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Historiography, Diagnosis, and Poetics*

Julia Epstein

Physicians began to record case notes and, in consequence, medical practice became a fundamentally discursive enterprise perhaps as early as the first appearances of the Asclepian temple inscriptions and of the forty-two case histories that make up Books 1 and 3 of Hippocrates' *Epidemics*. However, the written records kept by physicians were not fully instrumental in the professional institutionalization of medicine until the end of the eighteenth century. Recently, scholarly and critical attention has been turned to the signifying practices and to the *poetics* of the clinical case history, or, as the neurologist Oliver Sacks calls it, the "clinical tale."¹ But this attention also raises some problems. Medical narratives cannot easily be read as literary artifacts, and the methodologies of literary criticism employed to scrutinize them, without neglecting their foundation in the experience of the body and in the social and medical roles of clinical diagnosis.

We need, rather, to investigate the conventional structures of case-history writing in their clinical context to understand how the fundamental linearity of the patient history derives from the reconstituted and unified story it contains. In this reconstitutive process authority is displaced from the case historian to the text.² By discussing the history in relation to theories about other kinds of narrative—historical, anthropological, and literary—this essay examines the patient history as a way of knowing the human body and the human being. I shall argue that the patient history depends for its structure on a codified narrative form

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that works with the materials of chronicle, ethnography, and biography.³ Rules governing case reporting play a crucial role in the diagnostic process because the patient history reflects an epistemology of the body.

I. Toward a History of Case Reporting

To investigate the narrative genealogies and operations of the case history, it is first necessary to trace the provenance of this hybrid form of writing.⁴ The Hippocratic cases in the *Epidemics* inaugurate formal case recording in the West, though they remain largely descriptive, and other writings from antiquity, such as the treatise “On the Interrogation of the Patient,” by Rufus of Ephesus, suggest that anamnesis is not a modern art. The seventeenth century’s renewed interest in *Hippocratic medicine*—a medical practice based on speaking with and observing patients—turned one of the emphases of medical practice back to history taking and case recording. The Italian iatrophysicist Giorgio Baglivi was an important early modern proponent, along with the better-known physicians Hermann Boerhaave and Thomas Sydenham, of the importance of observation in physic.⁵ The first specific calls for a systematic record keeping in medical practice came from John Bellers’s *Essay Towards the Improvement of Physick* in 1714, and in 1731 from Francis Clifton’s *Tabular Observations recommended as the plainest and surest way of practising and improving Physick*.⁶ These systems, however, focused on data collection and correlation: they built nosologies rather than differential diagnoses. The full shift into placing diagnostic importance on a record of the body’s *story* occurred during the later eighteenth century, when diagnosis began to move away from the constraints of the humoral framework, as well as from astrological and iatrochemical theories, and began instead to rely on a combination of the patient’s narrative and visual observation.

The turn to organized case recording in medical practice coincided with a burgeoning of narrative forms in other cultural arenas; the eighteenth century in Europe witnessed in particular the birth of periodical journalism and the novel.⁷ This merger of a descriptive, or scientific, form of case recording with other forms of writing that partook more clearly of social and cultural change (demographic shifts, the formation of a mercantile class, the spread of literacy, the birth of a marketplace for words as well as for commercial goods) is for many reasons not surprising. The physician’s shifting social position itself mandated participation in the production of cultural discourses, in part because the

physician was gradually taking over for the clergyman in matters of health. At first, this occurred largely in the social realm, as demonstrated by the language of lay medical advice. We know from the period's diaries and correspondence that patients put themselves "into the care of" or "in the hands of" or "under" medical practitioners, and these practitioners "pronounced," "declared," or were "of the opinion."

