NEGATIVE CAPABILITY AS AN ETHIC OF EMPATHY: PRACTICING NARRATIVE MEDICINE WITH JOHN KEATS IN MIND

BY

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for Professor Onita Vaz,
who first taught me how to read and love Keats
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ABSTRACT

This thesis identifies and explicates the similarities between elements of narrative medicine theory and John Keats’s quality of negative capability and explores the ways in which an understanding of negative capability can inform narrative medicine practices and guide narrative medicine beyond its present theory. I argue that scholars and practitioners of narrative medicine ought to consider Keats and his works in their efforts to cultivate and encourage empathetic clinical practices. My thesis begins with an overview of narrative medicine and Rita Charon’s methods of incorporating narrative knowledge into clinical practice. I provide a biographical sketch of John Keats’s life and his medical training, and I discuss literary scholarship that has explored the ways in which Keats’s medical background influenced his poetry. I discuss Keats’s elusive concept of negative capability and incorporate scholarly analyses of the concept into my own analysis of negative capability as it appears in Keats’s letters and poetry. The final two chapters of my thesis move toward a consideration of negative capability in the context of medical practice and narrative medicine. I identify the similarities between the poetic quality of negative capability and the physician’s ideal state of attention described in Charon’s narrative medicine philosophy and the language used to describe both concepts. Finally I consider criticisms of narrative medicine methods and discuss the ways in which an invocation of negative capability in narrative medicine theory could help narrative medicine scholars and practitioners address and overcome the shortcomings of their methods.
INTRODUCTION

The Romantic poet John Keats first defined ‘negative capability’ in a letter to his brothers in 1817, although evidence of the concept exists in many of Keats’s letters and poems. Keats writes, “I mean Negative Capability, that is when man is capable of being in uncertainties, Mysteries, doubts, without any irritable reaching after fact & reason” (27 December 1817; *KSL* 79). For all the apparent simplicity Keats’s own definition appears to convey, negative capability has grown, through Keats’s own poetic and philosophical elaboration and subsequent scholarly interpretation, into a complex and multi-faceted concept since its epistolary conception nearly 200 years ago. A gross summarization of the vast content of negative capability would loosely define the concept as the human capacity to remain open to and receptive of the ideas and experiences of the world and to the evolving formation of the self, so the poet may approach a more complete knowledge of truth. Linda von Pfahl’s tidier definition describes negative capability as the poet’s creative capacity to “expand the self and increase our capacity for understanding” (451). For Terrence Holt, negative capability describes the “capacity to suspend especially the foundational certainty of identity” (332). My thesis question is inspired by and indebted to the work of Terrence Holt, specifically his article for *Literature and Medicine* titled “Narrative Medicine and Negative Capability.” Holt identifies the positive influence negative capability can and should have on the medical profession, specifically those who practice and teach narrative medicine.

Rita Charon defines narrative medicine as medicine practiced with “the narrative competence to recognize, absorb, interpret, and be moved by the stories of illness” (Charon vii). The narrative medicine movement aims toward a practice of medicine that
is more attentive to the patient’s experience of illness and is therefore more humane, ethical, and effective. Charon advocates for an approach to medical training that is fortified with narrative competence. Narrative training encourages health care practitioners to more fully comprehend their patients’ experiences of illness and to confront the difficulty and understand the significance of their own role as individuals who care for the sick. I understand narrative medicine to have two interdependent goals. First, narrative medicine aims to encourage health care practitioners to recognize and acknowledge their patients’ experiences of illness and suffering. Second, narrative medicine urges health care practitioners to recognize their own experiences and to acknowledge the difficulty and significance of their experiences. To practice medicine with narrative competence is to enter the worlds of one’s patients and to address one’s self (Charon 9).

My thesis explores the ways in which Keats’s concept of negative capability can inform the first goal of narrative medicine. I originally intended to examine Keats’s concept in the context of both goals of narrative medicine. However, my own interpretation of negative capability, which evolved throughout the duration of this thesis, provides more specific insight to the elements of narrative medicine concerned with clinicians’ efforts to recognize, acknowledge, and empathize with patients’ experiences of illness.

Terrence Holt’s observations more specifically inform the second goal of narrative medicine. Holt views the physician as containing a distinct form of negative capability. Through the design of their education and the unique demands of their profession, physicians experience a “fragmentation of the self,” in which they maintain
and attend to multiple threads of reality, as they engage in clinical practice, care for their patients, and care for themselves (330). Holt acknowledges that the physician’s fragmented identity is often criticized as a failure of the physician’s humanity, yet he also views the fragmented self as essential to the identity of an effective physician. Holt envisions a profession and a system of medical education that addresses the physician’s negative capability: “we need to address it: encourage it, cultivate it, learn it, and teach it. Make it not a loss but a gift, an instrument as important to medical care as any other technique at our disposal. And in literature we have ready-made the tool our culture has developed for this task” (331). To Holt, negative capability is a concept of significant value to the medical profession.

My thesis builds upon Holt’s argument for the examination and cultivation of negative capability, as it is relevant to clinical practice, especially the practice of narrative medicine. I argue that elements of narrative medicine theory seem to unconsciously or subconsciously borrow from the language Keats and Keatsian scholars use to describe and define the quality of negative capability. Yet, with the exception of a brief, two-line reference in a 2005 article in Narrative magazine, Rita Charon’s narrative medicine philosophy makes no mention of Keats’s concept (262). This thesis endeavors to incorporate a discussion of John Keats and negative capability into narrative medicine discourse. I address negative capability in the context of narrative medicine’s first goal, which encourages physicians to acknowledge their patients’ stories of illness. I ultimately argue that the concept of negative capability can contribute the philosophy of narrative medicine and provide insight to clinicians as they endeavor to understand their patients’ experiences and provide empathetic and effective care.
The first chapter of my thesis provides an overview of narrative medicine theory and places the narrative medicine movement in the context of the postmodern illness narrative. I begin with an exploration of the ways in which the popular conception of illness has changed in the last thirty years. I describe a widespread reconceiving of illness experience that culminates in the publication of Arthur Frank’s book *The Wounded Storyteller*, which identifies the postmodern illness narrative as the product of efforts of ill people to reclaim their voices in the telling of illness narratives.

I understand the narrative medicine movement to be the natural response of the medical profession to the postmodern reconceiving of illness, as health practitioners acknowledged the importance and necessity of patients’ stories of illness in the clinical encounter. I provide a summary of the narrative medicine movement and its philosophy, and I outline the two conceptual goals of narrative medicine that my thesis addresses: to encourage the physician to enter the world of the patient and acknowledge the patient’s experience of illness, and to encourage the physician to address and explore his or her identity. I emphasize that the goals of narrative medicine are working toward a larger end, which is to improve medical practice, and I discuss how the efforts of narrative medicine achieve this end. I discuss the ethics of narrative medicine and the importance of narrative competence in the ethical practice of medicine. I have chosen to look specifically at Rita Charon’s particular brand of narrative medicine as explicated in her book *Narrative Medicine* (2008), although many other scholars and practitioners have championed methods of narrative inquiry in clinical practice that warrant attention and exploration.
The second chapter of my thesis shifts its attention to John Keats. I provide a biographical sketch of Keats’s life and his experiences as a student of medicine. John Keats had no formal literary training, but he did receive an extensive medical education, and the majority of his short life was spent preparing to practice medicine. My second chapter provides a brief history of Keats’s life and his medical career, and examines the ways in which Keats’s medical background influenced his poetry, his poetic philosophy, and his identity as both a poet and healer. It is my hope that a knowledge of Keats’s medical background and the relationship between his poetry and his scientific knowledge may encourage readers of this thesis to grant authority to Keats and his ideas, and to view negative capability as relevant to narrative medicine and clinical practice.

The third chapter of my thesis explores negative capability in its literary contexts. I begin with a summarization of negative capability and its importance to Keats’s life and his poetry. My third chapter includes a comprehensive review and analysis of Keats’s letters and select poems. Literary scholars have identified evidence of negative capability in the content of Keats’s letters and his poetry. My interpretation of negative capability is guided by a literature review of literary scholars’ interpretations of negative capability and the content of Keats’s works that contain evidence of the concept. I pay special attention to the works of Walter Jackson Bate and Li Ou, who have both written book-length discussions of negative capability.

Keats was greatly influenced by his friends and the individuals within his social circle and literary community, and he frequently allowed his peers’ ideas to influence his poetic philosophy. Keats was also a self-taught student of literature, and an important element of his creative process was the diligent study of the great British poets, especially
Shakespeare and Milton. My third chapter explores the literary sources that influenced Keats’s concept of negative capability, specifically the lectures and essays of William Hazlitt and the works of William Shakespeare.

The final two chapters of my thesis move toward an integration of Keats’s ideas into narrative medicine discourse and endeavor to place negative capability in the context of narrative medicine and clinical practice. My fourth chapter introduces the concept of the sympathetic imagination, and considers the sympathetic or empathetic capacities of a negatively capable mind. I consider eighteenth-century conceptions of the sympathetic imagination, especially Adam Smith’s notion of sympathy in his Theory of Moral Sentiments, and I demonstrate the ways in which negative capability moves beyond sympathy to cultivate an effective and productive empathy in the observer of suffering. I incorporate Leslie Jamison’s essay “The Empathy Exams” and Anatole Broyard’s work Intoxicated By My Illness in my discussion of the unique empathetic capacities of the negatively capable mind, and interpret Broyard’s description of the ideal physician as a physician of negative capability.

The fifth and final chapter of my thesis returns to the theory of narrative medicine. I identify and explore the similarities between elements of narrative medicine theory and the language Keats uses to describe negative capability. I argue that Keats’s concept of negative capability and the effective empathy it encourages are compatible with the philosophy of narrative medicine and its efforts to encourage physicians to acknowledge and empathize with their patients’ experiences of illness and suffering. I argue that negative capability ought to be included in the philosophy and discourse that guides narrative competence in medical practice. I use Mark Seigler’s story of Mr. D. and
Jay Katz’s commentary on Seigler’s story as a case example to demonstrate the positive effect a physician with an active empathetic imagination may have on a difficult clinical encounter. I conclude my final chapter with a personal story of an encounter with a physician who possessed the quality of negative capability, which fortified the care he provided with a unique capacity to empathize with his patient.

As I conclude my thesis, I reframe the concept of negative capability and my thesis question in the context of narrative medicine and its goals to improve clinical practice. I restate my arguments concerning the authority of John Keats as a Romantic poet-physician and the ethical authority of his concept of negative capability. I argue that narrative medicine scholars ought to pay attention to John Keats and negative capability. I reinforce Holt’s ultimate proposition that the medical profession address negative capability as an idea that is relevant to clinical practice and may serve to improve or enlighten the care physicians provide as they attend to and commune with their patients’ stories of illness.
Illness is an experience that exceeds the sum of its parts. My thesis recognizes illness as a term that is distinct from disease or pathology and from sickness. Marshall Marinker describes three “modes of unhealth,” the second of which is illness (82). Illness, Marinker writes, is “a feeling, an experience of unhealth which is entirely personal, interior to the person of the patient” (82). Illness is distinct from disease, which is the pathological or physical manifestation of “some derivation from a biological norm” (Marinker 82). Disease is an objective and quantifiable entity that is valued among the medical profession as the factual indication of unhealth. As illness is the patient’s interior and personal experience of unhealth, sickness is the patient’s external and public experience of unhealth: “Sickness is a social role, a status, a negotiated position in the world, a bargain struck between the person henceforward called ‘sick’, and a society which is prepared to recognize and sustain him” (Marinker 83). Sickness is a fluid role that depends upon the social status of the sick person’s disease or ailment. Marinker makes a distinction between the social value of chronic and acute diseases and how the profile of the sick person may influence the disease’s social value. “Best,” Marinker writes, “is an acute physical disease in a young man quickly determined by recovery or death – either will do, both are equally regarded” (83). Today we may consider discrepancies in the social perceptions of mental illnesses and physical ailments, or how the mode of transmission of certain diseases may influence the ways in which the sickness of an individual is constructed and regarded.
Marinker’s explication of sickness in relation to illness and disease echoes Talcott Parsons’s notion of the “sick role.” In the 1950s, Parsons established an outline of the social roles of patients and physicians in modern medical practice. Parsons concludes that the distinct features of the sick person’s experience of disease determined the sick person’s social role and the complementary role of the physician. The sick person inhabits an undesirable place of need that exempts him or her from social obligations and relieves him or her of the principal responsibility of getting well. Parsons’s sick role is a passive one that renders a helpless individual prone to irrationality and vulnerable to exploitation. The sick person cannot help himself or herself or even legitimize his or her experience (Parsons 436-46). Meanwhile, the physician is the “direct legitimizing agent” whose “technical competence” grants him or her the authority to both proclaim and solve the sick person’s problem of disease (Parsons 436,434). Unlike Marinker, Parsons does not explicitly distinguish between the terms illness, disease, and sickness in his writings. Parsons alludes to the multifaceted nature of unhealth in his analysis of social roles in modern medical practice in *The Social System*:

> illness is a state of disturbance in the ‘normal’ functioning of the total human individual, including both the state of the organism as a biological system and of his personal and social adjustments. [Illness] is thus partly biologically and socially defined. (431)

Illness disrupts an individual’s biological processes, but it also disrupts the way an individual behaves in society and fulfills social obligations. Disease is likewise
understood as the agent that brings about an individual’s state of illness (432). Beyond these introductory distinctions, however, Parsons uses disease, illness, and sickness synonymously to describe the general affliction for which a patient may seek the care of a physician. Marinker’s distinctions are significant because they address illness as a personal experience that transcends pathology and social burden.

Arthur Frank might criticize Marinker’s distinctions, however, for their very act of distinction. For Frank, illness is not a single mode of unhealth but rather an encompassing experience that contains all of Marinker’s distinctions and more. Frank discusses the problem of the mind-body distinction in stories of illness. The act of distinguishing between the mental experience and the bodily experience of illness diminishes the truth of the total experience of illness:

Only a caricature Cartesianism would imagine a head, compartmentalized away from the disease, talking about the sick body beneath it. The head is tied to that body through pathways that science is only beginning to comprehend, but the general principle is clear: the mind does not rest above the body but is diffused through it. (Frank, *The Wounded Storyteller* 2)

If we apply Frank’s assessment to Marinker’s distinctions, we may understand illness to refer to the interior experience taking place within the mind, disease to the biological processes affecting the body, and sickness to the external social environment. We may also understand the problem of distinguishing between the three modes of unhealth: the
personal experience of illness is not separate from the biological processes of disease and the social burden of sickness. The experience of illness unfolds according to the body, which has a disease and exists within a society. To assign illness to the personal, sickness to the social, and disease to the biological is to “compartmentalize” an experience that actively resists compartmentalization (Frank, *Wounded Storyteller* 2).

Marshall Marinker’s analysis of illness, disease, and sickness was published in the *Journal of Medical Ethics* in 1975 on the brink of what may now be recognized as a public reconception of illness that culminated in the publication of Arthur Frank’s analytic study of illness narratives, *The Wounded Storyteller*, in 1995. In an earlier article, Frank identifies and discusses the presence of a new genre of illness storytelling, the first-person narrative of illness, which began to gain momentum in 1973 with the publication of Stewart Alsop’s book *Stay of Execution* (Frank, “Reclaiming an Orphan Genre” 3). Alsop uses the narrative medium to tell of his illness experience in the first person. Alsop’s fame as an influential political reporter at the time of his diagnosis ensured the wide dissemination of his narrative, and catalyzed the advent of the new genre: a public figure recounting a private experience in his own voice (Frank, “Reclaiming” 3). The emergence of a new genre of illness narrative lies at the heart of a much larger dialogue of change that has resulted in an ongoing reconsideration of what it means to be ill and how the medical profession should best care for ill people.

Susan Sontag employed a different approach to reveal the complex and extensive substance of the term ‘illness.’ Although certainly the proprietor of her own illness narratives—both Sontag and her mother had cancer—Sontag’s stated purpose in writing *Illness as Metaphor* (1978) and *AIDS and its Metaphors* (1989) was not to write her own
illness narrative, but to examine the multitude of metaphors that undermine the experience of illness. Illness always means something; to a physician in an emergency room, illness may mean the presence of a bacterium or virus; to the patient sitting on the exam table, illness may mean a sore throat. Sontag recognizes, however, that illnesses contain meaning beyond their attending pathologies and the physical effects they may have on an individual’s body. Illnesses are metaphors. Sontag describes how illnesses, specifically tuberculosis, cancer and HIV/AIDS, have acquired stereotypes and reputations that have colored the way society perceives the people who are ill and how ill people understand themselves.

Similar to the historical conception of tuberculosis, cancer has long been understood as an “insidious, implacable theft of a life” (Sontag 5). At the time of the publication of Illness as Metaphor, public imagination understood a cancer diagnosis as the equivalent to a death sentence, and cancer became representative of evil. Sontag tracks the spiraling effect of an illness armed with metaphor: “The disease itself becomes a metaphor. Then, in the name of the disease (that is, using it as a metaphor), that horror is imposed on other things. The disease becomes adjectival” (Sontag 58). American politicians wage a war against cancer. Cancer transcends its biological and bodily origins and becomes an evil enemy. The metaphor accumulates and gathers momentum and society begins to wage wars against other ‘cancers.’ Cancer becomes a metaphor for any circumstance or event that is “unqualifiedly and unredeemably wicked” and worthy of resistance and loathing (Sontag 82). Gang-related violence, illicit drug use, and terrorism become metaphorical cancers in need of irradiation and excision. In his address to the United Nations General Assembly in September 2014, President Obama referred to the
spread of ISIS’s presence in Iraq and Syria as a “cancer of violent extremism.” As the comparisons abound, so too does the symbolic evil of cancer itself, and the ability to distinguish between cancer, the disease, and cancer, the force of evil, atrophies.

Sontag’s argument does not suggest that medicine shouldn’t oppose cancer. Efforts to improve treatments for cancer and the care of cancer patients must certainly continue. Sontag argues that cancer should not be used as a metaphor. She writes, “Twelve years ago, when I became a cancer patient, what particularly enraged me—and distracted me from my own terror and despair at my doctors’ gloomy diagnosis—was seeing how much the very reputation of this illness added to the suffering of those who have it” (Sontag 100). “Cancer,” Sontag writes, “was regarded with irrational revulsion, as a diminution of the self” (100). Metaphors undermine and “deform” the experience of illness, because they are dependent upon representations of evil that have little to do with oncological science or the lived experience of cancer. The metaphors that permeate the social perception of illness, Sontag argues, harm the people who are ill: “they inhibit people from seeking treatment early enough, or from making a greater effort to get competent treatment” (102). Today the metaphors and stigmas attached to sexually transmitted infections and mental illness certainly influence individuals’ willingness to seek medical care. Sontag’s book is an antidote to the dangers of illness metaphors. She debunks the myths and demystifies the “fantasies” of cancer that have negatively influenced social consciousness and the consciousness of those living with cancer. She subverts a disease’s metaphorical power, deprives it of the ability to contain any meaning beyond itself. In doing so, she reveals the true source of meaning, the true meaning-maker in an experience of illness: the person experiencing the illness. Sontag’s choice is
to understand cancer as “just a disease—a very serious one, but just a disease.” The power of her book, however, comes from the path her choice paves for subsequent narratives of illness: a path that resists the socially constructed myths of illness and encourages the telling of the “real geographies” of illness according to those who experience illness (Sontag 3).

Although she criticizes the metaphors that have arisen and continue to arise from illness, Sontag nevertheless reveals how an illness can contain meaning beyond the pathology and symptoms of its associated disease. Illnesses contain stereotypes and myths that influence social perceptions and identities and compound the suffering of people who are ill. Illness can no longer be identified solely by its associated disease; it contains deep, socially constructed symbolism that may influence an ill person’s experience. Sontag’s analysis opens the dialogue to a discussion of what kinds of meaning (beyond biological and symptomatic meaning) can be contained in the term illness and how different threads of meaning affect the illness experience. Sontag’s normative conclusion is not that illness is without meaning. Instead she criticizes the false sources of meaning that ought not to negatively influence the social conception of illness and a person’s illness experience.

Arthur Kleinman confirms Sontag’s conclusion about meaning-making and illness: the meanings of illness are created by the people who are ill (48). Following Marinker, Kleinman described his own distinctions between illness, disease, and sickness in his book The Illness Narratives: Suffering, Healing, and the Human Condition (1988). Kleinman advocates for attention to the experience of illness as it is experienced by the patient and the patient’s family and social network. Health care practitioners, he argues,
must recognize “the difference between the patient’s experience of illness and the doctor’s attention to disease” in order to interpret their patients’ experiences of illness and be clinically effective (Kleinman xii-xiii). Illness is the total, human experience of unhealth (to borrow Marinker’s term), the symptoms and suffering that accompany unhealth, and an individual’s “illness problems” are the chief complications that unhealth creates in the individual’s life (Kleinman 4). Kleinman interprets illness as anterior to disease. An individual experiences illness and brings his or her “illness complaint” to a practitioner (Kleinman 5). Disease is the physician’s creation, a reinterpretation of the patient’s telling of illness according to a technical and theoretical understanding of disorder: “The healer—whether a neurosurgeon or a family doctor, a chiropractor or the latest breed of psychotherapist—interprets the health problem within a particular nomenclature and taxonomy, a disease nosology, that creates a new diagnostic entity, an ‘it’—the disease” (Kleinman 5). Rather than conceive of illness experience as a product of disease, as Parsons’s sick role might suggest—the particular disease determines the individual’s sick role—Kleinman reverses the trajectory of meaning-making. The patient’s experience of illness is the primary source of meaning, which is then shared with a physician. During this encounter, the physician transforms the subjective experience of illness into an objective entity: a disease. The patient’s expression of his or her illness experience precipitates the physician’s interpretation, which yields disease. Since disease, the objective entity that determines treatment, is determined from the telling of an illness, Kleinman’s point becomes clear: physicians must pay attention to their patients’ stories of illness.
However, the process of interpretation from subjective experience to objective disease poses a danger to the patient’s illness narrative. The physician is in danger of engaging in an act of “biological reductionism,” which is dependent upon a point of view that understands illness as only a disease, and disease is “reconfigured only as an alteration in biological structure or functioning” (Kleinman 5-6). A biological reductionist approach may sufficiently describe the nature of acute illness: “When chest pain can be reduced to a treatable acute lobar pneumonia, this biological reductionism is an enormous success” (Kleinman 6). The physician may treat the patient with antibiotics and solve the disease problem and the illness problem in one stroke. Biological reductionism, Kleinman argues, does not always adequately describe the nature of chronic illness: “When chest pain is reduced to chronic coronary artery disease for which calcium blockers and nitroglycerine are prescribed, while the patient’s fear, the family’s frustration, the job conflict, the sexual impotence, and the financial crisis go undiagnosed and unaddressed, [biological reductionism] is a failure” (Kleinman 6). Biological reductionism does not consider the intricate web of biological processes, psychological distress, and circumstantial conditions that determine suffering during illness. The reconstruction of illness as disease is certainly necessary, as the process contributes to the resolution of a patient’s disease problems (if those problems may be resolved). During this process, however, problems equally relevant to the experience of illness may be ignored, and if the disease problems cannot be resolved in the traditional, biomedical sense of improvement in biological processes, patients are left without solution and without the care or resources necessary to address and alleviate their suffering (Kleinman 6).
In the practice of biological reductionism, practitioners are also in danger of ignoring the myriad meanings of illness and impeding the meaning-making journey of their patients. A practitioner’s interpretation of a patient’s illness is only one source of meaning contained within the patient’s illness experience. “Illness experiences and events,” Kleinman writes, “usually radiate (or conceal) more than one meaning” (8). Therefore, it is important, he argues, for practitioners (and patients and families) to approach an illness in a way that acknowledges and addresses all meaning contained within it (Kleinman 8). Published in 1988, Kleinman’s book points to the nature of medical training and the structure of health care delivery as a system that discourages interest in the many meanings of illness beyond the “biological mechanism of disease” (9). The medical profession’s lack of interest in illness meanings influences the interests of patients and families: “It turns the gaze of the clinician, along with the attention of patients and families, away from decoding the salient meanings of illness for them” (Kleinman 9). This shift in attention interferes with patients’ and families’ abilities to identify the significance of illness in the context of their lives and “disempowers the chronically ill,” as they are unable to claim for themselves the breadth of meaning belonging to their experiences. The shift, Kleinman argues, also interferes with practitioners’ ability to provide more effective care, as they may be unable to address the full extent of a patient’s suffering.

Kleinman echoes Sontag’s argument that the cultural or social significance of disease contributes meaning to illness experience. Kleinman describes the social fears, stereotypes, and stigma associated with certain diseases as a “visible exoskeleton of powerfully peculiar meanings” that the ill person must wear and confront (22). Society’s
most persistent typecasts, such as cancer’s death sentence and HIV/AIDS’s badge of
promiscuity, are evidence of the meanings that may arise independent of biomedical and
personal sources and adversely affect the illness experience. Despite Sontag’s rejection
and derailing of illness metaphors, the cultural meanings of disease prove more potent
and more stubborn than efforts to diminish them. Kleinman laments the staining quality
of the illness exoskeleton: “That exoskeleton is the carapace of culturally marked illness,
a dominant societal symbol that, once applied to a person, spoils radically that
individual’s identity and is not easily removed” (22).

Kleinman identifies a third source of illness meanings: the ill person’s personal
and interpersonal world. The experience of illness is contained within the narrative arc of
a person’s life; it is a lived experience that draws upon the life of the ill person: “Acting
like a sponge, illness soaks up personal and social significance from the world of the sick
person. Unlike cultural meanings of illness that carry significance to the sick person, this
third, intimate type of meaning transfers vital significance from the person’s life to the
illness experience” (Kleinman 31). Biomedical and cultural meanings are applied to a
person’s life as he or she experiences illness; personal and interpersonal meanings are
derived from the person’s life and lived experiences. To illustrate the influence of
personal and interpersonal meaning, Kleinman tells the story of Alice Alcott, a middle-
aged woman with a history of juvenile onset diabetes and cardiovascular problems who
was recovering from surgery to amputate her leg below the knee when she became
Kleinman’s patient (32-33). Kleinman explains that he became aware that Alice was
grieving the many losses she endured and would continue to endure during her life with
chronic illness. After decades of diabetes and a series of rapid-fire complications, she
began to feel angry. The amputation compounded her anger with overwhelming grief and depression, as she grieved for the physical loss of her leg and the symbolic loss of her sense of health and physical stability, which she worked her entire life to maintain. She grieved, too, for her eventual death, as she believed the advent of irreversible physiological decline was near if not already begun. As Alice’s psychiatrist, Kleinman made an effort to recognize and affirm the personal and interpersonal meanings that influenced Alice’s experience of her illness and create a space for her to mourn and to eventually overcome her grief (Kleinman 35-39).

