he commented that "... short stories, [at least] great short stories, have tremendous power and economy ... You don't understand why it has such power, but it can hold the whole thing in your head" (Guo Yan, personal communication, December 1, 2013). Fascinated by the power of the short forms, and taking verbal economy as a rule of writing, from the 1980s to the mid-1990s, Goldsworthy published collections of poetry and short stories, two of his favourite forms of writing, "I always liked the natural, short forms that are part of our common human make-up: poetry, songs, short stories, these are things that every culture has" (Marshall, 2007, p. 160).

It was only in his late thirties that the author started trying out the longer forms. In an interview with me, Goldsworthy said it took him a certain time to appreciate the beauty of the novel, "I thought it was artificial and it took a long time to learn the pleasure of getting lost in that world, that creative world, which is what a novel does" (Guo Yan, personal communication, December 1, 2013). Goldsworthy's novels, which he describes as "long adventures", develop, to a certain extent, the perspectives and perceptions found in his earlier and more condensed forms, as A. P. Riemer keenly observes: "His poetry, I came to understand, considers, in the characteristic way of short lyric verse, many of the issues and preoccupations of his fiction. I found indeed that the material of some of his poems made its way directly into the fiction" (1994, p. VIII); "they (his short fiction) contain the germs of many of the preoccupations of the novels" (1994, p. IX). In *The Ironic Eye*, a piece of literary journalism that offers a thorough reading of Goldsworthy's earlier works from the collection of poetry *This Goes With That: Selected Poems 1970-1990* (1991) to such novels as *Maestro* (1989) and *Honk If You are Jesus* (1992), Riemer has lauded Goldsworthy's work for its economy, intellectual integrity and its

"often surprising depth of feeling". In the winter of 1993 when this piece of literary journalism was written, which was before the publication of Goldsworthy's short story collection *Little Death*, Riemer commented that "Goldsworthy is still a relatively young man; admirable though his work is, the best is probably yet to come" (1994, p. VII). Riemer's prediction turned out to be insightful. In the past two decades, Goldsworthy has maintained a constant and consistent literary production. Up till now, the doctor-writer has published five poetry collections, four collections of short stories, seven novels, two libretti, one essay collection and one memoir. Some of them have been translated into European and Asian languages.

Having made his name as an outstanding writer, Goldsworthy has not given up his medical practice. In more than one interview, Goldsworthy stresses the mutual benefits he has gained from the two careers. On the one side, his doctoring experience has largely shaped his writing. Firstly, he explains that the practice of medicine keeps the doctor-writer's feet on the ground. In an interview with Samela Harris, Goldsworthy admits that medical practice balances the isolating journey of writing, and keeps him connected with humanity (2006, p. 8). In his interview with Elizabeth Marshall in the following year, he adds that "I think I'd very much disappear up my own sort of verbal arsehole without the earthing of medicine. It could easily become all style, no substance …" (2007, pp. 160-161). Secondly, medicine trains a doctor to observe human nature. Goldsworthy in his interview with Stephen Pincock quotes Somerset Maugham in saying that the best education for a writer was a medical degree (2010, p. 1819). Last but not least, the frequent contact with patients offers a rich source for his writing. In his latest interview with me, Goldsworthy comments that "Medicine allows you the privilege to look into people's life", and this human experience is "valuable for novels" (Guo Yan, personal communication, December 1, 2013).

At the same time, Goldsworthy believes that writing has assisted his practice of medicine, on both a personal and professional level. "Being a writer helps make you a better listener as a doctor" (Guo Yan, personal communication, December 1, 2013). In the

doctor-writer's own words, he has been transformed from a "science nerd doctor" who only liked diagnosis and was good at quick decision-making, to a much more patient doctor who becomes interested in people as much as in diagnosis, all thanks to writing (Marshall, 2007, p. 161). In addition, holding that "writers are always taking, from people, people's lives, loved ones, families, children", Goldsworthy argues that writing offers him the opportunity to give back, "You can give it back by the insights it gives you, making you a better practitioner" (Guo Yan, personal communication, December 1, 2013).

By contrast with her Australian counterpart, Bi Shumin was born in 1952 in Yining, Xinjiang and grew up in Beijing. She joined the army in 1969 and was a member of the first, which was also the last, group of female soldiers sent to Ali, Tibet, where she was assigned to become a medical orderly. Three years later, she was sent to the Field Hospital in Xinjiang for medical training. Though the school offered her a position after the training ended, she decided to go back to the troops, being concerned with the lack of doctors in the army. So, she moved back to Ali, where she worked as an army doctor for five years (Chai Fushan, 2004). This strong sense of public obligation is considered by many reviewers as being carried on through her doctoring and writing careers later on. After eleven years working at the Plateau, Bi Shumin was transferred to a civilian post back in Beijing, and worked as Chief Internist in a factory. Experiencing a sharp contrast living in the city, Bi Shumin began to have a strong wish to pass on stories about the remote plateau area to more people. Having had a passion for literature since childhood, from 1982 to 1985, Bi Shumin started studying part-time for a diploma in Chinese literature. From 1987, a series of novellas set in the Kunlun Mountains and based on her life as an orderly were released, among which "Die Young in the Kunlun Mountains" (《昆仑殇》) was the most popular with critics and the general public (Niu Liming, 1998; Bi Shumin, 1999, p. 88; Bi Shumin, 2010, pp. 257-268).

From 1988 to 1991, she studied further for a Master's Degree in Literature at Beijing Normal University. Meanwhile, the writer turned her gaze to urban life and wrote a series of novellas and short stories about ordinary people's loves and pains, life and death. She

has always had a special concern for children and women, perhaps because of her experience as a paediatrician and gynaecologist for years (Yu Wei & Wu Zhifei, 2012). Such works as An Appointment between Women (《女人之约》) and The Cycle of Life (《生生不已》) are two of the best examples. Having established herself as a writer, Bi Shumin began to feel somewhat torn:

> Dressed in my noble, white gown, I am pensive.
>
> Medicine is my occupation; literature is my passion.
>
> Both are careers for human benefit, but there exists an incompatibility between them.
>
> I've got to make a choice. I'm unable to treat patients when my brain is churning with storylines. To do so would be to disrespect people's lives.[22] (Bi Shumin, 2010, p. 284)

Therefore, in 1991, twenty-two years after she started working as a practising physician, Bi Shumin became a full-time writer, choosing a different path from Anton Chekhov, William Carlos Williams and Peter Goldsworthy, who were able to maintain a strong relationship between the two careers because of the mutual benefits the dual careers brought to each other. Nevertheless, she insisted that she did not give up medicine; she only left medicine for writing temporarily, lest one day she might run out of stories to tell (Bi Shumin, 1999, p. 89). In 1998, Bi Shumin became interested in the mind and started pursuing a PhD degree in psychiatry:

> For me, my interest in human beings is actually the interest in knowing myself. It's indeed hard to know oneself. You don't know why you react in certain ways and make decisions under certain circumstances. And why you love these people, but not those ones. Why? There must be an unknown logic that functions behind all these questions. And I think these are the motivations for me to study [psychiatry].[23] (Liu, 2007)

In 2002, Bi Shumin finished her courses in psychiatry and opened a psychiatric clinic

[22] Most of the Chinese resources are translated by the writer of this thesis.

[23] The original version used the word psychology, but it should be psychiatry.

with a friend.[24] People rushed in because of the writer's reputation and the clinic was always fully booked. In 2004, because of the great pressure this job put on her, she decided, once more, to quit practising. Though she gave up the practice of psychiatry, her experience as a psychiatrist has never stopped lending her insights for the practice of writing. Since 2002, Bi Shumin's novels have been influenced more and more by her study and practice of psychiatry. In both Save the Breast (《拯救乳房》, 2003) and The Female Psychiatrist (《女心理师》, 2008),[25] for example, one finds the writer's literary experimentation based on her clinical experience as a psychiatrist.

Clinical experience as a physician and psychiatrist has not only offered the author rich materials for writing, but also trained her to be a keen observer, an objective and calm storyteller, and more importantly, reinforced her concern for humanity, as the author reflects:

> The training and practice of medicine and psychiatry have given me great insights and will continue to do so for the rest of my life. It has taught me to love life, both my own and the lives of others; it has taught me to be calm and collected, objective and realistic; it has taught me to value equality and humanity. In all of these ways it has greatly influenced my writing. (Wang Xiaojun, 2012, p. A06)

Therefore, Bi Shumin has not abandoned medicine or betrayed her training; rather, she has chosen to be a good doctor by becoming a writer, writing about medical issues, and circulating knowledge about physical and psychological health. Till now Bi Shumin has published five novels, three collections of novellas, numerous short stories, essays and a travel journal. Of all the literary forms, essays and novels are her favourites. While likening the essay to an inn, in that its soothing effect on human minds is akin to what a

[24] She did not complete her PhD degree. In an interview with Xinmin News, Bi Shumin reveals that to be awarded a PhD degree, she needed to finish a thesis and pass a foreign-language exam. Afraid that thesis writing would leave her no time for her creative literary work, and lacking confidence in her foreign-language proficiency, Bi Shumin decided to give up applying for the degree.

[25] The 2010 edition of the novel was published with an English title, *The Female Psychologist*, although I think The Female Psychiatrist is more accurate.

lodging place offers for travelers, she compares the novel to a quadrangle courtyard, in the sense that a writer must take everything into consideration during composition – the layout, the language, the structure, as well as the rhythm (Bu Changwei, 2006, p. A23). While her essays deal with a wide range of subject matter, such as the appreciation of love and the wisdom of embracing death, the pursuit of emotional and psychological health, her writing principles and travel experience and so on, most of Bi Shumin's fictional works are specifically dedicated to the practice of medicine and psychiatry, a topic which I shall deal with in detail later.

As writers, both Goldsworthy and Bi Shumin have been productive and popular, and their works have been well received in both academia and popular culture: on the one hand, works by the two doctor-writers have aroused systematic discussion among scholars and reviewers. Such texts as *Maestro* by Goldsworthy and "One Centimetre" by Bi Shumin are anthologized as set texts on the syllabus for secondary schools in their respective countries. In addition, several adapted works by the two authors have made their way to such popular media as theatre and TV. For example, Goldsworthy's novels *Honk If You Are Jesus* and *Three Dog Night* have been adapted for the stage, and Bi Shumin's novels A Red Prescription and A-Cute Blood Disorder[26] (《血玲珑》) have been made into TV dramas.

In short, having published a great number of creative works and won both national and international awards,[27] both doctors have fully established themselves as writers, not simply as a sideline career but as a lifetime career. Believing that the two careers "play off each other nicely" (Marshall, 2007, p. 161), and emphasising the importance of "get[ting] the balance right" (Guo Yan, personal communication, December 1, 2013), Goldsworthy divides his time equally between the two – writing in the morning and practising medicine in the afternoon – and excels in both fields. Unlike Goldsworthy and some other

[26] The original Chinese title tends to create ambiguity, since 玲珑 can mean pretty and cute, but in the novel it is the name of a treatment plan for a girl with terminal blood disease. With A-Cute, I was trying to create a similar ambiguity.

[27] Unfortunately, only a few works by Bi Shumin have been translated into English, such as the novella *An Appointment with Death* and the short story "One Centimetre".

doctors, who have found a balance between medical and literary practice, Bi Shumin seems to view the practice of literature as a more likely vehicle to channel her concern for humanity. Or rather, for Bi Shumin, the sense of the doctor's obligation to treat patients humanely may have eventually merged into her desire to communicate with the general public about ethical issues.

There are a great number of parallels between the two writers' works. Both writers have extensively represented the complexity of human nature and the subtlety of human emotions; they have examined the physical, mental and psychological diseases of human beings; they have striven to unravel some of the existential mysteries of life and death. A number of their works revolve around doctor-characters, set in medical contexts, or reflect the practice of medicine. This may reflect the fact that the training in, and practice of, medicine preoccupy both writers' life experience. "With all writers, they write about what they know about. It just happens that way. Some of the best stories I hear of or think of revolve around medicine, where the stakes are high", so Goldsworthy comments in his interview with me (Guo Yan, personal communication, December 1, 2013). Bi Shumin offers a similar explanation for drawing on her doctoring experience in her writing, "I am probably someone who is deeply attached to the past. I cannot help writing about hospitals and examining the world from a doctor's perspective" (Bi Shumin, 2010, p. 286).

With a rich source of intense and insightful storytelling, these works involving doctors, hospitals and medical practice have engaged readers in profound discussions about such controversial topics as the concepts of healing, doctor-patient interactions, medical science and medical ethics. Like the six doctor-writers discussed in the previous chapter, whether consciously or not, both Goldsworthy and Bi Shumin have participated in the promotion of a balanced, holistic medicine: a medicine which is equally supported by high technology and empathy; a medicine which is based on both standardised and personalised care; a medicine which is an integration of scientific knowledge and the art of healing. The two doctor-writers' literary participation more or less echoes the Narrative

Medicine programme that calls for a human and individualised, patient-oriented and narrative-based medicine, in response to the development of an ever more "efficient" but dehumanised, and specialised but indifferent medicine. Nevertheless, the two writers' approaches to medicine-themed writing are rather different. For Goldsworthy, the medicine-themed writing seems to serve as a way to test and explore the puzzles he encounters during medical practice; while for Bi Shumin, writing about medical themes seems to have become a way to carry on her duty as a doctor – to communicate with the public about medical areas that they are not knowledgeable about.

Goldsworthy compares his fiction writing to "thought experiments" and "philosophical hypotheticals" (1998, p. 23). He has repeatedly invited readers on a series of thought experiments through fictional adventures. Science fantasy *Honk If You Are Jesus* (1992), for example, leads readers on such a wild scientific adventure as cloning Jesus. The book stemmed from the author's idea of bringing back to life extinct animal species from their salvaged remnants, after he read an article about genetic science (Goldsworthy, 1998, p. 9). Written almost in parallel with Michael Crichton's *Jurassic Park*, the novel reflects the doctor-writer's curiosity and exploration of genetic science. "The Duty to Die Cheaply" depicts a doctor who fails to take quick action to rescue a patient who has had a heart attack and tries to exonerate himself from feeling guilty. The story was originally generated from the doctor's inquiry, "what is a human being, and what are his or her rights and obligations?" after he read about medical rationing in countries which could not afford to provide such medical services as dialysis to everyone (Goldsworthy, 1998, pp. 20-21). Last but not least, the novel *Three Dog Night* guides readers on a trip to a death ritual, to a primitive and Aboriginal culture, and to the human emotional and psychological world, all at the same time. The novel itself represents the author's own exploration of love, death and Aboriginal cultures, and even the influence of psychiatry on medical practice in modern times. It will be discussed in detail later.

Therefore, for Goldsworthy, fiction writing becomes a way to unravel his puzzle, express his critical thinking, and carry out his "thought experiments". As is mentioned in his

biography, Goldsworthy has had a lasting curiosity about science and other forms of knowledge since his boyhood. “I was *very* curious about science”, so Goldsworthy informs us, in his essay “Honk If You Love Science”. Admiring science for its reason, logic and testability, Goldsworthy considers it as a trustworthy way to “get closer to an understanding of the world than could any other method of thinking” (Goldsworthy, 1998, pp. 13). “Those fascinations from childhood, the theories and possibilities of science, flowed into his writing”, as Harris observes (2006, p. 8). Nevertheless, Goldsworthy’s writing brims with, as Noel Henricksen points out, “a complex interfusion of belief and scepticism; a mixture of faith in the physical and hope in the metaphysical” (2011, p. 262). To such a comment, Goldsworthy responds in his interview with me that he is a sceptic and agnostic: “Basically I’m still in pursuit of science, but I know there are mysteries that science can’t explain, no one can explain” (Guo Yan, personal communication, December 1, 2013). This scepticism has been reflected in many of his medicine-themed writing, as if he is seeking the answer to the question “why is there something rather than nothing?”

Though the author confirms that he has “flirted with the edges of science-fiction” in a couple of his novels (1998, p. 23), Goldsworthy resists the label of science-fiction with which some of his works are tagged, as much as he resists the “the myth of an arts-science great divide” (1998, p. 14). In fact, even though most of his works may be based on scientific knowledge or from the perspective of science, they are mostly dedicated to an ethical or philosophical examination of human beings and humanity. One of his favourite approaches to such “thought experiments” and “philosophical hypotheticals” is a comic parody of the characters or scenes he has encountered during medical practice, perhaps because of the doctor-writer’s notion that writing is a way of capturing what obsesses him in his everyday life. For example, in creating the female protagonist Doctor Fox and the “wunderkind and mad scientist” Doctor Scanlon in *Honk If You Are Jesus* (Goldsworthy, 1998, pp. 13), Goldsworthy parodies his own obsession with science since boyhood. The short story “Waiting for the Barbarians”, which offers a comic picture of a superstitious doctor, is also a parody of Goldsworthy’s own experience – waiting for a foretold death but ending up being disappointed (Goldsworthy, 1998, p.