Nevertheless, medical knowledge was not spirited away to its own domain and professionally guarded there until the end of the eighteenth century. This is clear, the historian Roy Porter has shown, from the evidence of eighteenth-century periodicals: the *Gentleman's Magazine*, for example, instituted a medical correspondence feature in 1751, and its technical nature seems to confirm that medical knowledge of a quite sophisticated sort existed in a common province and was not yet exclusively owned by trained consultants.⁸ This shared world of knowledge allowed patients and physicians to negotiate at the bedside about therapeutic intervention.⁹ Disease in the eighteenth century was no longer read as a providential sign or instrument, and the narrative of illness was no longer, even in part, a spiritual narrative in which the body operated merely as a casing for the soul. However, the spectacle of disease, though becoming increasingly understood as a *material* spectacle, was not yet a monopolized zone inhabited solely by the prognosticating medical expert.¹⁰

Beginning in the eighteenth century, these experts received part of their training by keeping detailed case notebooks on the patients they observed. Students of Pierre Foubert, chief surgeon at the Charité hospital in Paris from 1735–45, counted among their clinical responsibilities the obligation "to keep an exact journal of the disease and of the course of treatment of those who had been confided to [them]. At the end of the cure, in cases of cures and, after the autopsy, in cases of deaths, [they] would write up [their] findings in the form of a reasoned observation."¹¹ In their 1778 proposal for a teaching hospital, Claude-François Duchanoy and Jean-Baptiste Jumelin included under student duties the requirement to "carefully observe everything which occurs relative to the diseases and medications in order to be able to give a precise and accurate account (by memory and in writing) to the physicians and their colleagues during the next rounds."¹² Accurate observation, communicated in written records, became the basis for clinical medicine and for the early-nineteenth-century development not only of widely institutionalized clinical instruction, but also eventually of clinical statistics as a basis for research.¹³ The clinical case histories that the eighteenth century produced were elaborate and aimed at precision and detachment

as well as at diagnostic documentation. Because, even in the late eighteenth century, sophisticated technologies and laboratory data did not yet impinge from outside the physician's observational ken (and physicians were only then beginning to touch their patients), a focus on the patient's sense impressions made these documents very concrete.¹⁴

Although some medical historians view the Asclepian temple inscriptions as the first case histories,¹⁵ record keeping was sporadic and idiosyncratic until records became absolutely necessary to the practice of medicine as a system of both scientific and social authority—until, that is, barber-surgeons and surgeon-apothecaries gave way to physicians who were university-trained members of regulated professional organizations. The general historical assumption has been that medicine remained a bedside or protoclinical practice until the French Revolution, at which time the *clinic*—or modern hospital medicine—was born.¹⁶ Early clinics were simply nosological theaters, whereas practical observational diagnosis and treatment require an institutional structure to support hospital teaching, ambulatory services, dispensaries, and the development of pathological anatomy itself. The Hippocratic art of passive observation could be replaced by active therapeutics only when diagnoses could include statistical considerations and when clinical correlations could be based on frequency. The human body became less opaque, partly as a consequence of clinical practices such as the autopsy (autopsies became routine by the end of the eighteenth century) that involved the composition of rigidly structured reports. The hospital could become a new site for clinical experience and for the production, accumulation, and reproduction of medical knowledge only insofar as institutional records could be kept and conventional expectations and formal requirements for these records were established.¹⁷ The patient chart, from this point on, becomes coadjutant with patients and physicians themselves in the production of what has come to be called the *clinical picture*.

II. Clinical Pictures

The current patient history of the sort that begins "Jane Doe is a 38-year-old woman with a history of diabetes since the age of 12" has evolved from the need to identify certain features of the patient-physician encounter in the case record. This form derives not only from the codification procedures in record keeping that accompanied professionalization in medical practice, but also from an array of narrative forms that have been used in the service of telling stories about the human body.

The argument that the patient history has a poetics requires some illustrative texts from a range of narrative traditions. The examples here each concern neurological symptoms and are presented in chronological order to facilitate a better understanding of the genealogical connections between them.

We need to begin with an account that precedes structural codification and technological expertise. On 17 June 1783, the great lexicographer, poet, dramatist, biographer, and critic Samuel Johnson wrote an account of what was clearly a cerebrovascular accident. Johnson's story requires citation at length:

On Monday, the 16th, I sat for my picture, and walked a considerable way with little inconvenience. In the afternoon and evening I felt myself light and easy, and began to plan schemes of life. Thus I went to bed, and in a short time waked and sat up, as has long been my custom, when I felt a confusion and indistinctness in my head, which lasted, I suppose, about half a minute. I was alarmed, and prayed GOD, that however he might afflict my body, he would spare my understanding. This prayer, that I might try the integrity of my faculties, I made in Latin verse. The lines were not very good, but I knew them not to be very good: I made them easily, and concluded myself to be unimpaired in my faculties.