Margaret Edson’s Pulitzer Prize-winning play, W;t, provides a second example of a patient who must mediate between the biomedical sources of illness meaning and the meaning derived from her life world. Dr. Vivian Bearing, the play’s protagonist, is a scholar and professor of seventeenth-century English poetry. At the beginning of the play, Vivian learns she has ovarian cancer. In the opening conversation with her oncologist, Vivian reminds her audience of the many meaning-making forces at work in an illness experience:

Kelekian: You are a professor, Miss Bearing.

Vivian: Like yourself, Dr. Kelekian.

Kelekian: Well, yes. Now then. You present with a growth that,

unfortunately, went undetected in stages ones, two, and three.

Now it is an insidious adenocarcinoma, which has spread from the primary adnexal mass—

Vivian: “Insidious”?
Kelekian: “Insidious” means undetectable at an—

Vivian: “Insidious” *means* treacherous. (Edson 7-8)

The term *insidious* has a legitimate medical definition. An insidious cancer is one that progresses gradually without apparent symptoms. Dr. Kelekian is not incorrect in his description of Vivian’s cancer. But Vivian is a scholar of English poetry, and she is familiar with a different interpretation of the term *insidious*, which she promptly identifies and brandishes: “‘Insidious’ *means* treacherous” (8). Her remark is a correction. The italics are a stage direction: the actor portraying Vivian should emphasize the word *means* in order to communicate to her physician that she, the scholar of English poetry, is the linguistic authority in the room. The remark also serves to remind Kelekian (and the audience) that the medical profession does not have a monopoly on the word *insidious*.

The exchange between Vivian and Kelekian is a power struggle, but it is also evidence of the personal sources of meaning that influence how Vivian begins to understand her illness. To Dr. Kelekian, insidious means undetectable at an early stage. To Vivian Bearing—a scholar of seventeenth-century English poetry who probably read Milton’s *Paradise Lost* countless times during the course of her graduate education, who is probably more familiar with the most insidious character in the English literary canon, Milton’s Satan, than with the complexities of cancer staging—insidious means treacherous. Vivian’s life revolves around her scholarship. Her identity as an eminent scholar and professor constitute the majority of the fibers of her personal and interpersonal world. Vivian interprets the term *insidious* and derives meaning according to her life and her personal identity. As she challenges her physician’s narrow
understanding of the term *insidious*, Vivian claims the authority she needs to make sense of her situation and determine the meanings of her illness.

Kleinman advocates for an understanding of illness and illness experiences that places the ill person’s interpretation of illness experience at the center of the meaning-making machine and at the forefront of clinical decision-making. Alice Alcott reveals the grief that colors her experience of diabetes, and Vivian Bearing challenges a biomedical model of language with her own, singular perspective. Ill people create their own illness meanings, and they have an authoritative hand in the formation of others’ interpretations. The physician’s core task, Kleinman argues, is “to affirm the patient’s experience of illness as constituted by lay explanatory models and to negotiate, using the specific terms of those models, an acceptable therapeutic approach” (49). Physicians who lend this assistance create a space for their patients to address the personal meanings and significances that influence and contribute to their whole illness experience and empower patients as they take part in the process of care and healing (Kleinman 43).

**THE POSTMODERN ILLNESS NARRATIVE**

For Arthur Frank, empowering the ill requires reclaiming the voices of illness narratives. Thus far, this chapter has endeavored to illustrate the ways in which the collective understanding of illness has changed since 1975. Frank classifies the change as a shift from modern times to postmodern times. “Illness has come to feel different during the last twenty years,” Frank writes, “and today the sum of those differences can be labeled postmodernism” (*FWS* 4). Various disciplines and fields have their own versions of postmodernism, which is loosely identified as the period of intellectual, artistic, and
social change that developed in the late twentieth century. Frank does not delve into the details of the philosophical and artistic movements that identify as postmodern. He equates the shift from modern times to postmodern times to the crossing of a divide:

Journeys cross divides. Once on the other side, the traveler remains the same person, carrying the same baggage. But on the other side of certain divides, the traveler senses a new identity; that same baggage now seems useful for new purposes. Fundamental assumptions that give life its particular meaning have changed. Postmodernity is such a crossing, occurring when the same ideas and actions are overlaid with different meanings. (FWS 4)

So, too, does illness cross such a divide during the shift from modern to postmodern times. The salient features of illness remain the same—although the medical landscape certainly has changed—but the meaning of illness and the sources of meaning change, and illness begins to “feel differently” to those who experience it, those who care for the ill, and those who witness their suffering (FWS 4).

The modern experience of illness resembles the biological reductionism Kleinman warned against: a patient delivers her illness complaint to a physician who derives the objective disease from the patient’s subjective illness experience and translates the complaint into the technical language of disorder. “The modern experience of illness,” Frank writes, “begins when popular experience is overtaken by technical expertise, including complex organizations of treatment” (5). An unfamiliar medical language takes
over the illness experience, and the medical narrative—the story a practitioner tells of symptoms, pathologies, diagnoses, treatments, and prognoses—becomes the “official story of illness” (FWS 5). The modern medical narrative is complementary to Parson’s sick role, in which the ill person is expected to yield herself to the care of a practitioner. Frank recognizes this moment as a “narrative surrender,” which functions in the modern illness experience as the exchange of the ill person’s narrative authority for medical care (FWS 6). The health care practitioner ascends the authoritative seat of “spokesperson” for the ill person’s disease, and the ill person’s illness narrative becomes dependent upon what the practitioner says of her disease, which she can only repeat and reinterpret (FWS 6). “The postmodern experience of illness begins,” Frank writes, “when ill people recognize that more is involved in their experiences than the medical story can tell” (FWS 6). Vivian Bearing realizes that the term *insidious* means more to her than it does to her oncologist. Alice Alcott’s medical history cannot divulge the depths of despair and loss she endures during her life with chronic illness, nor can it account for the grief she feels. The ill person’s voice is required in postmodern times; the ill person longs for a voice with which she can identify; and postmodern storytellers of illness feel compelled to speak in their own voices and provide the required solidarity (FWS 7). In postmodern times, the ill person’s voice is no longer secondary to the practitioner’s voice and the medical narrative. The personal, first-person narrative of the ill person’s illness experience achieves primary authority. A postmodern illness narrative is a narrative that is “reclaimed” by the person who experiences illness, as the ill person simultaneous reclaims the capacity to tell her story in her own voice (FWS 7).
Frank notes that the shift from the modernist medical narrative to the reclaimed, personal narrative of illness is not just a shift to the postmodern, it is a shift to the postcolonial: “Just as political and economic colonialism took over geographic areas, modernist medicine claimed the body of the patient as its territory, at least for the duration of the treatment” (FWS 10). I am not under any delusion that modern medicine’s colonization of disease, the ill body, and, subsequently, the illness narrative was motivated by any sort of malicious intent. Medicine has made extraordinary improvements and transformed its practice in the last fifty years according to its desire to care for others and to save lives. But the success of modern medicine has changed the experience of illness in such a way that previously logical interpretations of the illness experience no longer apply. Frank draws attention to the category of illness experience he calls the “remission society” (FWS 8-9). “In modernist thought,” Frank writes, “people are well or sick” (FWS 9). Frank alludes to Parsons’s sick role, in which individuals shift back and forth between the two distinct spheres of health and sickness. Sontag’s Illness as Metaphor complements Parsons’s analysis, as she describes human beings as dual citizens of “the kingdom of the well and the kingdom of the sick” (3). For members of the remission society, however, the spheres of health and sickness are not always distinct and may overlap. Frank adjusts Sontag’s kingdom metaphor and describes the remission society as citizens “on a permanent visa status” (FWS 9). Either way, Parson’s sick role and Sontag’s dual citizenship metaphor do not adequately account for the experience of members of the remission society.

Just as Kleinman recognizes the dangers that biological reductionism pose to the experience of chronic illness, so too does Frank recognize the frustration, anger, and
resentment many ill people feel toward a model of medicine that colonizes and reduces their experience of illness. Postmodern and post-colonial narratives challenge the status quo of modernist medicine. What emerges is an archive of voices that represent a collective “demand to speak rather than being spoken for and to represent oneself rather than being represented or, in the worst case, rather than being effaced entirely” (FWS 13). Postmodern illness narratives have needs and they make demands. In his book-length meditation on mortality and his cancer, Anatole Broyard identifies the need for “good” illness narratives:

When I got out of the hospital my first impulse was to write about my illness. While sick people need books like The Transit of Venus to remind them of the life beyond their illness, they also need a literature of their own. Misery loves company—if it’s good company. And surprisingly enough, there isn’t much good company in this rapidly proliferating field. A critical illness is one of our momentous experiences, yet I haven’t seen a single nonfiction book that does it justice. (Broyard 13)

Broyard stakes a claim for his experience of his illness, criticizes Sontag’s harsh critique of illness metaphors, and fashions his illness as an “overrated text” over which he can wield power through close reading (18). His preferred sort of physician is, similarly, a “close reader of illness and a good critic of medicine” (40). Broyard insists that a poet stirs beneath the surface of every patient, and that illness and dying resemble poetry in their shared qualities of disorder and disarrangement. Broyard desires a physician “who...
can treat body and soul” and asks his ideal physician to read his poetry, to engage in an individualized exploration of Broyard, so that the physician may see Broyard’s personal illness narrative: “My ideal doctor would ‘read’ my poetry, my literature. He would see that my sickness has purified me, weakening my worst parts and strengthening my best” (Broyard 41). Critical illness is a singular and momentous experience for Broyard, who describes his cancer diagnosis as a kind of revelation. He develops a new and profound appreciation for time and the simple wonders of experience. He is enlightened, elevated to a higher realm of clarity and consciousness, and he is giddy with the desire and enthusiasm for the most complete life. Broyard wants his doctor to appreciate the singularity of Broyard’s experience, and to see and address his illness as the total experience Broyard proclaims it to be.

Perhaps Broyard’s demands are a tall order, but the postmodernity of his narrative reveals itself because it begins with his desires, not with what is practical or possible according to the capacities of medicine and medical professionals that may otherwise dampen and diminish the potency of the desire if considered first. Broyard is probably aware of the magnitude of his demands, but he is a postmodern narrator because he is convinced of the primacy and necessity of his voice, and he expresses his needs and demands anyway.

**THE EMERGENCE OF NARRATIVE MEDICINE**

If illness has come to feel different in the last twenty (or thirty) years, as Arthur Frank suggests, it is possible this new feeling is the product of an ongoing reconception of illness and what it means to be ill. Arthur Frank categorizes the reconception of illness
as a shift from modern times to postmodern times and identifies the significance of the postmodern illness narrative, which emerged from a collective desire and need to reclaim the ill person’s voice as the dominant voice in the illness narrative. Frustrated with medicine’s colonization of the illness experience, postmodern and postcolonial storytellers want to proclaim and exercise the strength of their voices and their capacity to tell their own stories and to represent their own experiences of illness. Narrative medicine also grew out of wanting. Rita Charon, the narrative medicine movement’s eminent champion, defines narrative medicine as “medicine practiced with the narrative competence to recognize, absorb, interpret, and be moved by the stories of illness” (vii). Charon acknowledges the remarkable technical advancements the medical profession and the biomedical sciences have achieved in the last fifty years, but she also recognizes the ways in which the medical profession has failed the people it serves. From the perspective of the patient, it seems that health care practitioners often lack the ability to understand the full extent of their patients’ suffering, adequately empathize and commune with their patients’ circumstances, and offer genuine and unwavering support for those to whom they offer care (Charon 3). Patients feel they must make a choice when they seek the care of a physician: “patients have come to reconcile themselves to a forced choice between attentiveness and competence, between sympathy and science” (Charon 21). Simultaneously, patients’ excessive expectations for the capabilities of medicine often distress and discourage physicians. The narrative medicine movement is the response to medicine’s perceived lack of empathetic substance. Frank illustrates ill persons’ need for stories and the space to tell their stories of illness in their own voices. Frank also urges the medical profession to acknowledge the need it has of the clinical material of illness
stories and the advantage it takes of that clinical material while leaving the individuality of suffering by the wayside (FWS 12). Frank and Kleinman both emphasize the relevance of illness narratives and patients’ voices to clinical practice. The call to action is obvious: the medical profession needs to recognize and learn from its patients’ stories of illness. Narrative medicine answers the call. When we consider how the collective understanding of the illness experience has changed since Parsons’s sick role, the emergence of narrative medicine follows as a natural prologue to the next chapter of illness evolution, one in which the medical profession responds to desires of their patients and adapts its conception of illness according to the experiences of those who are ill.

The Goals of Narrative Medicine

The narrative medicine movement endeavors to cultivate physicians’ ability to listen to their patients, to understand the extent of their patients’ troubles and suffering, to acknowledge the multiple meanings an illness narrative can contain, and to be affected by the stories they hear in a way that allows them to act in support of their patients (Charon 3). Narrative medicine philosophy aims to cultivate these abilities by teaching narrative competency through narrative skills, specifically close reading and reflective writing.

As Kleinman and Frank have emphasized, those who experience illness often require the narrative act of storytelling to determine the many meanings of their experiences. The act of storytelling implies the presence of a recipient of the story, either direct or indirect. The patient-physician encounter, Charon argues, is a narrative act of storytelling and receiving, as the patient tells a story of illness to the physician and the physician listens. Scholars of narrative medicine recognize that medicine is “a more
narratively inflected enterprise than it realizes,” but the narrative skill necessary for narrative competency requires an intentional awareness of the narrative features of a situation or encounter (Charon 39). Narrative medicine training encourages health care practitioners to actively listen for stories:

To listen for stories, we have to know, first of all, that there are stories being told. We have to notice metaphors, images, allusions to other stories, genre, mood—the kinds of things that literary critics recognize in novels or poems. When doctors or nurses listen to patients in this way, related to what psychiatrists call ‘listening with the third ear,’ they will ask themselves readerly questions: ‘Why is she telling me this now? How come I feel irritated or distracted or sad as I listen to her? How come she started with the end of the story and told it backward? Why did she leave out the chest pain until the very end? Why has she included her sister’s accident in the story of her bellyache?’ What I am trying to convey is the kind of listening that will not only register facts and information but will, between the lines of listening, recognize what the teller is revealing about the self. (Charon 66)

Just as Anatole Broyard views his cancer as an overrated text to be read and scrutinized, so too do practitioners of narrative medicine make an effort to listen to and interpret their patients’ stories with the attention they would give a novel or a poem. This act of reading is not to be confused with act of voyeurism or any method that would diminish the
humanity of the patient. Placing a patient’s story of illness beneath the lens of close reading helps to reveal elements of the patient’s experience that may have not been previously apparent and may be relevant to the patient’s care and healing process.

Charon recalls an encounter she had with a young woman with severe abdominal pain. The three specialists with whom she met before Charon could find no source of the woman’s symptoms. Charon watched and listened as the woman described her pain. When she asked the woman about her family medical history, Charon watched and listened as the woman described her father’s death from liver failure. The woman wrapped her arms around her abdomen when she spoke of her father’s illness. Charon noticed it was the same gesture the woman used when she spoke of her own pain. Charon described this pattern of body language to her patient. The woman was silent for a moment before saying, “I didn’t know this was about my father” (66). The detail Charon noticed is small and may not have been apparent or considered relevant in a different situation, but in recognizing the subtle connection between the woman’s pain and her father’s pain, Charon helped her patient as she endeavored to understand the meaning of her illness experience. Without this kind of listening and attention, Charon argues, essential elements of a patient’s experience may go unnoticed or be dismissed, and the elements that are lost may hold the key to treating the patient’s illness as it affects the patient’s whole life—the body, mind, and sense of self (67).

Health care practitioners can cultivate narrative competence through the technique of close reading. Borrowing from Jonathan Culler, Charon identifies close reading as the process of interrogating a text’s meaning, which exists “in the dynamic relationship between what it is about and how it is built” (109). A good reader is one who can take in
a text, appreciate its meaning, and identify how its structure contributes to its meaning.

Charon applies the technique of close reading to the clinical encounter:

we realize that our ‘reading’ of disease takes place at the level of the body’s surface and its pathophysiological structure underneath the skin, while our reading of what a patient says takes place at the level of the evident meaning of the words and their implications buried in the clinical and/or personal state of affairs represented. (109)

In a close reading of a patient’s illness complaint, the physician’s task is doubled, as the physician must identify the dynamic between the content and the structure of both the disease and the means by which the patient tells of her illness experience. The goal of narrative medicine training in close reading is to open the minds of practitioners and strengthen their perceptive faculties in a way that renders them open to the subtleties and complexities of their patients’ experiences.

Charon has adapted a method of close reading for students and practitioners of narrative medicine. The method borrows from the literary model of close reading and encourages clinicians to recognize five aspects of narrative text as they listen to and absorb their patients’ stories of illness: frame, form, time, plot, and desire. Frame refers to the “narrative situation” of the text—the narrator, the audience, and the situational context of storytelling are elements that determine the narrative situation of a text. Form refers to the structural, or formal, elements of a text; Charon identifies the genre, visible structure, metaphor, allusion, and diction as structural elements that determine a text’s
form. Time refers to the text’s “temporal scaffolding,” which may include the chronology, length, and velocity of time represented in the text (Charon 120). Plot refers to the action of the text, or what happens during the course of a story. Finally, desire refers to the text’s effects on the reader and how the text satisfies the reader. Narrative competence builds upon a deeper, more complete examination of a text. Practitioners who are able to recognize the multiple elements at work in a narrative are better equipped to recognize the full content of a narrative, whether it is a novel, an autobiography, or a patient’s oral narrative.

The practice of narrative medicine also relies on the act of reflective writing, and many health care practitioners and instructors appreciate the influence the writing process has on their efforts to cultivate empathy and reflect on clinical work (Charon 131). As an educator in a medical school, Charon uses a technique she calls the “Parallel Chart” to incorporate reflecting writing into her clinical curriculum. The Parallel Chart is a separate writing assignment that supplements the writing medical students contribute to their patients’ hospital charts. The Parallel Chart provides medical students with a space to recognize and interpret the elements of their patients’ experiences that cannot be recorded in the hospital chart. “If your patient dying of prostate cancer reminds you of your grandfather, who died of that disease last summer, and each time you go into the patient’s room, you weep for your grandfather,” Charon tells her students, “you cannot write that in the hospital chart. We will not let you. And yet it has to be written somewhere. You write it in the Parallel Chart” (156). The Parallel Chart is a place for students to reflect on the task of bearing witness to human suffering, and it is also a place to reflect on their own journeys as they learn and care for those who are ill. Reflective writing harnesses the
power of narration as an “avenue toward consciousness, engagement, responsibility, and ethicality,” all of which are relevant to effective clinical practice (Charon 131).

Narrative writing requires the narrator to achieve three essential and interdependent states: attention, representation, and affiliation. Charon imagines the work of a physician as a metaphorical heart:

As I sit in the office with a patient, I am doing two contradictory and simultaneous things. I am using my brain in a muscular, ordering way—diagnosing, interpreting, generating hypotheses that suggest meaning, making things happen. This is the systolic work of doctoring—thrusting, emplotting, guiding action. At almost the same time or alternating with this systolic work is the diastolic work—relaxing, absorbing, making room within myself for an oceanic acceptance of what the patient offers. (132)

Charon’s metaphor is as effective as it is beautiful. Like the heart, the art of doctoring requires both systolic and diastolic motions to work in tandem in order to function. The state of attention takes place in the diastolic position of doctoring. During this state, attention requires that the individual in the role of listening and absorbing empty his or her self, so he or she may become “an instrument for receiving the meaning of another” (Charon 132). A health care practitioner in the state of attention is able to silence the distractions of the self—one’s thoughts, concerns, fears—in order to fully “donate oneself” to the patient and to make room for the patient’s concerns (Charon 133). The state of representation is achieved when the practitioner must interpret and impart that
which she absorbed from her patient. The state of attention is a “formless experience,” but in the state of representation the practitioner bestows form upon the formless experience of attention, and the content of the patient’s conveyed experience materializes into something that can be perceived and understood (139). Representation occurs in the diastolic position of doctoring. Finally, the state of affiliation is a product of the acts of attention and representation, after which the practitioner enters into a unique relationship of understanding and support with the patient and is moved to act on the patient’s behalf (149).

Narrative medicine’s ultimate goal is to improve the practice of medicine. I understand the movement to contain two interdependent sub-goals: First, narrative medicine aims to encourage and teach health care practitioners to recognize, acknowledge, and more fully comprehend their patients’ experiences of illness and suffering. Second, narrative medicine encourages and teaches health care practitioners to recognize and reflect on their own experiences as practitioners and to acknowledge the difficulty and significance of their profession. To practice medicine with narrative competence is to enter the worlds of one’s patients and to address one’s self (Charon 9). In caring for those who are ill, health care practitioners bear witness to others’ pain, and they simultaneously expose themselves to suffering and endure the burden of their witness (Charon 234). Narrative competence is a therapeutic instrument with dual strength. It is the physician’s necessary mechanism for “communion” and “self-knowledge,” as she interacts with and cares for her patients and as she reflects upon her practice and understands herself (Charon 40).
During the twenty-five years of his short life, John Keats became acutely acquainted with the task of bearing witness to the suffering of others. The slow, consumptive deaths of his mother and his brother bookended his six years of medical training at a time when medicine was not equipped to anesthetize, treat infection, or adequately manage pain. However, Romantic medicine compensated with a vigorous emphasis on compassion for what it could not accomplish within the parameters of its science. Early-nineteenth century medical texts considered the responsibility and the role of the medical professional, established curricula on the physician’s duty, and outlined ethical guidelines for practice. A good physician demonstrated humility, kindness, and an ability to sympathize with patients. Professors of medicine like Astley Cooper and William Babington knew the limits of their profession, but they never doubted the immensity of the human capacity to do good and to care for others. As he trained to become an apothecary-surgeon, it is likely that Keats received an education in empathy. His witness of the outer bounds of the human experience cultivated his compassion and his strength to address human suffering. As he drifted from medicine toward poetry, he found a new purpose for his compassion, and his medical education influenced his writing and his ideas as he crafted his own unique creative philosophy. I argue that Keats’s medical training and his conception of the poet as a healer grant him a novel authority within the field of medical humanities and the discipline of narrative medicine.
CHAPTER 2: THE POET-PHYSICIAN: JOHN KEATS AND ROMANTIC MEDICINE

Most of us know John Keats, the poet: the author of those miraculous Odes; the young Romantic who endured an untimely demise at the age of 25. “He’s not my favorite,” a fellow student announces, as he surveys my armful of Keats volumes at the library circulation desk, “I prefer Shelley, or Byron. They have more fire.” Surely Shelley’s drowning and Byron’s womanizing make for more enthralling Romantic tales of intrigue and poetic genius. But most of us only know Keats, the poet.

John Keats is a member of a celebrated cohort of writers who also studied or practiced medicine, including François Rabelais, Tobias Smollett, Oliver Goldsmith, George Crabbe, Oliver Wendell Holmes, Sr., Anton Chekhov, Arthur Conan Doyle, Robert Bridges, Somerset Maugham, William Carlos Williams, Walker Percy, and Oliver Sacks (Epstein 57). Although unique and widely diverse in styles, subject matter, and temporal and social contexts, these physician-writers are united, as Joseph Epstein writes, by their collective witness of human suffering: “they had all seen life in extremis, seen men and women in fear and in bravery, in selfishness and in astonishing selflessness, up close and not merely personal but indeed beneath the skin” (57). As their medical experience broadened their view of humanity, so too did medicine influence their writing. Epstein quotes Chekhov, who understood his experiences as a physician as essential to his unique creative process: “I don’t doubt that the study of the medical sciences seriously affected my literary work,” said Chekhov; ‘they enlarged the field of my observations, enriched me with knowledge, the true value of which for me as a writer can be understood only by one who is himself a physician’” (57).
Alan Richardson identifies the irony of contemporary critiques of Keats and his poetry that scoffed at Keats’s lack of traditional education and belittled his pursuit of medicine as an apothecary-surgeon (230). Scholars like Richardson and Donald C. Goellnicht have instead addressed and admired the depth of Keats’s character and the meticulousness and complexity of his writing, which can only be accurately attributed to his many years as a student of medicine (Richardson 230). As Richardson and Goellnicht impart, Keats’s poetic genius is at least partially indebted to his medical education. In order to fully appreciate Keats’s poetry, his poetic philosophy, and his general life perspective, it is important to consider the six years of Keats’s life that were dedicated to the study of medicine. Fortunately for this thesis and literary scholarship in general, an abundance of invaluable literature dedicated to the influence of Keats’s medical experience already exists. My thesis works in the reverse and endeavors to make a case for the value of Keats’s genius to the extant medical profession. What wisdom can Keats share with the profession that influenced his life and his poetry? Literary scholars must address Keats’s medical experience, if they are to fully appreciate his poetry. I argue that medical professionals and medical humanities scholars ought to join with the efforts of literary scholars to understand the symbiosis of poetry and medicine in Keats’s life, so Keats’s genius may, in turn, influence modern medical practice. To do so, we must first consider the medical education that preceded the most creatively prolific years of Keats’s short life.
Keats began school when he was seven and attended John Clarke’s Enfield school in north London. Enfield was a progressive and liberal institution among the Nonconformist schools of the time, and Clarke emphasized the importance of the sciences, teaching astronomy, geology, botany, and physics in addition to Latin and French (Goellnicht 12). Goellnicht describes Keats’s schooling at Enfield as the unofficial beginning of his medical training. After seven years at Enfield, Keats chose to begin his training as an apothecary-surgeon.