43). What is more, he has parodied a number of characters and events from his daily practice, first in his short stories and then as subplots or anecdotes in his novel *Three Dog Night*: the kind of doctor who cannot hide his lust for a friend's wife in "The Death of Daffy Duck"; the unpleasant coincidence of his first day in the dissecting room and the cold pork served at dinner in "The Duty to Die Cheaply"; a woman whose lover died of a heart attack is less occupied by grief than moving the dead man's car from her driveway, before her husband discovers it in "The Car Keys".

Unlike Goldsworthy's works, which may tend to unravel his own puzzles in the form of literary creation, Bi Shumin's fictional works seem to serve more for the purpose of public education. While Goldsworthy prefers to carry out "thought experiments" with a comic or sarcastic parody, Bi Shumin's approach to creative writing seems to be imbued with insights derived from reportage. Based on her knowledge of medicine and her experience as a doctor, Bi Shumin's stories lead readers to the joy and sorrow of patients and their families who face such fatal diseases and terminal conditions as a brain tumor in "The Circle of Life", drug addiction in A Red Prescription, pernicious anaemia in A-Cute Blood-Disorder, breast cancer in Save the Breast, and a life-threatening virus in *Corolla Virus*.[28] These works involve this or that kind of cultural taboo, what Goldsworthy would describe as "high stakes", and what readers may attempt to avoid but at the same time are tempted to know about. In this sense, Bi Shumin seems to serve as a reportage writer, introducing a taboo subject to more readers. Take the novella *An Appointment with Death* (《预约死亡》, 1994) for example. The concept of hospice service reached China in the late 1980s.[29] When the novel was written, the hospice service system was in its infancy and the concept of the hospice was still a relatively new concept to Chinese readers. Therefore, by leading readers to the work of a hospice, the novel not only responds to the

[28] The novel has not been translated into English but it was published with an English title.

[29] The first purpose-built hospice was established in 1967 by a British nurse called Cicely Saunders, and strove to offer expert palliative care and emotional support to the dying. In China, the first hospice was founded in Beijing in 1987. In the following year, Tianjin Hospice Care Research Institution was established, the first research institution of this kind, which attracted the attention of the media nationwide. From then on, more hospices have been set up in such cities as Shanghai, Xi'an and Guangzhou, and meanwhile, a series of International forums and workshops have been organised. In 1992, hospice care was officially absorbed into the Chinese healthcare system by the National Health Commission.

fact that most people are either ignorant of or have little courage to talk about dying and death, but also manages to trigger discussions on such controversial issues as palliative care for the dying.

What is more, unlike her earlier works, which may have come directly from her experience as surgeon or internist, the area she touched upon in this novella is one she had not been so familiar with herself. "In the hospice, the moment I was lying on the death bed, I realised that I had never fully understood death, despite the fact that I worked as a physician for decades" (Bi Shumin, 2010, p. 273). The author admitted once in an essay that she prefers to deal with subjects she is familiar with or confident about (Bi Shumin, 2010, p. 272). Therefore, to develop her understanding of these unfamiliar fields, the author has explored them in person, undertaking "field research" before translating them into creative literary form. She visited a hospice, tape-recording the last words of the dying, conversing with doctors, nurses and volunteer workers, and letting herself lie in the slim sunken spot in a bed that had been laid on by many dying people (Bi Shumin, 2010, pp. 273-275). She also visited hospices in San Francisco and New Orleans in the US, though the trip to the US may have been after the publication of the novella. In addition to *An Appointment with Death*, the novel A Red Prescription is based on the author's personal research on drug rehabilitation, and *Corolla Virus* is based on her visit to the isolation wards during the outbreak of SARS in 2003. It seems that each of her medicine-themed literary creations becomes an adventure, in both the literal and symbolic sense. In this sense, too, the author imbues her fiction with insights comparable to that of reportage.

This reportage approach, however, leads to some sceptical reactions from readers: "After so many return trips, tape-recordings, notes, library research, and even lying on the death bed ... you've produced a novel", a friend of Bi Shumin's expresses scepticism about the composition of *An Appointment with Death*. "This is not how a novel is, or should be, written" (Bi Shumin, 2010, p. 275). Indeed, this approach somewhat blurs the boundary between fiction and non-fiction, and this blurring may disrupt readers' expectations.

Nevertheless, Bi Shumin's fictional writing involves an artistic forging and processing, rather than a replication, of the raw materials the author has collected. "My fiction is highly worked, yet it is honest and true. It's as if I keep on grinding up countless real stories with my pestle and mortar, and produce pills out of the mixture. They look nothing like the original materials, but they contain their essence", so the author comments, on the writing of *An Appointment with Death* (Bi Shumin, 2010, p. 275). In addition, as one critic comments, a short period of experience would not necessarily make great storytelling, however keenly the writer observes (Bei Ming, 1995, p.83). Fortunately, what Bi Shumin has built into each of her works is not simply intensive and deliberate experience during a short period of time as in a hospice or a drug rehabilitation centre. It is rather keen observation from her everyday personal life and career life, an accumulation of emotional experiences and critical thinking. This is how Bi Shumin describes the composition of A Red Prescription: "it reflects my personal experience of working in a drug rehabilitation unit, but is perhaps not limited to the few months I spent there, rather it represents the accumulation of my twenty-odd years of working as a doctor" (Bi Shumin, 2010, p. 295).

Of all subject matter touched upon, dying and death are subjects of interest for both authors. This can be ascribed to the fact that as medicos, they both have (or had) to deal with the paradoxical situation, seeking to fix what, in the final analysis, cannot be fixed – human mortality. Both writers have dwelt on different types of deaths: the premature death of a child in *Jesus Wants Me for a Sunbeam* by Goldsworthy and A Seamless Surgery (《天衣无缝》) by Bi Shumin; the hospitalised death of a patient in Goldsworthy's "The Destroying" and Bi Shumin's A-Cute Blood Disorder; palliative care for the dying in *Three Dog Night* and *An Appointment with Death*; the death of a medical doctor in *Three Dog Night* and A Red Prescription. These works on death reflect not only the two doctor-writers' attempts to look death in the face from direct experience, but also the two writers' philosophical thinking on life. Through a fictional character called Felix in *Three Dog Night*, for example, Goldsworthy expresses his life philosophy that learning to die is essentially learning to live (Goldsworthy, 2003, p. 132). A similar life principle is

expressed by Bi Shumin in one of her interviews: “Only by understanding the meaning of life, would one have the courage to talk about death. Only by having a profound understanding of death can one genuinely have life in one’s hands” (Wu Fei, 2002).

In both their representations of dying and death, there prevails a sense of detachment. Nevertheless, there are subtle differences between Goldsworthy’s detachment and Bi Shumin’s detachment. In Goldsworthy’s representation of dying and death, the light sense of detachment is often blended with a heavy dose of black humour; while Bi Shumin’s handling of the cultural taboo reflects a philosophical embrace of death and a celebration of life. The ways they respond to the frequent contact with dying and death may offer a clue to how differently they approach the topic. For Goldsworthy, pain, suffering and death are what preoccupy him most during his practice:

> I’ve been faced with a lot of deaths. I try to help people, sometimes not very well, sometimes well. Sometimes people die. It can be nasty deaths, too, like accidents or failed resuscitations. Things like that, so they leave an indelible trace in your mind. Those images that you don’t want to see again. But they pop up ...You are fighting against your own sense of infallibility. That’s one particular area – it’s interesting to follow sometimes, for doctors. I’m probably more interested in what it takes to survive as a doctor. I mean emotionally. What are the emotional costs of that to be maintained. (Guo Yan, personal communication, December 1, 2013)

Therefore, the detachment in Goldsworthy’s works is in fact a fictional parody of the clinical distance the doctor has developed during his practice: “those sort of strategies, if you like, that you develop for survival in medicine, can be quite useful in writing, in tone” (Marshall, 2007, p. 163). Since medicine involves contact with a lot of human misery and human stupidity, it is essential to see the suffering or dying of patients as “an intellectual puzzle to be solved”, so as to survive, or at least to sleep peacefully, so Goldsworthy suggests in his essay “Death and the Comedian” (Goldsworthy, 1993, p. 31). The other way to distance oneself from such an emotionally overwhelming world, according to the doctor-writer, is the use of humour (Goldsworthy, 1993, p. 31). “There is no doubt it starts off as defence. I’ve always liked dark humour. That’s probably before I

did medicine. I've always liked sarcasm. The study of medicine certainly made me a lot darker" (Guo Yan, personal communication, December 1, 2013). This type of "too-clinical" voice – what Goldsworthy considers as self-parody for the purpose of "attempted exorcism" – leads to criticism. For example, Andrea Stretton (1988) in a review of Goldsworthy's short story collection *Bleak Rooms* suggests: "[this] sparse and understated prose brings out this reader's bloodlust: the desire for one of these fictional medicos to undergo major fictional surgery – without an anaesthetic" (as is cited in Goldsworthy, 1993, p. 31). Personally, I do not quite agree with Stretton. Having offered black humour as his trademark, Goldsworthy takes heed not to go overboard: "Over a period of years, working long hours, and with no sabbaticals to allow a refilling of the reservoirs of compassion, the gallows humour process in many doctors goes too far, and becomes its own caricature: cynicism, indifference" (Goldsworthy, 1993, p. 31). What the author attempts to achieve with the use of black comedy is not cynicism; rather, it has become a process of sense-making and a search for understanding. "Sometimes, to use an old truism, if we don't laugh, we cry – and sometimes even both at the same time, our worst jokes and favourite tears tangled hopelessly together" (Goldsworthy, 1993, p. 31).

While Goldsworthy's representation of dying and death may reflect his concern with the emotional survival of doctors, Bi Shumin's response seems to emphasise the doctor's duty in the existential puzzle of life and death:

> Having witnessed many deaths, a doctor cherishes life all the more. People tend to have contact with a doctor only at their most miserable moments. They entrust the most precious thing they have – their life – to the doctor. At such times, everything the doctor does and says should express care and love for life. This is what a good doctor should do. We should always offer love and care, even when death is unavoidable. (Wu Fei, 2002)

According to the author, she has had frequent contact with death since she was seventeen: ten years of facing the snowy mountains in Ali offered her many opportunities to meditate on the meaning of life; during her twenty years of working as a doctor, Bi Shumin witnessed countless deaths of patients; having saved many lives during her two decades

of practice, however, Bi Shumin could not do anything when her father died of blood disease and her mother died of liver cancer. The intimate contact with death may have provoked in Bi Shumin a philosophical reflection about life. On the one hand, Bi Shumin believes that "life is brief, vulnerable and meaningless". It is meaningless in the sense that everyone is born to die – "life is a process of living towards death". On the other hand, she believes that since life itself is meaningless, she must live it fully so as to endow it with value and meaning (Wu Fei, 2002). Influenced by such a paradoxical philosophy, deaths in Bi Shumin's works are represented not as an end to life, but a process – "the last phase", to quote the author's own words – in the life-long course of growing up. With regard to the composition of *An Appointment with Death*, for example, the author comments, "I could have made the story about hospice care sentimental, or frightening, or sadly beautiful, but I chose to downplay the drama, and show life as it is" (Wu Fei, 2002). Therefore, like Goldsworthy, Bi Shumin narrates her stories about death with an air of detachment: what they convey is never indifference – on the contrary, what they convey is passion for living and compassion for human beings. In this sense, Bi Shumin's representation of death is "ahead of its time" in the sense that, as Cai Anyan comments, she manages to illuminate thinking about death in a nation that has an ambiguous view of life and death, and her works are infused with humanist concern (2003, p. 42). The different approaches employed in the representation of dying and death by each doctor-writer best illustrate their distinctive writing styles, more or less informing the way they approach the issue of what makes a good doctor. While Goldsworthy's overall style of writing is comic and ironic, Bi Shumin's writing tends to be philosophical and more serious. Nevertheless, exceptions exist in both writers' cases since some of Bi Shumin's works can be humorous while some of Goldsworthy's writing can be heavy and serious.

In short, Goldsworthy-the-writer has processed those moments that obsessed Goldsworthy-the-doctor and skilfully turned them into a series of striking fictional moments, during which he maintains a proper detachment but not indifference; he makes good use of black humour without ill intention. From the eyes of a scientist and a humanist, or a clinician and a caricaturist, Goldsworthy carries out thought experiments,

grapples with suffering and pain, undertakes an existential inquiry about life and death, and manages to provoke the worst laughter and the sweetest tears. Perhaps for such a reason, Goldsworthy is described by Heather Falkner as "the Chekhov of his time and place" (as cited in Goldsworthy, 2003, back cover).

Unlike Goldsworthy, to whom the practice of medicine and the practice of writing are mutually beneficial, Bi Shumin has built into her writing her moral commitment as a doctor. With her knowledge as a physician and psychiatrist, from the eyes of a reportage-writer and philosopher, Bi Shumin the writer manages to communicate with the public not only knowledge about diseases and symptoms, the work of hospitals and institutions, but also her philosophical thinking on death, her passion for life, and her concern for humanity. For such a reason, Bi Shumin has been compared to a "white angel" among literati (Wang Meng, 1995). Because of her personal experience of working in "the three most important studies of human beings – medicine, literature and psychiatry" (Bi Shumin, 1999, p. 88), her works have been received as of medical authority and credibility, which, in return, seems to confirm her role as an "educator".

3-3: The Portrayal of Doctors by Goldsworthy and Bi Shumin

Both writers have portrayed a variety of doctors, offering a spectrum of perspectives to examine the issue of what makes a good doctor. In the following section, I shall offer analysis of representative portrayals of doctors by each doctor-writer, and observations on how remarkably but distinctively each writer illuminates the discussion of what makes a good doctor.

Like Chekhov, Goldsworthy is extremely interested in, and is very good at, portraying human beings confronting the human condition and human beings with flaws. This may reflect his role as a general practitioner who offers primary care and has intimate contact with a broader public and makes overall diagnoses. Goldsworthy seems to be able to capture a spectrum of personalities and emotions. In such comic caricatures of doctor-characters as the self-deceptive doctor in the short story "The Duty to Die

Cheaply", the indifferent doctor in "Tattoo", the aggressively competitive doctor in "The Nice Chinese Doctor", the superstitious doctor in "Waiting for the Barbarian", for example, the author represents a variety of images of doctors who may make mistakes or make fools of themselves, who may be academically intelligent but are emotionally, morally or spiritually ignorant.

"The Duty to Die Cheaply" vividly presents a doctor who is self-deceptive and even a little hypocritical. The story is set during a flight when a patient is having a heart attack and the air hostess is calling for help. Doctor Philip, the only doctor on board, knows well that it takes only four minutes to cause brain death, yet "decently" he waits till an attendant locates him, busy looking for excuses to exonerate himself from duty. Soon he is led to where the patient is seated. Finding out that the victim died long before the first announcement, rather than feeling sorry for the loss, Philip ironically, feels relieved. To the doctor's surprise, however, his duty does not expire with the expiration of the patient's life. Considered as the only "experienced" passenger – with regard to care for the dead – Philip is asked to babysit the deceased passenger. Having had to accept the purser's arrangement and other passengers' expectations for "a doctor", Philip takes the seat, but not without grumbling. He begins to tease the attendant, scares the little girl sitting in front, and constantly asks for drinks. At the death of a passenger, the doctor is too busy excusing himself from the responsibility to offer any help or empathy. Rather than regretting his delayed first aid measures, he is more occupied with critiquing others: the purser makes excuses for leaving the dead body next to Philip as "space is at a premium"; the lady in the seat in front refuses to eat with a dead man sitting behind her; the airplane company Philip once flew with forbids offering prescription drug to a dying passenger for fear of being sued.

Even though he has a brief self-reflection on his indifference and "lost sensitivity", he immediately recovers from the "brief, foolish outbreak of sentimentality", assuring himself that "If he was sensitive enough to grieve for lost sensitivity, then surely he hadn't, in fact, lost it" (Goldsworthy, 2004, p. 27). As the journey draws to the end, Philip

cannot help recalling his dissection classes when he still had fascination and awe for the "frail body", the "whole package of organs", and the miracle of life (Goldsworthy, 2004, p. 30). Ironically, once again, it takes him no time to forgive and return to his "sterner" self. The caricature is freeze-framed as Philip firmly presses the call-button after landing, wrapping up the story with one last moment of humour – in spite of the pressure of the seat belt against his full bladder, he decides to order one more drink. No one shows up to serve him. The story best illustrates Goldsworthy's ironic and humorous style.