Soon after I perceived that I had suffered a paralytick stroke, and that my speech was taken from me. I had no pain, and so little dejection in this dreadful state, that I wondered at my own apathy, and considered that perhaps death itself, when it should come, would excite less horreur than seems now to attend it.

In order to rouse the vocal organs, I took two drams. Wine has been celebrated for the production of eloquence. I put myself into violent motion, and I think repeated it; but all was vain. I then went to bed, and, strange as it may seem, I think, slept. When I saw light, it was time to contrive what I should do. Though God stopped my speech, he left me my hand; I enjoyed a mercy which was not granted to my dear friend Lawrence, who now perhaps overlooks me as I am writing, and rejoices that I have what he wanted. My first note was necessarily to my servant, who came in talking, and could not immediately comprehend why he should read what I put into his hands.

I then wrote a card to Mr. Allen, that I might have a discreet friend at hand, to act as occasion should require. In penning this note, I had some difficulty; my hand, I knew not how nor why, made wrong letters. . . . My physicians are very friendly, and give me great hopes;

but you may imagine my situation. I have so far recovered my vocal powers, as to repeat the Lord's Prayer with no very imperfect articulation. My memory, I hope, yet remains as it was; but such an attack produces solicitude for the safety of every faculty.¹⁸

Johnson's speech improved rapidly, though for a time his articulation was slow and talking for more than short periods fatigued him. This event, recounted in a letter to his friend Hester Thrale in Bath, presaged the beginning of Johnson's physical decline: by 1783, he suffered from a chronic bronchitis that had turned into emphysema, congestive heart failure that was evidenced in his complaints of dropsy, circulatory problems that may have culminated in this cerebral event, and the progressive arthritis that he persisted in calling "gout," a fairly all-purpose medical term in the eighteenth century. He died in December 1784, eighteen months later. It is not possible from Johnson's narrative alone to pinpoint the exact anatomical location of the lesion that precipitated this event. But despite the fact that he could not have understood the physiology of what had happened in his brain, Johnson's self-diagnosis—a "paralytick stroke"—was accurate: he had suffered a cerebral ischemic attack that evolved into a mild stroke.¹⁹

One of Samuel Johnson's physicians was well known: William Heberden (1710–1801), who saw his patient on 17 June 1783, the day of his stroke. In the Heberden manuscripts at the Royal College of Physicians, London, in a section on "Paralysis," the doctor jotted the following observation on Johnson: "Voice suddenly went in man aged 74, mind and limbs affected; voice almost restored within a few days."²⁰ Johnson has become here not human being or even human body, but an accumulation of voice, mind, and limbs. Heberden writes about the patient as *other*; this clipped account differs from Johnson's version of his experience in that its staccato, stripped-down language reveals a radical, metaphorical absence of the subject in official clinical prose. Indeed, what is so remarkable about Johnson's own account of his stroke is the absolute presence of its subject, of the great Lexiphanes himself in full literary regalia. Johnson's clinical self-portrait presents him, not as *other* in relation to his narrating voice, but as a man determined to remain in control.

It is useful to compare the prose of Johnson and Heberden to a more self-consciously composed autobiographical narrative. This is a third-person account published in 1973 by a Norwegian neuroanatomist writing about his own illness:

The patient is a 62-year-old professor of anatomy who was suddenly taken ill during a lecture-trip abroad. He had had no serious ailments. About a year before, one evening in the course of a few minutes he suddenly had paræsthesiæ around the left corner of the mouth, in the radial side of the left hand and in the left great toe. There was dizziness on vertical movements of the head. The paræsthesiæ and the dizziness persisted, although in diminishing intensity, for nine months.

. . .