At the beginning of the nineteenth century, the medical profession in Great Britain was separated into three categories of practice: physicians, surgeons, and apothecaries. Physicians were men of wealth and social repute who attended university at Edinburgh, Oxford, and Cambridge. Physicians held the official title of ‘doctor’ and were permitted to join professional associations, or Colleges of Physicians (Goellnicht 17). The physician’s position in society and the cost of his services isolated the reach of his practice to the upper class. Medical care for the middle and lower classes was provided by surgeons and apothecaries, “who were, for all intents and purposes, the general practitioners of the nation” (Goellnicht 18). Surgeons and apothecaries received the most practical clinical training of any medical professional, which involved a five-year apprenticeship. Upon completing the apprenticeship, a student could begin practicing as an apothecary or complete the Royal College of Surgeons’ licensing examination, which permitted the individual to practice as a surgeon and perform operations (Goellnicht 19). Keats left Enfield in the summer of 1810 and began an apprenticeship under the tutelage
of Thomas Hammond, an apothecary-surgeon in Edmonton who had cared for the Keats family as well as the students of Enfield.

Keats’s motivation to enter the medical profession is unclear and contested by scholars and biographers. Many suggest Keats was pressured by his guardian, Richard Abbey, to enter the profession and assume that his reputation as a “delicate spirit” contradicts any self-motivated interest in medicine (Goellnicht 14). Goellnicht, as well as Robert Gittings and Dorothy Hewlett, reject the assumption that the decision to pursue medicine was not Keats’s own autonomous choice. Goellnicht argues that the tragic circumstances of Keats’s family probably contributed to his decision. During the Christmas holiday of his last year at Enfield, Keats spent his time caring for his mother, who was dying of tuberculosis: “[Benjamin] Haydon relates how Keats, apparently convinced that the medicines prescribed by Hammond, the surgeon, could save his mother, reserved the right of administering them for himself only. He cooked her meals, sat up nursing her at night, and read novels to her” (Goellnicht 15). Despite his exhaustive efforts, his mother died in March of 1810. Keats’s mother’s death was the fourth Keats family death in six years. Keats’s father died following a riding accident in 1804; his grandfather died in 1805; and his uncle died in 1807 (Goellnicht 15). In the last year of his education at Enfield, Keats’s true work ethic emerged and his dedication to intellectual pursuits redoubled. He was imbued with a sense of purpose and determination that was probably fueled by his mother’s illness and death: “It has often been observed that this loss matured Keats emotionally; I am convinced that it also intensified his desire to heal the sick, which resulted a few months later, in the summer of 1810, in his decision to become an apothecary-surgeon” (Goellnicht 15). Goellnicht attributes Keats’s
intellectual determination and his decision to pursue medicine in part to his role as his mother’s caregiver. “For Keats,” Goellnicht writes, “medicine offered a practical application of his new sense of purpose and of his altruistic ideas” (15).

Keats began his apprenticeship and took up residence with Hammond in Edmonton. An apothecary-surgeon’s apprentice functioned as a servant, performing duties such as tending to his master’s horses. Keats was also probably responsible for maintaining and cleaning Hammond’s surgery, restocking medicine jars, and delivering medicines to Hammond’s patients (Goellnicht 16). An apothecary-surgeon’s training depended upon the merit and skill of his master. Hammond was a respected and adept surgeon who trained at Guy’s Hospital, one of London’s foremost teaching hospitals, where he was honored with an appointment as dresser to William Lucas Sr., a reputable surgeon (Goellnicht 19). As Hammond’s apprentice, Keats would have observed the practice of surgery and learned to set bones, bandage wounds, pull teeth, apply leeches, perform venesection, and deliver babies. He would have acquired the practical knowledge to identify symptoms and diagnose disease, and he would have learned to compound and administer drugs (Goellnicht 20).

Keats’s time as Hammond’s apprentice did not preclude his interest in literature. While in Edmonton, Keats maintained his connection to Enfield and his friendship with Charles Cowden Clarke, John Clarke’s son, when he would walk several times a week to Enfield and spend the afternoon studying with Clarke (Epstein 52). Epstein writes that it was in these afternoons spent with Clarke that Keats was able to cultivate his interest in literature: “During this period, Keats’s education took, for the first time, a distinctly literary turn. He completed a prose version of Virgil’s *Aeneid*, began reading Spenser,
read Milton and Byron, and Tasso in translation; and, through reading the journalist-poet
Leigh Hunt’s paper The Examiner, which Clarke had introduced to him, became
politicized” (Epstein 52). He wrote his first poem during his years as an apprentice.

Medicine practiced in 1810 was practiced without anesthetics fifty years before
the application of germ theory and the use of antiseptics. Accordingly, Keats would have
been exposed daily to the human agony that accompanied disease and medical care in the
nineteenth century (Goellnicht 20). Keats’s contemporaries and biographers have often
portrayed him as a delicate and emotional individual of weak physical constitution. Percy
Bysshe Shelley’s elegy for Keats, Adonais, although a beautiful and poignant tribute to
Keats, is one such example. Shelley’s preface to Adonais laments the injustice of a
particularly scathing, anonymous review of Keats’s Endymion, which was published in
1818. Shelley was under the impression that the criticisms catalyzed Keats’s physical
decline and death, and that his mind and his emotions were likewise delicate and
alarmingly susceptible to such criticism (Shelley 839). Most scholars and biographers
now reject Shelley’s conclusion, and modern medicine can attest to the communicable
nature of tuberculosis, which Keats probably caught from his brother Tom. However,
Shelley’s Adonais is an enduring (and frequently-anthologized) example of the popular
conception of Keats at the time of his death. The celebrated elegy paints a lasting image
of a man whose genius was both vast and fragile:

‘Oh gentle child, beautiful as thou wert,
Why didst thou leave the trodden paths of men
Too soon, and with thy weak hands though mighty heart
Dare the unpastured dragon in his den?
Defenceless as thou wert, oh where was then
Wisdom the mirrored shield, or scorn the spear?
Or hadst thou waited the full cycle, when
Thy spirit should have filled its crescent sphere,
The monsters of life’s waste had fled from thee like deer. (Shelley 235-43)

In Shelley’s illustration, Keats is a “weak” and “Defenceless” child, who prematurely tested the powers of his genius against the unconquerable “dragon” of unfavorable reception and criticism, which he was unprepared to withstand (235-43).

Goellnicht challenges the popular conception of the fragile poet with Keats’s experiences as a student of medicine: “[Keats] was a normal, healthy boy with strong animal spirits and a fighting will who had seen much disease and death in his own family; he was not the delicate spirit that Shelley portrays in Adonais” (21). Of course, we must allow Keats some complexity and not dichotomize the male character. Keats can be both a man of strength and spirit with a “fighting will” who is simultaneously attuned to the value and legitimacy of his emotions and the feelings of others. Goellnicht’s point is that Keats was not weak as some contemporary accounts suggest; he did not shy away from the darkest elements of human experience, and he cultivated his strength as he cared for the sick.

As Keats completed his apprenticeship with Hammond, the landscape of medical education in Great Britain began to change. Medical education reform at the beginning of the nineteenth century altered the requirements for apothecary training and established a
formal regulatory body. The new Apothecaries Act established in July of 1815 required apothecaries’ apprentices to attend an additional six-month residency at a teaching hospital in order to obtain a license to practice. Licensing for surgeons required a twelve-month residency (Goellnicht 22). According to the new requirements, Keats registered for residency at Guy’s Hospital in London in October of 1815 with the intention of completing the required training for an apothecary-surgeon.

During his residency at Guy’s, Keats attended lectures in anatomy, physiology, chemistry, the theory and practice of medicine, and materia medica, or pharmacology. He attended the lectures of Astley Cooper, who is revered as one of the greatest surgical teachers in Europe at the time of Keats’s enrollment. Students traveled to Guy’s from all over Europe to learn from Cooper, and Cooper helped to establish Guy’s as a famous school of surgery (Goellnicht 26). In addition to attending lectures and taking notes, students at Guy’s were required to observe surgeons and physicians as they made their rounds through the hospital wards and treated patients. As a surgical pupil, Keats was permitted to observe the hospital’s surgeons as they practiced and ask questions (Goellnicht 37).

The surgeons at Guy’s each employed four dressers. The surgeons’ dressers lived in the hospital on rotation, with one dresser living in the hospital and acting as house doctor for a week-long shift. The resident dresser would evaluate and treat patients as they arrived at the hospital. When the attending surgeon arrived, the dresser would refer the patients in need of further evaluation and treatment to the surgeon. The dresser determined which patients were admitted to the wards. Once the patients were admitted, the surgeon began his rounds through the wards addressing the patients’ needs. The
dresser and any other student permitted to observe would accompany the surgeon on his rounds (Goellnicht 37-8). In the case of an emergency on the wards, the resident dresser was responsible for addressing the situation and sending for his surgeon should the emergency require the surgeon’s attention. The dresser would also assist the surgeon as he performed surgeries, dress the patient’s wounds after surgery, and change the dressings as the patient recovered (Goellnicht 39).

Keats was the first student in his class to be appointed dresser. Appointment to the position of dresser was a great responsibility and a great honor. His receipt of a dressership suggests that Keats’s merit as a student earned him the position (Goellnicht 39). Although honorable, the dresser’s job required frequent exposure to the more awful and nauseating aspects of nineteenth-century medicine. Sir William Hale-White, a consulting physician at Guy’s Hospital in the 1930s and one of Keats’s medically focused biographers, describes the conditions Keats and his fellow dressers encountered on a daily basis: “When Keats was dresser almost every wound was or quickly became a foul-smelling, festering sore, the dressing of which had to be frequently changed, often more than once a day” (Hale-White 15). More revolting than the wounds were the operations that produced them. Guy’s maintained one large operating theater where surgeons performed procedures without anesthetics or antiseptics for a teeming audience of eager students vying for a view of the patient (Hale-White 16-17).

Keats was appointed dresser to Billy Lucas, Jr., and began his dressership in March of 1816. Billy Lucas did not practice with the same skill as his colleagues, and his radical and often dangerous surgical techniques resembled butchery (Goellnicht 40). Hale-White describes Lucas as a likeable individual; however, his surgical expertise was
less than admirable: “‘His surgical acquirements were very small, his operations
generally very badly performed and accompanied by much bungling if not worse. He was
a poor anatomist and not a very good diagnoser, which now and then led him into ugly
scrapes’” (17-18). Goellnicht suggests that Lucas’s example probably contributed to
Keats’s decision to leave the medical profession.

As he fulfilled his duties as dresser, Keats also began to develop relationships
with the literary figures who he would eventually regard as friends and who would
influence his poetry. He met Leigh Hunt and Benjamin Haydon and their literary circle in
1816, who eventually introduced him to William Hazlitt and Percy Shelley, and these
men probably influenced and cultivated his interest in poetry as a career (Goellnicht 43).
Keats received his “Certificate to Practise as an Apothecary” from the Licentiate of the
Society of Apothecaries in July 1816 (Goellnicht 41). After the completing the
examination, Keats went on holiday with his brother Tom and later traveled home to ask
his former schoolmaster, John Clarke, for advice. Keats had begun to doubt his interest in
medicine and wondered if his purpose lay in poetry instead (Goellnicht 42). Keats later
revealed to his friend Charles Armitage Brown that his motivation to abandon medicine
originated from his fear of the implications of failure in the medical profession.

Goellnicht references Brown’s biography Life of John Keats, in which Brown recalls a
conversation with Keats about his decision to quit medicine. Keats assured Brown that
his decision was independent of his desire to pursue poetry and was instead derived from
his own fear and conscientiousness. Brown recounts Keats’s justification for his decision:
He ascribed his inability to an overwrought apprehension of every possible chance of doing evil in the wrong direction of the instrument. ‘My last operation,’ he told me, ‘was the opening of a man’s temporal artery. I did it with upmost nicety; but, reflecting on what passed through my mind at the time, my dexterity seemed a miracle, and I never took up the lancet again.’ (43)

Goellnicht reminds his readers of the likely significance of Keats’s dressership under Billy Lucas: “Keats’s fear of failure as a surgeon, of destroying instead of saving life, is perfectly understandable, especially when we remember that in Billy Lucas he had a standing example of the butcher a poor surgeon could be” (44). Keats chose to leave the medical profession in the autumn of 1816; however, he maintained his position as dresser at Guy’s until March of 1817. Keats’s first volume of verse, Poems, was published on the day his dressership at Guy’s ended (Goellnicht 45).

The knowledge and experience Keats obtained as a student of medicine followed him after he left the medical profession. He continued to face personal tragedy, as he cared for his brother Tom, who died of tuberculosis in 1818. Tom began to decline in the winter of 1817-18, and Keats and his brother George shared the duty of tending to Tom. Keats left for a tour in Scotland with Brown in June of 1818 (Hale-White 37). He returned from Scotland in August and resumed his care for Tom, who was in an advanced stage of tuberculosis (Hale-White 37; Epstein 44-5). Keats attended his brother at his residence in Well Walk, and, according to Robert Gittings, he rarely left Tom’s beside (239). Keats wrote to his sister Fanny in late November expressing his concern for Tom’s
condition: “Poor Tom has been so bad that I have delayed your visit hither—as it would have been so painful to you both. I cannot say he is any better this morning—he is in a very dangerous state—I have scarce any hopes of him” (KSL 267). Dorothy Hewlett’s discusses how Keats’s friend Joseph Severn repeatedly offered to relieve Keats of his steadfast attendance during Tom’s worst months and volunteered to sit up at night with Tom so Keats could rest, but Keats would not permit anyone else to assume his place at Tom’s bedside. Hewlett describes the effect of Tom’s decline on Keats:

His face was haggard and his eyes strained: he told Severn he felt his own vitality ebbing away with his brother’s life. Both Severn and [William] Haslam feared that his health might be damaged, and that he might in the end succumb to the same malady. Severn went so far as to press Keats not to live with his brother, to take rooms near by. But he was Tom’s ‘only comfort’ and he never left him. (232)

Tom died on December 1, 1818. Haslam immediately informed George Keats of his brother’s death, and Keats wrote to George and his wife, Georgiana, two weeks later:

The last days of poor Tom were of the most distressing nature; but his last moments were not so painful, and his very last was without a pang—I will not enter into any parsonic comments on death—yet the common observations of the commonest people on death are as true as their
proverbs. I have scarce a doubt of immortality of some nature of [for or] other—neither had Tom. (KSL 269)

The letter explains well enough why Keats was unable to immediately inform his brother of Tom’s death himself, and he undoubtedly required the two weeks to recover from the emotional trauma of witnessing his brother’s slow and painful demise and the physical exhaustion of serving as his primary caregiver. Absent from his letter are any poetic or philosophical ruminations on the significance of human suffering and death. Instead he humbly supplements his brief account with the collective voice of the ‘commonest people’ and offers no comment except to affirm their ordinariness and their accuracy. For Keats, death is neither enlightening nor inspiring, only wretchedly commonplace and thoroughly exhausting.

Keats himself began to show signs of illness shortly after his brother’s death. His letters indicate minor cold symptoms and sore throats, but he began to show signs of tuberculosis and serious bleeding of the lungs in February 1820 (Epstein 62). He returned to the home he shared with Brown in Hampstead on the evening of February 3, and complained of a severe chill. When he coughed blood, he asked Brown to bring a candle so he could better examine the stain: “Brown recalled Keats looking at him with great—I like to think with physicianly—calm and saying: ‘I know the colour of that blood;—it is arterial blood; I cannot be deceived in that colour; that drop of blood is my death-warrant. I must die’” (Epstein 62). Keats diagnosed the severity of his illness long before any physician. The physicians who examined him thereafter repeatedly rejected the conclusion that the disease was of his lungs and assured Keats that his anxious mind was
Nevertheless he was advised to move south in the summer of 1820 and avoid the English winter. He sailed for Italy on September 17, 1820, with Joseph Severn. His arrival was delayed by weather and quarantines, and the trip took more than two months. During the voyage, Keats tended to another passenger, Miss Cotterell, who was also stricken with tuberculosis, with patience and much success, according to Severn. Severn concluded that Keats would have been a fine practitioner if he pursued the career (Goellnicht 46). Dr. James Clarke assumed the care of Keats when he arrived in Rome, although he, too, misdiagnosed Keats’s tuberculosis as stomach trouble (Epstein 63). Keats’s condition worsened, and he suffered from relentless fever and hemorrhaging until he died on February 23, 1821. Dr. Clarke, Goellnicht writes, “was shocked to find [Keats’s] lungs deteriorated when an autopsy was performed, but Keats had known the nature of his disease all along” (46). Keats was buried in the Protestant Cemetery in Rome.

**The Science of Keats’s Poetic Genius**

John Keats, the poet, achieves a new authority when his life is considered through the lens of his medical context. Keats was both a member of the medical profession and a patient. He studied medicine, cared for the sick, and bore witness to unimaginable human suffering. He himself experienced a terrible illness, and his experiences of terminal illness and suffering are well-documented in his own letters and in the accounts of his closest friends. He knew what it meant to suffer, and he knew the burden of those charged with the responsibility to alleviate suffering. Although Keats never formally practiced medicine, the qualities, knowledge, and wisdom he retained as a student of
medicine and as a patient did not go unused during his lifetime. Keats scholars including Donald Goellnicht, Alan Richardson, Stuart Sperry, and Hermione de Almeida have written extensively about the ways in which Keats’s medical education influenced his poetry and his ideas. Keats’s poetry and letters are awash with vocabulary and concepts to which he was probably introduced as a medical student and apprentice, and the tenets of his creative process are imbued with a grasp of the “empirical ethos” taught at Guy’s hospital (Richardson 234).

Donald Goellnicht’s work *The Poet-Physician: Keats and Medical Science* discusses the medical education Keats would have received as a student at Guy’s in 1815 and the ways in which the Guy’s curriculum influenced Keats’s intellectual development and writing. Goellnicht refers to the primary texts and lectures pertaining to chemistry, botany, anatomy, physiology, and pathology that Keats would have been exposed to during his training, and he locates and discusses evidence of scientific influence in Keats’s poetry and letters. During Keats’s lifetime, the paradigm of scientific inquiry began to shift. Prior to the late eighteenth century, scientific knowledge was derived from vague theories that relied on speculation, imaginative analogies, and even superstition. Scientists like Joseph Priestly and Humphry Davy championed the integrity and the necessity of empirically based research, and established the scientific standard of inquiry and accuracy, which required rigorous empirical research and the simultaneous acknowledgement of the limits of human understanding of scientific phenomena (Goellnicht 48–9).

Romanticism, the artistic movement of which Keats was a part, is often understood as being at odds with science and the scientific advancements that took place
at the end of the eighteenth century. Goellnicht acknowledges that the limited empiricism of the new scientific approach conflicted with the Romantic notions of creativity and existence. Romantic poets and thinkers like William Blake believed intuition and imagination to be the keys to any significant explanation of worldly phenomena and the forces and components of life (Goellnicht 49-50). However, many scholars including Richardson argue that efforts to depict Romanticism in conflict with science are narrow-minded and deceptive: “There is an equally misleading tradition of casting the relationship between science and Romanticism as hostile” (230). The Romantic poets’ own words seem to contradict Richardson’s claim. Even Keats may be considered responsible for encouraging the feud between Romanticism and science. Scholars and anthologies often reference the “immortal dinner,” a gathering hosted by Benjamin Haydon in December 1817 that included Keats, William Wordsworth, Charles Lamb, as well as other members of Haydon and Keats’s literary circle (Richardson 49). During the dinner, Richardson writes, “Keats is said to have joined Charles Lamb in drinking ‘Newton’s health, and confusion to Mathematics,’” agreeing that Newton had ‘destroyed all the poetry of the rainbow by reducing it to the prismatic colours’” (231). Richardson also refers to Keats’s narrative poem Lamia as a frequently-referenced example of Romantic distaste for the charmless products of scientific inquiry:

Do not all charms fly
At the mere touch of cold philosophy?
There was an awful rainbow once in heaven:
We know her woof, her texture; she is given
In the dull catalogue of common things.
Philosophy will clip an Angel’s wings,
Conquer all mysteries by rule and line,
Empty the haunted air, and gnoméd mine –
Unweave a rainbow, as it erewhile made
The tender-personed Lamia melt into a shade. (KCP II.229-338)

Keats’s comments at the immortal dinner and his narrator in Lamia articulate a fear for the consequences of an unfeeling scientific reductionism that threatened to diminish the beauty and the mystery of nature the Romantic poets held dear. Richardson suggests that such passages are often taken out of context and cannot account for the multifaceted and complex relationship between science and Romantic literature, especially since, Richardson argues, “the arts and sciences had yet to harden into two distinct cultures” (231).

Goellnicht’s analysis suggests that Keats’s opinion of the shift in science from the theoretical to the practical was more favorable that his Romantic contemporaries. Keats’s poetry was dependent upon analogy and insisted upon the necessity of the imagination, however, his analogies were frequently derived from his knowledge of the sciences: “Ironically, [Keats] adapted analogies from his scientific knowledge to describe aspects of his world of art, whereas previous scientists had adapted analogies from the sphere of the imagination to describe their ‘scientific’ theories of immanence” (Goellnicht 50). The concepts and vocabulary Keats would have learned in chemistry lectures as a student at Guy’s appear in his poetry and letters. Goellnicht explains the ways in which Keats
derived metaphors from chemical terms and theories to explain the subtleties of his creative process. Medical chemistry, Goellnicht writes, “is largely concerned with describing processes of change, combination, decomposition, and refinement,” and “Keats saw these processes as analogous to what occurs when the imagination works on various ideas, sensations, and emotions to produce poetry” (52).

In a letter to Benjamin Haydon on April 8, 1818, Keats writes, “The innumerable compositions and decompositions which take place between the intellect and its thousand materials before it arrives at the trembling delicate and snail-horn perception of Beauty—I know not you[r] many havens of intenseness” (KSL 138). Goellnicht identifies the passage from Keats’s letter to Haydon as similar to the definition of chemistry outlined in Dr. William Babington and Dr. William Allen’s syllabus for a chemistry course at Guy’s, which Keats would have attended. Goellnicht refers to the syllabus definition in his discussion of Keats’s letter: “‘CHEMISTRY therefore defined, The Science of the Composition and Decomposition of the heterogeneous particles of Matter’” (56). Adapting his description of the intellect and the creative process from the chemistry curriculum at Guys, Keats identifies similarities between chemical processes and the creative process. Just as chemical processes involve the composition and decomposition, or the “analysis” and “synthesis”, of heterogeneous particles of matter, which are drawn together by the forces of chemical attraction, so, too, do the observations and the sensations of the poet combine and synthesize within the poet’s imagination to form the new, refined product of poetry (Goellnicht 55-6). The accuracy of Keats’s metaphors and analogies suggests he used his scientific knowledge in his poetry in a deliberate and conscious way, but Goellnicht concedes that there is no way to truly know if Keats
intended to incorporate scientific concepts into his work (53). Deliberate or unconscious, Keats fashions a “perfect metaphor for the workings of the imagination” (56), and the metaphor’s vehicle can be traced to the course materials Keats encountered during his residency at Guy’s.

Keats’s chemical metaphors and analogies are derived from his scientific understanding of the natural world, and his creative process reflects the emerging empiricism in science and medicine in the Romantic era. Astley Cooper was one of Guy’s more persistent advocates of empiricism and practicality in medical science. Epstein quotes Cooper in his article discussing the influence of Keats’s medical education: “‘Nothing is known in our profession by guess,’ remarked Astley Cooper, then the most distinguished teacher at Guy’s, ‘and I do not believe that from the first dawn of medical science to the present moment, a single correct idea has emanated from conjecture alone’” (50). Keats certainly valued intuition in the creative process, but his letters suggest that Cooper’s dislike of speculation and conjecture influenced Keats’s poetry and his understanding of knowledge and experience (Goellnicht 50). As Goellnicht points out, Keats wrote in a letter to George and Georgiana Keats in March 1819, “Nothing ever becomes real till it is experience” (KSL 330). In May 1818, Keats wrote to John Hamilton Reynolds, “axioms in philosophy are not axioms until they are proved upon our pulses” (KSL 151). Keats clearly believed that he could only know the true nature of something if he himself experienced it, and his belief is probably derived from his exposure to Astley Cooper and the new scientific empiricism at Guy’s.

Keats’s poetry reflects his interpretation of experience, especially the physiological experience of emotion. Keats paid frequent attention to the effects and
dynamics of bodily fluids in his poetry, especially blood, tears, and sweat, as they were related to the mind and the body’s physical response to emotion (Richardson 235). Such interaction between the body and the mind were of interest to scientists at the time: “The flush of embarrassment or the trembling of sexual excitement revealed how richly and inextricably thought and feeling, body and imagination were intertwined” (Richardson 235). In Keats’s poem *Isabella; or, The Pot of Basil*, the narrator does not simply describe Lorenzo’s feelings for Isabella but instead reveals them to the reader as a conflict between a body and mind stricken with strong emotions:

> and all day
> His heart beat awfully against his side;
> And to his heart he inwardly did pray
> For power to speak; but still the ruddy tide
> Stifled his voice, and pulsed resolve away –
> Fevered his high conceit of such a bride,
> Yet brought him to the meekness of a child:
> Alas! when passion is both meek and wild! (KCP 41-48)

As Richardson indicates in his analysis of the lines from *Isabella*, Lorenzo is overcome with feelings of love that interfere with his efforts to articulate his sentiments to Isabella. Lorenzo’s love is not a simple emotion, it is a situation of conflict that “arises from a complex system of mental intentions and physiological operations, physical sensations and unconsciousness as well as conscious fears and desires” (Richardson 236). Keats’s
capacity to write eight verses of poetry that convey the complexity of a highly wrought
system of mind and body, consciousness and unconsciousness, is probably adapted,
Richardson argues, from his specific knowledge of human anatomy and the science of the
mind-body connection, specifically the relationship between the heart, the blood, and the
lungs (236). The passage from Isabella is not only evidence of Keats’s medical training,
it contains literary value that is enhanced by the subtleties of its medical undertones.
“Lorenzo’s love for the wealthy Isabella,” Richardson writes, “is rendered more genuine
for the reader by its physiological signs. It is literally proved upon Lorenzo’s pulses”
(236).