Like "The Duty to Die Cheaply", "Tattoo" offers an image of a surgeon who may be skilful in surgery but is indifferent to the patient's feelings. The story is about a girl who wants to have the tattoo of her ex-boyfriend's name removed. For most of the story, the surgeon only acts in the background, responding carelessly, from time to time, to the girl's inquiries. Even though he initiates some small talk, it seems to the girl that it is only a routine conversation that the medico is normally required to make with a patient:

> 'Care to talk about it?' he said eventually, mechanically: a formula learnt in medical school perhaps.
>
> 'Why not?' she said. 'Why on earth not?'
>
> No further prompts were forthcoming.
>
> 'It didn't work out,' she pressed on. 'We were different people. Too different.'
>
> 'Different?' The echo of interest came reluctantly.
>
> 'He's a man. I'm a woman.'
>
> The joke sank without trace. She doubted he was listening.
>
> 'He never listens,' she said. 'I left him because he never listens.'
>
> Still there was no reaction. (Goldsworthy, 2004, p.150)

Interestingly, a subtle comparison is established between the surgeon and the girl's ex-boyfriend. While she is complaining about how her boyfriend was always working and ignored her feelings, ironically, the surgeon is fully absorbed in his operation and does not bother to listen. At the end of the story, the girl asks whether she can keep the removed tattoo, the surgeon agrees to give it to her; after all, it is, in his words, her "property". He

puts on a generous air in doing and saying so. But meanwhile, he seems to be detached from and indifferent toward his patient. What interests the surgeon is surgery itself rather than the person he operates on. The tattoo and the story behind it seem to be an unimportant distraction from the surgical business. Though only appearing in sketch form, the surgeon in the story seems to represent the kind of doctor who is skilful in treating disease but unable to, or not concerned to, offer emotional comfort to patients and may trigger reflection in the reader about professional indifference.

More often than not, doctors in Goldsworthy's work are portrayed in pairs. By pairing doctors in a particular context, a sense of rivalry and intensity is always formed, which helps highlight doctors' ignorance, arrogance, or stupidity through the reflection of themselves in each other's eyes. "The Nice Chinese Doctor", for instance, offers the portrayal of a competitive doctor Nick by pairing him up with Dr Ng. Dr Nick is a local Australian doctor on call 24 hours almost every day. As a Vietnamese doctor named Ng moves to premises opposite, Nick becomes ridiculously possessive and competitive. Even though he has a waiting room full of paying customers, he urges his assistant to squeeze in more patients. Months later he receives a call from Ng, who informs Nick that his clinic has not worked out and asks Nick to buy some of his equipment. Only by then, does Nick show his delayed empathy and generosity by offering to share patients and workload. Unfortunately, Ng has made up his mind to leave. At the news, Nick who is supposed to feel ecstatic and triumphant feels "strangely, weirdly, empty".

As in "The Duty to Die Cheaply", Goldsworthy does not give readers the opportunity to stop laughing at Nick's ridiculous behaviour: he is preoccupied with his competitor even before Ng's clinic is properly set up; he starts spying on Ng as a joke, but the self-mocking behaviour gradually turns into a "habit" which even his assistant feels sick about; as he pretends to be a patient and makes an appointment with Ng, his assistant mocks him, but Nick assures her that this is only for "peer review"; before the "consultation" with Ng, Nick looks in medical journals for "a good disease" so as to set up an impossible task for Ng. By contrast with Nick's behaviour, Ng's consultation turns

out to be on a professional basis. As Nick is trying to find out whether his patients come to Ng to complain about him, Ng does his best to protect patient confidentiality. Though Ng is a subordinate character in this story, it is through the interaction with him that Nick's problem is fully exposed. Nick is certainly an enthusiastic and qualified doctor, but at the same time he is selfish and mean, leaving his peer no chance to survive. When his brother suggests that there is room for both Nick and Ng, Nick does not agree. He is like a "jealous lover", as his brother describes, too possessive of his patients, as if they were his "flock" (Goldsworthy, 2004, p. 125). It is understandable because medical professionals may work under financial and psychological pressures; nevertheless, the story, in a strikingly sarcastic way, represents the kind of doctor whose laudable qualities of devotion and enthusiasm can turn into selfishness and possessiveness.

Like "The Nice Chinese Doctor", "Waiting for the Barbarians" also offers a comic picture of a main doctor-character from the reflection of the supporting doctor-character, perhaps in a more direct way, since the supporting character is the narrator. Doctor Bernie invites the doctor-narrator and some doctor-friends to his party, where Bernie is waiting for his death to occur at midnight, as was predicted at a party back in his school days. Bernie seems rational in planning everything in detail: the tool bag for intensive care and the request for the narrator to keep an eye on him. Comically, the rational doctor is waiting for his superstition to be fulfilled. While he is waiting for his possible fate to come, ironically, he invites many friends to his party hoping that witnesses might scare Fate or Nemesis off. After midnight, when found sitting in darkness in his room, alive, Bernie has difficulty staying cheerful. Though he "survives" the fatal prediction, he does not quite survive his perplexed sense of embarrassment, silliness and shame. What is even worse, as his superstition proves wrong, his confusion about life and death still has not been resolved. He is cast back into the darkness of an unknown world, which seems to scare him more than the foretelling of his death. The title of the story may be a reference to Constantine P. Cavafy's poem "Waiting for the Barbarians", or J. M. Coetzee's novel of the same name. Barbarians, in this story can be read as "death", or Fate, or any solution to the existential puzzle experienced by human-beings. The result of Bernie's waiting seems

echoed in Cavafy's poem "And now what shall become of us without any barbarians? Those people were some kind of solution." In this story, Bernie turns to superstition for solution. To his disappointment, what he has been waiting for – the solution to his puzzle – is yet to come.

Either in a face-on portrait or a sketch, or in pairs, these stories offer a spectrum of portrayals of doctors who may be qualified in skill and technique, but flawed when such issues as empathy, rivalry, personal emotions (e.g. fear of death) and so on are taken into account. In addition to the image of the doctor as a flawed individual, Goldsworthy is also interested in portraying doctors as involved in relation with other doctors, whose doctoring journeys may have once converged at an earlier time but later diverge. This may in part be ascribed to the fact that having worked in the primary area of the healthcare system, general practitioners like Goldsworthy need to categorise patients and refer them to specialists who provide secondary or tertiary care. These experiences lend Goldsworthy profound insights to depict a medical professional in relation with other medical workers.

Take "A Cobbler's Child" for example. The story involves three doctors, Tim, doctor of palmistry and iridology, and Jill, a smart female medical doctor and a divorced mother, and the doctor-narrator. As practitioners of modern medicine, neither Jill nor the narrator is at all convinced by the alternative medicine practised by Tim. While Jill takes every opportunity to mock Tim, nevertheless, the narrator tends to defend Tim. The twist occurs as Jill's son falls seriously ill. Having not seen Jill for weeks, the narrator is invited to Jill's, and is shocked to discover that not only is Doctor Tim a welcome guest at Jill's home, but that Jill will soon be leaving with Tim to seek a faith healer for her son. Jill, the cynical doctor who was insisting on the need to "use science" and "use the probabilities" at the bridge table, now seems to believe, as the narrator has said before, there are "more things in heaven and earth than are dreamed of" in Jill's bidding system (Goldsworthy, 2004, p. 285). The novel indicates, as does "Waiting for the Barbarians", there are things in life that even the most knowledgeable people may be unable to explain.

“There’s so much nonsense around (referring to superstition) that I suppose people want to believe. I’m always interested in what people want to believe” (Guo Yan, personal communication, December 1, 2013), so Goldsworthy comments in his interview with me, when asked about the purpose of creating such doctor-characters in “A Cobbler’s Child” and “Waiting for the Barbarians”. Both novels depict the kind of doctors who are intellectuals, equipped with science but who may not be immune from superstition, especially when they confront the existential puzzles posed by life and death. Nevertheless, compared with “Waiting for the Barbarians”, the critique of the doctor in “A Cobbler’s Child” seems to be more empathetic and less sarcastic. On the other hand, however, the fact that a whole subset of doctors turn to alternative approaches to medicine may indicate, as some reviewers may argue, the human need to believe in something when conventional medicine fails to offer solutions. In this story, Goldsworthy employs one of his favourite trio patterns in his portrayal of doctors – two male doctors plus one female doctor. It helps bring a spectrum, even though on a small scale, of doctors’ personalities, views of life, as well as their attitudes towards the medical profession. In addition, the pattern helps form dynamic interactions between three characters, allows for complex relationships, and prompts varied responses among readers.

In “Quantified”, the pattern of a trio is applied once again. Frank, Scotty and Lindy were “Three Musketeers” at medical school eleven years ago. The story is set in a lecture hall where Scotty is giving a lecture on medicine. Frank, the closest friend of Scotty at school, comes to audit, not for the lecture but in the hope of renewing the friendship. Slightly deviating from the pattern of a trio, however, Lindy is absent, and is replaced by a stranger called Rachel, practitioner at the Women’s Clinic. She does not appreciate Scotty’s performance-styled lecture, criticising Scotty for his insincerity towards medicine, “You were playing games. Word games” (Goldsworthy, 2004, p. 167); “Medicine is not a game. It’s not a lot of debating tricks. It’s about real people with real problems” (Goldsworthy, 2004, p. 168). In addition to Rachel’s head-on challenge, Scotty is at the same time critiqued by Frank, though in a much milder way. For this purpose, Lindy is brought back to a “reunion”, in conversations between Frank and Scotty:

> Scotty: I can't believe, that Lindy is still wasting her time on this Third World trip.
>
> Frank: She doesn't think it's a waste.
>
> Scotty: Oh, I don't mean that. Cost-benefit medicine, et cetera. But she shouldn't be doing it.
>
> Frank: What should she be doing?
>
> Scotty: She could have done anything. The world's first brain transplant. (Goldsworthy, 2004, p. 169)

The conversation offers a glimpse into how far in the past decade the three of them have drifted apart in pursuing their professional lives, though nothing seems to have changed: Lindy is still serving in the Third World; Scotty is still a speaking star; Frank is still a believer in the golden mean (Goldsworthy, 2004, p. 168). Yet, during his conversation with Scotty, Frank comes to realise the person he loved dearly has become an "acquaintance". Compared with Rachel, Frank's criticism of Scotty is less aggressive, perhaps because of his belief that "the truth always lies somewhere between extremes" (Goldsworthy, 2004, p. 168). But when Scotty declares in his lecture that "diseases are not essences. Not things-in-themselves. They are provisional concepts" (Goldsworthy, 2004, p. 164); when Scotty seems to be "more interested in catching up on ten years of gossip", which to Frank is but "history without meaning"; and when Scotty takes Lindy's devotion as a waste of time, Frank reaches his epiphany in realising that his friendship with Scotty is by no means renewable, "it *was* different, utterly", though "no quantitative difference" can be detected (Goldsworthy, 2004, p. 171). In both "Quantified" and "A Cobbler's Child", Goldsworthy seems to pay special interest to how doctors, who have trained in the same medical system, turn in totally different directions in their future careers because of the different types of doctors they have striven to become. This concern is raised again in Goldsworthy's group portrayal of doctors in *Three Dog Night*, a full length novel about three doctors published in 2003.

It is noteworthy that in "A Cobbler's Child" and "Waiting for the Barbarians", and a few stories not mentioned in this thesis, there is a doctor-narrator who is relatively non-judgmental, subscribing to the golden mean. He always chooses a neutral stance in

telling the story, trying to balance extreme opinions posed and represented by other characters. This may be what Goldsworthy defines as the "ideal narrator", a narrator who is able to "handle all the stories of horror, squalor, stupidity, death – and occasionally, transcendent courage or love" (Goldsworthy, 1993, p. 31). On the one hand, the employment of the "ideal narrator" reflects Goldsworthy's belief that the path follows somewhere in the middle, "I'm more and more suspicious and maybe I'm just getting older and more conservative. I'm suspicious on both sides" (Guo Yan, personal communication, December 1, 2013). On the other hand, with the ideal narrator, the author manages to create a sense of detachment, generating uncertainty and ambiguity, and inviting varied interpretations and debates. This type of ambivalent narrator, together with other literary devices and techniques, and Goldsworthy's trademark black humour, has been more skilfully employed in *Three Dog Night*, though it is a much more serious and intense work than his previous writing. In a word, with either the individual or the group portrayal of doctors, who display different personalities, experience subtle emotions, or are involved in complicated relationships with other doctors, Goldsworthy approaches the issue of the good doctor from a variety of perspectives such as doctors' stupidity and vulnerabilities, the issue of duty and devotion, science and humanity, all of which are picked up again and fully developed in *Three Dog Night*.

Like Goldsworthy's, a number of Bi Shumin's works are dedicated, either directly or indirectly, to the discussion of what makes a good doctor. While Goldsworthy's stories about doctors mostly involve interactions between colleagues, many of Bi Shumin's early stories involve doctors of different generations. Such stories as "A Cross-Eyed Woman", "A White Poplar Nose" and "The Professor's Ring", for example, capture an interesting and sometimes unpredictable interaction between a medical professor and a medical student. The contrast between an experienced and a less experienced doctor both brings about the dramatic conflict and also offers dual points of view in the examination of such issues as the training of a good doctor, the doctor-patient relationship, as well as a wide range of issues in medical ethics. In one way or another, the mentor-student/intern relationship pattern offers an ideal context for the discussion of what makes a good doctor,

and determines how differently Bi Shumin represents the issues of the good doctor from Goldsworthy.

"A Cross-eyed Woman" offers such an example. On her way home, the narrator bumps into her professor who is an eye-doctor. They have had a good conversation until the female student feels stung by a woman gatekeeper's gaze – the conflict forms – she watches the professor and the student out of the corner of her eyes, and the narrator immediately feels that rumours about her and her professor will soon spread. The next day when she admits to the professor that she cannot walk home with him, because of the gatekeeper's judging eyes, the professor looks a bit upset. A little unexpectedly, however, he is upset not because of the intern's refusal to walk with him, but the fact that he did not notice such a pair of eyes. As readers may think the dramatic tension eases, on the contrary, it turns out to intensify a bit more: the next day, the professor not only shows up on time, insisting on walking home with the narrator, but when they come through the gate, the professor walks straight toward the woman gatekeeper. The narrator thinks a fight is to be waged. As she expected, the professor tells the gatekeeper that she is sick, after staring at her eyes for a while. The tension forms again since such a comment in Beijing dialect also means "you are insane" or "you are a psycho". Still, as expected, the woman flies into a rage and shouts back immediately, "YOU are sick!" Unexpectedly, however, the professor explains to the woman that he is an eye-doctor, and upon his observation, she must have an eye disease. He would like to give her a careful examination if she does not mind. Tears roll down from those squinting eyes.

What makes the micro-fiction special is the series of dramatic conflicts, as well as the twists that ease the conflicts one after another. Just when the interaction between the professor and the gatekeeper seems about to turn into a moral fight, it unexpectedly turns into a "medical consultation". The professor is not irritated by the gatekeeper's enmity; instead, he resolves the conflict by admitting humorously that he *is* sick – he has some health problems in the heart and knees, and this assures the patient that he is in the same boat. The story is narrated by the medical student. Since a student or intern's knowledge

lies between that of an expert and a lay person, the narrative engages readers, who are mostly lay people, in discussion about medical issues in a most effective way.

Like "A Cross-Eyed Woman", "A White Poplar Nose" is narrated by an intern in the first person. The story starts with suspense. On a quiet night, the corridor echoes with the noise of footsteps. In the emergency room comes a young woman called Xiao Cha, accompanied by her much older husband Lao Jiang, who is an experienced carpenter. At the interview with the intern-narrator, Jiang admits that he cut Cha's nose with a hand-saw when he saw a man about Cha's age kissing her on the nose. To the narrator's surprise, in spite of his brutal attack on Cha's nose, Jiang appears to be a caring husband. But when the intern tries to ask more questions, his supervisor stops him, suggesting that a doctor's duty is to save lives or fix bodies rather than to pry into patients' personal life. After examining the cut nose, which is carefully preserved by the husband, the professor decides to fix it and Jiang is grateful. The surgery is a great success. Strangely, as Cha's nose gradually recovers, Jiang becomes increasingly hostile again. Soon Cha is discharged, having completely recovered. Nevertheless, what seems to be a happy ending is suddenly disrupted. On another quiet night, much the same story happens all over again. Strikingly, the only difference is that the nose handed to the professor this time was spitefully mashed by Jiang, as Jiang proudly admits. Ironically, the nice-tempered supervisor who always asked his students to act professionally in front of patients is driven mad at the scene. He curses Jiang outrageously and then sobs helplessly. At the same time as offering first aid to Cha, the narrator has to rescue his professor who almost has a heart attack. In the end, Cha leaves the hospital without her nose.

This is a story of unhappy marriage or domestic violence in the first place. The names of the couple seem to imply their unhappy union. Xiao Cha and Lao Jiang are literally translated as Young Leaf and Old Ginger, respectively, indicating their age disparity.[30] At the end of the story, the narrator hears that Cha is now wearing a mask, under which is a

[30] Besides, Chinese readers would also easily associate Old Ginger to the idiom "spicier is the older ginger", which could be interpreted as "the older, the wiser", and meanwhile it could be used in a negative way – "the older, the more wicked".

white nose exquisitely carved out of poplar. That a white poplar-nose takes the place of the surgeon's exquisitely-repaired nose reveals the other theme – even the most exquisite surgery cannot mend every human wound, the husband-wife relationship, and the unsuccessful marriage. Somewhat resembling the neutral narrator in some of Goldsworthy's stories, the intern in this story seems to be ambivalent in portraying his mentor.

On the one hand, he seems to admire the professor for being strict with his students and precise with his work: he corrects the intern's dress etiquette; he tries not only to finish the surgery, but to leave the patient as little scarring as possible; when the narrator plans to have an article on the successful surgery published, the professor insists on waiting for a full recovery. On the other hand, however, the intern-narrator seems to mildly critique his professor for being an expert capable of fixing the patient's physical wounds but not their emotional or psychological wounds; being interested more in refining surgical crafts than caring about the patient's story of suffering.