The present illness started suddenly when the patient woke up and turned in his bed on the morning of April 12, 1972. In the course of a few minutes an initial heavy, but uncharacteristic, dizziness was followed by dysarthria, double vision and a marked paresis of the left arm and leg. There was no loss of consciousness, no headache or vomiting and no stiffness of the neck. In the very beginning, there were paræsthesiæ of the left side of the head, especially the scalp.²¹

Brodal, the author of a neuroanatomy textbook as well as the victim of an insult to the brain, understands, unlike Samuel Johnson, the physiology of what is happening to him. He dwells, as Johnson does, particularly on everyday disturbances, and we sense his sudden realization of disorder when his world uncharacteristically alters as he turns over in bed. But this patient has access to a specialized vocabulary (*dysarthria; paræsthesia; paresis*) with which to describe his experience. By subsuming himself as patient into the role of formal narrating historian, Brodal thereby produces a narrative that presents a man determined to come to terms with the slippage of bodily control.

Brodal describes an experience one researcher calls "a sudden discontinuation of self," in which the stroke victim experiences himself or herself "as a stranger and an alien in his own environment."²² Surely this could also be said of Samuel Johnson. Brodal's account is specific enough (with its accompanying data) to locate the site of his lesion as a branch of the middle cerebral artery. It reproduces a clash between the patient's experience of physical uneasiness, of change from his normal experience of the world, and the distancing terminology that explains this change in pathophysiologic terms. In Brodal's case, the conjunction of patient and physician makes the clash especially poignant.

A 1986 account of a woman eventually diagnosed with malignant lymphoma of the central nervous system contains some of the features of disjunction present in both Johnson's and Brodal's case narratives.

This patient presented with neurologic complaints and died as a result of respiratory failure. The case presentation begins:

A 55-year-old right-handed woman was admitted to the hospital because of blurred vision.

She was well until 28 months earlier, when she began to experience blurring of vision in both eyes. An ophthalmologist found no history of a preceding respiratory tract infection and made a diagnosis of "papillitis." Her symptoms resolved in six weeks on prednisone. She was then well until nine months before admission, when numbness developed in the right hand, and she dropped a cup of coffee from that hand. The numbness waxed and waned during several days and then worsened, accompanied by headache and slurred speech.²³

The history draws clearly from material elicited from the patient: she remembers the dropped cup of coffee as a key sign to her of something wrong, and the physician's account maintains that sense of everyday gestures gone awry by including this detail. We get a sense of the patient as an individual who is careful and controlled, not the sort of person to lose her grip on a coffee cup. The case presentation depicts someone who is under control and whose chief complaint—of blurred binocular vision—is also in a larger way a complaint about the loss of control over her body.

This history's opening is written in the language of its subject; technical jargon is avoided in such a way that the reader can imagine the questions the physician asked to elicit the information. That clarity changes later in the report. On subsequent visits, we learn that "while the patient was playing tennis, she noticed difficulty in depth perception. She subsequently observed a 'purplish haze' in the right visual field" and "the patient reported the onset of diplopia five days earlier, and four days thereafter she was aware of drooping of the right upper lid and dizziness. That evening a mild ache developed in the right periorbital area." Even a patient who is described, in one of the report's oddest phrases, as "a thin woman with excellent use of language" is unlikely to refer to "diplopia" to report double vision, nor is she apt to locate a headache "in the right periorbital area." The physician takes over as the case record moves away from the history to the physical and then on to more technical accounts of studies ordered and medications given.

All three of these case reports demonstrate that a certain sense of self-division characterizes neurologic ailments and that the fear of losing self-control fuels the patient's anxieties. In addition, the two twentieth-

century reports reflect the modern acceptance of the physician's authority and, relatedly and perhaps of greater importance, of the authority of scientific description and technological intervention. For Heberden, Brodal, and the *New England Journal of Medicine* historians, the patient is *clinicalized* in medical language: the human woman who drops coffee cups and plays tennis as the history begins becomes, as the report progresses, an accumulation of computed tomographic (CT-scan) findings and increasingly severe pathologies.