In an alternative edition of Isabella, Keats could have easily delivered narration or
fashioned a soliloquy in which Lorenzo proclaims his love for Isabella, and the reader
would have been left to determine the integrity of Lorenzo’s proclamation. Instead, Keats
offers physiological proof of Lorenzo’s feelings for Isabella, and consequently leaves
little room for the readers’ doubts. Keats’s medical education was certainly not wasted on
an intellect intended for the pursuit of poetry. Keats’s poetry is fortified with the
knowledge he acquired as a student of medicine. He incorporated his medical and
scientific knowledge into his poetic genius, rather than allow the two to stand in
opposition, and he did so in a way that was consistent with the shifting paradigm of
scientific inquiry: he allowed his observations of life and the human body to determine
the direction and beauty of his poetry.
THE POET-PHYSICIAN

Charles Brown confirms that Keats’s decision to leave the medical profession was not made for the sake of his pursuit of poetry; however, biographers and scholars, such as Joseph Epstein, often describe Keats’s decision to leave medicine as the product of a clear “skirmish” between his two distinct interests: “It was apparently not in John Keats to keep these same two loves going simultaneously” (Epstein 52). Epstein’s analysis is correct if we only consider the fact that Keats never formally practiced medicine, and, instead of setting up shop as an apothecary, he chose to pursue poetry full-time. However, popular conceptions of the physician and the poet during the Romantic period in England were not as distinct as Epstein suggests. As Hermione de Almeida articulates in her book *John Keats and Romantic Science*, the aims of the poet and the aims of the physician may not have been entirely different during the early-nineteenth century.

The Romantic period is loosely defined as the intellectual movement that began at the end of the eighteenth century and persisted until 1850. Literary scholars begrudgingly recognize British Romanticism as beginning in 1798, with the publication of William Wordsworth and Samuel Taylor Coleridge’s *Lyrical Ballads*, and lasting until 1850, which is the year Wordsworth died. However, myriad scholars and texts contest the true boundaries of the Romantic period, and others deny the existence of boundaries altogether.

The era of biomedical inquiry that occurred between 1800 and 1850, known today as Romantic medicine, is not often remembered with particular fondness or admiration, if it is remembered at all. “Romantic medicine,” de Almeida writes, “has existed as a hiatus in the history of science” (3). In 1956, Iago Galdston wrote that the period is “generally
treated like a pariah among the medical-historical episodes” (346). To consider the biomedical advancements of the Romantic period, however, is to assign little credit to any medical historian who chooses to discredit the significance of the period. The early anesthesia experiments of Henry Hill Hickman, René Laënnec’s invention of the stethoscope, the improvement of microscopic lenses, and Charles Bell’s studies of neuroanatomy are just a handful of examples of influential biomedical inquiry and progress made during the Romantic period (de Almeida 3). Moreover, the turn of the nineteenth century experienced a shift in the paradigm of scientific inquiry as practical and empirical techniques earned priority over the prevailing theoretical approaches to scientific deliberation and discovery.

The new emphasis on practicality was especially persuasive in the medical profession, and its practitioners and professors rejected the theoretical and superstitious conjectures of preceding generations (de Almeida 34). In 1810, Andrew Duncan, Jr., a Scottish physician and professor of medicine at Edinburgh, defined medicine as a “‘human invention and ‘social art’” and identified Hippocrates as medicine’s revived exemplary (qtd. in de Almeida 34). The Hippocratic conception of medicine in the Romantic period placed an emphasis on the practitioner’s “social duty to humanity,” and understood medicine to be both a “humanitarian philosophy” and “practical art” (de Almeida 34). Fortified with its Hippocratic foundations, medicine joined with the other intellectual groups of the Romantic movement to pursue the period’s unifying ambition to understand the significance of life and to be thoroughly engaged with every human faculty in the full depth of its meaning (de Almeida 4). Consequently, the objectives of Romantic philosophers and artists were not considered distinct from the objectives of
Romantic physicians. Both sects of intellectuals were occupied with the common interest of benefiting humanity. Humility was considered the foremost distinction of the good physician, and ethical considerations focused on the physician’s bedside manner and his ability to sympathize with and show compassion for his patients (de Almeida 36). Texts concerned with medical ethics emerged at the end of the eighteenth century, including John Gregory’s lectures on the duties of physicians and Thomas Percival’s code of ethics, which was expanded in 1803 (de Almeida 35-6).

Although it seems that Keats divorced from medicine in favor of poetry when he left the profession in 1817, Keats managed to marry his love of poetry with his love of medicine, and came to understand poetry as a method of healing. During his residency at Guy’s, Keats attended the chemistry and theory of medicine lectures of Dr. William Babington, who was a full physician at the hospital. In his introductory lecture “On Chemistry,” which Goellnicht references, Babington considers the differences between the “Artist” and the “Man of Science”:

The Artist is selfish, for he is constantly labouring for his own interest; he works from imitation & without principle…

The Phylosopher or man of Science is in search of truth in order to make a general application of it to the benefit of his fellow creatures & values his experiments no further than as the[y] tend to the discovery or establishment of some general Law. (qtd. in Goellnicht 51)
Babington’s lecture, Goellnicht writes, is one example of the characteristically philosophical questions scientists and medical professionals were considering at the time of Keats’s education, as they attempted to ground the purpose and the responsibilities of their profession (51). Babington’s philosophical musings are also of great importance to the later considerations of Keats’s own writings and ideas. As Goellnicht and Richardson have illustrated, Keats’s writing is certainly filled with evidence of his medical knowledge, but his poetry and his letters also consider the roles of the scientist and the artist, the poet and the physician. The self-consciousness of the medical profession during the Romantic period is mirrored in Keats’s own self-consciousness, as he considers the poet’s purpose. Goellnicht wonders if Keats would have found fault in Babington’s classification of the artist as a selfish being (52). Goellnicht references Keats’s letter to Shelley in 1820, in which Keats proclaims, “an artist…must have ‘self concentration’ selfishness perhaps” (KSL 548). Keats writes later in the letter, “My Imagination is a Monastery and I am its Monk,” suggesting that an artist must inhabit his own imagination, which would require a certain degree of self-concentration or selfishness. However, in an earlier letter to Richard Woodhouse in 1818, Keats considers the self-less nature of the poet:

A Poet is the most unpoetical of any thing in existence; because he has no Identity—he is continually in for—and filling some other Body—The Sun, the Moon, the Sea and Men and Women who are creatures of impulse are poetical and have about them an unchangeable attribute—the poet has
none; no identity—he is certainly the most unpoetical of all God’s Creatures. (KSL 263)

For Keats, the poet “has no self” and inhabits an existence of self-less-ness, which is constantly open to the natures and selves of the creatures and phenomena the poet observes and depicts in poetry (KSL 263). A poet of true self-less-ness, which Keats calls the “camelion Poet”—I will address this concept in more detail in the following chapter—cannot afford to be selfish, as such an attribute would negatively affect the poetic process and prevent the poet from knowing and articulating the truth and beauty of his subjects (KSL 263). Babington’s assessment of the selfish artist would also conflict with Keats’s altruistic character and contradict his intentions to benefit the lives of others. Keats considered the role of the poet throughout his intellectual lifetime, but, as his short life drew to a close, his designation of the poet appears to solidify in the form of a response to Babington’s assessment of the artist.

Keats abandoned his epic poem Hyperion in April 1819, but he began working on a second poem of similar theme and title in the summer of 1819: *The Fall of Hyperion: A Dream* (Greenblatt, Lynch, and Stillinger 952). *The Fall of Hyperion* recounts the same events of *Hyperion*: both epics were concerned with Greek mythology and the Olympians’ usurpation of the Titans. *The Fall of Hyperion* begins with a frame story of a poet, the poem’s protagonist, who falls asleep and is led in his dream by Moneta, the goddess of memory, through the narrative of the Titans’ defeat (Greenblatt, Lynch, and Stillinger 952). Keats eventually abandoned *The Fall of Hyperion* in September 1819, but the contents of the existing fragment are essential to Keats’s conception of the role of the
poet. In their introduction to Keats’s epic fragment in *The Norton Anthology of English Literature*, Stephen Greenblatt, Deirdre Shauna Lynch, and Jack Stillinger discuss the significance of the frame story in *The Fall of Hyperion*. “By devising this frame story,” they write, “Keats shifted his center of poetic concern from the narration of epic action to an account of the evolving conscience of the epic poet, as he seeks to know his identity, to justify the morality of poetry, and to understand its place in the social world” (952).

Keats was certainly his own example of a poet grappling with the ethicality of poetry and the social responsibilities of the artist. The goddess Moneta poses a question to the poet-protagonist reminiscent of Babington’s skepticism: “What benefit canst thou do, or all thy tribe, / To the great world?” (*KCP* I.167-8). The poet-protagonist responds:

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sure not all

Those melodies sung into the world’s ear

Are useless: sure a poet is a sage,

A humanist, physician to all men. (*KCP* I.187-90)
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Moneta supplements the poet’s appeal to the medicinal qualities of poetry and emphasizes the nature of the true poet, who is a humanist and a visionary who “feel[s] the giant agony of the world” and “pours out a balm upon the world” (*KCP* I.157, 201). Here, in one of Keats’s last poems, the long-contemplated relationship between Keats’s two pursuits of poetry and medicine culminates, and the poet becomes a physician and the physician a poet as both of Keats’s identities make a collective, lifelong effort to alleviate the suffering of humanity.
Goellnicht suggests that Keats’s interest in medicine was primarily influenced by the profession’s altruistic purpose to care for and relieve the suffering of the sick (163). The altruistic motivation of medicine would have been confirmed and emphasized by Keats’s teachers at Guy’s, including Alexander Marcet, who taught chemistry during Keats’s residency. In his book, Some Remarks on Clinical Lectures, Marcet reminds members of his profession to “never lose sight of the primary object of this, and all other hospitals, which is—the relief of suffering humanity” (qtd. in Goellnicht 163). Marcet insisted that health care practitioners must always prioritize the comfort and well-being of their patients as the “principal aim” of every effort and decision (qtd. in Goellnicht 163). And it is from the principally altruistic understanding of medicine that Keats probably adapted his notion of the poet as a healer. Keats had to construct his notion of the poet in accordance with his own altruism and the responsibilities he assumed as a student of medicine:

John Keats, being John Keats, apparently could not do anything out of purely selfish motive, even if he wished. When he left medicine for poetry, Keats tended to regard the latter, poetry, as itself a form of medicine—that is to say, of doing good—by other means. (Epstein 55).

The life of a selfish artist would not satisfy Keats, who had completed six years of training in order to join a profession that placed the needs of others above all else. The purpose of the poet needed to be adjusted in order to imitate the selfless physician.
Apollo, the god of medicine and poetry, provided the perfect inspiration for a poet straddling the arts of medicine and poetry, and, accordingly, Apollo is one of the principal characters in and the “presiding deity” of Keats’s poetry (Goellnicht 164). For Keats, poetry and healing are associated by virtue of Apollo’s dualistic governance, and poetry is repeatedly fashioned as a “healing balm” capable of alleviating pain and mental anguish in Keats’s poetry (Goellnicht 164-5).

In his poem “Sleep and Poetry,” Keats’s narrator resolves to abandon the joys of a poetry concerned only with the beauties and pleasures of life in favor of a “nobler life, / Where I may find the agonies, the strife / Of human hearts” (KCP 123-5). In the lines of verse that follow, the narrator sees Apollo’s approaching chariot descend upon the earth. Apollo encounters a group of people, “Shapes of delight, of mystery, and fear” (138), who are depicted as the embodiment of a spectrum of human emotions and madness. At once, Apollo is among the distorted and raving figures and listens to those who surround him: “Most awfully intent / The driver of those steeds is forward bent, / And seems to listen” (151-3). Drawing inspiration from his encounter with the group of people, Apollo creates poetry, writing down the stories of the people with a “hurrying glow” (154).

Goellnicht wonders if Keats’s image of Apollo listening to and writing about the individuals is derived from the image of a physician recording the medical history of a patient (167). Goellnicht suggests that it is in the example of Apollo that Keats finds inspiration for his “nobler life” of poetry: “Apollo listens to, and sympathizes with his patients; he has found the ‘nobler life’ by understanding ‘the agonies, the strife / Of human hearts,’ the ideal to which Keats aspires” (Goellnicht 167). While it is possible that the “nobler life” to which Keats aspires is medicine—Keats was still a dresser at
Guy’s when he wrote “Sleep and Poetry”—Goellnicht is more convinced that Keats is alluding to the kind of poetry he eventually describes in The Fall of Hyperion, the poetry that “pours out a balm upon the world” (440). Keats aims to produce the genuine kind of poetry that acknowledges and confronts the full spectrum of the human experience and “comes to terms with, and offers relief for, human agony and suffering” (Goellnicht 166). He chooses to pursue the nobler form of poetry rather than delight in the pleasures of “escapist poetry,” which is the poetry of the “dreamers” (162, 198) in The Fall of Hyperion, who “sleep away their days” (151) and remain contentedly ignorant of the world’s troubles. Moneta mistakes the poet-protagonist in The Fall of Hyperion as one of the dreamer poets, who does little to serve and care for humanity, but the poet-protagonist challenges Moneta’s assumption and wonders if he can be a different kind of poet, the poet who is “a sage, / A humanist, physician to all men” (189-90).

Scholars and biographers make a clear chronological distinction between Keats’s life as a medical student and his life as a poet, and agree that, between the fall of 1816 and the spring of 1817, he gradually removed himself from the medical profession. Closer examinations of Keats’s poetic aspirations and the influence of his medical education on his life and poetry reveal that his professional life was anything but dualistic. Keats never formally practiced medicine, but Keats never truly left medicine, at least, not in the sense that he ever abandoned his efforts to benefit the lives of others and to heal.

Epstein reminds his readers that six of Keats’s twenty-five years of life were spent as an apprentice to a respected apothecary-surgeon and as student of medicine at one of Europe’s finest medical schools. Moreover, Keats’s six years of medical training
“represented more than half of his intellectually conscious life” and had a profound effect on his life and creative philosophies, and his poetry (Epstein 58). Keats learned and derived much of his wisdom and his poetic genius from the medical profession and from his experiences as a medical student. It is not unreasonable to propose that the ideas formed in Keats’s writings may, in turn, be of use to those who study and practice medicine.
CHAPTER 3: NEGATIVE CAPABILITY

Keats demonstrated a concern for the nature of the poet and the poet’s role in society throughout his entire poetic career. He was eager to have a positive impact on the world, and desired to achieve “as high a summit in Poetry” as possible in both the realms of creative genius and noble altruism (*KSL* 263). He desired to exemplify the nature of the poet-physician he conceived in *The Fall of Hyperion*, for whom “the miseries of the world / Are misery,” who confronts the suffering inherent to the human condition, and “pours out a balm upon the world” (*KCP* I.148-9, 201). Keats identified the quality that permits a poet or artist the capacity to understand and commune with the beings and creatures who inhabit the earth and manifest and contain a spectrum of experience and existence. He developed an understanding of this quality, which he termed “negative capability,” in his poetry and letters throughout his poetic career, and endeavored to exemplify its features and achieve the elevated degree of insight it yields. Although Keats describes negative capability in the context of his poetic endeavors, this thesis endeavors to expand the influence of Keats’s immortal concept and argues that negative capability is relevant to medical practice, especially the practice of narrative medicine. Before such an argument can materialize, a close examination and explication of negative capability is required. The present chapter traces the development of negative capability throughout Keats’s letters and poetry and considers relevant scholarship that enlightens and expands upon the breadth of its meaning.

**WHAT IS NEGATIVE CAPABILITY?**

What is negative capability? The opening chapter of Li Ou’s book-length explication of negative capability concludes with the broadest statement contained in his
comprehensive study: “Ultimately, negative capability is a way of being, conveying an attitude toward human experience” (22). An equally broad gloss of negative capability might understand it as a theory of creative and intellectual development and achievement, or even a creative philosophy. The *Oxford English Dictionary* identifies the term as a “quality of a creative artist.” I began this thesis with my own summarization of negative capability, identifying the phrase as the human capacity to remain open to and receptive of the ideas and experiences of the world and to the evolving formation of the self. For the purposes of his article “Narrative Medicine and Negative Capability,” Terrence Holt defines negative capability as the “capacity to entertain a schism within one’s identity,” which is derived from the “capacity to suspend especially the foundational certainty of identity” (330-2). Linda von Pfahl’s analysis understands negative capability to be the poet’s creative ability to “expand the self and increase our capacity for understanding” (451). Walter Jackson Bate dedicated his Harvard undergraduate honors thesis to negative capability and published the monograph in 1939. In a later introduction to Keats’s letters for an anthology of criticism, Bate neatly defines negative capability as “the ability to negate or lose one’s identity in something larger than oneself—a sympathetic openness to the concrete reality without, an imaginative identification, a relishing and understanding of it” (*Criticism: The Major Texts* 347).

Themes of identity, experience, openness and receptiveness, uncertainty, sympathy, imagination, and understanding underscore even the most basic descriptions of Keats’s complex term, yet, no two definitions are the same. The irony of this opening paragraph, which I will later demonstrate, is that negative capability resists definition. To make up one’s mind about negative capability, to settle upon a definitive definition, is to
contradict the very essence of the term. Nevertheless, the term has a rich history of influence and cultivation, as it follows the trajectory of its author’s short life. The argument of this thesis requires close analysis of Keats’s development of the repertoire of ideas that comprise negative capability. But no definition, no matter how comprehensive, will ever satisfy the breadth of Keats’s immortal and infinite concept.

John Keats formally entitled the cornerstone of his creative philosophy only once in a letter to his brothers written on December 27, 1817. Keats writes,

several things dovetailed in my mind, & at once it struck me, what quality went to form a Man of Achievement especially in Literature & which Shakespeare posessed [sic] so enormously—I mean Negative Capability, that is when man is capable of being in uncertainties, Mysteries, doubts, without any irritable reaching after fact & reason. (KSL 79)

Keats’s letter is one of many written throughout his lifetime that explores the substance of an artist’s character and identity. As I demonstrated in the previous chapter, Keats’s intellectual pursuits were concerned with the poet’s role in society and his personal role as an aspiring poet of distinction. In a letter to Richard Woodhouse on October 27, 1818, Keats writes, “I am ambitious of doing the world some good” (KSL 263). Pursuit of a career in medicine initially satisfied his altruistic character, and, as a poet, he was determined to construct and pursue the ideal poetical character that complemented his altruistic ambitions. Negative capability is essential to the poet of genius and achievement. Keats began to formulate his distinction of the Man of Achievement, or the
Man of Genius, in a previous letter to his friend Benjamin Bailey on November 22, 1817. To Bailey he writes,

In passing however I must say of one thing that has pressed upon me lately and increased my Humility and capability of submission and that is this truth—Men of Genius are great as certain ethereal Chemicals operating on the Mass of neutral intellect—by [for but] they have not any individuality, any determined Character. I would call the top and head of those who have a proper self Men of Power. (KSL 69)

The character of the Man of Genius has an ethereal quality—a term that is probably derived from Keats’s training in medical chemistry at Guy’s—and resists the formation of a concrete identity. Much has been written about Keats’s use of the term *ethereal* throughout his poetry and letters. Ethereal may refer to ether, the substance thought to inhabit the space between the heavenly bodies and the earth’s atmosphere. *Ethereal* acquires a metaphoric authority in Keats’s poetry derived from the nineteenth-century definition of ether and may describe an object or individual as celestial or heavenly and exhibiting the qualities of a spirit or otherworldly being (Goellnicht 66-7). R.T. Davies was the first to suggest the word might have a chemical origin. Goellnicht references Davies’s explication of Keats’s use of *ethereal*: “Keats uses ethereal in a variety of senses. When applied to physical things and actions it can mean having the insubstantiality and rarity of ether, delicate, refined, volatile. It seems to be derived from Keats’s medical studies in which he would have found ether contrasted with heavy
spirits”” (qtd. in Goellnicht 67). Keats’s understanding of genius is imbued with the knowledge he acquired as a medical student, and the identity of the Man of Genius mirrors the chemical qualities of ether.

But the Man of Genius is not simply ethereal and without identity, or self-less. The identity of a negatively capable individual is fluid and impressionable. It is a state of existence that allows the poet to observe his surroundings and take part in the multitude of life and experiences that occur in tandem with his own. “[I]f a Sparrow come before my Window,” Keats writes in the same letter to Bailey, “I take part in its existence and pick about the Gravel” (KSL 72). To secure negative capability is to acquire the ability to inhabit or fill the identity of another, to take part in its existence, just as the “camelion Poet” is “continually in for—and filling some other Body” (KSL 263).

Walter Jackson Bate places special emphasis on the diction Keats uses to describe his observation of the sparrow: “It is not enough for the artist to view his model—whether a creature or an object—with a generous and warm feeling about the heart. His conception must involve a very active participation in the existence, work, and fortune of the object toward which he has extended his sympathy” (BNC 40). The poet must observe the sparrow and fill its identity, but he must do more. “He must not only become the sparrow,” Bate writes, “but he must work with it” (BNC 40). The poet must take an active part in the sparrow’s experience. The negatively capable poet’s business is one of imagination and sympathy, and Bate highlights these two qualities that are essential to understanding and demonstrating negative capability.

Negative capability is the ability to fill the identity of another, but it also refers to the capacity to receive and be moved by another’s otherness, to fill and be filled by the
identity of another. As Tom lay dying in Well Walk, Keats was his brother’s constant companion. During his months as Tom’s caregiver, Keats became susceptible to the painful nature of Tom’s existence. Keats wrote to his friend Charles Dilke in late September 1818 of Tom’s worsening condition: “I wish I could say Tom was any better. His identity presses upon me so all day that I am obliged to go out” (KSL 237). Tom’s identity, which was colored in 1818 by the pain and suffering of tuberculosis, affects Keats in such a way that he must remove himself from Tom’s presence in order to feel relief, although Tom obtains no such relief from his illness.

In 1818, one of the most creatively prolific years of Keats’s life, Keats’s mind was so saturated with his negative capability that he felt compelled to resist the dangerous outcome of its extreme, which is to drown in another’s pain. To borrow from Aristotle’s virtue ethics, we may understand negative capability as a mean between two extremes. One extreme is apathy combined with aloofness. The other is that which Keats fears: overwhelming personal distress and delusion. Still, the poet of negative capability must seek to understand the “intensity” of the subject he depicts (BNC 48). For Keats, intensity refers to the force of existence within a being or an object. Bate describes this Keatsian intensity as the “concentrated life, force, and meaning of a particular” (BNC 48). “By an intuitive working of the Imagination,” Bate writes, “[the poet] must grasp the life, the force, which is at work within [the poetical subject]; and, through an annihilation of his own identity, become a part of them, and speak out the truth of each” (BNC 47). The poet must recognize and experience the particular and singular condition of another being in a sympathetic act of self-transcendence, which is the pivotal gesture of negative capability.
Keats’s correspondence with Dilke regarding Tom’s health is evidence of Keats’s sympathetic capacity, which is a central feature of negative capability. Negative capability requires strength of imagination, and a strong imagination requires sympathy. Bate suggests that the negatively capable poet’s imagination works to penetrate “the barrier which space puts between it and the object of its contemplation” (BNC 24). The poet overcomes the barrier via “the momentary identification of the Imagination with its object – that is, through sympathy” (BNC 24). The necessity of sympathy is related to the poet’s ability to disregard his own identity for the sake of the identity of the poet’s subject. The poet, Bate writes, must be “passive in character” (BNC 24). Bate references a letter Keats wrote to Reynolds on February 3, 1818: “Poetry should be great & unobtrusive, a thing which enters into one’s soul, and does not startle it or amaze it with itself but with its subject” (KSL 109). Bate suggests that the character of the poet of negative capability is similarly unobtrusive (BNC 24). The negatively capable poet is a passive and receptive being, whose own character recedes as it fills with the identity of its subject, thereby destroying the barrier between the poet and that which is other.

The capacity to be filled with another’s identity grants the poet an expanded perception of life and the true breadth of existence. On October 24, 1818, Keats wrote to George and Georgiana Keats,

I feel more and more every day, as my imagination strengthens, that I do not live in this world alone but in a thousand worlds—No sooner am I alone than shapes of epic greatness are stationed around me, and serve my Spirit the office which is equivalent to a King’s body guard—the
‘Tragedy, with scepter’d pall, comes sweeping by’ According to my state of mind I am with Achilles shouting in the Trenches or with Theocritus in the Vales of Sicily. Or I throw [first written as through] my whole being into Triolus [sic] and repeating those lines, ‘I wander like a lost soul upon the stygian Banks staying for waftage,’ I melt into the air with a voluptuousness so delicate that I am content to be alone. (KSL 258-9)

Fortified with the strength of his imagination, the mind of the poet is at once a fluid, ethereal, and malleable substance that throws itself into the characters it depicts. The subject of a poem is not simply a sparrow or the warrior Achilles, it is the poet’s embodiment of his subjects and the summation of infinite identities impressed upon a single mind.

Keats understood that in order to reap the creative rewards of negative capability, the poet needed to be open and active in the observation and experience of the people, creatures, and elements of nature contained in his poetry. Following the empirical ethos of his instructors at Guy’s, Keats determined that poetic genius could not be “matured by law & precept” and instead required the poet’s commitment to “sensation and watchfulness” and exercise of his powers of observation (KSL 242). In a letter to James Hessey written on October 8, 1818, Keats refers to his poem Endymion: “In Endymion, I leaped headlong into the Sea, and thereby have become better acquainted with the Soundings, the quicksands, & the rocks, than if I had stayed upon the green shore, and piped a silly pipe, and took tea & comfortable advice” (KSL 242). The key to the
authenticity of Keats’s poem is its effort to experience as fully as possible the truth of its subject, and to experience the subject from within.

Keats’s declaration calls to mind the logic of a fellow British Romantic artist, Joseph Mallord William Turner. Turner painted his proto-impressionist, maritime storm-scene, *Snow Storm—Steam-Boat off a Harbour’s Mouth*, in 1842. Turner claimed that in order to capture the true chaos of a storm at sea, he booked passage aboard the steamboat depicted in the image and ordered the crew to tie him to the mast of the ship for the duration of the storm. Scholars debate the factual basis of Turner’s claim, but John Ruskin, Turner’s contemporary and a prominent art critic, recalls a conversation with Turner in which he proclaimed the truth of the incident and described his motivations: “I did not paint it to be understood, but wished to show what such a scene was like; I got the sailors to lash me to the mast to observe it; I was lashed for four hours, and I did not expect to escape, but I felt bound to record it if I did” (qtd. in Butlin and Joli 247). Turner’s painting was poorly received by critics, and Turner angrily muttered in Ruskin’s presence, “What would they have? I wonder what they think the sea’s like? I wish they’d been in it” (qtd. in Butlin and Joli 247). Regardless of the truth of Turner’s encounter with the storm, reports of Turner’s passion and the intensity of his painting demonstrate the need he probably felt to allow the true nature of the storm to fill his imagination. His heated response to his critics is laden with the authority of experience. His critics did not personally experience the snowstorm; they did not lash themselves to the mast of a foundering ship. How could they accurately criticize his depiction of his actual experience? Keats wrote in March 1819, “Nothing ever becomes real till it is experienced” (*KSL* 330). Turner certainly would have agreed that no person can ever
speak with authority about an experience unless they themselves have had the same experience. For Keats, experience grants truth to the artist and the work the artist produces.