Unlike "A Cross-Eyed Woman" and "A White Poplar Nose", "The Professor's Ring" is narrated in the third-person involving interactions between doctors of two generations. The story starts with a typical Bi Shumin moment of suspense – Qu asks his girlfriend to spy on his supervisor. Rather than resolving the suspense, one mystery seems to lead to another: Qu's supervisor is a renowned medical professor, who has seldom misdiagnosed in his life; he is extremely strict and none of his graduate students have graduated so far; they all have been persuaded to quit one after another, after having a meal with their supervisor. It is finally Qu's turn to be invited, together with his girlfriend, to the professor's home. Luckily for Qu, they have a pleasant meal, though the strange thing is that at the dinner table, the professor asks his wife to score the young couple. After building up so many mysteries, the biggest secret is finally revealed later that night when Qu and his girlfriend are informed that the old man says he is going to die soon. Based on his long-term evaluation of Qu's performance and his wife's score of the two, the professor decides to reveal his secret to Qu. In the course of each diagnosis, he puts a

ruby ring against one of the patient's acupoints, the "Nei Guan."[31] Once the ruby connects the doctor with the patient, the bio-current of the patient is transmitted to the doctor, allowing the doctor to experience what the patient feels. Based on the same sort of suffering and pain, the doctor is able to make a precise diagnosis. The professor decides to pass the ring to Qu, on the condition that he promises to use it only for the benefit of patients, and on the condition that Qu's girlfriend is willing to be supportive of Qu. Before long, he passes away. After his funeral, one more secret is revealed: the professor's wife turns out to be a robot designed by the professor, when the professor's ex-wife left him.

Despite the fact that the story goes beyond Bi Shumin's usual realistic realm, and evolves into a medical fantasy, it offers rich perspectives for the discussion of what makes a good doctor. That the professor's secret lies in the magic ring proves just the contrary – magic does not make a great doctor. Per contra, a good doctor is made by diligence, a loving heart, and what is more, empathy – to be in the patients' shoes. "At the moment of the diagnosis, I myself become the patient. This is the secret I want to pass on to you." What the professor essentially attempts to teach Qu is empathy, which Bi Shumin values as one of the most important qualities of a good doctor. The regard for empathy in this story resonates nicely with Goldsworthy's suggestion in his interview with me that the doctor should experience what the patient experiences before they diagnose and prescribe:

> ... if you can order enemas maybe you should have had an enema yourself. If you're going to order this or that test, it might pay to have one yourself. If you're going to put patients through an ordeal, it's not a bad idea to put yourself in that situation". (Guo Yan, personal communication, December 1, 2013)

In addition, the professor's ex-wife left him because of his whole-hearted devotion to medicine; though his second wife is all loyalty and devotion, she is a robot. The professor's marriage highlights the importance of a supportive family, for a devoted

[31] It is an acupoint corresponding to the function of cardiovascular and digestive disease according to Traditional Chinese Medicine.

doctor. That explains why the professor involves Qu's girlfriend in the conversation in the first place, the moment he decided to pass his secret to Qu. On the other hand, however, the story may indicate the danger of over-commitment to the job. The issue about how much doctors should devote to their jobs seems to be one of Bi Shumin's primary concerns. In A Red Prescription, the author draws on the issue of proper devotion again, from the perspective of the other gender – how a female doctor attempts to balance family and career, which will be discussed in the next section.

Furthermore, the story may indicate what is valued most in a good doctor of TCM, namely, clinical experience, empathy, and the spirit of devotion and sacrifice. In fact, all three stories discussed above reflect the inheritance of the art of healing in TCM, which informs how the good doctor is represented in Bi Shumin's works: on the one hand, when a teacher chooses to pass his knowledge to a student, the student's morality, diligence and devotion are often considered more important than skills and craft; on the other hand, to be able to become a good doctor, one needs guidance from a good teacher. The good teacher is ideally depicted as one who is open-minded, exemplary in both word and deed, and able to pass his knowledge and skills on to students without reservation. These stories more or less reflect the apprenticeship-like medical training in the Traditional Chinese Medicine.

In her later works, Bi Shumin's representation of doctors focuses more on the interaction with patients or in the context of a medical institution, reflecting the fact that Bi Shumin works in a different medical system from Goldsworthy.[32] Accordingly, these works are not based on the mentor-student pattern any more. Nevertheless, the type of narrator is largely preserved, his or her identity lying somewhere between the fully qualified medical professional and the lay person. Their special identity and ambiguous standpoint effectively invite readers to the discussion of controversial issues. The best example of all is *An Appointment with Death*. The novella is narrated in the first person by a fictional

[32] In China, the health care service heavily relies on the medical institutions. Even though there are private clinics, people tend to go to hospitals and see specialists rather than GPs. The GP system was just established in 2012 in China.

character with the same name as Bi Shumin, which makes it easier for her to directly channel her observations and opinions. Besides, by setting up the narrative mode, Bi Shumin seems to foreground her reportage insight. In this novella, the doctor-writer turns her gaze on what she considers as a blind spot of modern medicine and a cultural taboo for most Chinese readers, institutionalised dying and death – the hospice service – and related ethical issues. The opening paragraph displays a notice of critical illness, establishing a suspense typical of Bi Shumin's stories. It runs:

> Name: Bi Shumin Age: 70
>
> Sex: Female Place of Birth: Shandong
>
> Diagnosis: Liver Cancer (Advanced). (Bi Shumin, 2009, p.2)

In the storytelling that follows, it is revealed that the narrator has just come back from a visit to a hospice, where she pretended to be a patient with liver cancer, so as to experience the hospice service. As she unpacks, she explains to her husband about a collection of tapes she has recorded in the hospice – conversations with doctors and nurses, the breathing sound of the dying, the visit of a hospice-care specialist from England – till her husband refuses to listen any more. In spite of her husband's discouragement, the narrator directly addresses readers, as if sending an invitation, "I am about to explore dying and death. You decide whether or not to follow" (Bi Shumin, 2009, p.5). From there the main story unravels. In flashback, a great number of stories unfold, with regard to the dying and their families, from a wide range of narrative perspectives, including the director of the hospice, doctors, nurses and volunteer workers. Sometimes a second story is embedded in the first. With the huge amount of interwoven storytelling, a series of moral crises are triggered one after another. For example, from the perspective of the director, a story unfolds as the man who is about to travel abroad for an important job opportunity is waiting for his dying mother to die. In spite of his piety, his patience seems to gradually run out. Another man urges the doctor to apply euthanasia to his dying father who suffers from skin cancer. Ironically, when the doctor suggests ending hospitalisation if he wants his father to die, the man rejects the suggestion angrily and expresses his fear

of karma. In presenting this or that kind of moral dilemma, the novella does not offer any solutions; rather, it consistently invites readers to debate such issues as euthanasia, palliative treatment, and the care of dying family members.

In *An Appointment with Death*, as in many other stories by Bi Shumin, there is often, as Chen Diyong accurately summarises, a narrator who is a passionate observer and active participant rather than a passive, indifferent spectator (2008, p. 106). Such a narrator guides readers through the inside story and invites them to the discussion of medical ethics provoked in the storytelling. The kind of narrator employed in *An Appointment with Death*, together with the interwoven storytelling, as well as the suspense and dramatic conflicts, make their way to Bi Shumin's full length novel published three years later, A Red Prescription.

In conclusion, while Goldsworthy's representations of doctors tend to focus on doctors as ordinary people with flaws, experiencing emotional turbulence, or having this or that kind of "illnesses", or doctors in relation with each other, Bi Shumin's portrayals of doctors often show them in their relationship with patients, or in her late works, in the context of a medical institution. The good doctor can only be examined in a certain medical system, whether it is a GP system as in Goldsworthy's case or an institutional system in Bi Shumin's case. Starting with "comic sketches", and taking "less is more" as his writing principle, Goldsworthy has written gradually longer and more serious works. Starting with topics she was familiar and comfortable with, Bi Shumin's works began to reach out of comfort zones to unfamiliar areas. In different ways and from a variety of perspectives, both writers seem to have dug a little deeper and pushed a little further in their literary experimentation. Neither of the writers aims for novelty-seeking. Rather, they seek to raise serious issues in the medical humanity, and to test the boundary of acceptance of ethical issues. Of all their later, and more mature works, *Three Dog Night* by Goldsworthy and A Red Prescription by Bi Shumin treat the issue of 'what makes a good doctor' in rather oblique and extreme ways.

A Red Prescription was published in 1997. Being her first full-length work, A Red

Prescription picks up some typical Bi Shumin features and puts them to the best use. To some extent, the novel develops on insights already offered in *An Appointment with Death*. With the location switched from a hospice to a rehabilitation centre for drug addicts, A Red Prescription explores the living conditions of human beings at the edge of dying and death (Going Ailing 2006, p. 54). In addition, before drafting the novel, the author undertook thorough research and obtained almost all the data she could find about drug abuse and rehabilitation; she stayed in a rehabilitation hospital for several months to interview many addicts and doctors. For such a reason, the novel is taken by commentators as the first "realistic" novel about drug-rehabilitation in China. There is a blurring of genre, though. In large part, the novel is a medically realistic novel in a detective frame. As it develops, it evolves slightly into a science fantasy.

Three Dog Night was published in 2003. The novel is much more intense and serious than the author's previous fictional works, although in terms of the characterisation, the author's role as a scientist and satirist is still visible. In creating the narrator Martin, for example, the author portrays, in either a sarcastic or an empathetic way, a nerdy psychiatrist who becomes trapped in his emotional dilemma. In the characterisation of Felix, a surgeon who attempts to look death in the face, the author employs his trademark black humour. Reading like a love story in the first instance, the novel involves a subtle exploration of human emotions and philosophical thinking on human life.

In extreme and quite oblique ways, both novels trigger profound discussions regarding the issue of proper care, the balance between doctors' personal lives and their professional lives, and such ethical concerns as palliative care and hospice service – almost all the issues raised in their earlier and more condensed works. When read analogically and comparatively, the two novels illuminate the issue of what makes a good doctor, with two remarkable accounts of the death of a good doctor.

3-4: From "Death of the Good Doctor" to "What Makes a Good Doctor"

The title "A Red Prescription" refers to a pinkish-red-coloured sheet of paper used in

China for prescribing controlled drugs or medicine for drug addicts, normally by hospital doctors only. The novel involves a story about Peace[33], head of a drug rehabilitation centre, being trapped in the course of becoming a good doctor. *Three Dog Night* is a desert expression, the Australian Aboriginal measurement of the coldness of the wild by counting the number of dogs needed to hug to keep warm at night. The title refers to the nights three doctors – Martin the narrator, Lucy his wife, and Felix, Martin's best friend – spend together in the desert, where they attempt to make sense of love, life and death.

Interestingly, both novels end with the death of a good doctor. What is more, in both cases, the death of the good doctor is presented as a rational decision and well-arranged ritual, as if both doctors prescribe for their own death. In *Three Dog Night*, Felix is a surgeon, devoted to the treatment of indigenous people. As if playing a bad joke on him, the job he selflessly takes on sends him to his doom. During his last surgery, which ended with the death of a tribal child, Felix caught hepatitis. From then on, he is tortured not only by the degradation of his physical condition, but also the psychological stress of making amends for his surgical error. In order to make compensation or to make sense of life, Felix travels deep into the desert to die in an Aboriginal manner. In A Red Prescription, Peace, the doctor treating addiction, is tricked by a female patient called Feather into getting addicted, as the patient is offended by the fact that the doctor always treats her as a patient rather than a friend. After discovering her addiction, Peace consults Professor Jing, her mentor and an authority on drug-relief treatment, for a remedy. To Peace's disappointment, the only solution available is to cut the locus ceruleus in the brain which is involved with human psychological and emotional responses. To die as a person with emotions and feelings rather than to live emotionlessly and unresponsively, Peace prescribes for herself an overdose of drugs on a red piece of prescription paper.

[33] I have translated the characters' names in A Red Prescription into a single word so that English readers have no difficulty following them. The names of the three main characters, Peace (简方宁), Fish (沈若鱼)/ Barley (范青稞), and two additional characters, Feather (庄羽), and Friday (周五) are translated according to the meanings of their given names. For such supporting characters as Professor Jing (景天星教授), Pan (潘岗), Doctor Cai(蔡医生), Doctor Teng (藤医生), Mama Meng (孟妈) and Qin (秦炳), pinyin romanised spelling of their Chinese surnames is used; the name for the Dark-skinned Nurse (栗秋) is translated according to her complexion. For others, I may simply offer description of the character.

Both stories about the death of the good doctor are narrated from the point of view of a doctor. *Three Dog Night* is narrated in the first person by Martin, a psychiatrist specialising in obsession. He cares about Felix and follows his dying friend into the desert to offer thorough care, together with his wife Lucy who is also a psychiatrist. Though A Red Prescription is narrated by an anonymous third person, it is based on the perspective of Fish, a retired doctor who disguises herself as an addict and stays at Peace's hospital to collect materials for her book and to support her friend's campaign against drugs. With a doctor's account of the death of a good doctor, both novels set up the discussion of what makes a good doctor in extreme and extraordinary ways: while in *Three Dog Night*, Martin's account of the three doctors' journey to the death ritual examines the issue of what makes a good doctor in terms of how doctors handle their emotions and private life, in A Red Prescription, Fish's account of what she has seen and heard at the hospital sets out the issue of what makes a good doctor, especially a good female doctor, in the context of a medical institution.

When considered alongside each other, the two novels illuminate a series of issues around "the good doctor". For example, both novels set up extremely complicated doctor-patient relationships: in A Red Prescription the good doctor loses her life to a patient she is trying to save, and in *Three Dog Night*, the doctor-patient relationship between the doctor-couple and Felix becomes entangled with their personal relationships. For another example, both novels offer portrayals of a considerable number of medical workers. Goldsworthy's portrayal seems to focus on how doctors, in spite of a similar generational, educational and academic backgrounds, diverge in very different directions because of their personalities or the decisions they make in their career lives; whereas Bi Shumin's doctors are portrayed as coming from different educational and family backgrounds, representing different generations of doctors, bearing distinctive sociohistorical marks, and serving in the same hospital for different motives. In spite of the differences, portrayals of medical workers in both novels offer a spectrum of criteria for defining "the good doctor".

In short, with the story about the death of a good doctor, narrated from the perspective of a doctor-character, setting up extreme doctor-patient relationships, and offering the spectrum of doctor-portraits, both novels manage to tackle such issues as proper care, the tension between devotion to patients and devotion to family, the expectations for female doctors to be more caring, doctors dealing with such challenging situations as addiction and death, doctors facing their own death and so on. In the following sections, I shall offer a close reading of the two novels to explore how they approach these issues, and essentially, how they represent the issue of what makes a good doctor.

3-4-1: The Three-Doctor-Night

The novel is ultimately concerned with "the philosophical challenge of learning how to die" (Ley, 2003, p. 15). Goldsworthy involves three doctors, rather than one, in the exploration of dying and death – the trio being his favourite pattern. The portrayal of Martin, Felix and Lucy not only offers a spectrum of types of doctor, but makes it easy to see how each of the qualified doctors may be trapped in their own emotional problems. In this sense, the issue of the good doctor is discussed in the light of how doctors handle their emotions and private lives, especially when they face the dying and death of their patients, of loved ones, and of themselves. How the three physicians handle death trigger a variety of issues about dying and death. When all three of them have to face the topic of "death" for the first time, the active interaction between the three offers an indication of each doctor's outlook on dying and death and offers a clue as to how each of them may handle the existential puzzle:

> Felix: A line from one of Waldo's Greeks came back to me the other day: The central task of philosophy is learning how to die.
>
> Martin: Socrates.
>
> Lucy: He meant, surely, learning how to live. (Goldsworthy, 2003, p. 132)

Ironically, while Felix and Lucy exchange their understandings about life and death, Martin is busy with identifying the source of the sentence. They keep on exploring the

existential puzzle by sharing how they want to spend their last days. Martin's answer indicates that his prime interest lies in the "life of the senses" such as travel, orchestras, and restaurants and so on; Lucy wishes to get closer to the world and enjoy her last days more intensely; Felix makes comments such as "Live every moment as if it were an unexpected gift" and "Perform every act as if it were your last". While Felix's life philosophy resonates with Lucy's, comically, Martin is still burying himself in identifying sources for these sentences (Goldsworthy, 2003, p. 133). Once again in the desert, Felix poses the question of why the void after people die terrifies them more than the void before they are born, and Lucy suggests it is not death but the life people miss out on that they fear, which again accords with Felix's motivation for coming out to the desert, to see what he can live without. During the whole conversation, Martin is again occupied with identifying the sources – "Waldo quoting Plato quoting Socrates" (Goldsworthy, 2003, p. 286).