Poets with the capacity to receive the truth of experience will, Keats argued, be justly rewarded for their elevated approach to poetry. Bate refers to the reward of negative capability as “poetic insight” (BNC 24). Keats contrasts two kinds of human intellect in a letter to John Reynolds on February 19, 1818; the first form of intellect he compares to a buzzing bee, the second to a flower. Keats favors the latter intellect:

let us not therefore go hurrying about and collecting honey-bee like, buzzing here and there impatiently from a knowledge of what it is to be arrived at: but let us open our leaves like a flower and be passive and receptive—budding patiently under the eyes of Apollo and taking hints from eve[r]y noble insect that favors us with a visit. (KSL 116-7)

What is sought is not a rapid accumulation of knowledge, but a blooming of understanding prompted by the influence of visiting minds. The bee-like accumulation of knowledge is reminiscent of the “irritable reaching after fact & reason” that is the opposite of negative capability (KSL 79). Poetry, Keats argues, should be an unobtrusive entity, “a thing which enters into one’s soul, and does not startle it or amaze it with itself but with its subject” (KSL 109). As Keats’s bee-flower analogy suggests, the poetic subject should be the active being in the poetic equation. The poet is passive; the poet absorbs; the poet receives that which is actively surrounding him. The flower-like
passiveness is equivalent, Bate suggests, to the poet’s sympathetic capacity, as the poet
who acknowledges the miseries and suffering of the world is more likely to assume a
passive and receptive stance, “contemplating with an understanding eye, and feeling with
a sympathetic heart” (*BNC* 34). The negatively capable intellect is essential to the poet’s
manner of observation, as it accounts for a poet’s receptive and fluid identity and allows
the artist to experience and inhabit infinite identities.

In September 1819, Keats discussed the character of Charles Dilke in a letter to
George and Georgiana Keats, concluding that “Dilke was a Man who cannot feel he has a
personal identity unless he has made up his Mind about every thing” (*KSL* 456). Dilke’s
need to have a calculated opinion about everything, a trait that is established in Keats’s
buzzing bee analogy, is a failing of Dilke’s character. Keats argues that such an approach
to knowledge limits the creative intellect. “The only means of strengthening one’s
intellect,” Keats writes, “is to make up ones mind about nothing—to let the mind be a
thoroughfare for all thoughts. Not a select party” (*KSL* 456). Keats concluded that Dilke’s
efforts to acquire knowledge would impede his eventual grasp of truth: “Dilke will never
come at truth as long as he lives; because he is always trying at it” (*KSL* 456). Truth, in
Keats’s mind, appears as a sort of logarithmic function, constantly approaching the
distinct threshold of truth but forever approaching until infinity. The only way to continue
approaching truth is to allow the mind to remain open to the possibilities of sensation and
experience, resist conclusion, and remain “content with half knowledge” and uncertainty
(*KSL* 79). The passive and receptive flower that blooms under the supervision of Apollo,
the god of poetry and the original poet-healer who exemplifies the noblest pursuit of
poetry, is the equivalent of the mind that is a “thoroughfare for all thoughts” (*KSL* 456).
Bate draws parallels between Keats’s statements about Dilke and his earlier discussion of the unobtrusive poetical character. Keats’s critique of Dilke, Bate argues, suggests that he understood Dilke as a man who “approached life with a predetermined conception of it, obtruding his own character and his own views” (BNC 68). According to Keats, the poet, or the man of achievement and genius, should do the opposite; he should negate his identity and recede in the presence of that which is poetical: “The Sun, the Moon, the Sea and Men and Women who are creatures of impulse are poetical and have about them an unchangeable attribute” (KSL 236). The poet has “no identity,” he is the “most unpoetical of all God’s Creatures,” and his poetry should, therefore, startle and amaze with the singularity of its subject and not that of its unpoetical author (KSL 263).

To obtrude one’s identity upon the purity of the poetic subject is to diminish the truth of that subject, which is the poet’s task to convey. “The only way to arrive at truth,” Bate determines, “is to make up one’s mind about nothing—to let the mind be a thoroughfare for all thoughts,’ and to accept man individually, with all the absurdity, pathos, and nobility woven into his every speech, action, thought, and aspiration” (BNC 68). Only through persistent openness of the observational and receptive faculties may the poet successfully penetrate the barrier between himself and the subject whose identity he attempts to inhabit and depict. The barrier will remain between the poet and his subject until the poet achieves a capacity to identify with the subject (BNC 24).

Li Ou suggests that it is through the negatively capable poet’s lack of self-interest, or disinterestedness, that the poet achieves an expanded perception of life and the human condition. The man of genius and achievement who contains negative capability has “no self but metamorphic identities, which furnish him with constant sympathetic
identifications with nature or human beings alike, and a disinterested embrace of disparate or completely opposite aspects of life” (Ou 6). The negatively capable poet does not have to irritably reach after fact and reason or make up his mind about anything, because he delights in all the possible particulars of existence, even if they be contradictory or conflicting. Similar to Bate’s analysis, Ou suggests that the poet’s openness rewards him with a unique poetic insight: “A great poet of negative capability, like the retired flowers ‘budding patiently’ and absorbing from ‘every noble insect’, by disregarding the self-interest of giving or taking and directing the sole attention to the object, opens his poetry to a much vaster realm than the self” (Ou 7). Poetic “[m]agnanimity,” Ou argues, is derived from the negation of the self (7).

Keats’s epistolary deliberation on the nature of the poet culminates in a letter to Richard Woodhouse on October 27, 1818. In his letter to Woodhouse, Keats describes his unique conception of poetic genius as the “camelion Poet” (KSL 263). Keats’s “poetical Character” has no self, “it is everything and nothing—It has no character—it enjoys light and shade; it lives in gusto, be it foul or fair, high or low, rich or poor, mean or elevated—It has as much delight in conceiving an Iago as an Imogen. What shocks the virtuous philosop[h]er, delights the camelion Poet” (KSL 262). The poet’s mind is adaptable and elastic; it revels in the full spectrum of environment and experience. Keats alludes to two of Shakespeare’s characters: Othello’s deceitful antagonist, Iago, and Cymbeline’s virtuous damsel, Imogen. Iago and Imogen represent the skill with which Shakespeare, a man of literary genius whom Keats revered, could depict such diverse but equally authentic characters. Poetic genius is able to inhabit the identity of any being or object: “A Poet is the most unpoetical of any thing in existence; because he has no
Identity—he is continually in for—and filling some other Body—The Sun, the Moon, the Sea and Men and Women who are creatures of impulse are poetical and have about them an unchangeable attribute—the poet has none” (*KSL* 263).

Keats imagined the process of receiving and filling myriad identities as an *annihilation* of his own identity: “When I am in a room with People if I am ever free from speculating on creations of my own brain, then not myself goes home to myself: but the identity of every one in the room begins to to [for so] press upon me that, I am in a very little time an[ni]hilated” (*KSL* 263). Twenty-first century readers might find the term *annihilate* to connote violence and call to mind images of war. I prefer to think of *negation* as a synonym for Keats’s *annihilation* of his identity, as the identities of others press upon him. The negation of the self must take place in order for the mind of the poet to become the “thoroughfare” for all the contents of the identities he encounters and imagines, so he may, in his creative process, as easily conceive an Iago as an Imogen.

John Clubbe and Ernest J. Lovell, Jr. describe the Keatsian camelion Poet as a “being of immense variety and breadth” who “delight[s] in every level of existence” (134). The camelion Poet is motivated by an “expansionist urge to move outside the self, to unite with that which is not-self” (Clubbe and Lovell, Jr. 135). The transformation from ordinary poet to the camelion Poet, the poet of negative capability, requires the enlargement or expansion of the poet’s mind in order to contain all that it must to relish the full spectrum of existence. Keats muses at the end of his letter to Woodhouse that his ideas about the camelion Poet may not be truly his own: “But even now I am perhaps not speaking from myself: but from some character in whose soul I now live” (*KSL* 264). For the poet of negative capability, the contents of the mind and the nature of the self are
indistinguishable and inextricably bound to a state of openness that permits the influence of infinite ideas and identities.

Shakespeare, Hazlitt, and Keats’s Negative Capability

Keats contained within him what A.C. Bradley calls the “Shakespearean strain” (237). The Shakespearean strain, Bradley explains, is twofold. It contains the Romantic pursuit of beauty and truth, or the ideal, and the Romantic urge to praise beauty and convey truth through the purest medium of poetry (Bradley 237). The true tendency of the Shakespearean strain, Bradley writes,

works against any inclination to erect walls between ideal and real, or to magnify differences of grade into oppositions of kind. Keats had the impulse to interest himself in everything he saw or heard of, to be curious about a thing, accept it, identify himself with it, without first asking whether it is better or worse than another, or how far it is from the ideal principle. (237-8)

Keats’s negative capability permits an intellectual and creative aptitude reminiscent of the poet-protagonist’s pursuit of a nobler kind of poetry in “Sleep and Poetry” that confronts the “agonies, the strife / Of human hearts” (KCP 124-5) and the poet-physician of The Fall of Hyperion for whom “the miseries of the world / Are misery,” who “pours out a balm upon the world” (KCP 148-9, 201). The fluid and expansive qualities of Keats’s negatively capable mind are able to contain both the poetic pursuit of the ideal
and the reality of imperfection, human suffering, and hardship. Preservation of the mind’s openness and “natural receptiveness” that “welcomes all the influences that stream upon it” is necessary for the poet’s growth and creative genius (Bradley 220).

Christopher Ricks discusses the depth of Shakespeare’s influence on Keats’s poetry and creative philosophy. Ricks writes, “Shakespeare has soaked Keats’s heart through” (154). Keats’s inheritance of the English poetic tradition, Ricks argues, is central to his creative process, his subject matter, and the extent of his genius. Keats viewed himself within the context of the great English poets, the vanguard of whom was Shakespeare. Keats wrote to George and Georgiana Keats on October 14, 1818, saying, “I think I shall be among the English Poets after my death” (KSL 246). Keats’s prediction, Ricks writes, is free from hubris, and it is symbolic of Keats’s place within the English poetic tradition (168). Keats’s place among the English poets is twofold. His prediction came true, as he is revered as one of the most important poets in the history of the English language. But Keats’s poetry, Ricks concludes, “had always been among [the great English poets],” as it dwelled in the influence of Chaucer, Spenser, Milton, and Shakespeare since its inception, “enjoying their company and having them live again in the life of his allusive art” (168). Alluding to Shakespeare’s *Twelfth Night*, Ricks concludes that “Keats was born great, whatever his social class; he achieved greatness; and he did so because greatness was thrust upon him, by courtesy of his predecessors, their greatness” (154). And Keats devoured the genius of his predecessors, especially the works of Shakespeare and the Shakespearean scholarship of his contemporaries.

Keats began careful and serious study of Shakespeare in the spring of 1817, and he became, as Li Ou describes, a “committed bardolater in the most profound sense”
(55). Ou references Keats’s letter to Benjamin Haydon on May 10, 1817, as the most famous example of Keats’s reverence for Shakespeare (56). Keats’s writes: “I remember your saying that you had notions of a good Genius presider over you—I have of late had the same thought. for things which [I] do half at Random are afterwards confirmed by my judgment in a dozen features of Propriety—Is it too daring to Fancy Shakespeare this Presider?” (KSL 34). Equally flattering is Keats’s determination of Shakespeare as an exemplary of negative capability. Negative capability, Keats determines, is the quality which Shakespeare “possessed so enormously” (KSL 79). At once, Shakespeare is predecessor, presider, exemplar, and the reigning beacon of poetic genius in Keats’s own catalogue of artistic achievement and the nature of the poetical character.

Although he conducted his own study of Shakespeare’s plays and engaged his correspondents in discussions of the bard in his letters, Keats’s fascination with and admiration for Shakespeare found a cornerstone in the scholarship of his friend William Hazlitt. Keats and Hazlitt became acquainted through their mutual association with Leigh Hunt. They remained acquainted until Keats’s death through their overlapping circles, and Keats greatly admired and occasionally sought guidance from Hazlitt (Ou 25).

Between January 13, 1818, and March 3, 1818, Hazlitt delivered a series of lectures at the Surrey Institution in London, many of which Keats attended. The lectures were later published under the title, Lectures on the English Poets. The third lecture in the series is titled “On Shakespeare and Milton.” Hazlitt’s discussion of the genius of Shakespeare both affirmed and influenced Keats’s budding notion of negative capability, which he first articulated in December 1817, the month before Hazlitt’s lecture series began.
Shakespeare was, in Hazlitt’s view, among “the giant sons of genius” (68) and one of the “four greatest names in English poetry,” which included Chaucer, Spenser, and Milton (69). Shakespeare possessed a unique strength of imagination, and his imagination was driven, according to Hazlitt, by a “force of passion, combined with every variety of possible circumstances” (69). Hazlitt declared that the pivotal distinction of Shakespeare’s genius from the genius of the other great English poets originated in “its virtually including the genius of all the great men of his age, and not differing from them in one accidental particular” (70). “The striking peculiarity of Shakespeare’s mind,” Hazlitt writes, “was its generic quality, its power of communication with all other minds—so that it contained a universe of thoughts and feelings within itself, and had no one peculiar bias, or exclusive excellence more than another” (70). Hazlitt imagines Shakespeare’s mind as a plurality, or a storehouse, as it communicates with and absorbs the contents of infinite other minds. Hazlitt continues:

He was just like any other man, but that he was like all other men. He was the least of an egoist that it was possible to be. He was nothing in himself; but he was all that others were, or what they could become. He not only had in himself the germs of every faculty and feeling, but he could follow them by anticipation, intuitively, into all their conceivable ramifications, through every change of fortune or conflict of passion, or turn of thought. (70)
Like the ethereal poetical character associated with negative capability, Shakespeare’s mind has an insubstantial quality. His identity is determined not by himself, but by the selves of others whom he encounters and creates. Emily Dickinson writes, “I dwell in Possibility - / A fairer House than Prose” (1-2). Dickinson conceives of poetry not simply as the literary form that is distinct from prose, but as the very essence of possibility. Hazlitt fashions his understanding of Shakespeare’s genius in a similar manner. The possibility of experience, of human experience, was Shakespeare’s dwelling place, and his mind inhabited the minds of the characters he depicted in his plays and poetry. For Hazlitt, Shakespeare is the “genius of humanity,” whose poetry—or dramatic verse—is the mouthpiece of every human “faculty and feeling” and every frontier of human experience (71). Shakespeare is a dramatic “ventriloquist” who “throws his imagination out of himself, and makes every word appear to proceed from the mouth of the person in whose name it is given” (75).

Elements of Hazlitt’s lecture on Shakespeare bear obvious resemblance to Keats’s evolving development of negative capability, and many scholars have concluded that Hazlitt’s lecture on Shakespeare is one of the primary sources of influence on Keats’s negative capability. Bate writes that Hazlitt’s lecture was both an “expansion and a more definite articulation of what [Keats] himself had felt a month before when he wrote to his brothers” about negative capability and attributed the quality to Shakespeare (28). Bate writes that Keats’s later letter to Woodhouse, in which he describes the camelion Poet, is a more substantial example of the influence of Hazlitt’s lecture on Keats’s view of the poetical character, as he describes a poet of genius as a self-less being, because “he has no Identity—he is continually in for—and filling some other Body” (27 October 1818;
The predecessor of Keats’s camelion Poet appears to be Shakespeare, who is “nothing in himself,” because he is “all that others were, or what they could become” (Hazlitt 70). Moreover, the influence of Shakespeare and Hazlitt on Keats is a manifestation of Keats’s conception of negative capability. Flower-like and receptive, Keats allows the genius of Shakespeare and Hazlitt to press upon and influence of the formation of his own mind, just as the flower is receptive of the passing insects, which may, if we extend the metaphor, pollinate the poet’s mind and prompt its blooming into understanding, so that it may more fully convey the truth of that which it observes.

**NEGATIVE CAPABILITY’S NEGATIVE CAPABILITY**

Keats’s own conception of negative capability is a perpetual working definition. Its definition is perpetually incomplete for at least two reasons: first, Keats died before he ever had the opportunity to establish a concrete definition or compose a coherent treatise of negative capability. Keats’s budding conception is fragmented. The concept itself is a bricolage of scattered paragraphs of letters, studied echoes of contemporary scholarship, and poetic glimpses. One aim of Keatsian scholarship has been to place these fragments in an order that yields a comprehensive, chronological, and intelligible description of negative capability, just as Keats might have done had he lived to be as old as Shakespeare or Wordsworth. Second, negative capability resists definition, because the concept itself exhibits its own negative capability.

As Bradley articulates, Keats had “a strong feeling that a man, especially a poet, must not be in a hurry to arrive at results, and must not shut up his mind in the box of his supposed results, but must be content with half-knowledge, and capable of ‘living in
uncertainties, mysteries, doubts, without any irritable reaching after fact and reason’” (Bradley 235). A large portion of these boxed results must include any sort of conclusion about the nature of the self and the breadth of the poet’s identity. To neatly box up an identity with a presumption of understanding and definition is to limit the possibility of creativity, which is achieved by not making up one’s mind about anything, including the self. So, too, did Keats not hurry to tie down a definition or a concrete understanding of negative capability, as he knew it would limit the complexity of his creative ideal.

Li Ou suggests that one of the key features of negative capability is its constant evolution. However, the evolution is not marked by alteration but by expansion:

Negative capability, therefore, with its development over time, has evolved into a more mature and pregnant conception without contradicting its original central idea of opening the self to the multifarious otherness of the world and human beings. The composite key elements of negative capability may include imaginativeness, experiential and artistic intensity, submission of the self, sympathetic identification, the dramatic quality of the poet, disinterestedness, a neutral intellect tolerating diversity and contradiction, and a tragic vision of human experience, all of which are intricately related to one another. (Ou 8)

Negative capability is constantly evolving and expanding throughout Keats’s life, as he, the flower, is visited upon by the lives and suffering of his loved ones, the buzzing intellects of his friends and literary heroes, and the humanity and earthly phenomena that
surround him. Negative capability is at once a summation of its myriad elements. Bate considers these elements, such as “the implicit trust of the Imagination” and “the Shakespearean quality of annihilating one’s own identity by becoming at one with the subject” (BNC 63). But he views these related elements as “accompaniments or outgrowths” of the primary conception of negative capability, which is, Bate writes,

an acceptance […] of the particular, a love of it and a trust in it; and an acceptance, moreover, with all its ‘half-knowledge,’ of the ‘sense of Beauty,’ of force, of intensity, that lies within that particular and is indeed its identity and its truth, and which overcomes every other consideration, or rather obliterates all consideration.’ (BNC 63)

Ou pushes against Bate’s distinction between the “accompaniments and outgrowths” of negative capability and the true essence of negative capability. Ou writes, “all those ‘accompaniments and outgrowths’ are also parts of the entity” (13). To distinguish a true essence of negative capability is to suggest that there is a true essence of negative capability. But as Ou acknowledges, negative capability is often “treated as a dogmatic principle when it is rather an organic conception that is itself growing all the time” (13). Negative capability is an infinite, ever-expanding repertoire of creative philosophy intended to guide the poetic process. Negative capability resists definition in the same way that the negatively capable poet resists concrete conclusion and is comfortable with “half knowledge” (KSL 79). Perhaps Keats planned to refine his blossoming ideas into a single, polished concept, but he never did, and we must treat negative capability as we
treat Keats, as open and receptive observer of all ideas and experience that may favor him
with a visit, and who stands in awe of the beings and the phenomena that surround and
press upon him.
CHAPTER 4: NEGATIVE CAPABILITY AS AN ETHIC OF EMPATHY

Negative capability, Walter Jackson Bate explains, is achieved through the synchronized engagement of imagination and sympathy. The negatively capable poet’s imagination works to penetrate the barrier between itself and its subject and so achieve a “momentary identification of the Imagination with its object – that is, through sympathy” (BNC 24). Romantic thinkers and artists inherited their intellectual interest in the relationship between the imagination and human sympathetic capacities from eighteenth-century Enlightenment philosophy. Intellectual discourse relevant to the sympathetic imagination, especially the dialogue adopted and perpetuated by William Hazlitt, probably influenced Keats’s development of negative capability. As this thesis moves toward the placement of Keats’s concept of negative capability in the context of narrative medicine and clinical practice, the relationship between negative capability and the sympathetic imagination must be considered. As it requires the openness of a receptive mind and the exercise of the sympathetic imagination, negative capability cultivates a kind of empathy that is as active as it is passive, as inquisitive as it is receptive. The effective empathy of the negatively capable mind is productive and articulate and maintains a transformative quality similar to the nobler category of poetry that confronts the miseries of humanity and “pours out a balm upon the world” (KCP I.201). The empathetic capacity of the negatively capable individual is primed to address and soothe the pain and suffering its subject experiences.
NEGATIVE CAPABILITY AND THE SYMPATHETIC IMAGINATION

On October 8, 1817, Keats declared in a letter to Benjamin Bailey that his poem *Endymion* would be “a test, a trial of my Powers of Imagination” (*KSL* 57). “A long Poem,” Keats continues, “is a test of Invention which I take to be the Polar Star of Poetry, as Fancy is the Sails, and Imagination the Rudder” (*KSL* 57). For Keats, a poet’s imagination is his fundamental creative faculty. The genius and the creative capacity of the negatively capable poet is deeply rooted in the poet’s imaginative capacity. Keats alludes to the connection between his imagination and his negative capability in a letter to George and Georgiana Keats on October 24, 1818: “I feel more and more every day, *as my imagination strengthens* (italics mine), that I do not live in this world alone but in a thousand worlds” (*KSL* 258). Keats’s bolstering imagination precedes his perception of the widening expanse of his mind. The imagination is the faculty that allows Keats to perceive his figurative inhabitance of infinite worlds, or infinite spheres of experience. He finds himself “with Achilles shouting in the Trenches or with Theocritus in the Vales of Sicily,” and he throws his “whole being into Triolus [*sic*]” (*KSL* 258). His imagination allows him to “melt into the air,” his mind transformed into the ethereal substance of his negative capability, and to inhabit the infinite existences of other beings and objects and the worlds of the characters he depicts.

Keats’s conception of the imagination as it relates to negative capability is born out of a larger intellectual dialogue that originates in the eighteenth century. In the negatively capable mind, the process of filling the character and identity of the poetic subject, Bate explains, is facilitated by the imagination: “the character and identity (or ‘truth’) of the object, its essential form and function (or ‘beauty’) are grasped and relished
by the imagination in their full significance” (*Criticism* 348). The exercise of the imagination yields “sympathetic identification” with the poetic subject, and the poet is able to sympathize with his subject and fully experience the particulars of its existence (*Criticism* 348). The sympathetic identification, or imaginative sympathy, Bates identifies in Keats’s works is probably derived from Hazlitt’s exploration of the sympathetic imagination, as Keats regularly attended Hazlitt’s 1818 lectures on the English poets at the Surrey Institution. Scholars, including Devindra Kohli, argue that Coleridge’s works are certainly another source of Keats’s interpretation of the imagination as it relates to negative capability (22). The broader concept of the sympathetic imagination, however, has deeper roots in eighteenth-century philosophy.

For the Romantic poets and critics, Shakespeare exemplified the sympathetic capacity of the imagination, and Hazlitt’s high praise of the genius of Shakespeare’s sympathetic imagination is typical of Romantic criticism. Walter Jackson Bate traces the notion of the sympathetic capacity of the imagination, which occupied a substantial amount of Romantic discourse and thought, to the moral philosophy of the eighteenth century. Bate explains that the characteristically Romantic “insistence that the imagination, by an effort of sympathetic intuition, is able to penetrate the barrier which space puts between it and its object” and enter imaginatively into the object and “secure a momentary but complete identification with it,” is derived from eighteenth-century philosophical discourse (“The Sympathetic Imagination in Eighteenth-Century English Criticism” 144). Bate’s analysis of the sympathetic imagination considers the works of many eighteenth-century philosophers, including William Shaftesbury, Thomas Nettleton, David Hartley, Francis Hutcheson, David Hume, Adam Smith, Dugald...
Stewart, Samuel Johnson, James Beattie, Alexander Gerard, and others. This thesis does not provide the space for a comprehensive review of all relevant eighteenth-century moral philosophies concerned with the sympathetic imagination. I will, however, consider Adam Smith’s conception of the sympathetic imagination outlined in *The Theory of Moral Sentiments*, as I believe it to be relevant to Keats’s creative philosophy and the concept of negative capability.

Smith’s *Theory of Moral Sentiments* interprets sympathy to be derived from the understanding that a person may never fully know the extent or the sensations of another’s suffering by observation only:

As we have not immediate experience of what other men feel, we can form no idea of the manner in which they are affected, but by conceiving what we ourselves should feel in the like situation. Though our brother is upon the rack, as long as we ourselves are at our ease, our sense will never inform us of what he suffers. They never did, and never can, carry us beyond our own person, and it is by the imagination only that we can form any conception of what are his sensations. Neither can [our imagination] help us to this any other way, than by representing to us what would be our own, if we were in his case. It is the impressions of our own senses only, not those of his, which our imaginations copy. (Smith 10-11)

The imagination of the “spectator,” through an act of projective sympathy, must exert itself to enter into the situation of the individual “principally concerned” in order to
approach a more complete understanding of that individual’s pain (Smith 30). We cannot
directly feel the sensations of the principally concerned individual, but, by virtue of our
imagination, we may imagine ourselves into the place of the individual and imagine how
we ourselves would feel if we endured the same circumstances. “By the imagination,”
Smith writes, “we place ourselves in his situation, we conceive ourselves enduring all the
same torments” and “form some idea of his sensations, and even feel something which,
though weaker in degree, is not altogether unlike [his sensations]” (11). The spectator’s
sympathetic imagination approaches the equivalent sensations and distress of the person
who suffers, but it is simultaneously aware of the diluted quality of its imagined
sensations and distress. Smith describes a natural and justified frustration that may
originate from the sympathetic encounter: the spectator can never know the true extent of
the principally concerned person’s suffering, and yet the spectator must endeavor to
understand as fully as possible.

The person principally concerned, Smith explains, is cognizant of the inherent
incompleteness of a spectator’s sympathetic efforts, and yet, the person principally
concerned still yearns for the most complete sympathy: “He longs for that relief which
nothing can afford him but the entire concord of the affections of the spectators with his
own. To see the emotions of their hearts in every respect beat time to his own, in the
violent and disagreeable passions, constitutes his sole consolation” (Smith 30). Spectators
long to share in the suffering of the person principally concerned, and the person
principally concerned longs for those who observe him to share in the true nature of his
suffering. What is required for effective solidary between the spectator and the person
principally concerned is not the equivalency of their shared sensations, but rather the
effort of sharing and communion between two souls. Compassion, Smith writes, “can never be exactly the same with original sorrow,” but the sentiments of the person principally concerned and those of the spectator may “have such a correspondence with one another, as is sufficient for the harmony of society. Though they will never be unisons, they may be concords, as this is all that is wanted or required” (Smith 30-1). Through observation and imaginative sympathy, the spectator achieves a harmony or an agreement of understanding with the person principally concerned, as the sympathetic act is derived from and determined by the original sorrow.

Smith’s conception of sympathy, however, is not simply an act of neutral observation and imagination. To sympathize with another is to make a moral judgment of another’s suffering. The spectator may only enter into the condition of the person principally concerned through the imagination, which allows him to imagine himself in the position of the sufferer and determine how he would respond under identical conditions. But the spectator’s sympathetic capacities are only engaged if the sufferer’s response is similar to the response the spectator imagines he would have under identical conditions: “In every passion of which the mind of man is susceptible, the emotions of the bystander always correspond to what, by bringing the case home to himself, he imagines should (italics mine) be the sentiments of the sufferer” (Smith 12). In order to sympathize, the spectator must make a moral judgment about the appropriateness of the sufferer’s response to distress. Without qualification, Smith’s interpretation of sympathy as a moral judgment is problematic, because it limits the scope of the spectator’s sympathy to his individual conception of suffering and allows the spectator to make subjective predeterminations about how other people ought to suffer or respond to
suffering. However, Smith qualifies his argument with the introduction of the impartial spectator.

Emily Brady describes Smith’s concept of sympathy as having “double movement” (100). The spectator’s sympathetic imagination moves twice as it attempts to enter into the condition of the sufferer. First, it moves into the place of an impartial spectator. From the position of the impartial spectator, it moves into the position of the sufferer, so the moral assessment of suffering is performed not by a biased spectator, but by a neutral, hypothetical Everyman (Brady 100). The intermediate position of the impartial spectator distances (but does not separate) the spectator from any predetermined personal biases relevant to suffering. The act of sympathy remains an act of moral judgment, but it is less problematic because it is done from the position and perspective of an impartial spectator. Yet, while the spectator may base his moral judgment of the sufferer on personal biases, the impartial spectator’s judgment is dependent upon his or her society’s moral norms, which cannot be reasonably generalized to apply to all people in all societies. Samuel Fleischacker notes that the impartial spectator’s entrenched social biases prevent the hypothetical perspective from being truly impartial and diminish the spectator’s capacity to therefore sympathize impartially with all human beings (1).

Keats might allow that Smith’s illustration of the sympathetic imagination approaches the disinterested ideal of negative capability. Yet in the equation of sufferer-spectator, the spectator’s sympathy for the sufferer is nevertheless dependent upon the spectator’s own moral framework, no matter how impartial or relevant to social norms it may be. Negative capability moves beyond sympathy because it moves beyond consideration for the self. The “imaginative openness of mind” and “heightened
receptivity to reality,” both of which Bate identifies as key elements of negative capability, require “negating one’s own ego, or submerging the self-centered consciousness of one’s own identity, in favor of something more important: an awareness and savor of the reality outside us” (Criticism 349). The poetic subject takes precedence over all else.

Keats advocates for an annihilation of the self in the moment of poetic attention and composition. Poetry, he writes, should enter into a soul and not “startle it or amaze it with itself but with its subject” (KSL 109). The poet of negative capability must silence his self-centered consciousness and allow the subject to impart its own truth. Smith’s notion of sympathy is inherently self-centered, because it encourages sympathetic spectators to use their self-centered consciousness as a tool to determine for themselves the nature of another’s suffering. The spectator’s moral identity is the measuring rod of sympathy, rather than the truth of the sufferer’s experience. Negative capability rejects the necessity of measurement altogether and cultivates an openness and receptiveness necessary to elicit and receive the sufferer’s story and to enter into and inhabit the sufferer’s condition.

**SYMPATHY, INPATHY, AND EFFECTIVE EMPATHY**

Leslie Jamison might equate Smith’s sympathy with what she calls “inpathy.” Jamison’s essay “The Empathy Exams” details the complexity and necessity of empathy as it appears (or fails to appear) in personal, professional, and clinical relationships and encounters during illness. Empathy, or sympathy, Jamison writes, is different from inpathy, which is its more self-centered sibling (20). I have chosen to use the terms
sympathy and empathy interchangeably throughout this thesis, although there is a substantial body of literature that considers sympathy and empathy as two distinct sentiments. A longer, more detailed discussion of the sympathetic imagination would warrant more comprehensive exploration of this distinction.

Jamison recalls the September morning when her brother woke up, realized he could not move half his face, and was later diagnosed with Bell’s palsy. Her brother’s illness consumed Jamison, and she found herself caught between empathy and obsession:

I found myself obsessed with his condition. I tried to imagine what it was like to move through the world with an unfamiliar face…I tried to imagine how you’d feel a little crushed, each time, coming out of dreams to another day of being awake with a face not quite your own.

I spent large portions of each day—pointless, fruitless spans of time—imagining how I would feel if my face was paralyzed too. (20)

But Jamison does not understand her fixated imaginings as examples of empathy. For Jamison, her imaginings resemble theft: “I stole my brother’s trauma and projected it onto myself like a magic-lantern pattern of light” (20). Jamison certainly cares for her brother, and she is deeply troubled by his pain and the derangement his condition has probably caused in his life. Initially she confused her theft with empathy: “I obsessed, and told myself this obsession was empathy. But it wasn’t, quite. It was more like inpathy. I wasn’t expatriating myself into another life so much as importing its problems into my own” (20). Earlier in her essay, Jamison explores the etymology of the term
empathy, and explains that empathy comes from the Greek empatheia: em denotes ‘into’ and pathos denotes ‘feeling’ (6). Empathy is also derived from the German Einfühlung (‘feeling into’), which was translated into English in the early twentieth century as empathy (Hodges and Myers 296). True empathy, Jamison recognizes, is the process of entering into the condition of another via imaginative sympathy. Instead, Jamison engaged in a deep imagining of her brother’s condition, but she did so from a selfishly stagnant position. She groped for the imagined truth of her brother’s condition and dragged it back to drape its fabric across her own life. Jamison writes, “I wasn’t feeling toward my brother so much as I was feeling toward a version of myself—a self that didn’t exist but theoretically shared his misfortune” (22). Even within her well-intentioned efforts to empathize with her brother, Jamison inadvertently placed the feelings, reactions, and determinations of her self at the center of her empathetic narrative.

What is necessary for an effective empathizing with her brother, Jamison determines, is that which her partner, Dave, exemplifies as he supports her during her own illness saga. Dave places Jamison at the center of his empathetic efforts: “Dave doesn’t believe in feeling bad just because someone else does. This isn’t his notion of support. He believes in listening, and asking questions, and steering clear of assumptions. He thinks imagining someone else’s pain with too much surety can be as damaging as failing to imagine it” (20). Like Keats, Jamison has learned that the process of imagining oneself into the pain of another has a caveat. As we exercise our sympathetic imagination, as we enter into the pain of another, we risk losing our balance and falling into an imagined version of ourselves afflicted with another’s pain. We make ourselves
vulnerable to the personal distress and delusion that are the extreme ends of empathy, which are hardly empathetic at all. And we risk losing sight of the suffering that initially captured our attention, our desire to understand it, and our productive efforts to alleviate it.

Effective empathy, which is the kind of empathy that steers clear of assumptions and walks the line between imaginative sympathy and inquisitive impartiality, of which Dave is an exemplar, is as active as it is passive:

Empathy isn’t just listening, it’s asking the questions whose answers need to be listened to. Empathy requires inquiry as much as imagination. Empathy requires knowing that you know nothing. Empathy means acknowledging a horizon of context that extends perpetually beyond what you can see. (Jamison 5)

When we empathize with others, we must enter into their conditions with the understanding that we can never fully realize the true extent of their suffering. We can never grasp the full “horizon of context” in which they exist. In our empathy, we must be content with uncertainty and half-knowledge. To reach irritably after the full truth of someone’s experience, to imagine someone else’s pain with too much surety, is to deny the vastness of that person’s experience. Effective empathy requires negative capability.

One misconception about negative capability that could be reasonably determined from Keats’s writings and this thesis, which I now hope to dispel, is that negative capability precludes inquiry, that it is clearly and exclusively synonymous with
passiveness, stagnation, and nihilism. I argue that negative capability requires the quality Jamison requires of empathy. Negative capability directs the poet to be content with half-knowledge, to be like the flower, passive beneath the supervision of Apollo (KSL 116), and to avoid any irritable reaching after fact and reason, as Keats observed Dilke and Coleridge were wont to do. “Dilke,” Keats writes, “will never come at truth as long as he lives; because he is always trying at it” (KSL 456). “Coleridge,” Keats insists in the letter to his brothers in which he describes negative capability, “[…] would let go by a fine isolated verisimilitude caught from the Penetralium of mystery, from being incapable of remaining content with half knowledge” (KSL 79). A “fine isolated verisimilitude caught from the Penetralium of mystery” might be paraphrased as a striking, singular, perhaps incomplete perception of truth that emerges suddenly and unexpectedly from the most profound depths of the mind as it considers the mysteries of the universe. The partial perception sprung from the Penetralium of mystery might, with the careful contemplation of a receptive mind, develop into a more complete understanding of truth. But Coleridge, Keats suggests, passes through the moment of perception without consideration because he is unable to “be in uncertainties, Mysteries, doubts” or reap the creative rewards of entertaining a state of half-knowledge (KSL 79).

Despite his praise of passiveness and receptiveness and the poet’s susceptibility to the identities of the people and objects he observes, which press upon him and fill the negative space of his self with their identities and spirits, Keats understood the poet of negative capability to have dual passive and active qualities of observation. Negative capability, von Pfahl writes, “implies more than passivity; rather it is the ability to do something, i.e., to assume other characteristics as a chameleon does” (455). I argue that
the poet of negative capability does more than simply assume the characteristics of a subject. Negative capability is about cultivating a deeper understanding of the other via an imaginative entering into the condition and perspective of the other, and maintaining an openness to the other as it reveals the truth of itself. The poet must fill and be filled by the identities around him. As it attempts to understand the truth of its subject, the negatively capable mind ebbs and flows, probes and absorbs, as it maintains the tension between inquiry and reception and the tension between the pursuit of knowledge and the reality of uncertainty.

Uncertainty does not discourage the poet of negative capability from immersing himself in the depths of the human condition. Clubbe and Lovell write that the poet of negative capability “thirsts after knowledge, the highest form of which is knowledge of the suffering of the human heart” (140). Keats understood that the poet must confront the suffering of humanity and offer solidarity in suffering. He knew of the necessity of having one’s pain acknowledged and addressed, even if nothing can be done to alleviate it. He knew that his poetic genius would concern itself with all aspects of human life, and his achievement of Shakespearean greatness “would require delving into the dark recesses of the human condition” (von Pfahl 457).

Keats wrote to Reynolds on May 3, 1818, “Until we are sick, we understand not” (KSL 151). At the time, Tom was suffering from worsening symptoms of tuberculosis and Reynolds was recovering from a severe illness. Affected personally by his brother’s illness, Keats is able to empathize with the emotional distress and hopelessness Reynolds feels in the face of his illness: “You say, ‘I fear there is little chance of any thing else in this life.’ You seem by that to have been going through with a more painful and acute
zest that same labyrinth that I have” (KSL 150). Keats knows Reynolds’s direct experience of illness is more acute than his own. As his letter continues, he weaves an analysis of Milton and Wordsworth’s poetry into his postulation on the purpose of human suffering. Wordsworth has, Keats observes, a greater or more palpable “anxiety for Humanity” than Milton and “martyrs himself to the human heart,” which is the “main region of his song” (KSL 150). For this reason, Keats admires Wordsworth as the more profound poet.

Keats conceives of human life as a “large Mansion of Many Apartments” through which the mind moves in a modular fashion along the linear trajectory of life. In 1818, Keats understands that he has moved through only two apartments: the “infant or thoughtless Chamber” and the “Chamber of Maiden-Thought,” in which he now resides (KSL 152). During residence within the Chamber of Maiden-Thought, the cognitive capacities awaken, and the mind delights in the wonders of existence and perception. Gradually the mind matures within the Chamber of Maiden-Thought, the perceptive faculties sharpen, and the complexity of the human experience becomes apparent. The mind becomes aware

that the World is full of Misery and Heartbreak, Pain, Sickness and oppression—whereby This Chamber of Maiden Thought becomes gradually darken’d and at the same time on all sides of it many doors are set open—but all dark—all leading to dark passages—We see not the ballance of good and evil. We are in a Mist—We are now in that state—We feel the ‘burden of the Mystery.’ (KSL 153)
Keats references Wordsworth’s poem *Lines Written a Few Miles above Tintern Abbey*, which was first published in 1798. For Wordsworth and Keats, the “burden of the mystery” describes the uncertainties of human experience and the uncertain purpose of life, which is so often characterized by distress and suffering. The key to Wordsworth’s genius, Keats suggests, is his exploration of the “dark passages” of human life:

To this point was Wordsworth come, as far as I can conceive when he wrote ‘Tintern Abbey’ and it seems to me that his Genius is explorative of those dark passages. Now if we live, and go on thinking, we too shall explore them. he is a Genius and superior to us, in so far as he can, more than we, make discoveries, and shed a light in them. (*KSL* 153)

Wordsworth is undaunted by the dark passages of life and the reality of suffering, and he “think[s] into the human heart” and embraces all of its shades of experience (*KSL* 154). Wordsworth’s explorative efforts lead to a better understanding of or appreciation for the vastness and complexity of the human experience.

Walter Jackson Bate argues that Keats’s sought to emulate Wordsworth’s “anxiety for humanity” and elevate his work to the tier of poetry that confronts the complexity of the human experience and devotes itself to the human heart (*KSL* 150). Keats sought to exemplify the qualities of the “camelion Poet” who attends equally to the “dark side of things” and the “bright one” (27 October 1818; *KSL* 263). He sought to experience the conditions of his subjects from the inside, to throw his imagination into
the beings and phenomena he observed and depicted: “In Endymion, I leaped headlong into the Sea, and thereby have become better acquainted with the Soundings, the quicksands, & the rocks, than if I had stayed upon the green shore, and piped a silly pipe, and took tea & comfortable advice” (8 October 1818: KSL 242). Keats believed that the truth of a life could not be understood from a safe and comfortable distance. Educated in the empirical tradition at Guy’s, Keats understood the value of experience, and the effort and courage required to acquire experience, to throw oneself into experience. “The knowledge and experience thus gained in the world,” Bate writes, “will deepen and enlarge the heart, and will intensify the heart’s capacity to sympathize, understand, and express” (BNC 35).

Keats’s advocacy for a poetic anxiety for humanity and concern for suffering culminates in the Fall of Hyperion. The poem’s speaker, the poet-protagonist, enters the temple where Moneta, the goddess of poetry, resides, and ascends the “immortal steps” of the altar. As the poet-protagonist approaches the altar shrine, Moneta tells him he would have been unable to enter the temple and mount the steps if he had not cultivated an empathetic concern for human suffering. Moneta speaks to the poet-protagonist, telling him,

‘None can usurp this height,’ returned that shade,
‘But those to whom the miseries of the world
Are misery, and will not let them rest. (KCP I.147-149)
All others, Moneta explains, who are unable to feel and empathize with the miseries of the world, are unable to enter the temple and ascend the stairs to the altar shrine, and they perish on the temple floor (KCP I.150-153). Bate views the temple as representative of truth, and “the poet may not enter it until he has ceased to be a ‘visionary,’ recovered from his state of selfish isolation, and acquired an active sympathy with the pain and miseries of the world” (BNC 37). Linda von Pfahl confirms Bate’s interpretation: “only one who intensely feels the pain of others, a poet with the ability to share ‘the miseries of the world,’ has the strength to earn a place at Moneta’s altar” (463). The poet-protagonist’s empathetic capacity, von Pfahl argues, is derived from his negative capability.

Moneta stresses the importance of the difference between the true poet and the dreamer: the poet, she says, “pours out a balm upon the world, / The other vexes it” (KCP I.201-202). The poet’s negative capability, his capacity to enter into the pain of others and feel the “giant agony of the world” (KCP I.157), yields a great responsibility: a “responsibility for healing” (von Pfahl 463). The poet’s negative capability contains normative implications for the poet’s role in the world. Clubbe and Lovell categorize the poetic imagination, which conceives of the miseries of the world, as an ethical imagination: “[Moneta’s] allocution implies clearly that the poetic imagination cannot truly exist unless it is an ethical imagination, feeling alive to the ‘giant agony of the world’” (141). The ethical imagination, Clubbe and Lovell explain, “presupposes that the poet feels empathetically with all that lives,” and can therefore exercise his enlarged capacity to sympathize, understand, and express the toils of every individual he
encounters and create poetry, which has healing powers and is the true work of the poet, who is a “sage, / A humanist, physician to all men” (KCP I.189-190).

Clubbe and Lovell’s ethical imagination is similar to the notion of the moral imagination, which was originally described by Edmund Burke at the end of the eighteenth century in his political essay *Reflections on the Revolution in France* (1790). Burke’s notion of the moral imagination, Russell Kirk explains, describes the “power of ethical perception which strides beyond the barriers of private experience and momentary events” (Kirk 38). In her July 2016 op-ed for the *New York Times*, Jennifer Finney Boylan defines the moral imagination as the “idea that our ethics should transcend our own personal experience and embrace the dignity of the human race” (A19). The individual of negative capability exemplifies the ideal of the ethical or moral imagination, as negative capability is, von Pfahl explains, a “capacity for transcending the self” (543), and, as Clubbe and Lovell explain, an “expansionist urge to move outside the self, to unite with that which is not-self” (135). The expansionist urge for self-transcendence that negative capability cultivates is necessary for poetic creativity, because it allows the poet to imaginatively enter into the condition of his poetic subject and more fully understand the breadth and complexity of the subject’s experience, especially the subject’s experience of suffering.

But the poet of negative capability also knows he may never achieve a full understanding of a person’s suffering, because suffering is a singular experience, and each person experiences pain in his own way. Keats learned from Astley Cooper and his other teachers at Guy’s to be comfortable with scientific uncertainty, and today physicians learn to encounter diagnostic and prognostic uncertainty as they learn to
practice medicine. Practicing physicians are certainly familiar with the tension between the pursuit of knowledge and the reality of uncertainty. Uncertainty is a frequent guest of exam rooms, operating theaters, and laboratories. Uncertainty does not discourage the scientist from hypothesizing or conducting research, nor does it persuade the physician to abandon pursuit of the source of a patient’s mysterious symptoms. Physicians must extend the same willingness and patience to the vastness and uncertainty that characterizes the collective human experience of illness. Illness is an experience that exceeds the sum of its parts. Physicians must be aware of the immensity and unknowability of the illness experience, but they must not be daunted by it, and they must seek to more fully understand a person’s experience of illness so they may demonstrate empathy and provide empathetic care, which is ethical care.

Negative capability is the process of entering into the condition of the other, of opening up oneself and allowing the other to fill the receptive space of the mind with the truth of his or her experience. Negative capability is about steering clear of assumptions, of remaining content with half knowledge, of inhabiting a space of uncertainty while simultaneously engaging the subject in an exercise of exploratory inquiry. The noble category of human beings who concern themselves with the care of the ill must enter into the experiences of their patients and allow their patients to reveal themselves to open and receptive minds, all the while knowing that, although clinicians seek to understand so that they may help and care for those who suffer, they can never fully know the true extent of someone’s experience of illness and suffering, yet they must make every effort to know as fully as possible.
SEEING THE POETICAL IN THE PATIENT

The imagination belonging to the individual of negative capability has the ability to temporarily penetrate the barrier of otherness between itself and the object—the being, natural phenomenon, animal—of its contemplation (BNC 24). The disintegration of the barrier is accomplished “through the momentary identification of the Imagination with its object,” which is a sympathetic imagining of the essence of the subject—its existence, its feelings, its purpose (BNC 24). In order for the individual to maintain such imaginative sympathy, he must remain “passive in character” (BNC 24). He must negate the self; for poetry, Keats writes, “should be great and unobtrusive” and the poet, who has “no identity,” must remain open and passive and allow his mind to be a “thoroughfare for all thoughts” (KSL 109, 263, 456). The momentary suspension of the self and the penetrative power of the imagination are accomplished via the individual’s sympathetic (or empathetic) capacity, his ability to sympathize and identify with his subject.

The reward for the negatively capable individual is what Bate calls “the poetic insight,” or the poet’s capacity to see the true essence and the beauty of his subject. The poetic insight achieved via negative capability is derived from the poetical nature Keats identifies in his poetic subjects. Keats writes to Woodhouse, “A Poet is the most unpoetical of any thing in existence,” but the bodies, objects, and beings that the poet fills as he undertakes the creative process are poetical: “The Sun, the Moon, The Sea and Men and Women who are creatures of impulse are poetical and have about them an unchangeable attribute” (KSL 263). This “unchangeable attribute” of the poetic subject may be paraphrased in Keats’s works and Keatsian scholarship as a subject’s “intensity” or “particular,” that is, the singularity of an object, the “concentrated life, force, and
meaning of the being the poet observes and contemplates” (BNC 48). The poetical nature of an object is that which makes the object a worthy subject of poetry.

For Hazlitt, everything has a poetical quality. The first lecture in his 1818 series on the English poets, “On Poetry in General,” suggests that every object—and certainly every human being—contains poetry: “for all that is worth remembering in life, is the poetry of it. Fear is poetry, hope is poetry, love is poetry, hatred is poetry; contempt, jealousy, remorse, admiration, wonder, pity, despair, or madness, all are poetry. Poetry is that fine particle within us, that expands, rarefies, refines, and raises our whole being” (Hazlitt 2). “Poetry,” Hazlitt writes, “is strictly the language of the imagination” (5) and “the highest eloquence of passion, the most vivid form of expression that can be given to our conception of anything, whether pleasurable or painful, mean or dignified, delightful or distressing” (11). Poetry is at once an element, “a fine particle,” of existence contained within the soul of a being, and it is the product of imaginative sympathy, the articulation of intense observation and contemplation. The purpose of the poet is to identify the poetry within his subject and give eloquence or poetic articulation to his subject’s poetry. Similar to the impression of light upon camera film, the poetical nature of the subject presses upon the sympathetic imagination of the poet, which renders an image, a representation of the truth and beauty of the subject, which is poetry.

To grasp at poetic insight, which is achieved through the imaginative sympathy and passive character of a negatively capable individual, is to recognize the poetical qualities of the lives and existences of one’s subjects—to recognize the poetry within a person, as Anatole Broyard might say. Broyard began writing his essay Intoxicated by My Illness after he was diagnosed with metastatic prostate cancer in 1989. In an exercise of
inverted medical examination, Broyard titles the third section of his essay “The Patient Examines the Doctor.” Broyard observes, “Inside every patient there’s a poet trying to get out” (41). For his physician, Broyard desires a “close reader of illness and a good critic of medicine” with the ability to read the “literature” of Broyard’s life with illness: “My ideal doctor would ‘read’ my poetry, my literature” (40-1). Broyard recognizes the poetry of illness and dying, the poetry contained within the patient as they endure life in extremis. “Dying or illness,” he writes, “is a kind of poetry. It’s a derangement” (41). As the patient-poet attempts to make sense of the derangement of his life, he boils over with poetry, with intensity, with a singular force of life and meaning. Broyard wants his doctor to recognize his poetry:

My friends flatter me by calling my performance courageous or gallant, but my doctor should know better. He should be able to imagine the aloneness of the critically ill, a solitude as haunting as a Chirico painting. I want him to be my Virgil, leading me through my purgatory or inferno, pointing out the sights as we go.

My ideal doctor would resemble Oliver Sacks. I can imagine Dr. Sacks entering my condition, looking around at it from the inside like a kind of landlord, with a tenant, trying to see how he could make the premises more livable. He would look around, holding me by the hand, and he would figure out what it feels like to be me. Then he would try to find certain advantages in the situation. He can turn disadvantages into
advantages. Dr. Sacks would see the *genius* of my illness. He would mingle his daemon with mine. (43)

Broyard describes his ideal physician as someone who will enter into his condition, who will imagine himself into Broyard’s illness experience, and by his efforts be privileged with a greater understanding of what it means to be Anatole Broyard with metastatic prostate cancer and the ability to see the genius, the poetry, the poetical substance of Broyard and his illness. Broyard imagines his physician as Virgil, a poet of epic proportions, who joins Broyard in his survey of and journey through his illness. Broyard’s Sacksian physician-poet imagines himself into Broyard’s illness, bears witness from the inside, and re-presents the circumstances to Broyard as a premise that is, in fact, livable and containing advantages.

In her essay, “The Empathy Exams,” Leslie Jamison performs her own examination and critique of her physicians’ responses to her illness experience. Anticipating both heart surgery for supraventricular tachycardia and an abortion, Jamison struggles with the burden of unilaterally determining her needs and desires: “I needed something from the world I didn’t know how to ask for. I needed people—Dave, a doctor, anyone—to deliver my feelings back to me in a form that was legible. Which is a superlative kind of empathy to seek, or to supply: an empathy that rearticulates more clearly what it’s shown” (15). Jamison seeks from her physician an exercise in re-presenting her situation, a reimagining of her illness.