The series of dramatic encounters among the trio shows how the three medical professionals lack insight into such an existential puzzle as "death" before their journey starts; how they strive to make sense of death in their own manner; how they exchange thoughts about dying and the meaning of living. More importantly, in the course of making sense of dying and death, Lucy and Felix develop a more intimate relationship, as the two come to realise that they share so much in their view of life and death – learning to die, they both say, is essentially learning to live, more intensely and insightfully. While Lucy joins hands with Felix, Martin, the husband, is gradually left out as his understanding about life and death fails to resonate with that of the other two. In addition, the way each doctor handles death reflects in a certain sense what kind of doctor they are. Compared with Lucy and Felix, who seem to have relatively human responses to dying and death, Martin represents the type of physician that is an academic medical scholar who is knowledgeable about the classifications of psychiatric symptoms, but ignorant of emotions, relationships, life and death. Nevertheless, rather than from the point of view of Felix or Lucy, the novel is narrated by Martin in the first person in the present tense. The narrative mode is both brave and intelligent.

It is brave in that this narrative mode causes ambiguity and arouses debate among critics. The use of the present tense "catches up" to the point in time from which the story begins and then the reader follows Martin's final insights in real time. Moreover, the narrator is conscious of employing the present tense, from the very beginning: "I'm setting this down as if I am still back there, telling my story as it happens, live, in the freshness of the present" (Goldsworthy, 2003, p. 22). This narrative mode easily reminds readers of the narrator's unreliability. Giselle Bastin is critical of this device, suggesting that "the narrative needs to stop trying quite so hard – to be less self-aware and less chuffed with itself and what it knows" (2003 p. 24). Ben Kostival is not impressed with the narrative engine, either. He argues that Martin's role as a primary storyteller is not justified since he himself "exists so thinly", and "his judgment carries little weight", and point-of-view becomes problematic (2005, p. 102). Nevertheless, making Martin's perspective questionable to readers, in my reading, is exactly what the novel aims for – to create ambiguity and bring about obstacles for readers so as to invite different interpretations. As José Borghino fairly comments, using a narrator who is not only unreliable, but by the end "positively unattractive" is a measure of Goldsworthy's bravery (2003, p. 47).

The narrative mode is a clever device, in that it demonstrates the narrator's lack of insight into the minds of his counterparts and the development of the story. As a result, readers can experience the three-doctor journey entirely and exclusively from Martin's perspective. In this sense, the story in the first place examines how Martin handles Felix's death, by probing into Martin's emotional and psychological world. Consequently, the issue of what makes a good doctor is examined in a "microcosmic" context, namely, the emotional world. It is through Martin's fluctuating emotional journey that a series of issues regarding what makes a good doctor are most effectively triggered, such as boundaries between profession and emotion, the proper care, doctors' expertise and the redundancy of that expertise in some circumstances, and so on. This is because Martin is both the doctor and the friend of the dying person: while he is eager to examine his patient, he has to deal with a demanding friend; he on the one hand attempts to offer help, but on the other hand is badly in need of help. Besides, Martin is Felix's friend and

Lucy's husband, and it is Martin who initiates the relationship between Felix and Lucy, and as a result, his medical career largely intertwines with his private life and his professional world intertwines with his emotional world.

The emotional journey of Martin starts from his return to his homeland to be reunited with Felix, his best friend from school, whom he has lost contact with. On his way to Felix's terrace, Martin is overwhelmed by the joy of self-assurance and eager to introduce his wife Lucy to Felix. As if echoing Martin's joy, or a mockery of his self-assurance of his possession of Lucy, tireless descriptions of trees, birds and fruit are offered to form a picture of nature, fertility and liveliness. The opening scene would easily remind readers of the Garden of Eden, hinting at all three doctors' fall later. The highly anticipated scene of reunion, as well as his "emotional complacency", however, "suffers a dreadful but deserved mauling" (Ley, 2003, p. 15) in a sense that not only does Felix look unhealthy but he seems to be indifferent to his old friend. From then on, Martin's analysis of Felix begins. Since Martin is motivated by both his concern for a friend and his curiosity to study a patient's mind, an irregular doctor-patient relationship forms. Out of pride or self-esteem, Felix rejects his friend's help, or sympathy, especially as he views Martin's kind gesture of introducing Lucy to him as showing off a trophy. What further complicates the situation is the fact that the patient himself is a doctor. Though his specialty is in surgery, he seems to be familiar with how psychoanalytic therapy is practised. In a certain sense, all Martin and Lucy's "tricks" do not quite work for Felix. This irregular configuration of relationships foreshadows Martin's frustrated analysis of his patient-friend Felix.

Breakthroughs are gained through two gatherings with Martin's medical schoolmates, which serve as turning points of the storytelling. After the first party, Martin begins to comprehend the negative changes in Felix; after the second party Martin is informed of Felix's planned ritual death journey into the desert. In fact, both are typical of Goldsworthy's social gatherings, which normally evolve into farce; and where characters are often presented as caricatures with flaws or even stupidity. At both events, Frank,

another doctor, “stands out” because of his “life-of-the-party” personality and his obvious lust for Lucy. Such a doctor, who is represented as a terrible human being, regardless of his success in his career, is one of the most frequently depicted doctor-characters, an interesting addition to the trio of Goldsworthy’s doctor-portrayals in this novel. After the parties, even though Martin gains a breakthrough in his examination of Felix as a doctor, he suffers emotional turbulence as a human being. Not only does Felix intend to exclude Martin from his death ritual, what is even worse, Felix asks to “borrow” Lucy to accompany him into the desert. Here Martin’s analysis of Felix suffers a short suspension, though his emotional journey continues in that Martin is badly tortured – by the desire to help a friend and the jealousy of a husband.

Martin is finally brought into a kind of reunion with Lucy and Felix, as Felix’s condition deteriorates and Lucy asks Martin for help. Nevertheless, while he attempts to include himself in the death ritual, Martin is still excluded from it; yet, as he finally becomes part of the trio-journey, Martin realises that he is no longer interested in, or can no longer afford the price of, getting involved. Led by Martin, readers travel deeper and deeper into a primitive desert. It is described as being barren and wild, cut off from the outside world. The desert for one thing symbolises the mysterious existential puzzle of dying and death which the three doctors strive to gain insight into. What is more, the primitive setting represents the inner landscape of the three doctors. This is where all three doctors are forced to confront their true emotions and to dissect their innermost selves, since they are now facing death not only as medical practitioners, but as ordinary human beings: Felix eventually confesses to Martin that he has been using black humour and cynicism all the way through this journey to hide his fear of death; moreover, he admits that he has fallen deeply in love with Lucy. Ironically, when Martin the psychiatrist has finally got Felix “on the couch” (Goldsworthy, 2003, p. 304) – succeeding in analysing his patient – he cannot handle the outcome as a person with emotions. After experiencing different sorts of feelings, whether it is the stubbornly existing jealousy mixed with a lagging empathy; whether it is an increasing hatred mixed with an equally increasing shame; whether it is a

flash of desire to kill mixed with tortoise-like[34] pity, the rational doctor makes a most irrational decision, near the end of the preparations for Felix's death. When it is his turn to take care of Felix, without anyone noticing, Martin slightly increases the amount of morphine which ends Felix's life slightly earlier than it would naturally have occurred.

Herein lies the biggest irony of the novel, in the sense that this murderous act in fact makes less difference to Felix than to Martin himself, because the former has already lost consciousness and will die shortly. But this is exactly where the issue of what makes a good doctor comes to its most controversial point. "What's his motive, when he kills his friend, for compassion – to save him from pain? Or is there also a genuine spark of revenge?" Goldsworthy poses the rhetorical question, when asked the reason to create such a controversial doctor in the interview with me:

> I wanted to leave it very complicated because he is complicated. He is actually following his friend's last wishes to put him out of his misery, to euthanize him, but on the other hand, is there a slight hidden pleasure in that, or release for Martin? Because Martin is getting really angry, outraged ... (Guo Yan, personal communication, December 1, 2013)

Goldsworthy did not offer an explicit answer as whether the act of euthanasia on Felix is Martin's attempt "to cure" or "to kill". What is explicit, however, is that it triggers, in the most striking way, the thinking that doctors, the experts at treating patients, may be the least capable of dealing with their own emotional problems.

Martin's emotional journey does not end with the termination of his friend's life in that he has to handle the emotional costs of discovering the secret between his friend and his wife. In the last chapter "Tortoise Dreaming,"[35] the narrator brings the reader back to the present. Martin sits on Felix's terrace, which has been willed to Martin by the latter. The title of this final chapter refers to Martin's always lagging guilt and confession. As he is packing Felix's belongings, however, Martin discovers that Lucy is not as innocent as he

[34] Goldsworthy uses the word to describe Martin's lagging empathy.
[35] To offer a simple explanation, "dreaming" in Aboriginal culture refers to stories or storytelling.

thought, in that she initiated the relationship with Felix in many ways – what he thought was palliative care provided by his wife to his best friend turns out to be true love. Nor is Felix innocent. The letters from Lucy seem to be left there for Martin to discover, as if intended to spear his heart with one last shard of black humour. Having attempted to relate the story "as it happened, in the living, breathing present", without "getting too previous", however, the narrator comes to realise in the end that he has, in a sense, failed in this attempt (Goldsworthy, 2003, p. 340). He may have attempted to probe into how his marriage and friendship got into trouble, but he does not seem to understand his own emotions at all; he attempts to gain some insight into such human issues as dying and death, but his expertise fails to offer him any knowledge about it; he may attempt to make a confession or offer self-defence for his murderous act, but he realises, "we are all innocent till proven innocent" (Goldsworthy, 2003, p. 339). As its conclusion, the novel offers even more ambiguity. The story ends with Martin's comment that he is still waiting. He might be waiting for forgiveness, though the author leaves it uncertain whether Martin wants to forgive or to be forgiven. He might also be waiting for maturity, as Katharine England suggests, "the characters … have experienced life at a new depth and will be the better for it" (2003, p. 11).

By creating the character Martin, the author tends to create a sense of irony that "a psychiatrist who spends his life trying to understand people doesn't understand himself at all" (Guo Yan, personal communication, December 1, 2013). As a psychiatrist specializing in treating patients with obsession, Martin seems to have irremediable obsessions himself. He is obsessed with the sexual and possessive love for Lucy; he is obsessed with solidity, rationality as well as book knowledge; he is obsessed with the classification of symptoms and interrogation of people's minds. What is worse, Martin's expertise seems to present its own irony: the professional expertise of psychiatry does not offer him any help since psychiatry is "nothing if not the habit of hindsight" (Goldsworthy, 2003, p. 22). In fact, the use of Martin as the psychiatrist-narrator more or less "epitomises the influence of psychoanalysis over medicine", and through Martin, the author may challenge some Freudian theories, as Jean-François Vernay observes (2009,

pp. 87).

In addition to the portrayal of Martin, Goldsworthy makes outstanding use of irony in creating Felix and Lucy – acknowledging that doctors expert in treating others' problems may not necessarily be expert in their own emotional world or private life. From Martin's perspective, the other two doctors are also portrayed as having this or that kind of illness. By examining the way Lucy and Felix handle death, the issues of proper care and the tension between the devotion to patients and devotion to family are effectively set up. Lucy is a psychiatrist specialising in pain, who herself is a victim of pain. She has a limp, and the physical pain of childhood and the psychological pain it causes her in later life fortifies her empathy with others' pain and her desire to care for those in pain. She stops at animals injured on the road to offer them palliative care; she attempts to find out Felix's problem even as he tries to disturb and even scare her away; she follows the dying Felix into the wild and offers thorough care. She is described by her husband as having a loving heart, an "earth mother of all suffering creatures" (Goldsworthy, 2003, p. 26).

Ironically, what makes her a good doctor also is exactly what makes her a controversial doctor. Even though she is devoted to the care and love of patients without reservation, her dedication to the care of Felix is so intense that it becomes harder and harder to tell, as the story develops, whether it is out of the doctor's sense of responsibility or out of a woman's love. Till in the end, as Martin discovers Lucy's letter to Felix, it is made clear that she has confused the boundary between her profession and emotion. Besides, as she tries to ease Felix's pain, she cannot help intensifying her husband's pain and putting her own marriage at risk. With the portrayal of such a loving and caring female doctor, who is torn between commitment to her patient and the commitment to her husband, between duty to family and duty to her true feeling, the discussion about proper care is effectively set up. In fact, the question of what care is considered as proper is what the six doctor-writers in the previous chapters have referred to in one way or another. Nevertheless, it is Bi Shumin and Goldsworthy that pose the question in the most intense way. From both writers' works, it is implied that there is no easy answer to the question, since it is hard to define

how much is too much and how little is too little.

While Lucy may represent the kind of doctor whose care for the patient, in the form of love, exceeds what is considered proper, interestingly, counter-examples seem to be offered in "The Duty to Die Cheaply" by Goldsworthy and "A White Poplar Nose" by Bi Shumin discussed in the previous sections. In "The Duty to Die Cheaply", Dr Philip finds a number of excuses for being indifferent to the passenger who has a heart attack onboard. In "A White Poplar Nose", the old professor cares only about the success of the nose surgery, not the woman who has twice suffered from domestic violence. If Lucy's care for Felix is considered as being too much, both short stories seem to offer examples of care that is considered as being too little. It seems that neither love nor indifference is considered as "proper" care. In A Red Prescription, Peace seems to find a balance. Compared with Lucy in *Three Dog Night*, Peace attempts to keep a rational distance from the career she is taking on, even though she is also highly devoted. While she cares *for* patients, she does not necessarily care *about* them. For example, Peace sincerely cares for Feather, as her patient, and also as a trial for her new treatment plan. But she does not care about her as a person, as is described in the novel: she is "especially concerned with Feather's recovery, as if admiring her own artwork" (Bi Shumin, 2011, p. 349). When the therapy ends, the patient is no more than a finished product. As the novel presents it, "as a doctor, she is more interested in newly admitted patients, just like a farmer who wouldn't mind whether his wheat is going to be turned into bread or noodles after the harvest" (Bi Shumin, 2011, p. 350). But her rational distance from Feather is exactly what leads to her tragedy. The death of Peace may indicate that such an ideal concept as "proper" care for, or proper distance from, the patient, may never exist. It further emphasises how demanding a patient can be and how tricky the doctor-patient relationship is.

From Martin's perspective, Felix is depicted as the type of physician who is passionately devoted to improving the world with knowledge and expertise, "in a hurry to change the world" (Goldsworthy, 2003, p. 21). In order to serve and help the indigenous people, he has been adopted by them, taking skin names given by them, and even being circumcised.

Ironically, the good surgeon who has helped fix patients' injured bodies and restore their physical function is now threatened by the degradation of his own physical condition; moreover, it is the people to whom Felix is devoted that cause his death. What is even more ironic, when confronted by death, Felix the good doctor seems to become his own converse: the selfless and devoted doctor turns into a selfish and demanding patient.

The series of tragedies – his doomed career, degraded physical condition, and frustrated ambition and faith – seem to give the selfless surgeon every reason to behave like a selfish man. On the one hand, Felix fiercely resists the psychological examination by his psychiatrist-friends. He makes fun of Martin's foot-long quotations and success in his career; he makes horrible jokes to scare Lucy and even hurt her feelings. Even though he agrees to be taken care of by Lucy later on, he deliberately leaves Martin out, which causes irremediable damage to what was an intimate husband-wife relationship. On the other hand, however, he makes greedy demands on the couple. Compared with A Red Prescription, Felix offers an even worse example of a demanding patient than Feather, in the sense that while Feather is seeking sincere friendship, Felix is demanding love, from his best friend's wife. He endlessly "exploits" Lucy's caring and loving nature, such that she becomes his lover. What is even more selfish, he seems to demand Martin's understanding while turning the latter into a jealous but helpless outsider. In the context of selfishness and self-indulgence, Goldsworthy expresses a great interest in exploring, "what selfishness are we entitled to if we are going to die?" and "As we are all dying ... how do we balance duty and selfishness?" (Bantick, 2004).

It is remarkable that when facing the death of their patient, of loved ones, or of themselves, all three good doctors end up turning into the reverse of what made them a good doctor. Felix the most selfless doctor ends up turning into the most selfish patient; Lucy the best care-provider for her "patient" turns herself into the worst betrayer of marriage; Martin the most knowledgeable and rational doctor makes the most stupid and irrational decision by killing his friend. By forming such contrasts, the novel seems to suggest that the most qualified or even excellent doctor may turn out to be flawed as an

ordinary human being. Especially when confronted with such existential puzzles as dying and death, doctors may have the same fear, demands and self-indulgence as lay people.

The journey terminates at a huge pit, which is inhabited by flesh-eating creatures and compared to the mouth of hell. The destination forms a sharp contrast with the Eden-like opening scene, bringing the story to its final climax. This is where Felix's life is finally "stripped back to its basics" and he has to look death in the face. Moreover, the medical specialties of all three doctors' seem redundant in the journey of dying and death: Martin's specialty limits him to the role of an onlooker. As a bookworm who is able to quote foot-long sentences from the classics, Martin's expertise does not offer him any insight into dying and death. As the three doctors travel deeper and deeper into the desert, Martin finds himself more and more inept in tending to his dying friend until he becomes a total outsider. Having operated on countless tribal people, Felix the surgeon is unable to ensure his own fitness. In such a sense, Felix's specialty proves to be the most redundant since now the helpful doctor turns into a helpless patient, and his condition is too extreme to be treated. Lucy's expertise and her loving nature make her a vital participant in caring for Felix. Nevertheless, as they move closer and closer to the destination, even Lucy becomes less and less capable of helping Felix out. In the end, what she can offer narrows down to the role of a nurse.