Prior to her abortion, Jamison calls her primary cardiologist, Dr. M, to tell her about her decision to have an abortion and to ask if her heart condition is relevant to the
procedure. She describes Dr. M’s tone as “harrried and impatient” (14). Jamison shares her decision with Dr. M and waits. She waits to hear a statement of sympathy, an answer representative of Dr. M’s comprehension of Jamison’s unique circumstances. She expects Dr. M to put the pieces of her narrative together, to see in her question her concern for her heart and her concern for how an abortion might complicate her already-complicated medical condition. Instead, Dr. M. responds in the interrogative: “Her voice was cold: ‘And what do you want to know from me?’” (14). Jamison fumbles: “I went blank. I hadn’t known I’d wanted her to say I’m sorry to hear that until she didn’t say it. But I had. I’d wanted her to say something. I started crying. I felt like a child. I felt like an idiot” (14). Jamison is eventually able to ask her question, and her conversation with Dr. M ends.

Later Jamison describes a conversation with Dr. G, the surgeon who performs her heart surgery. The initial surgery is not successful. Dr. G explains that she can elect to have the procedure again, but it might result in the implantation of a pacemaker. Dr. G explains the second surgery and the pacemaker calmly: “He pointed at my chest: ‘On someone thin,’ he said, ‘you’d be able to see the outlines of the box quite clearly’” (17). Dr. G’s calmness and his statement surprises Jamison:

I pictured waking up from general anesthesia to find a metal box above my ribs. I remembered being struck by how the doctor had anticipated a question about the pacemaker I hadn’t yet discovered in myself: How easily would I be able to forget it was there? I remember feeling grateful
for the calmness in his voice and not offended by it. It didn’t register as
callousness. (17)

Jamison recognizes that an empathetic encounter with Dr. G could have gone two ways: in one scenario, he could have identified with Jamison’s horror at the possibility of a pacemaker, inhabited her horror, and held it up to her as a mirror. Instead he was a pillar of calm, which is what Jamison needed him to be: “I needed to look at him and see the opposite of my fear, not its echo” (17). Jamison views Dr. G’s calmness as “assurance,” not empathy, but allows that his assurance may be evidence of his empathy (17). I agree; Dr. G’s assurance is a product of his empathetic identification with Jamison. He is able to quickly identify with Jamison’s situation and her concerns, and he anticipates her response to his prognosis. His delivery of the prognosis is not tinged with his own determination of how Jamison ought to order her priorities. His statement is neutral; it offers information without judgment of Jamison’s impending reaction to the prospect of a visible pacemaker. He anticipates fear and distress, and he simultaneously offers himself as representative of the opposite of her response, an antidote to her fear. Soothed by Dr. G’s calmness, Jamison feels secure and looks toward her second surgery with Dr. G with hope and positivity (17).

Dr. M does not offer herself as an antidote to Jamison’s fear. She is unable or refuses to anticipate Jamison’s needs, and she cannot anticipate Jamison’s burning question: Will her complicated body further complicate an already-complicated choice? Dr. M responds with a question. She holds up a mirror of unknowing tinged with aloofness and antipathy (“And what do you want to know from me”) to Jamison’s own
distressed state of unknowing (14). The outcome of their conversation is negative, as Jamison continues to feel unstable and uncomfortable in her efforts to understand her situation and her needs.

Effective empathy has a transformative quality. It enters into the situation of another, and reimagines the situation, sees its advantages with its disadvantages, sees the truth, even the beauty of the situation, and re-presents or rearticulates the truth in more intelligible and meaningful language, and delivers the rearticulated message back to the person in need of empathy. Jamison is unsure of her situation and her needs. She requires an extra set of eyes to assess and unpack the significance of her situation. Broyard is certainly aware of the subtleties and advantages of his illness. He see the singularity of his experience, the revelation his illness has afforded him, and the revelations it will continue to catalyze. “The patient,” Broyard writes, “is always on the brink of revelation” (44). Broyard wants his physician to witness the revelation, to witness the evolution of his revelation, to see the genius of his illness, and to expand upon the genius with his own witness: “He would mingle his daemon with mine” (43). I understand Broyard’s use of daemon to refer not to the archaic spelling of the Christian demon, but instead to the daemons of Greek mythology and philosophy, which are benevolent or benign divine or supernatural beings. Broyard desires a meeting of his spirit with that of his physician: “I’d like my doctor to scan me, to grope for my spirit as well as my prostate” (45). The clinical encounter and the medical examination must reach beyond the surface of the body. Broyard asks his physician to imagine himself into Broyard’s total experience of illness, to grope for Broyard’s spirit, and allow their spirits to mingle and collaborate and “wrestle with [Broyard’s] fate together” (43).
Broyard does not think he asks his physician for too much: “I wouldn’t demand a lot of my doctor’s time: I just wish he would brood on my situation for perhaps five minutes, that he would give me his whole mind just once, be bonded with me for a brief space, survey my soul as well as my flesh, to get at my illness, for each man is ill in his own way” (44). Broyard believes his physician’s imaginative sympathy or “empathetic witness” to be a necessary element of effective medical care (44). Without his physician’s recognition of his spirit or his soul, Broyard explains, “I am nothing but my illness” (45). When the physician fails to acknowledge Broyard’s whole person—his character, his spirit, and his soul—the physician sees only a body, which is only one variable of the total equation of Broyard’s complex illness experience. The physician performs an act of biological reductionism and ignores Broyard’s protesting spirit and the voices of Frank, Kleinman, and Sontag, who have long declared a truth of the human experience of illness: the self cannot be separated from the ill body, for illness is an experience of the whole person, not just the physical flesh and blood.

Certain doctors, Broyard writes, “give you a generic, unfocused gaze. They look at you panoramically. They don’t see you in focus. They look all around you, and you are a figure in the ground. You are like one of those lonely figures in early landscape painting, a figure in the distance only to give scale” (50). If a physician looks panoramically at his patient, looks with an unfocused gaze at everything but the person in front of him, what is he missing? If a physician, in the process of examination and diagnosis, creates a landscape painting of illness, and recognizes the patient as a mere figure placed on a hill in the distance for scale, the product of four miniscule brushstrokes, what details does he lose? Furthermore, if illness is a singular experience, if
“each man is ill in his own way” as Broyard claims, then what is the value of a generic gaze? Certainly a singular human experience demands equally specific human observation and participation from the person charged with caring for and preserving life. Broyard wonders, “How can a doctor presume to cure a patient if he knows nothing about his soul, his personality, his character disorders? It’s all part of it” (47). It is the total experience, the total human as they walk through the valley of the shadow of illness, not a Cartesian pathology dissociated from a body dissociated from a human being.

A museum visitor might spend an afternoon staring at a landscape painting, some Titian or Claude masterpiece, and never see the small, dark figure in the bottom left-hand corner of the painting staring indistinctly up at a large cliff or cluster of trees. The visitor could stare for hours at the sweeping Baroque mountain-scape and see the strokes of red in the brown cliff face, count the shades of green in the grass, notice the shadow of purple on the distant horizon, but never see the fellow in the corner if he never looks for him. Physicians must look for their patients as keenly as they look for hemorrhage on a CT, probe and grope for tumors, and listen for heart and breath sounds.

When physicians refuse to acknowledge the personhood of the patient, Broyard argues, they discourage the telling of illness stories. Broyard references Virginia Woolf’s essay “On Being Ill”: “Woolf wondered why we don’t have a greater literature of illness. The answer may be that doctors discourage our stories” (52). The patient’s experience of illness and the physician’s limited perception of the patient’s experience of illness represent an incongruity (Broyard 43). “To the typical physician,” Broyard writes, “my illness is a routine incident in his rounds, while for me it’s the crisis of my life. I would feel better if I had a doctor who at least perceived this incongruity” (43). More important
to the patient, however, is not simply the physician’s perception of the incongruity, but the revelation to the patient that the physician does, in fact, perceive. The ill person desires above all else for others to demonstrate an “appreciative grasp of his situation” or an “empathetic witnessing” of the ill person’s whole condition and experience of illness (Broyard 44). Broyard believes a physician’s work would be more gratifying if the physician could gaze directly at his patients and seek out their illness experiences, which may be the crises of their lives. Broyard wonders, “Why bother with sick people, why try to save them, if they’re not worth acknowledging? When a doctor refuses to acknowledge a patient, he is, in effect, abandoning him to his illness” (50). Broyard speaks to the physicians who “systematically avoid contact,” and he advocates for an active acknowledgment of illness and its crises of personhood, an openness to illness stories, and a palpable perception of incongruity. He asks that physicians demonstrate a “willingness to make contact” or, at the very least, “some suggestion of availability” to their patients’ experiences. For Broyard, it is not enough for physicians to only see the physicality of a person, the space a body occupies and its functions. A physician, Broyard argues, must see the completeness, the truth, of a person; the physician must see that which is poetical. Rita Charon wants clinicians to achieve a similar insight and make a concerted effort to listen for their patients’ stories of illness in which they are able to “grasp the plights of patients in all their complexity” (Charon 3), which is nearly identical to Broyard’s desire for a physician who practices a “more total embracing of the patient’s condition” and perceives the incongruity within the clinical encounter (Broyard 41). The poetical insight Bate describes can reveal this elevated perception to physicians, and poetical insight can be achieved through the cultivation of negative capability. The
physician Broyard desires, the clinician Rita Charon aims to educate, is the physician of negative capability.
CHAPTER 5: AN INVOCATION OF KEATS: NEGATIVE CAPABILITY AND NARRATIVE MEDICINE

RETURNING TO NARRATIVE MEDICINE

The practice of narrative medicine calls for the kind of medical practice that is fortified with narrative competence, which is the capacity to recognize, absorb, interpret, and be moved by the stories of illness. In the first chapter of this thesis, I argued that the narrative medicine movement appeared as the natural product of a popular reconfiguration of illness, as postmodern voices rose up to reclaim the patient’s voice as the primary authority in the illness narrative and health care practitioners and scholars responded with efforts to emphasize the necessity of the patient’s story of illness in the clinical encounter.

The work of the narrative medicine practitioner occurs in three stages, or movements: attention, representation, and affiliation. “Any effort to provide health care,” Rita Charon writes, “begins by bestowing attention on the patient” (132). In the state of attention, the clinician achieves a state of passive openness in which she listens to and absorbs the patient’s illness narrative. To illustrate the state of attention, Charon crafts a gorgeous metaphor of the physician’s work as comparable to the systolic and diastolic functions of the heart, to which I alluded in the first chapter:

As I sit in the office with a patient, I am doing two contradictory and simultaneous things. I am using my brain in a muscular, ordering way—diagnosing, interpreting, generating hypotheses that suggest meaning, making things happen. This is the systolic work of doctoring—thrusting,
emplotting, guiding action. At almost the same time or alternating with this systolic work is the diastolic work—relaxing, absorbing, making room within myself for an oceanic acceptance of what the patient offers. In the diastolic position, I wait, I pay attention, I fill with the presence of the patient. The systolic and diastolic movements of the heart together constitute cardiac function, by which the heart acts, and dysfunction of either is catastrophic. (Charon 132)

Attention is the diastolic function of doctoring, in which the clinician conceives of herself as a “vessel” into which the patient may pour the account of his or her suffering (Charon 132). The clinician must “actively mute inner distractions” and engage in an “emptying of self” in order to become an “instrument for receiving the meaning of another” and “concentrate the full power of presence on the patient” (Charon 132). Charon references various contemplative practices that are related to and inform her notion of attention in narrative medicine practice. She refers to practices such as mindfulness, Zen and Tibetan Buddhism, Sufism, Transcendental Meditation, and different forms of yoga as examples of human interest in and exploration of the attentive faculties of the mind, as well as philosophical examinations of the complexity of attention (132). Charon references the work of philosopher Simone Weil on the practices of religious mystics and meditators. According to Weil, a state of “‘[e]xtreme attention is what constitutes the creative faculty in man….Attention alone, that attention which is so full that the I disappears, is required of me’” (qtd. in Charon 132). Charon’s discussion of attention as an emptying of the self and a disappearance of the “I” seems to borrow subconsciously or unconsciously from
John Keats and the language he uses to describe and develop his concept of negative capability. In fact, several scholars have considered the work of Simone Weil as related to Keats’s negative capability (see French and Simpson, 2015; Kekes, 2016; and Shah, 2013). However, Charon’s narrative medicine philosophy makes no mention of Keats or negative capability. Nevertheless, the echoes of Keats’s language in Charon’s writing are worth highlighting.

Keats’s awareness of his annihilated self in the presence of the identities that press upon him is similar to Charon’s explication of attention as an “emptying” or “suspension” of self (Charon 132-3). Charon explains, “By emptying the self and by accepting the patient’s perspectives and stance, the clinician can allow himself or herself to be filled with the patient’s own particular suffering, thereby getting to glimpse the sufferer’s needs and desires, as it were, from the inside” (134). In the state of attention, the clinician allows herself to fill—Charon even places special, italicized emphasis on her word choice—with the patient’s condition. Charon’s choice echoes Keats’s description of the camelion Poet who inhabits the identities of his subjects and is “continually in for—and filling [italics mine] some other Body” (27 October 1818; KSL 263).

Charon imagines the clinician in the state of attention as a ventriloquist: “We clinicians donate ourselves as meaning-making vessels to the patient who tells of his or her situation; we act almost as ventriloquists to give voice to that which the patient emits” (132). Charon’s initial identification of the clinician as the “meaning-making vessel” in the clinical encounter may be problematic, especially if we consider Arthur Frank’s postmodern analysis of illness narratives, as the primacy of the ill person’s voice in Charon’s metaphor appears to be subverted by the more authoritative meaning-making
capacities of the clinician’s voice. But I do not believe Charon is advocating for any act of subversion. Charon identifies the process of attention as similar to ventriloquism because “the patient cannot always tell, in logical or organized language, that which must be told” (132). The patient’s story, Charon observes, may be told in many forms: “these messages come to us through the patient’s words, silences, gestures, facial expressions, and bodily postures as well as physical findings, diagnostic images, and laboratory measurements” (132). In the first chapter of this thesis, I referenced Charon’s account of a patient’s severe abdominal pain. Charon describes her encounter with the woman and how she observed that the gesture the woman made when she spoke of her own pain was the same gesture she made when she described her father’s death from liver failure. In both instances, she wrapped her arms around her abdomen. Charon described her patient’s pattern of body language to her patient, and together they were able to discern a connection between the patient’s abdominal pain and her father’s pain and the grief she felt for the loss of her father (66).

Charon was able to attend to the oral history her patient delivered, and she paid attention to her patient’s body language and how her body language was relevant to the oral history she told of her family medical history and her chief complaint. Charon gave voice to her patient’s mode of physical communication, so she could share her observation and its perceived meaning with her patient. In doing so, she created an open and communicative space in which the patient was better able to understand her pain. She did not subvert her patient’s voice. Instead, she translated her patient’s nonverbal communication into a medium both she and her patient could identify as relevant to her patient’s pain. In the state of attention, the clinician’s task is “to cohere these different
and sometimes contradictory sources of information so as to create at least provisional meaning” (Charon 132). The patient’s story—as it is both verbal and nonverbal—remains the crux of the meaning-making endeavor, but the clinician acts to catalyze the dialogue necessary to determine the truth and the meaning of the patient’s illness experience. Furthermore, the clinician’s contribution to the mutual process of meaning-making is donated (Charon 132). The clinician does not impose her voice or her analyses upon her patient; she offers her observations to her patient, and creates a neutral space in which her patient is able to determine for herself the meaning of her clinician’s observations: “[The patient] looked down at her hands, now in her lap. We were both silent. And then she said, ‘I didn’t know this was about my father’” (Charon 66).

In the poetic representation of a person or object, Keats’s negative capability is also similar to ventriloquism. Recall that William Hazlitt in his Lectures on the English Poets describes Shakespeare as a dramatic “ventriloquist” who “throws his imagination out of himself, and makes every word appear to proceed from the mouth of the person in whose name it is given” (Hazlitt 75). Shakespeare’s ventriloquism is the quality of the “genius of humanity,” which constitutes the unique nature of his poetry, in which he serves as the mouthpiece of every human “faculty and feeling” (Hazlitt 71). Keats aimed to write a similar kind of poetry that was the product of the poet’s capacity to enter into the condition of his subject and witness of the truth of its existence. Keats wanted to write poetry that did not shy away from the dark passages of life and that courageously confronted the “burden of the Mystery” (3 May 1818; KSL 153). To do so, he knew he would need to cultivate a mode of creative expression devoted to the most genuine attention to and representation of his subjects. The camelion Poet is a kind of
ventriloquist. In his October 1818 letter to Richard Woodhouse in which he describes the poetical character as a “camelion Poet,” Keats perceives himself as a mouthpiece through which his subjects may speak during the creative process of composing poetry, or even as he writes to Woodhouse: “But even now I am perhaps not speaking from myself: but from some character in whose soul I now live” (KSL 264). The camelion Poet throws his “whole being into Triolus [sic],” and he becomes the mouthpiece of his character, and Troilus speaks through him, such that the poet’s identity, now replaced with that of his subject, “melt[s] into the air” (24 October 1818; KSL 258).

The goal of the health care practitioner should be to inhabit the voice of the patient as Keats inhabits the voices of his subjects. Such an inhabitation of the patient’s voice resembles Arthur Frank’s postmodern clinical encounter. In practice, the difference between the postmodern approach to illness narratives and patient voice and the modern medical model of illness storytelling is subtle. “The modern experience of illness,” Frank writes, “begins when popular experience is overtaken by technical expertise, including complex organizations of treatment” (5). The patient speaks to the physician, who overthrows the patient’s subjective illness experience with medical language, and the medical narrative becomes the “official story of illness” (FWS 5). Frank calls this exchange of the ill person’s narrative authority for medical care the “narrative surrender” (FWS 6).

In the postmodern clinical encounter, the ill person’s voice is not secondary to the practitioner’s voice. The personal, first-person narrative of the ill person’s illness experience achieves primary authority. As Charon’s example demonstrates, a first-person illness narrative may not be entirely verbal; it may include nonverbal cues, such as body
language and facial expressions. In the state of attention, the clinician’s task is to observe, listen to, and inhabit the patient’s voice in all its forms. Voice is born out of experience. The physician must heed the voice of the patient, not to overthrow it, so that the physician may, in the process and method of care and communion with the patient, more fully represent and attend to the patient’s total illness experience, and achieve, as Broyard imagines, a “more total embracing of the patient’s condition” (41). The patient is, therefore, the chief meaning-maker in the clinical encounter, and the physician serves as a facilitator of the meaning-making process. The goal of the clinician’s attention and facilitation is not simply to generate meaning relevant to ensuing clinical, surgical, or pharmacological action. The clinician’s attention has inherent value, which resides in its efforts to expand the patient’s comprehension of the illness experience and to facilitate the patient’s interpretation of her experiences in a language that she understands.

Charon’s account of attention also invokes Broyard’s Sacksian physician. In the preceding chapter, I argued that Broyard’s ideal physician is a physician of negative capability. I believe Charon’s practitioner of narrative medicine deserve the same categorization. Charon aims to teach clinicians to attend to their patients in a way that allows them to begin to see illness and suffering “from the inside” (134). So, too, does Broyard desire a physician who will meet him and his illness on the inside: “My ideal doctor would resemble Oliver Sacks. I can imagine Dr. Sacks entering my condition, looking around at it from the inside like a kind of landlord, with a tenant, trying to see how he could make the premises more livable” (42-3). As Broyard’s metaphor suggests, the nature of a physician’s attention to a patient determines the clinical action that follows. Broyard’s Sacksian physician-landlord will learn much from his hypothetical
attentive approach to his patient’s condition. He will enter into Broyard’s illness and view it from the inside, from Broyard’s perspective.

The physician-landlord’s resulting determination from his entrance into Broyard’s illness will be to try to “make the premises more livable” (43). The specific determination is not to treat, cure, radiate, or excise Broyard’s cancer, but to improve Broyard’s living conditions. The physician-landlord will acknowledge the issue of “livability” in an illness experience and recognize Broyard’s inhabiting of his illness as an ill person. The physician-landlord’s concern for livability indicates his understanding of and respect for the irreducible, indivisible connection between Broyard and his ill body; Broyard is living, breathing, and existing in illness. “To get to my body,” Broyard writes, “my doctor has to get to my character” (40). Broyard’s character, his identity, and his personal experience of illness shall not be bypassed in the clinical encounter, and Broyard’s ideal physician will not balk at the challenge. Broyard demands that his physician see his inhabiting of the premises of his ill body. The ill body is not an inanimate heap ripe for a physician’s claiming; it contains life, a living, breathing existence from which it cannot be separated. The physician’s task is to perceive that which lives and breathes and to enter into the premises it inhabits.

Broyard’s language of entering appears distinct from Charon’s language of filling, but I argue that a grasp of Keats’s negative capability as relevant to both Broyard’s ideal physician and Charon’s narrative medicine practitioner may bridge the gap between these two distinct sets of language. Negative capability permits a simultaneously active and passive moment of attention in the mind of the observer: the passive openness of a receptive mind and the active exertion of the sympathetic imagination. The poet of
negative capability must fill and be filled by the identities around him. The negatively capable mind maintains an equilibrium of active and passive attention, as it cultivates a deeper understanding of its subject via an imaginative entering into the condition and perspective of the subject and simultaneously maintains an openness to its subject as the subject continues to unfold and reveal the truth of itself. The result of negative capability is the poet’s deep and effective empathetic communion with the poetic subject and a respect for the vastness and complexity of the human experience of suffering.

The physician of negative capability must attend to the identities and experiences of her patients in a similar way. Like the Keatsian poet, the mind of the physician of negative capability must ebb and flow and walk the line between imaginative entering and receptive filling as she attends to the patient’s story of illness. Along this line, the physician of negative capability will perceive the tension between her pursuit of knowledge and understanding and the reality of uncertainty, as the physician of negative capability is motivated to fully embrace the condition of her patient but understands she can never know the full extent of her patient’s suffering. The state of attention in narrative medicine as informed by negative capability requires that the physician enter into the condition of the patient, empty or negate the self, fill with the identity of the patient, and entertain at the same time a degree of uncertainty or unknowing about the true extent of the patient’s illness experience. The physician of negative capability must be “content with half knowledge,” or content with a perpetually incomplete understanding of the patient (27 December 1817; KSL 79). Uncertainty does not preclude the physician’s efforts to attend to and understand the patient’s illness experience. The physician’s attention demonstrates her commitment to her patient and her respect for the
value of her patient’s story and the primacy of her patient’s voice. Moreover, the physician’s attention is necessary for the systolic work of doctoring. Charon writes, “To attend gravely and silently, absorbing diastolically that which the other says, connotes, displays, performs, and means is required of effective diagnostic and therapeutic work,” which is the systolic work of doctoring (134). Attention is required for effective, thorough medical practice that attends to the whole patient.

Negative capability is most useful to narrative medicine philosophy as it may serve as a safeguard to one of the shortcomings of narrative medicine, which is the risk that, in the practice of narrative medicine, practitioners may probe too far into their patients’ personal lives, overstep boundaries of privacy, or make unwarranted assumptions about their patients’ experiences. Christine Mitchell argues that storytelling is not always the appropriate response to illness and suffering. While narrative is usually a universal and salient tendency of human beings, some individuals construct their sense of self and sense of meaning in non-narrative ways (Mitchell S13). Storytelling may not always be therapeutic or even relevant to a person’s experience of illness. Some may not be ready to tell their stories, and others may resist the pressure to use narrative as a mode of understanding or meaning-making. Some may simply not want to share their narratives (Mitchell S13). Mitchell writes, “It can be hard to tell when someone wants to share his or her story and just needs encouragement, time, and understanding and when someone is not ready or needs a more skilled listener” (S13). Narrative medicine or narrative approaches to medical practice are not applicable to every patient.

Criticism of narrative medicine often considers the propriety of narrative medicine practices, particularly those that actively seek out psychosocial or personal
information about patients’ lives. Mitchell praises the benefits of storytelling, but she also wonders about the extent to which health care practitioners can “press the limits ordinarily set by conventions of politeness and privacy” for the sake of narrative inquiry (S14). Mitchell admits to instances of pestering in which she pushed patients’ families to tell more about a situation or dilemma than was initially comfortable for the families.

Nancy M.P. King and Ann Folwell Stanford also express concern for the potentially invasive practices of narrative inquiry and storytelling in clinical practice. A biopsychosocial “reading” of a patient that extends beyond the necessary physical invasion of clinical exams and procedures and probes the personal and emotional aspects of a patient’s illness experience may intrude upon patient privacy and threaten patient autonomy (King and Stanford 186). Some patients may resist their clinicians’ efforts to learn or uncover as much information about patients as possible, and they may “wish to limit and control the information they share” with their clinicians (King and Stanford 188). Patients may doubt their clinicians’ capacity to accurately and appropriately respond to their stories of illness, and they may fear the likelihood of clinicians’ misinterpretation of the complexity of their illness experience:

In their desire to ascertain the true or deeper story of a patient’s life and illness, conscientious physicians may over-read or may impose private interpretations without having a corresponding interpretation from the patient. This monologic method of gathering and interpreting information about patients relies primarily on one-sided reading. It may include patient
input in the way of story, but it does not seek patient corroboration and collaboration in interpreting that story. (King and Stanford 189)

If the physician’s close reading of a patient is meant to parallel the literary scholar’s interpretation of a novel or other work of fiction, then physicians must allow, as literary scholars allow, for the possibility of flawed interpretation. Mitchell writes, “Some stories can be so complex, so important for the person telling them, so painful to hear, that we might ultimately fail to grasp the depth and breadth of stories we have solicited….Our own responses can be morally deficient in ways we should attend to” (S15). Moreover, monologic approaches to patient narratives deny the basic structure of meaning-making in close reading method and the importance of communication and dialogue between patient and physician. In literary analysis, the task of the reader is not to discover the correct truth hidden or embedded within a text, but to engage in the “process of interaction” that occurs “between reader (or auditor) and text (or speaker)” (King and Stanford 191). A text may contain multiple, even contradictory, truths. Without engagement and interaction with a text, readers risk, as the poet Billy Collins imagines, employing forceful and harmful methods of interpretation, such as beating the meaning out of a text with a metaphorical hose (“Introduction to Poetry”). To avoid misinterpretation and monologic hijacking of patients’ stories, King and Stanford propose the use of the “communications triangle,” a model of communication that places the reader, the subject, and the author at the three figurative points of a meaning-making triangle (191). In the clinical encounter, patients may be understood as authors, patients’ stories as subjects, and physicians as readers: “Meaning, then, occupies the ground
between physician, patient, and story and might, in the best worlds, enrich diagnosis, prognosis, and treatment” (King and Stanford 191). The patient’s input in the form of dialogue and the collaboration between physician and patient in the meaning-making endeavor is required.