To compensate for the inadequacy of the three doctors confronted with death, the fourth 'doctor', the Aboriginal Doctor Jerry is brought into the picture. The addition of the fourth doctor offers both a cultural and spiritual dimension to the journey of dying and death, and more importantly, one more possible way to define the good doctor, in terms of care for the dying. From here there is a noticeable switch of setting, from the modern and whitefeller landscape to the traditional and blackfeller Aboriginal landscape, which symbolises the shift of expertise regarding death from Dr Lucy and Dr Martin to 'Doctor' Jerry. The tribal doctor assists Felix to settle the dispute with the tribal family whose son died on Felix's operating table; he accompanies Felix into the desert and offers him the kind of care the latter feels comfortable dying with; at the end of Felix's journey of

atonement he assists in the "death memorial" for Felix by singing for him and striking his head with a stone for the ravens – so that his dead body can return to nature, as Felix requested. In comparison with Martin and Lucy, whose expertise becomes ineffective in treating Felix, Doctor Jerry plays the role of executor of Felix's death will and a spiritual healer all at the same time.

In addition, here the tribal doctor is in effect offering a kind of "hospice service". Unlike the standardised cremation or burial, the hospice service provided to Felix by the tribal doctor is de-institutionalised and de-standardised, where the "patient" is able to choose the way he feels comfortable in dying. In fact, during his death ritual, Felix relies on both modern medicine and tribal medicine, in terms of their healing concepts, tools as well as services. For example, he is offered morphine and oxygen from a cylinder and tended by Martin and Lucy, doctors of modern medicine; meanwhile he is offered the Aboriginal chanting and the lizard meat from Doctor Jerry and cared for by this old tribal doctor, in a way that accords with the concept of return to nature so as to complete the life cycle. In this sense, the fact that a white surgeon chooses to die in an Aboriginal ritual and be cared for by two friends who are also practitioners of modern medicine triggers a cultural exchange between the practice of modern medicine and tribal medicine. More importantly, it emphasises the importance of the human side of medical practice, to compensate for the more technically and scientifically based Western medicine, especially in treating cases where death is inevitable.

3-4-2: Death of a Good Female Doctor

While in *Three Dog Night* the big challenge for doctors is death, doctors in A Red Prescription are confronted by the challenge of addiction, which becomes a way for them to make sense of their own personal and professional lives. The difference is that, in *Three Dog Night*, the issue of what makes a good doctor is examined in a 'pre-institutional', emotional context, or the world of the id, as Martin would say, whereas A Red Prescription sets up the discussion in a special medical institution – a suffocating rehabilitation centre. It is described as a grey building located in an isolated suburb,

fenced by iron wire and locked behind three iron gates. These descriptions are supplemented by people's resistant attitude towards the special hospital: Fish's husband attempts to stop Fish's plan in the first instance, and a taxi driver refuses to take Fish there after she states that she is an "addict". The descriptions of the institution, together with people's reactions to it, indicate the fact that drug addicts and their doctors are in isolation, both geographically and because of public ignorance and common misunderstanding about this special community.

In fact, the concept of drug abuse and its rehabilitation was not new to Chinese readers. Nevertheless, when the novel was written, drug rehabilitation still heavily relied on compulsory treatment, which was conducted by the public security department, or relied on reeducation camps, and was conducted by the judicial department. The concept of treating drug abuse with *medical methods* and the concept of *drug rehabilitation institutions* are relatively new to Chinese people. As Huang Jie points out, while most discussion around drug abuse was from the perspective of law and morality, Bi Shumin manages to critique the issue from a pathophysiological and psychiatric perspective, adding a valuable dimension to the understanding of the drug issue (1999, p.76).

The fact that the novel is narrated by an anonymous third-person voice from Fish's perspective is an intelligent device. Fish is first of all a retired doctor, capable of recording stories from a relatively professional perspective; nevertheless, since she is fresh to the concept of, and lacks training in, drug rehabilitation, her conversations with nurses and doctors take place in a natural and logical way. Meanwhile, the moment Fish enters the rehabilitation centre, she is disguised as a country woman Barley – the name of Peace's housekeeper who is from the countryside. Though it takes Fish some time to get into character, this fake identity ensures her intimacy with the addicts. To the country woman Barley, many drug addicts are willing to share their drug-taking history, whether to brag, confess or seek sympathy. In consequence, it is possible for her to collect their stories.

In addition, since Fish's knowledge about drugs falls in between that of the medical professional and the lay person, her perspective can most effectively engage readers with

the field of drug rehabilitation. Guided by Fish, readers are introduced to the structure and function of this special medical institution. The inpatient ward in which Fish stays for most of the time is where doctors practise and patients receive treatment; Fish's tour through the laboratory guided by Peace introduces readers to an important component of the institution – laboratory experiments; Fish's visit to Professor Jing after Peace's death leads readers into the central concern of the rehabilitation enterprise – theoretical and academic research. Furthermore, by choosing a narrator of a similar life experience to the author herself, Bi Shumin is able to express her aesthetic principles and life philosophy more easily (Zhao Huiping, 1997, p. 30). Meanwhile it allows a perception of minute details about such an isolated rehabilitation centre, and enhances the credibility of the storytelling (Liu Yongsong, 2011, p. 63). In this sense, the narrative perspective makes it easy for the author to build into her novel insights comparable to reportage.

The novel is framed as a detective mystery through which Fish solves the mystery of Peace's death. Fish is informed of Peace's suicide as she comes back from a trip. What further colours the storytelling with a tinge of mystery is the fact that when the details of Peace's death are about to be revealed to her, Fish seems to be able to name every detail of the death scene. The suspense causes readers prolonged anxiety and the urge to resolve the mystery (Chen Chunjie, 1999, p. 71). In retrospect, Fish attempts to find out what leads to her doctor-friend's death, in her recollection of stories about the rehabilitation centre. Through Fish's eyes and ears, the investigation into the murder mystery branches out into a wide range of storytelling by and about medical workers and patients. In accordance with the great number of narrative perspectives, the story is divided into forty-three small chapters. The careful division helps postpone the solving of the murder mystery; the short but frequent breaks formed by the division produce a narrative rhythm, which effectively invites readers on the journey of both investigation into the murder mystery and getting to know the world of drug rehabilitation.

The plot develops mainly in the form of conversation, though no quotation marks are employed. Without quotation marks, the distinction between dialogue and narration is

diminished, which in fact meets the special need for storytelling in this novel: on many occasions, dialogue between certain narrators and Fish-as-Barley may evolve into a relatively long, unbroken monologue by the various narrators. Therefore it is difficult and also unnecessary to tell dialogue apart from narration, as so much storytelling is involved. This technique creates a sense of flexibility and diversity and makes it easy for the reader to transfer among narrative points of view. Though no quotation marks are employed, conversations are skilfully designed to match each character, in terms of the content, word choice and even accent, which effectively help highlight each character's personality.

In addition to conversations, a variety of drug-related references in the form of journal articles, fairy tales, legends, data from international organisations and so on are inserted into the main body of the novel, in the name of drug-related resources which Fish's husband has collected for her. The use of technical information about drugs in the main body of the work has triggered diverse responses among readers. While some readers find such information about drugs educational and entertaining, others find it overwhelmingly didactic. For instance, Hu Guanglu thinks highly of its authenticity, credibility, and vividness (1999, p.12) and both Zhang Deli (2002, p. 100) and Ren Xianghong (2007, p. 106) suggest that the technical resources add a scientific or even psychiatric dimension to the novel. On the other hand, Tang Ren argues that a novel should not rely on too much detailed non-fictional material (1998, p. 38). Chen Chunjie also criticises the author for being too "generous" in using the materials she collected. Though it makes the storytelling more convincing, it somewhat undermines the readability of the novel (1999, pp. 71-72). Quoting and agreeing with Chen Chunjie, Liu Lili in her review further suggests that, in trying to offer every detail, the author leaves little space for hidden meaning between the lines (2000, p. 76)

Personally, I tend to agree with Hu Guanglu that most of the technical information is "closely related to the storytelling, rather than randomly inserted" (1999, p.11). These materials effectively promote the development of plot, diversify the means of storytelling and provide readers with supplementary knowledge about drugs and the rehabilitation

enterprise of past and present, at home and abroad, although some of the technical information does seem less relevant to the storytelling and could have been deleted. Whether or not in response to readers' comments, Bi Shumin published a revised version of A Red Prescription in 2012, fifteen years after the first edition. Three major changes were made: firstly, the forty-three chapters were condensed to nineteen chapters, subtitled "Prologue", "Entering the Rehabilitation Centre", "Feather's Story", "Stories about Opium", "Epilogue" and so on; secondly, quotation marks were added to distinguish dialogue from narration so as to, as the author explains in an interview, offer readers a clearer understanding; last but not least, some materials about drugs that are less relevant to the storytelling were withdrawn from the main text and inserted into an Appendix so as to "make the main body neat and tidy", according to the author herself (Wang Xiaojun, 2012). "As our pace of life speeds up, readers, especially a younger audience, have less and less time and patience for heavy reading", Bi Shumin observes (Wang Xiaojun, 2012). Since reading is such an individualised and subjective experience and habit, this can be debated but it is not easy to reach a conclusion on whether such a reworking is as rewarding as the author wished. Personally, I see the third change as being positive but the first two changes as destroying the original narrative rhythm and diversity. What is laudable, however, is the author's attempt to be more reader-friendly, which once again shows Bi Shumin's sense of duty as a doctor-writer and the desire to reach a larger audience. The discussion which follows is based on the original edition.

While the many stories from and about doctors and addicts which comprise the body of the novel gradually and jointly unravel what leads to Peace's tragedy, it is Peace's own letter that eventually brings the murder mystery to full revelation near the end of the story. In her letter to Fish, Peace expresses her vulnerability: "I felt helpless and useless. My doctor resigned, my nurse quit, my husband cheated on me, and the remedy was taken away" (Bi Shumin, 2011, p. 379-380). Peace's desperate words accurately summarise what leads to her collapse – the resistance of patients, the lack of solidarity among colleagues, the lack of effective remedy, and lack of family support. These factors illuminate the issue of how a good doctor can be destroyed.

First of all, the resistant and demanding addicts are primarily responsible for Peace's suicide. Through Fish's conversation with a variety of addicts and their families, it is revealed that the business of working with addicts is exhausting. Whereas readers are likely to anticipate that the addicts in the novel would be a group of nasty, degraded and helpless people from the lower class, they are portrayed as coming from all walks of life and displaying a variety of personalities. Rather than putting labels on characters or making moral judgments, the novel is more interested in suggesting that no matter what backgrounds these addicts are from or what sorts of life they have lived, they are now trapped in the same situation, and may end up dying the same kind of death. It more or less reflects Bi Shumin's life philosophy that, faced by the big issues of disease and death, such matters as social status, educational background, wealth and possessions seem to make little difference.

Nevertheless, though some of them are depicted as nice, humble people, becoming addicted only by accident, most addicts are depicted as being psychologically or morally flawed people. They may display such common problematic qualities as being irresponsible, exceedingly curious, self-deceiving or lacking discipline, and are primarily responsible for their own tragedy. That explains why doctors in the rehabilitation centre compare their work to a campaign – they have to fight against drugs and drug-addicts, both literally and metaphorically. Here an intensive or even hostile doctor-patient conflict is portrayed, on two levels. On the surface, doctors have to fight against addicts who threaten the security of the inpatient unit. For example, Beiliang (北凉) and Qiren (琪仁), whose names sound like Miserable and Grotesque respectively, as Hu Guanglu observes (1999, p. 10), have a big fight, in order to get the attention of a nurse. Interestingly, like these two, addicts from extremely different backgrounds are sometimes designated to share the same ward, and stories about their drug-taking are often narrated in pairs. In addition to Beiliang and Qiren who break the regulations, bigger potential safety hazards exist: a hooligan whose wife and mistress have a "fight", one for him and the other for his money, turns out to be a criminal and is hiding from the police; a secret drug dealer who disguises himself as an addict makes a good fortune by trading drugs in the rehabilitation

centre. On a deeper level, doctors have to fight against addicts in a metaphorical sense – against addicts' self-destructive behaviour. They repeatedly revert to drugs after quitting, making doctors' efforts in vain. Feather offers such an example. It is Feather who is directly responsible for Peace's death, taking the tension between patients and doctors to an extreme. Feather shares the ward with Fish. During the conversations between the ward-mates, the reason for drug-taking, the harm caused by drugs and the difficulty of quitting are further revealed. According to Feather, she was brought up in a privileged family, which formed in her a strong sense of self-importance and pride. She took drugs out of curiosity and as a gesture of rebellion against her privileged youth. She attempted to quit once, but reverted to drugs when she returned to her familiar environment. Later she even dragged her husband into the abyss, seized by the idea that she would make a better match to her husband if he took drugs as well. On her husband's insistence, the couple enter Peace's hospital for treatment. Therefore as the novel starts, it is Feather's second time entering Peace's rehabilitation centre.

If the first time is caused by Feather's psychological obsession, which is frustrating but at least not ill intended, the second time is a spiteful attempt to take revenge on her doctor. The drug-taking satisfies her curiosity and rebellious intention, but also frustrates her pride and self-image as a noble lady. In Feather's eyes, Peace may represent an ideal image of herself before her degradation, in that she is authoritative, elegant and admired by everyone in the centre. After quitting drugs for the second time, Feather leaves the hospital with a strong wish, to befriend her doctor Peace. To her disappointment, however, whenever she calls, the doctor is only concerned about whether she is totally clean, as her doctor rather than as a friend. Furious at her doctor's "graceful superiority", which is in fact in her own imagination, she vengefully sends the doctor an oil painting whose paints are mixed with powdered drugs. The painting is specially designed so that it only fits into Peace's office. When the sun shines on the painting every morning, the paints dissolve and the female doctor breathes in drugs till one day she is surprised to find that she has long been addicted to the strongest drug of that time, Drug No. 7. From now the realistic novel seems to evolve into a science fantasy. Regardless of the feasibility of the painting as a

weapon, the fact that Peace loses her life to Feather reflects "a conflicting and even hostile doctor-patient relationship" (Chen Diyong, 2008, p. 107). Like Felix in *Three Dog Night*, patients in A Red Prescription on the one hand resist doctors' help, but on the other hand endlessly demand doctors' attention. Apart from the standard medical care, patients may ask for personal care, empathy, sincere friendship or even more. Feather's wish to befriend the elegant female doctor indicates her desire to be considered equal, and to have an equal voice in the patient-doctor discourse. Nevertheless, like the demanding Felix, Feather no doubt pushes the issue too far.

Secondly, lack of support and teamwork indirectly leads to Peace's emotional collapse. A large number of medical workers are portrayed, which is rather different from Goldsworthy's group portrayal of doctors. At the end of *Three Dog Night*, the narrator recalls the first anatomy class he had during his medical studies. The way in which each medical student reacted displays their different personalities: the "clever, methodical" Stella "unsheathes her scalpel" and slices open a cadaver's foot in a neat and fearless manner; still drunk from some all-night party, Frank the party guy is unable to focus his eyes or steady his tools; the overly studious Martin is still busy memorising the obscure Latin terms from his anatomy coursebook; Felix throws up badly because he had a cold pork sandwich for breakfast. Martin kindly offers a cup of water, but Felix rejects his help and offers a humorous self-mockery to hide his embarrassment. These students' reactions more or less predict the kinds of doctor each will become in future, as is echoed at the two parties of Martin's medical schoolmates.

Unlike Goldsworthy's group portrayal of doctors whose journey was once in tandem but later diverges, Bi Shumin portrays a group of doctors that come from different social, educational, and family backgrounds, but are now confronted with the same challenge – treating addiction. As in *Three Dog Night*, the way they respond to addiction – relatively newly recognised as a "disease" – and the way they treat addicts, to a certain extent reflects the kind of doctor they are. Doctor Teng who works in the reception area, for example, belongs to the old generation who are clinically experienced but untrained in

modern ways of drug rehabilitation. This is because the relevant knowledge has been introduced to China only in the past few decades. Though Doctor Cai, the young doctor, specialises in drug rehabilitation, he is too young to be trusted with serious cases. Besides, he has never taken addicts as patients; instead, he compares them to "containers" of heroin. The contrast between the two doctors offer pairs of criteria in defining a good doctor – book knowledge versus experience, or expertise versus empathy. Friday, a male nurse, comes from the countryside and has received informal medical training. He is grateful for the job opportunity but does not like it at all. Though Friday is grateful and loyal to his job, he is impatient and complains a lot – he regards this job as being the lowest of all nursing jobs. Though the Dark-skinned nurse, who has no family background, or social status or beauty, takes what Friday considers as a degrading job without any complaint, she proves to be disloyal to her job. After she has learnt enough skills, she quits the hospital when it hits harsh times. The contrast between the two nurses offers important criteria for defining a good care-provider – endurance and stamina.

Even though these medical workers are more or less qualified – they are obedient to Peace's orders, conscientious about their jobs and skilled in taking care of patients, they are portrayed as being flawed in one way or another. Individually speaking, they may lack expertise, or clinical experience, or empathy, or devotion or loyalty. Altogether, they fail to offer teamwork and support to Peace, their Chief. If these medical workers are only somewhat flawed, Mama Meng, the middle-aged female doctor, proves to be morally corrupt and devastating to Peace's rehabilitation enterprise. She is described as being business-like and selfish. She tries to impress each patient with her insincere kindness and asks for bribes from patients; she secretly runs a private rehabilitation clinic and has schemed to transfer patients from Peace's hospital to her own; she buys medicines from Peace's patients and sells them to her own patients at a profit. Her betrayal more or less contributes to Peace's collapse, too. When put together, these medical workers illuminate the importance for a doctor of properly functioning in a team that has experience, empathy, loyalty, a sense of their professional obligations and support for each other.

Thirdly, the lack of an effective remedy, or in other words, the pressure to treat and cure, frustrates Peace's aspiration to become a good doctor. During Fish's conversation with Dr Teng and Dr Cai, a series of hypotheses and methods of drug rehabilitation from both Western medicine and TCM are traced. Unfortunately, according to the two doctors, none of them has been proven effective. What is even worse, in both Western and traditional Chinese medications for treating addiction, a horrifying circle seems to form – a new drug invented to treat a certain kind of addiction may end up leading to a new type of addiction, which is as if "drinking up one's own blood to quench one's thirst".[36]

In addition to medication, the effectiveness of drug rehabilitation is assessed in terms of biology. As Peace shows Fish around the laboratory in the rehabilitation centre, Peace explains, from a purely biological point of view, the sense of pleasure – whenever people feel happy, inside the locus ceruleus in the human brain, a circulatory pattern called Peptide F forms, which is the material base for the sense of pleasure. This Peptide F generates easily and decomposes easily, which explains why the sense of pleasure swiftly flees. Coincidentally, the structure of morphine resembles that of Peptide F, and therefore morphine easily takes the place of Peptide F, providing drug abusers with a virtual sense of pleasure. It explains why many addicts relapse into drug-use after they have become physically clean. Compared with helping patients rid themselves of the physical addiction, it is much more difficult to eradicate their psychological dependence on drugs. The nature of the rehabilitation job indicates the difficulty Peace is facing. It foreshadows Fish's frustrated journey and Peace's frustrated aspiration to be a good doctor.

Interestingly, there is a moment when Peace almost obtains a perfect remedy: during her conversation with Doctor Cai, Fish is made aware of a top secret treatment plan in the rehabilitation centre, the "Number Zero Rehabilitation Plan". One day a man named Qin visits, looking for the Chief. He says he has inherited a remedy for quitting drugs from his grandpa, who was a respected doctor of Traditional Chinese Medicine. In poverty, Qin wants to sell the remedy to the hospital. He refuses to provide the original materials and

[36] This is a Chinese idiom "饮鸩止渴".

only agrees to offer the ready-made medicine as long as the hospital can pay for him. This was where the Plan Zero came from. After the remedy is proven to be effective when tested on drug addicts, Qin finally decides to sell the remedy because he does not wish to live in poverty any longer. Unfortunately, Peace lacks financial support and has to give up on the remedy. Meanwhile a "scholar" from a foreign country has offered a good price to buy the remedy. What is heart-breaking, as Fish later discovers, is that the so-called foreign scholar is in fact a transnational drug-dealer. Even though the plot around the "perfect remedy" is highly dramatised, with the acquisition and loss of it, Bi Shumin seems to offer an irony, that the Plan Zero – the perfect remedy – like its name, is an unrealistic ideal. It more or less echoes Dr Teng's comment on medical scholars' effort on the drug rehabilitation as making a mess, and Fish's comparison of the work of drug rehabilitation to a building construction with sand. More importantly, it reveals what drives Peace to the wall – the lack of funds. It stresses the fact that a medical institution needs to be sufficiently funded, to be able to run properly. In a word, with Fish's investigation into what leads to her friend Peace's death, it seems to suggest that a good doctor can only function properly in an effectively-run institution, which includes cooperative patients and supportive colleagues, and a friendly working environment, valid remedy and sufficient funds.

But there is more. If the job Peace takes on leads to her doom, her family is the last straw. In spite of the ideal image of Peace as an admirable doctor, respected leader, considerate friend, from the perspectives of addicts, medical workers and Fish and Professor Jing, Peace the good doctor is also depicted from her husband Pan's perspective. Pan's depiction of his wife offers another clue to Peace's tragedy, and also includes the issue of family and private life to the discussion of what makes a good doctor. According to Pan, though Peace fulfils her obligations as a wife, she lacks the "passion and spice" he hopes for from a partner. If he could ever choose again, Pan tells himself not to marry someone who refers to joyful sex as "intercourse". He asks Peace to spend more time with the family lest he should cheat on her, but Peace does not take Pan's words seriously; instead, she thanks him for always being nice to her. After Pan does cheat on Peace, feeling

slightly guilty, Pan says in a half-warning and half-confessional manner that if a husband becomes too nice to his wife, then he probably has already cheated on her, but Peace still fails to read the sign. Till one day she comes home early, Peace discovers her husband's affair with her housekeeper Barley. Even though the plot thread about Pan's cheating remains undeveloped, it adds an important perspective to the discussion of the good doctor – the difficulty for the doctor to achieve balance between looking after patients and looking after family.

In addition to Peace, the author offers portrayals of two other female doctors Fish and Professor Jing, in terms of their devotion to work and their family life. Peace is described as coming from a humble family, educational, and academic backgrounds, and the most motivated to become a good doctor, but the fact that she treats her family as secondary to her career leads to her husband's cheating. The professor's role is important, despite the fact that she is only a supporting character in the story. She discovers Peace's potential and entrusts the job in the rehabilitation centre to her. Nevertheless, Professor Jing is portrayed as having chosen to marry science and remain single all her life. Fish is depicted as a less ambitious type of doctor. She becomes a doctor because her father has arranged it; she retires early, and she goes back to the hospital only to collect materials for a book she is planning; though she also wishes to help patients and save people's lives, she retreats when she feels overwhelmed by her experience in the centre. Despite the fact that she is less ambitious in her career, she has a normal family life and a relatively supportive husband: though he attempts to stop Fish's plan to stay in Peace's hospital at first, after Fish leaves for the rehabilitation centre, he sends her a quantity of technical materials related to drug abuse, drug-addicts, and medications for addiction; at the end of the novel, he even encourages Fish to take over Peace's job. The contrasting portrayals of the three female doctors reveal the extreme difficulty for women doctors to balance work and family.

Bi Shumin in "The Professor's Ring" seems to raise the same issue from a contrasting perspective. In the story, the old professor's first wife left him because of his devotion to medicine. To have a wife who can be wholeheartedly understanding and supportive, he

has to build himself a robot wife. The story suggests that the issue of balance between life and career is tough for all doctors, but it may trigger stereotypical responses among readers. In the case of the old professor, some readers may tend to criticise his ex-wife for being unable to understand and support her husband, but of course this response equally reinforces stereotypical expectations about wives' subordinate position to their husbands' careers. In the case of Peace, such a reviewer as Hu Guanglu suggests: "though Peace's devotion is to be applauded, the failure to take care of her family is questionable (1999, p. 11), which reveals the same pattern of stereotypical expectations for women to be more loving and caring. Lucy in *Three Dog Night* is portrayed as a case which takes the paradigm of the loving and caring woman to the extreme. While Martin's perspective might be construed as endearing, it fulfils his stereotypical expectations, but the irony is that her loving and caring qualities become a threat to him when she makes Felix the object of her ministrations. This exaggerated portrayal suggests an irony and critical authorial stance which contrasts with some of Goldsworthy's earlier writing. In "Death and the Comedian", Goldsworthy acknowledges that in his early works this type of gender stereotype does exist: "Several times I've used a female doctor persona to represent the 'feminine' side of these feelings, the caring side" (Goldsworthy, 1993, p. 31). But such critics as Ley and Elliot do not seem to recognise the potential for ironic critique in the portrayal of Lucy. James Ley suggests that compared with Martin and Felix, the characterisation of whom shows more control and complexity, Lucy is rather "thinly sketched" and "elusive" (2003, p. 15); criticising the portrayal of Lucy as "a caricature", "glossy and unbelievable", Helen Elliot does not seem entirely impressed by her "goddess complex", either (2003, p. B18).

The death of Peace seems to suggest that such an ideal model as "the good female doctor" is impossible to live up to. Despite the fact that the novel is a tragedy, it ends in a relatively idealistic way. At Peace's funeral, Fish finally meets patients who have actually recovered through treatment in the hospital. Encouraged by what she has seen, Fish recommends herself to Professor Jing to take over Peace's job. Fish's taking over the job seems to offer readers one more piece of suspense, making them wonder whether or not

Fish will also make a good doctor, and even survive as a doctor better than Peace. In addition, Fish's offer indicates that the job needs to be carried on, no matter how tough it is. The idealistic ending echoes Bi Shumin's philosophical thinking and her sense of duty as a doctor – even though medicine may not be almighty, it needs to be properly practised; even though doctors may attempt to cure what is in the end incurable, they still need to try their best to fulfil a doctor's obligation. It more or less echoes *Three Dog Night* in that even though the three doctors are confronted with what is incurable, too, they still strive to do something about it – to make amends, to take care of each other, or make sense of it – rather than doing nothing. This offers another way to examine the death of the good doctor. In *Three Dog Night*, though Felix has no choice but to die, he chooses to turn his inevitable death into a journey of atonement, which can be taken as a way to ease his guilt and anxiety, so as to maintain his own psychological health. In A Red Prescription, Peace's choice of "death with dignity" over "life without emotions" shows the doctor's effort to protect her emotional world from the harm of drugs. That both doctors "prescribe" for their own death represents their wish to die a death that maintains consistency with how they have lived their lives.

To be more specific, in *Three Dog Night*, Felix's planned death ritual on the one hand indicates a doctor's sense of responsibility to make amends for the error he made during his practice. After the death of the tribal boy on his operation table, he is tortured by the degradation of his physical condition, and more importantly, the psychological stress of making amends for his surgical error. In order to pay off this debt, he not only donates money to the boy's family, but also chooses to die an Aboriginal death – exposing his dead body in the wild to feed ravens so as to return to nature. On the other hand, the planned death ritual reflects the doctor's determination to confront death, "I just want to look death in the eye. Allow me that. No euphemisms. No sentimentality" (Goldsworthy, 2003, pp. 233-235). In spite of Felix's declaration that death "holds no imagined terror" for those who have a medical degree since all the terrors are seen and known, as Martin fairly comments, what they as physicians experience regarding death is only "from the outside". Therefore Felix's journey of atonement suggests that doctors should put

themselves in the same situation as their patients. In this extreme case, it is death.

In A Red Prescription, though very different reasons lead to the death of the good doctor, it is the doctor herself who brings her life to an end. After discovering that the only solution to eradicate addiction is to cut the locus ceruleus and become a person without feelings and senses, Peace decides that she would rather die than live, as a person deprived of laughter and tears, empathy and curiosity, love and hatred. By choosing to die, she intends to defeat Drug No. 7, "Since I cannot live in the way I desire, I have decided to let it go. I have been destroyed by drugs but I am not defeated" (Bi Shumin, 2011, p. 404). In addition, the fact that Peace's suicide is depicted as a ritual demonstrates the character's determination to make her life a perfect circle: she informs Pan that he is forgiven; calls Professor Jing to bid her farewell; leaves a letter to Fish; buries the smashed oil painting. After everything is arranged, she takes pills "one by one" so that her death can be "as neat as possible" (Bi Shumin, 2011, p. 405). In this sense, Peace's suicide demonstrates her respect, rather than disrespect, for life (Sun Lulu, 2008, p. 94). The way Peace arranges her death and what happens afterwards shows her concern for the dignity and quality of life (Chen Shanzhen, 2009, p. 19).

By emphasising doctors' dignity in death, both novels in fact raise a very important ethical issue in medical practice: as care-providers for patients at their most vulnerable moments, doctors have their own vulnerability and also need to be cared for. To take *proper* care of each other is what Fish and Professor Jing fail to do for Peace; even though Lucy and Martin do take care of Felix, unfortunately they let their emotions get in the way. Although Professor Jing may be generous in offering a job to Peace, the professor endlessly "exploits" Peace to enrich her research. She does not manage to offer Peace love and care, especially when Peace inquires about Drug No. 7, the professor fails to notice Peace's unusual reaction. Therefore, though she may help realise Peace's dream, she indirectly leads to Peace's death. As Peace's good friend, Fish came to the rehabilitation centre to support her friend for a certain period of time. Although she warns Peace of the danger of continuing working in the centre, she fails to stand by Peace's side and offer

more help at the end. Neither Fish nor Professor Jing offer sufficient care and support to Peace. In *Three Dog Night*, even though Lucy and Martin do manage to look after Felix, because of their personal relationship with him, they cannot help but be emotionally attached to their "patient" Felix. Though both of them attempt to be professional in treating their friend-and-patient Felix in the first place, they both fail to control their emotions and mix their personal life with their professions: Lucy mixes the "palliative love" towards her friend-patient with her "erotic love", and turns herself from the care-provider to love-provider; Martin cannot help but be fuelled by his jealousy and even hatred towards his patient-friend, and eventually, in both a factual and metaphorical sense, turns himself from doctor into "murderer". Both Lucy and Martin overestimate their ability to be professional in the treating of their friends, or in other words, both of them cross the boundary. In addition, in attempting to take care of Felix, both Lucy and Martin fail to take care of themselves. Both novels seem to value the importance for the doctor of being able to take care of themselves, and to know their own emotional and psychological boundaries. In A Red Prescription, Fish escapes from the rehabilitation centre when she is psychologically overwhelmed and emotionally drained, and returns only when she is emotionally and psychologically strong enough to face the rough situation there. Though Fish's "quitting" may seems a little unprofessional, Fish ensures her own health, not only her physical health, but more importantly her emotional and psychological health. Even though Peace ends her life so as to maintain her dignity and integrity of life, she has not taken good care of herself in the past. When she aspired to become a good doctor and save people's lives, or when she was trying to be a perfect wife, mother, doctor, and head of the rehabilitation centre, she was gradually and unconsciously tearing herself apart. If she had known her own emotional and psychological boundaries earlier, she might not have ended up committing suicide.

To sum up, though written against extremely different linguistic and cultural backgrounds, both novels involve a plot depicting the death of a good doctor. With the story about the death of a good doctor, narrated from the perspective of a doctor-character, the two novels explore what makes a good doctor, in the context of a medical institution and in the

context of doctors' emotions and private lives, respectively. Rather than offering explicit answers, both novels examine the issue of the good doctor in the light of interaction between doctors and patients, in the light of how doctors achieve balance between their family and career, and in the light of doctors as ordinary human beings with emotions and dignity, who need to be taken good care of, just as patients do.

Chapter 4: Conclusion

Uniquely positioned at the intersection between medical humanities and comparative literature and drawing on both disciplines in ways that mutually illuminate both, this thesis offers the first systematic comparative study of the creative representations of what makes a good doctor by eight physician-writers across-cultures. "What makes a good doctor" is one of the most widely debated topics among scholars and the public nowadays; it is also a central concern for physicians and medical scholars themselves. In this thesis I argue that a comparative study of doctors' creative writing about what constitutes good medical practice not only offers insights into enduring questions of medical education and training, but also enables all stakeholders in the healthcare service and the medical system to engage with the possibilities for good doctoring.

The eight doctors studied in this thesis are some of the most influential and widely quoted writers in their own times and places. They have written with a variety of motives, and their works are significant for different groups of readers. Some works may be more significant for general readers – offering medical knowledge, initiating a dialogue between doctors and the public, and calling for a more understanding working environment for doctors; others may be more helpful for medical colleagues – sharing experience, offering advice and emotional support for fellow doctors; some others may be more meaningful for doctors themselves, reminding themselves of their training and early experience, justifying their role as a doctor, straightening out their thoughts and unravelling their puzzles as a doctor. In spite of the different reading groups these works may speak more directly to, they all represent physician-writers making sense of being a good doctor in a more human and artistic way – in the form of creative writing. Compared with technical or academic writing on medical ethics, creative writing offers a more lively way for doctors to express their ideas, and a more accessible channel for doctors to communicate with the wider public. My thesis reveals the extent to which literature is an effective medium to promote communication between doctors and the public, especially on extremely controversial issues that they normally would not talk

about, at least not so straightforwardly and unreservedly; and the extent to which literature offers such a direct access to doctors' inner world that normally would not be accessible.