In the case examples she uses to demonstrate the positive effects of narrative competence in the clinical encounter, Charon often alludes to a distinct revelatory moment, in which the clinician breaks past the superficial barrier between herself and the patient and realizes the key to understanding the patient’s illness experience. The revelation nearly always leads to improved or more empathetic care for the patient. I return to the case example mentioned in the first chapter, in which Charon recounts her care of a woman with severe abdominal pain. Through Charon’s observation of the woman’s subtle but revealing body language, she and her patient realize together that the woman’s pain is related to her grief and her deep, consuming empathy for her father, who had recently died of liver failure (66). In this moment with her patient, Charon certainly engages narrative inquiry in a way that is respectful and attentive the patient and her story. Furthermore, she interacts and collaborates with her patient to deliver her observation of her patient’s body language, which helps her patient to expand upon her understanding of her condition. Although Charon’s case examples exemplify moments of commendable and effective communion between patient and physician, I do wonder to what extent narrative medicine case examples have led practitioners to believe that, in every difficult or uncertain case, there exists some revelatory piece of information the practitioner need only uncover in order to provide the kind of empathetic care illustrated in narrative medicine examples.
King and Stanford critique the narratively inclined clinician’s insensitive or inattentive pursuit of a patient’s “whole story” and advocate for the “respectful but attentive listening and watching of a more dialogic encounter,” a position that rivals Keats’s critique of Dilke and his dislike for the buzzing-bee intellects that reach irritably (and to no avail) after complete and objective truth (196). But the method of pursuit may not be the only troubling aspect of such a clinical encounter. Clinicians may be setting themselves up for failure if they repeatedly insist on seeking or obtaining the entire story of a patient’s illness experience. Illness is a singular experience wrought with uncertainties, contradictions, and sensations and emotions that often defy description or explanation. The true breadth of illness, the whole story of a patient’s illness, will never be revealed to the clinician in its entirety. The clinician cannot truly know what it means to be the patient, no matter the extent of the clinician’s own experiences. A clinician who acknowledges his or her perpetually incomplete knowledge of her patient exemplifies negative capability, and the clinician’s negative capability is required for respectful and empathetic engagement of clinician with patient. With regard to the vastness and complexity of the human experience of illness, clinicians must be able to entertain a state of uncertainty and unknowability and remain confident in their abilities to practice effective and empathetic medicine. When clinicians draw conclusions, understand with too much surety, or make assumptions about the nature of an illness experience, they risk diminishing the true extent of an illness experience in all its rich and complex singularity, which is only truly knowable by the person who is ill. The clinician may not experience a revelatory moment of understanding, the patient may not reveal himself or herself to the clinician in a way that is satisfactory or complete, or the patient may resist the
interpretation a clinician shares with the patient. Clinicians must be content with such instances of unknowing, with half-knowledge, and with the reality of uncertainty.

**THE NEGATIVELY CAPABLE PHYSICIAN: THE CASE OF MR. D**

Mark Siegler’s widely referenced 1977 *Hastings Center Report* article, “Critical Illness: The Limits of Autonomy,” tells the story of Siegler’s memorable encounter with the patient Mr. D. Siegler describes Mr. D, an otherwise healthy, sixty-six-year-old black man, who presented to the hospital with generalized pneumonia in both lungs (12). Mr. D was treated initially with an aggressive regimen of three antibiotics, but his condition worsened the following day. Mr. D’s physicians recommended two diagnostic tests: a bronchial brushing and a bone marrow test. Mr. D refused both diagnostic procedures. Siegler’s team continued to recommend the tests and Mr. D continued to refuse them. He became angry and agitated and eventually began to refuse more basic procedures. A psychiatric evaluation of Mr. D’s decision-making capacity revealed he was not mentally incompetent and was making a rational decision about his care. The psychiatrist believed that Mr. D understood the severity of his illness and his physicians’ reasons for recommending further diagnostic tests, and that he was nevertheless making a rational decision to refuse treatment. Mr. D’s condition worsened, and Siegler determined the next appropriate step was to place Mr. D on a ventilator. Mr. D refused ventilator support. The physicians working on Mr. D’s case were understandably concerned about the fate of their patient and strongly disagreed about Mr. D’s decision-making capacity. As the attending supervising Mr. D’s case, Siegler made one last effort to speak with Mr. D:
I spent two forty-five minute periods at his bedside and explained as clearly as I could the reasons for our recommendations. I said that if he survived this crisis he would be able to return to a normal life and would not be an invalid or require chronic supportive care. During these two sessions, Mr. D was breathing rapidly and shallowly, and he had trouble talking. But everything he said convinced me he understood the gravity of his situation. For example, when I told him he was dying, he replied: “Everyone has to die. If I die now, I am ready.” When I asked him if he came to the hospital to be helped, he stated: “I want to be helped. I want you to treat me with whatever medicine you think I need. I don’t want any more tests and I don’t want the breathing machine.” (Siegler 12)

In his conversations with Mr. D, Siegler makes a sincere effort to anticipate any of Mr. D’s potential or existing fears that may be influencing his decision to refuse medical treatment, just as Leslie Jamison’s physician anticipated her fears about the cosmetic presence of a pacemaker. Siegler’s reassurances have no effect on Mr. D’s decision, so Siegler speaks more frankly about the gravity of the situation and the likelihood of Mr. D’s death. It becomes clear to Siegler that Mr. D’s mind is made up, and there is little else Siegler can do to influence his decision: “I gradually become convinced that despite the severity of his illness and his high fever, he was making a conscious, rational decision to selectively refuse a particular kind of treatment” (12). Siegler accepts Mr. D’s refusal and resolves to honor his wishes. Mr. D continues to deteriorate, and he eventually goes
into cardio-pulmonary arrest. Siegler does not attempt to resuscitate him, and Mr. D passes away.

The case of Mr. D raises many questions about the limits of patient autonomy, especially in the care of the critically ill, which Siegler addresses in the remainder of his article. Several factors contributed to Siegler’s decision to honor Mr. D’s decision to refuse treatment, including his interpretation of Mr. D’s refusal as a rational decision, his confidence in Mr. D’s decision-making capacity, the severe and progressive nature of Mr. D’s illness, the strength and dignity with which Mr. D maintained his conviction, and his general belief in “the rights of individuals to determine their own destinies” (Siegler 13-5). Throughout the article, Siegler stands by his decision to honor Mr. D’s wishes and concludes that it was the right thing to do.

The case of Mr. D is unique to a discussion of narrative medicine because it is starkly non-narrative. As Siegler emphasizes, we know very little about Mr. D, other than the brief description he is given in his medical chart: a “previously health sixty-six-year-old black man” with a “three-day history of sore throat, muscle aches, fevers, chills, cough, sputum production, and blood in his urine” (12). Moreover, Mr. D consistently resists his physicians’ efforts to derive even a rudimentary narrative from his experiences. Mr. D arrives to the hospital without context beyond the history of his chief complaint, and his physicians obtain little information about him during the duration of his stay. Despite his physicians’ efforts, Mr. D maintains a non-narrative relationship with his physicians for the entirety of his medical care.

Although Mr. D’s refusal of the recommended procedures and treatments causes Siegler a great deal of concern and motivates him to try to change his patient’s mind,
Siegler is not preoccupied in his care of Mr. D with Mr. D’s specific reasons for refusing treatment. Siegler makes an effort to change Mr. D’s mind, but he does not doubt the rationality of Mr. D’s decision, nor does he ask Mr. D to explain himself and his decision. Jay Katz imagines he would have handled Mr. D’s refusal in a different way. In his book *The Silent World of Doctor and Patient*, Katz discusses the rare instances in which physicians should not honor their patients’ choices, and he offers a response to Siegler’s article.

Katz is less than satisfied with Siegler’s decision to honor Mr. D’s wishes, and understands Mr. D’s case to be one in which the physician should have the authority to override his patient’s decisions. Katz argues that the inadequacy or absence of a patient’s reasons for refusal may justify a physician’s decision to override that refusal (157). Katz writes, “I might not have deferred to Mr. D.’s wishes, if he had without any explanation persisted in his refusal to undergo diagnostic tests” (157). Katz’s principal issue with Mr. D’s case lies in Mr. D’s inability or refusal to explain his decision in terms Katz can understand. He interprets Mr. D’s silence as an either a concealment of explanation or a complete lack of understanding. Katz explains that he would have insisted on a conversation in which Mr. D’s motivations and values would have become apparent. He fashions his hypothetical response to Mr. D’s silence:

Had I encountered Mr. D., I would have told him that I was puzzled by his refusal to undergo the proposed diagnostic tests. I would have expressed to him my concern and confusion over my lack of understanding of what had led to his decision, as well as my concern and fear of perhaps not having
adequately conveyed to him why I thought that these tests were so
essential to his well-being. (158)

When juxtaposed to the content of Siegler’s two forty-five-minute conversations with Mr. D, Katz’s conversation script emits a self-centered tone. Katz’s immediate goal is to express the concerns, fears, and puzzlements Mr. D’s decision has caused in him. Whereas the goal inherent in Siegler’s conversations with Mr. D is to clarify the purpose of the diagnostic tests and the likely outcome of successful treatment, the contents of Katz’s hypothetical conversation imply that he is more concerned with alleviating his own confusion than learning about Mr. D.

Katz imagines he would persist in his efforts to elicit information from Mr. D, and, if faced with more silence, he might reveal to Mr. D his intentions of ordering the diagnostic tests regardless of Mr. D’s refusal: “I would eventually have been forced to tell him that I might very well order the tests, place him on a respirator, and resuscitate him if he refused to talk to me. ‘There is too much that we both do not understand,’ I would have added, ‘and you must not hide behind silence” (159). Even without the threat of imposing unwanted medical care on the patient, Katz’s approach to Mr. D’s refusal is problematic. Katz makes two careless assumptions about Mr. D’s illness experience. First, he assumes he has a right to know exactly why Mr. D is refusing recommended medical treatment. Second, he assumes that a concrete reason for refusal exists in the first place. Furthermore, Katz begins to obtrude his own uncertainties and misunderstandings on Mr. D’s experience of illness. Katz assumes that his own lack of understanding is indicative of Mr. D’s lack of understanding.
Mr. D becomes a disassembled puzzle missing half of its pieces. Instead of attempting to assemble and make sense of the available pieces, Katz insistently calls for the rest of the puzzle. Siegler is able to derive action-guiding significance from the limited pieces of Mr. D’s story that are available to him. Neither physician can know exactly why Mr. D has refused treatment. In the face of narrative uncertainty, the difference between Siegler and Katz is that Siegler is able to tolerate uncertainty and accept his half-knowledge as relevant and valid, which allows him to honor his patient’s explicit wishes and be content with his decision. The uncertainty and complexity of Mr. D’s case make Katz uncomfortable. He is unable to tolerate the uncertain context of Mr. D’s refusal, so he gropes for an explanation.

To alleviating his confusion and rid his cognitive map of uncertainty, Katz considers two familiar explanations for a patient’s refusal of life-saving medical treatment. Katz imagines Mr. D as a Jehovah’s Witness, or a person whose faith guides his refusal of specific treatment (160). Katz knows that profound religious beliefs are outside the control of any physician who would otherwise save the patient’s life with a blood transfusion. Katz concludes that if Mr. D had revealed his religious persuasion, he would have accepted Mr. D’s decision (160). Katz also alludes to Ruth and Alan Faden’s case of a 57-year-old woman who refused a hysterectomy because she did not believe she was sick. The woman’s physicians soon discovered that she was reluctant to believe her diagnosis because her treating physician was black. Upon engaging in discussions about her diagnosis with a white doctor, she changed her mind and consented to surgery (Katz 160-1). Katz’s allusions suggest that a legitimate reason for refusal probably lies beneath Mr. D’s decision just as the aforementioned reasons influenced the Jehovah’s Witness
and the racist woman’s refusal of medical treatment (although I doubt any 21st century health care practitioner or bioethicist considers racist sentiments a legitimate excuse to refuse medical treatment). Katz makes no effort to condemn the Jehovah’s Witness or the racist woman and their reasons for refusal, but his argument depends upon a pattern of reductive explanation, which is the assumption that beneath every patient refusal of beneficial medical treatment is a single, simple explanation for the refusal. Regardless of Katz’s well-intentioned efforts to obtain it, a neat and tidy explanation for Mr. D’s refusal may not exist, and the existence of an explanation does not oblige Mr. D to share it with his physician.

Although he does not explicitly say so, I believe Siegler does not feel entitled to an explanation from Mr. D. Siegler’s account shows evidence of his profound respect for Mr. D and his desire to honor his dignity and integrity. Siegler concludes his article in awe of Mr. D’s character: “The intellectual and emotional strength necessary to resist the powers of the medical system to persuade and force him to accept what they wanted to offer must have been enormous. He died a dignified death” (15). In the midst of an impossible situation marked by uncertainty, frustration, and concern, Siegler is able to see a beauty in Mr. D’s refusal. He sees the intensity, the life force that burns within Mr. D; he sees that which is poetical, and he stands in awe of his patient. Mark Siegler exemplifies the physician of negative capability, as he is capable of being in uncertainties. He does not allow his half-knowledge to impede his efforts to attend to, honor, and care for his patient. He enters into and allows himself to be filled with the limited and fragmented piece of Mr. D that is available to him. The physician of negative capability does not require a thorough or complete narrative in order to empathize with
and attempt to understand his patient, nor does the prospect of uncertainty and half-
knowledge intimidate him or interrupt his work.

When I was seventeen a horse kicked me in the face and broke my right orbit in
three places. A gaggle of ENTs and ophthalmologists attempted to examine my face in
the emergency room, but I could not open my eye. Between the pain, the morphine, and
my fear for the extent of my injuries, I could not bring myself to open my eyes and
confront whatever damage had been done. The physicians and nurses trying to care for
me and diagnose my injury were understandably frustrated; I was impeding their exam. I
was cognizant of my obduracy and the physicians’ frustration throughout the whole
ordeal, but I was so terrified of the prospect of blindness or some degree of vision
impairment that I kept my eyes shut. The physicians asked me again and again to open
my eyes. I continued to refuse. The interrogative shifted to the imperative, as they
implored with more effort, meeting stubbornness with stubbornness. No one ever tried to
manhandle me or force my eyes open. No one threatened me with the prospect of
permanent damage. But no one ever asked me why my eyes were closed in the first place.

My saving grace was a resident ophthalmologist named Dr. Fletcher. He asked the
right questions. My stubbornness was more intriguing to him than it was frustrating. He
tried once to coax my eyes open, then he asked why I refused to open my eyes. I told him
I was afraid. He asked if I had opened my eyes since I was delivered to the emergency
room. I said no. Finally, he asked, “Are you afraid you won’t be able to see?” I nodded.
He sat down on the edge of my hospital bed. He told me about my CT scans: I had a
blowout fracture to my right orbit. He most frequently encountered my kind of fracture in
basketball players who get jabbed with flying elbows. He had recently treated a fracture like mine. He did not think I was blind, but he was concerned that my vision might be impaired by the entrapment of the delicate muscles and nerves that control eye movement and function. He assured me his team of skilled ophthalmologists would do everything in their power to address and fix any impairment. But before he could make any determinations, he needed to shine a light in my eyes. I agreed.

When I reimagine my encounter with Dr. Fletcher, I imagine he was, at the time, adeptly juggling a set of two robust forces: his pressing duty to perform a thorough examination of my eye and my need for a physician to recognize the crisis taking place on my face. My injury was not purely physical. While I was in a great deal of physical pain, my principal concerns were existential and vain. Would I be blind in my right eye? Would my perception of the world be forever altered? Would my face be permanently misshapen? I believe Dr. Fletcher was aware of my state of crisis. Broyard observes, “To the typical physician my illness is a routine incident in his rounds, while for me it’s the crisis of my life. I would feel better if I had a doctor who at least perceived this incongruity” (43). I was experiencing a crisis, and Dr. Fletcher was experiencing a busy afternoon in the pediatric emergency room, but Dr. Fletcher perceived the incongruity of our conditions. He knew my face was not simply an injury to be examined and diagnosed. The eyes he needed to examine were my eyes. Any recommended surgery would take place on my face. If the eyes are the window to the soul, Dr. Fletcher was trespassing upon the portal of my identity; he knew he needed to tread lightly. I imagine Dr. Fletcher entering into the darkness I had created for myself, and allowing my crisis and my experience to guide his actions. He went beyond a sympathetic identification with
my condition. For hours I had been subjected to the same indifferent demand: *Open your eyes.* Dr. Fletcher changed the language; he flipped the script: *Why not?* He compelled me to explain myself and to begin to confront my reality. But he also showed me he understood that the meaning of my trauma was not wholly his to determine. He could shine a light in my eyes and make a diagnosis, but I would ultimately determine the meaning of that diagnosis.

Dr. Fletcher perceived the incongruity of our situations, but he also demonstrated a familiarity with my particular brand of crisis. My fracture, although not identical to any other fracture in the history of orbital trauma, was familiar to him, and he shared this familiarity with me. He had studied my scans, and my face reminded him of the faces of the basketball players he had treated. His familiarity with my condition was comforting. He was neither condescending nor assuming. I never had the impression that he was making potentially inaccurate generalizations or attempting to rid me of my singularity. Instead, he was approaching my face and my eyes with a reassuring amount of information, which assured me of his abilities as a physician and his care as a human being.

The ENT who visited me after Dr. Fletcher, however, demonstrated a degree of familiarity with my condition that was particularly distressing. The ENT performed his exam, asking me to open my eyes and follow his finger across a plane of white light. He informed me my right orbit was severely damaged. I would need surgery. I couldn’t speak, as my brain wordlessly navigated the space between terror and shock. The ENT attempted to reassure me. He told me about the similar surgery he had years ago. A surgeon had overlaid his orbit with titanium plates. He motioned for me to touch his left
temple. I reached up and gingerly touched the place where bone should have been. Instead I felt the unnatural edges of metal screws beneath his skin. I thought of Frankenstein’s monster with the jagged stitches and metal bolts protruding from his head. I vomited on everything, including the sleeves of the ENT’s white coat.

I remember the delight and bravado with which the ENT talked about his titanium plates, as though his bionic face was one of his most cherished features. Perhaps he thought I would respond to the prospect of my surgery with a similar awe-struck enthusiasm. The surgical fellow eventually assigned to my case displayed a similar kind of delight. Dr. Irina Shapoval had all the superficial qualities of an effective communicator: she maintained eye contact, she spoke directly to me with clarity and confidence, she gracefully answered my questions, and she smiled. Yet, she was menacing. While I folded into myself, faint with fear and dread, tears welling in my undamaged eye, terrified of the prospect of eye surgery, she was filled with unmasked, shameless delight. I was horrified. I was horrified that I was so gravely injured by a horse. I had spent my entire life around horses, and in a matter of seconds my sanctuary had transformed into a nightmare. I was horrified with myself. How could I be stupid enough to walk so close the back end of a mother-horse with her foal? I feared for my sight, that I might never regain full function of my eye. I was terrified of my imminent surgery. I had never undergone surgery before; I had never been put under anesthesia. What if I had a bad reaction? What if my heart stopped? What if the surgery failed? I was terrified of the outcome. I was terrified of the scars the surgery would leave on my face.
I was horrified, and Dr. Shapoval was delighted. She was utterly delighted to be performing my surgery. Her eyes were bright, the corners of her mouth upturned. I recognized her expression, the excitement in her voice. I imagined this was the way I appeared to others when I described my recent college acceptance. She was thrilled. For Dr. Shapoval, my surgery was an opportunity, her opportunity to obtain coveted surgical experience, to perfect a certain suture technique. I was needlepoint pattern. I was the raw material for her masterpiece. As she spoke, I imagined the glee filling her eyes as she sliced through my face. Dr. Shapoval and the ENT could not perceive the incongruity of our circumstances, nor were they aware of the damage their ignorance was causing. Neither physician could entertain the possibility that I was feeling something other than delight or enthusiasm at the prospect of surgery, and their inability to imagine preemptively intimidated and silenced any protestations or dissenting emotions that filled my brain and colored my experience.

Dr. Fletcher successfully and unobtrusively exercised his powers of imagination and effective empathy. In “The Empathy Exams,” Dr. G presents himself as an antidote to Leslie Jamison’s fear in her moment of crisis. Dr. Fletcher’s gentle confidence achieved a similar effect in the face of my overwhelming uncertainty, as he was able to provide the information and the encouragement I needed to confront my fears and move forward. Neither he nor I knew what challenges would present themselves in an ensuing eye exam. But instead of struggling against uncertainty or attempting to squelch it or obtrude upon it with his own sentiments, Dr. Fletcher chose to dwell in that uncertainty with me. He perceived the incongruity between his experience of the routine and my experience of disorder, and he stepped into my crisis. Effective empathy allowed him to
move beyond a sympathetic identification with my condition. He shared as much information he could, knowing he could never completely alleviate my dread of the unknown, but nonetheless offering himself as an antidote to my fear. He began to assemble the puzzle of my crisis. He began to work with the pieces available to him, rather than demanding the complete version. Most importantly, he shared his half-finished work with me. Sharing transformed into dialogue, as I was given the space to consider and confront the fear that impeded the progression of my care. I wonder if Mark Siegler had shared his observations about Mr. D’s character—his conviction, his soundness of mind, his dignity and integrity, his steadfastness in the face of unrelenting pressure—with Mr. D, perhaps a more substantive dialogue relevant to Mr. D’s refusal of treatment could have cultivated a more substantive understanding between the two men.

The negatively capable mind maintains a productive tension between passive receptiveness and active inquiry, and demonstrates a quality of observation and understanding that allows the observer to engage in an imaginative entering into the condition and perspective of its subject while maintaining an openness to the subject as its reveals the truth of itself. I believe Dr. Fletcher exemplified the quality of negative capability as he cared for me. Unlike his colleagues, he avoided making assumptions about the nature of my experiences. He paused and entered the space of uncertainty I inhabited, and understood that my refusal was the product of my fear and not a deliberate stubbornness intended to frustrate my physicians. From this perspective, he made an effort to include my voice in the ensuing dialogue and engaged with me in an exercise of explorative inquiry, which revealed the extent of my fear. The dialogue was beneficial to
us both, as Dr. Fletcher was able to effectively share in my uncertainty and offer a conceivable solution, and I was able to trust him and open my eyes.
CHAPTER 6: CONCLUSION

The narrative medicine movement advocates for a method of clinical practice fortified with the narrative competence to receive, absorb, interpret, and be moved by the stories of illness. Through training in literary methods, such as close reading and reflective and creative writing, practitioners of narrative medicine are better equipped to attend to and empathize with their patients as they experience the complexities and hardship of illness. A popular reconception of illness in the last thirty years has driven a narratively inclined approach to medicine, as the ill have striven to reclaim the authority of their voices in the stories of their illnesses. Narrative medicine practitioners and scholars argue that clinicians’ more engaged attention to a respect for patients’ stories of illness in the clinical encounter leads to more empathetic, ethical, and effective care.

As it continues to explore the relationship between literature, narrative, and clinical practice, narrative medicine ought to consider an invocation of John Keats. Narrative medicine theory, especially its explication of the state of attention in the clinical encounter, shares similar language with the language John Keats used to describe negative capability. Furthermore, Keats’s ideas about the poetical character can inform clinical practice as clinicians endeavor to more fully empathize with their patients and cope with the myriad uncertainties that may arise during the diagnosis and care of a patient. John Keats is worthy of the medical profession’s attention, and he is certainly worthy of study by narrative medicine practitioners and scholars.

The most glaring weakness of this thesis is its lack of explicit, prescriptive content or any empirical evidence to support the clinical value of narrative medicine practiced
with negative capability. Rita Charon, Nellie Hermann, and Michael J. Devlin have identified a growing number of outcome studies and qualitative research projects that demonstrate the value of narrative medicine practices (346). But there is certainly a need to continue and expand upon the empirical investigations of the efficacy and validity of literary method in clinical practice.

The intention of this thesis is to identify and explicate the similarities between elements of narrative medicine theory and Keats’s quality of creative genius, and to determine the ways in which an understanding of negative capability can guide narrative medicine beyond its present theory. In his short life, Keats was, in addition to his identity as a poet, a medical student, a caregiver, and a patient. He treated and cared for the ill, and he himself suffered and succumbed to a terminal illness. His poetry and his poetic philosophy contain and reflect evidence of his medical training, his altruistic ambitions, and his caring nature. Much remains to be learned about the ways in which Keats’s life and wisdom may inform the way health care practitioners practice medicine and care for those who are ill.

John Keats and negative capability certainly have more to offer narrative medicine philosophy and narrative inquiry in medical practice. Terrence Holt considers the relationship between the fragmented nature of the physician identity and how Keats conceived of the poet’s identity (330-32). Although this thesis is inspired by and indebted to Holt’s observations about the relationship between narrative medicine and negative capability, I was unable to explore and expand upon Holt’s observations within the space of this thesis. Additional research and analysis of Keats’s conception of the poet’s self in
the context of medical practice and the ways in which the physician conceives of identity and sense of self is certainly warranted and would probably yield invaluable insight.

An area worthy of future exploration in the fields of narrative medicine, narrative ethics, the health humanities, and other interdisciplinary fields that explore the intersections of literature and medicine is how poetry, and the unique poetic philosophies of notable poets, can influence narrative inquiry in medical practice, especially inquiries dedicated to non-narrative forms of experience, storytelling, and meaning-making. Illness experiences do not always fit within a narrative framework. As Anatole Broyard observes, “Dying or illness is a kind of poetry. It’s derangement. In literary criticism they talk about the systematic derangement of the senses. This is what happens to the sick man” (41). Poetry can assume a narrative form, but it is often deranged, disordered. Wordsworth called poetry a “spontaneous overflow of powerful feelings” (598). Poetry may startle or amaze with the force of its representation and the truth of its derangement and disorder. “So it seems to me,” Broyard writes, “doctors should study poetry to understand these dissociations, these derangements, and it would be a more total embracing of the patient’s condition” (41). Poetry moves beyond narrative form to represent and reveal non-narrative experiences and truths. Clinicians must equip themselves to embrace such diversity of experience as they encounter and care for the ill. I believe poetry contains invaluable insight, and Keats is a mighty good place to start.


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