Creative writing by physicians represents not only the technical aspect of being sick but the human experience of being sick, not just the technical competence of being a doctor, but a human, personal, emotional experience of being a doctor. As John Skelton, scholar in medical communication at the University of Birmingham, suggests:

> Literature, if we trust its strength and accept that to become its student is to undertake something always rich and often difficult, is a way of understanding what it is to be human. One central gift it can give to those with a scientific training is that, because it is not reductive, it can bring home the fact that there are ways of understanding which cannot be tested by MCQ. (2003, pp. 216-217)

My thesis provides an excellent example of how literature offers a way of understanding of what it is to be human, and helps promote, in a profound manner, a balanced practice of medicine, as both science and art, involving both technique and humanity. It shows how creative writing and technical writing largely inform, and offer insights to, each other. Physicians build technical information and medical knowledge into their creative writing; at the same time, creative writing makes technical information and medical knowledge more easily understood and accessible to a wider range of readers.

This thesis offers a comparative reading of a selected single work by each doctor that deals with the question of what makes a good doctor from a wide range of perspectives including the form of writing, doctors' gender and specialty, as well as the cultural contexts within which these doctors have written. Some writers such as Bi Shumin or Mates may be more preoccupied with issues of gender; many writers reflect their medical specialty, in their work, for example, Colquhoun and Sacks; some writers' works, such as Shem's and Verghese's, may bear more socio-cultural marks. A comparative reading of these works both reveals the influence of each doctor's gender and specialty and the

socio-cultural contexts within which each writer has written on their representation of the good doctor, and yet at the same time, the comparative approach employed brings to the fore the disparate commonality of these doctors' representations of what makes a good doctor. The contribution that my thesis makes is to show both the specificity and the commonality in these writers' works.

Firstly, this thesis shows the extent to which physician-writers' representations of what makes a good doctor are shaped by the form of writing each has written in. Most authors employ a first-person narrative, though third-person texts equally draw on the values and experience of the author. For example, although Bi Shumin's A Red Prescription is narrated in the third-person, the narrator's values and experience largely resemble those of the author. While they employ the first-person narrative mode in varying ways, these doctor-writers all portray the sense of being a doctor, drawn from their own experience, even if the works themselves may not be explicitly autobiographical. For example, Weston narrates in the first person the experience of the transformation of a female intern to a mature doctor, but she insists that the book is not autobiographical. Sacks, on the other hand, claims more explicit autobiographicality, such that, problematically, the portrayal of the ideal good doctor is a self-portrayal, even if the portrayal of individual patients tends to be drawn from an amalgamation of cases. I argue that by using of this kind of narrative mode, doctors are able to make the exclusive world and experience of being a doctor accessible to a lay readership.

Furthermore, this study shows how some of these doctors work with forms that more easily allow them to relate their personal experience as a doctor. For example, Shem, Goldsworthy and Bi Shumin have offered a fictional depiction of being a doctor. All three authors have made use of what the literary form allows them to do – unravelling a fully developed storyline, offering detailed depictions of characters and triggering a series of complex discussions that illuminate thinking on the good doctor. Nevertheless, they have used the form of the novel in rather different ways. Shem employs irony and black humour in an unreserved way to offer a caricature-like picture of his personal experience

as an intern; Goldsworthy makes good use of his lively imagination to develop a serious and intense plot about the emotional world of doctors and intersections between Western and Aboriginal medicines; Bi Shumin has developed her novel in a detective-story frame. It is in the course of unravelling the mystery the novel sets up that the author offers her critical thinking on what makes a good female doctor in a drug rehabilitation centre. By contrast, Mates in her short stories relies on the economy and intensity that the literary form can produce, to draw readers directly to the climax and the most controversial moments of debates. Colquhoun has used poetry, an even more highly condensed form, rich in metaphor, to offer vivid pictures of patients and diseases he has known, interesting consultations he has had with patients, as well as a portrayal of himself as a doctor who remains ambivalent about his choice of career. Like Colquhoun, Sacks bases his case studies largely on consultations, or to be more accurate, his own interpretation of consultations, with patients, which is more philosophical and human than technical or scientific. Weston and Verghese vividly chronicle the professional, emotional and psychological journey of a doctor in the form of an essay collection and a memoir, respectively. While the form allows Weston to develop a full repertoire of story types and dialectical arguments in each essay and to treat the large theme of a female surgeon's maturity in the whole collection, the personalised form of the memoir presents readers with not only the clinical experience of Verghese as a doctor treating patients with AIDS, but a lively picture of an ordinary person trying to fit into his new country, going through ups-and-downs in life, and experiencing the emotional costs of being a doctor.

Secondly, it is only in the context of comparison that the extent to which a doctor-writer's specialty is reflected in the work becomes apparent. My study first shows the extent to which a doctor's specialty is reflected in the very fabric of their writing and style. For example, Colquhoun's poems reflects the nature of his work – general practice that deals with a wide range of diseases and symptoms but in a less detailed way than a medical specialist. His poems are multifarious in style and content, and might be likened to a patchwork quilt, and the interactivity of his poems also reflects his daily engagement with patients. By contrast, Sacks writes in a rather stylistic manner, which is very reflective of

his specialty as a neurologist: the well-organised narration, the frequent use of medical terminology, as well as the analytic language style. What is more important, my study reveals the extent to which the medical specialty determines how these doctor-writers represent the good doctor: in Colquhoun the GP's case, the good doctor is defined more as a good listener and interpreter, and as having good communication skills. In Shem the psychiatrist's case, the good doctor is portrayed as one who is able to be with patients – what Shem considers as the core to his specialty, psychiatry. In Weston the surgeon's case, the good doctor is described as being swift and efficient, although she also reflects on the good doctor as being essentially the same in all specialties, that "more fundamental than being a surgeon is being a doctor".

Thirdly, aware of the male dominance in today's medical practice, my study shows how both male and female doctor-writers draw attention to the problematic of common social expectations for women doctors. Both Bi Shumin in A Red Prescription and Goldsworthy in *Three Dog Night* depict the kind of female doctor who has struggled to fulfil the stereotypical expectations for them to be more loving and caring. That both characters end in tragedy – suicide in the former case and endangered marriage in the latter – indicates the extreme difficulty for women to cope with the expectations about their being a good doctor. My thesis also reveals how some of these doctor-writers, especially the female ones, raise the issue of what makes a good female doctor in a male-dominant world. Weston, for example, in her essays suggests the importance for a female doctor of handling issues around gender, power and hierarchy. In the short stories "Laundry" and "The Good Doctor", Susan Mates not only offers a strategic gender critique of stereotypical expectations for women doctors, but also demonstrates possible ways for women to challenge the stereotype in a male-dominant medical system. While the mother-doctor in the story "Laundry" questions the masculine mode of practice by making a gesture of retreat and admitting to her incapacity, the senior doctor in the story "The Good Doctor" challenges the gender inequality in the medical world by abusing power as male doctors often do. I suggest that such an unsatisfactory portrayal draws attention to deep-seated social attitudes that entrap even the most able.

Last but not least, this thesis shows the extent to which the specific socio-cultural contexts is reflected in these doctor-writers' works. Since the thesis discusses works written over a time span as long as thirty-one years (from Shem who published in 1978 to Weston who published in 2009), it offers an account of how medical practice and social attitudes toward certain ethical issues across cultures have evolved in the past three decades. A number of the works considered can be read as breaking cultural taboos of their times, particularly, with regard to certain ethical issues. Shem in his novel depicts the challenges of the American internship system of the 1970s, a time when few people dared to criticise this cultural taboo in such an unabashed manner. Sacks started his writing career in the UK at a time when the use of such offensive terminology as "retardate" was not yet problematic, and yet, at the same time his work reveals ground-breaking sympathy and understanding. Verghese's memoir reflects the experience of being an expert on AIDS in the US in the mid-1980s to 1990s when medication for treating AIDS was still largely unavailable, and the humanity and empathy the work reveals not only challenged discrimination against the infected when the book was published, but offers insight to other cultures where battles against such prejudice still prevail. Bi Shumin's novel explores a relatively new type of hospital in China – the drug rehabilitation centre, as well as the way doctors adapt to a new institutional system in China established in the 1990s. It is one of the first novels published in China that tackles the issue of drug rehabilitation from a pathophysiological and psychiatric perspective. Weston's essay collection reflects a much more tolerant environment in which physicians could admit to their true emotions and their limits after the implementation of the Patients' Charter of 1991 in the UK. Goldsworthy's novel demonstrates the clash between the white and Aboriginal cultures in Australia with regard to medical practice, and especially in terms of treating the dying. I argue that not only do these works offer insights into enduring questions of medical education and training, but that their greater values lies in their transcendence of their original cultural context, when read in new contexts, in the sense that the issues described are being experienced anew.

Drawing on personal experience either indirectly or directly, the works of the

doctor-writers discussed provide compelling access to a world beyond the experience of lay readers. In different literary forms, from a wide range of perspectives that are jointly influenced by medical specialty, gender, socio-cultural contexts the work has been written in, each doctor has contributed, in different ways, to the discussion of what makes a good doctor. Although each work has its own emphasis, they jointly promote a combination of scientific knowledge and professional expertise with humanity and artistry in medical practice.

In particular, I highlight the striking examples of honesty in these doctors' representations of the challenges they face in their professional lives. One such challenge is to acknowledge doctors' limits to cure. Weston in her essay makes the comment that "what matters more in a doctor than knowledge is knowledge of one's own limits"; Bi Shumin in her novel compares doctors treating drug addiction to fetching the moon in the water and building with sand; Goldsworthy has represented the kind of situation where Western medicine reaches its limits in dealing with inevitable death. By acknowledging such limits, these doctor-writers do not attempt to deny the capacity of medicine; rather, they attempt to advocate the human and artistic side of medicine. Shem, for example, in his novel makes the bold statement that doctors "hardly ever cure", but at the same time suggests that a good doctor should always try to do something for patients, and in his case, it is to "be with" patients, which is precisely what Weston regrets in "Children" – having not "been with" an underage patient before his death. This view to a certain extent echoes that of Verghese, since at his time of practice, there was no effective remedy for treating AIDS, and the doctor feels as if he is fighting without a weapon. In spite of the limited capacity to cure, the doctor tries his best to offer basic care and bedside medicine for AIDS patients. Even though he could do little else to keep patients alive, he tries his best to lead patients to a proper end. Verghese's bedside medicine echoes the kind of care offered by a nurse in Mates' "Ambulance" for patients out of consciousness – smoothing patients' pillows, in spite of the other nurse's advice not to expect to be able to solve all their patients' problems. In Sacks' cases, patients mostly suffer from a neurological disorder and a medical cure is not easy to achieve. Nevertheless, Sacks suggests what a

doctor like him can do for patients – that is, to value a patient's narrative, to appreciate their condition and help them come to terms with their circumstances, to recognise the beauty and creativity in every patients' situation and help them discover or develop their talents. In one way or another, the eight doctor-writers all have highlighted empathy, humanity and compassion in good doctoring.

In addition to acknowledging one's ability to heal, these doctor-writers emphasise the importance and necessity of keeping a professional distance. Mates in "The Good Doctor" depicts the kind of doctor whose professionalism as a doctor gives way to her personal longings as a woman, even though she did not intend this should happen in the first place. The issue of boundaries has been taken to its extreme by Goldsworthy and Bi Shumin in their novels. In Goldsworthy's story, although the doctor-couple attempt to be professional in treating their friend, they cannot help but mix their personal life with their profession: the wife turns into love-provider, whereas the husband turns into a "murderer". In Bi Shumin's novel, although the good female doctor manages to maintain a certain distance from her patient, she is "murdered" by the patient she is trying to save. From the perspectives of doctors and patients, both novels indicate the difficulty for the doctor of offering proper care, without much in the way of solutions. In a similar reflection on the issue of boundaries, however, Shem offers the fictional figure of the Fat Man as a possible role model – he knows when to play the cynic and when to hold patients' hands. He knows how to keep a proper distance from the patient so as to offer the care patients need without taking on too heavy an emotional burden as a doctor. The balance the Fat Man keeps more or less echoes Weston's advice that a good doctor should know when to remain detached and distant and when to offer empathy and care – mastering what she describes as the "paradoxical art".

Another key issue raised in these doctor-writers' works is that, as care-providers, doctors also need to be cared for. Bi Shumin has written about the importance for doctors to ensure their own emotional and psychological health by offering alternative examples: the devoted doctor who did not take care of herself ends up being emotionally drained, and

committing suicide; whereas the doctor who escapes when she feels emotionally and psychologically overburdened, ensures her own health and eventually her return to take over her friend's job. In addition to doctors' care for themselves, Goldsworthy has underscored what doctors fail to do in Bi Shumin's case – to take care of each other. Goldsworthy's representation of the doctor-couple's care for their doctor-friend echoes what Shem encourages interns to do in *The House of God*. Shem suggests that doctors must not work in isolation. Only by supporting each other and caring about each other, are the medicos able to meet the challenges of their medical training and practice. Apart from the care for doctors themselves and for each other, several physician-writers also highlight the importance of caring for their own family. The doctor-couple's endangered marriage in Goldsworthy's novel, the female doctor's decision to quit full-time practice in Weston's essay, Bi Shumin's depiction of the husband's cheating on the good female doctor, as well as Verghese's metaphor of his job as a mistress that he dare not introduce in conversation at home, all highlight the importance for the good doctor of finding a balance between family and career.

Some doctor-writers have also examined the good doctor in the context of a healthy institutional system and a friendly social environment. Bi Shumin and Shem offer a fictionalised depiction of a dysfunctional medical institution that causes damage to a good female doctor and a group of interns, respectively. They both highlight the importance for a good doctor to work in an effectively run medical institution where there are supportive colleagues, understanding patients, effective remedies, sufficient funds and so on. Both fictional depictions more or less echo the tough situation Verghese faces in his memoir. In addition to the call for an effective working environment for doctors, Verghese further advocates a more understanding and friendly social environment for patients with AIDS and a doctor who treats AIDS. By linking his own sense of foreignness as an immigrant with that of his patients who suffer discrimination, Verghese has attempted to break the cultural taboo and the stereotypes people in his time and place imposed on AIDS patients. Verghese's effort echoes that of Sacks, who has attempted to earn understanding from the outside world for his patients with neurological deficits.

To sum up, both the eight doctor-writers studied and additionally those briefly mentioned in the thesis are what I regard as "good doctor-writers", in the sense that, in addition to the literary competence that makes them good storytellers about patients, colleagues, themselves, medical institutions and medical systems, these writers have used creative writing to present a lively picture of the medical world, to build a more understanding environment for the discussion of medical ethics, and to explore, from the perspectives influenced by their gender, specialty and cultural contexts – what makes a good doctor. They have advocated a more human, artistic and holistic medicine, and their creative writings have anticipated and contributed to the emergence and development of medical humanities in the form of the Narrative Medicine movement; meanwhile, their creative writings have offered, and will keep offering, more resources for these medical humanities programmes to launch discussions on medical ethics.

The value of thesis lies first in its cross-cultural comparison. It for the first time brings together doctor-writers who have written in different cultural contexts and from a range of other perspectives. In addition, it brings together separate scholarship on creative writing by doctors for the first time, and in particular, tackles a series of broad issues associated with doctors' creative writing, such as why doctors write, what makes them competent storytellers, and the cross cultural history of creative writing by doctors which has not been systemically discussed before. Secondly, this study makes a significant contribution through its inter-disciplinarity. Located at the intersection between comparative literature and medical humanities, it offers insights to both fields. In the field of medical humanities, it brings comparative cultural perspectives to bear on current studies in medical education; meanwhile in the field of comparative literature, it provides the first systematic study of "doctors who write creatively".

Nevertheless, this choice of writers itself reveals the dominance of western cultural experience in the field of medical humanities. Word and time limitations restricted the opportunity to bring more writers from Asian countries into comparison. Works by doctor-writers have value both when they speak through and when they transcend their

original cultural context and this is equally true of work written in Asian, and indeed other non-European or American contexts. This study opens up the possibility firstly to address the dominance of western cultural experience in the field, and secondly, to explore the continuing development of the literary forms that doctor-writers use for the discussion of medical ethics, for example, the use of blogs in the internet age.

Zhang Yu, for example, is a Chinese gynaecological oncologist and a columnist for many well-renowned journals about pregnancy. She has been offering online consultations for patients and has reached seven million hits in the past five years. Her essay collection Only Doctors Know (@ Dr Zhang Yu's Private Letter to Women) (《只有医生知道》@协和张羽发给天下女人的私信) and its sequel published in 2013 have both been warmly received by the public. Writing in an era when the internet has become one of the most important vehicles for reading, Zhang Yu's works offer one of the best examples of physician-writers' creative writing in the E-times – attention-catching, easy to follow, highly informative but extremely entertaining. Comical as they are, both collections include rich medical knowledge and sincere advice, dedicated to the popularisation of better prenatal and postnatal care for women. In this sense, the good doctor in Zhang Yu's case is represented more as the one who cures future disease – by preventing patients from being sick in the first place – a very important notion in traditional Chinese medicine and also the core concept to modern preventative medicine. Writers like Zhang Yu, and writing by them, offer rich and interesting opportunities for future research. Above all, such an approach offers the possibility to develop further one of the central themes of this study, namely the enabling of works which are firmly located in a particular cultural context to transcend that context and be read meaningfully from new cultural and temporal perspectives.

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