Johnson and Brodal are, of course, not typical clinical historians for many reasons, but chiefly because they are doing self-description. But all three of these histories demonstrate that physicians participate in constructing stories about bodies, and that the construction of these stories is part of the politics of the cure the patient seeks. If pain and illness themselves clamp down on language and constrict the production of discourse, as the literary critic Elaine Scarry has argued, then the physician works with the patient to rebuild narrative "speakability."²⁴ The codified structure of the modern patient history derives from the need to harness this speakability.

III. Historiography and the Patient History

Johnson in the eighteenth century and Brodal in the twentieth make ideal case historians in light of the dictum once proposed by Plato that those who want to become physicians should first experience all the illnesses they want to cure.²⁵ This view holds that sense experience precedes other ways of understanding the world, that the body produces the primary kind of knowledge from which all other knowing must derive. Case histories—by the physician, by the patient, or by the biographer—try to mirror sense experience, to re-embodify the body in language. The objective body becomes the subject and, according to the critic Jean Starobinski, "Knowledge [in the French sense of *science*] of the body can and must be understood as knowledge which issues *from* the body and not as knowledge which aims *at* the body."²⁶ This knowledge is recorded in medical writing's most essential form, the case report; accurate diagnosis depends upon its discourse and its protocols. The case report shifts fluidly between representational, clinical, and rhetorical strategies and modes, engaging a variety of contradictory practices with its self-reflexivity and its apparent unself-consciousness. In other words, the case history is a coded document that aspires to be self-contained and entirely explicable from within.

The case reports cited above demonstrate that in a broad sense the case history engages the conventional features of historical and literary writing. As a consequence, a case report's success or failure as an authoritative account of the etiology and progress of disease constitutes a general paradigm for narratives of the human body. Clinical diagnosis, in fact, contains a narrative epistemology in its effort to encapsulate particular kinds of knowledge about the body. The case history's purpose is to narrow down the possibilities for disorder by a rigidly structured account that moves from first impressions to hypotheses to firm diagnoses. Three factors enter the discourse of the case report as it has been taught to medical students since the 1890s: first, symptoms, or complaints—the patient's own subjective perception of deviations from normal health; second, signs—the objective manifestations of disease located by the physician during a physical examination; and third (and historically most recent), laboratory findings.²⁷

The history is presented in a more or less standard order (there are variations, but they remain variations on a theme) that began to be established in the early nineteenth century and became codified in the last decade of the century as follows: (1) identifying information; (2) chief complaint; (3) history of present illness (or HPI); (4) past medical history; (5) system review; (6) family history; and (7) social history. This composition differs fundamentally from other clinicohistorical writings (e.g., progress notes, discharge summaries) in that its structure conforms to a standard. Even the relatively recent innovation of Lawrence Weed's "problem-oriented medical record" (the SOAP technique: subjective data—the history itself, objective data, assessments, plans) has historical roots in the nineteenth century, when hospital record keeping began to be institutionalized.²⁸ But whatever the system, now as earlier, the central section of the record—the HPI—presents a narrative. It stitches together the patient's complaints into a series of logical diagnostic clues that can frame a recognizable clinical picture.

The language of the patient history is as prescribed as its structure, and two crucial guidelines dominate. The chief complaint with which the patient presents should, if possible, be transcribed in the patient's own words. (Physicians are instructed, for example, to beware translating "I get dizzy" as "patient experiences vertigo.") And although all other sections of the report may be composed in telegraphic phrases, the HPI is written in complete sentences, a requirement stressed in medical textbooks to the point of exhortation. There is no doubt in the pedagogic literature of medical training, beginning in the nineteenth century, that this narration *as narration* embraces the heart of medical practice.²⁹ The

HPI requires complete sentences because, even though a chronological list or set of jotted phrases, like the *annals* form of historical writing, can be read as a narrative, it lacks syntax, the written relationship between events and observations that builds clear bridges from fact to fact. It is syntax, in a sense, that undergirds diagnosis.

The requirement for complete sentences in the HPI is routinely taught to medical students but never much reflected upon, and this requirement is worth looking at for its theoretical implications, for what it says about how the body can be written up into language, into a sequential series of observations that follow syntactic rules. (Facts, findings, laboratory results can be written *down* in list form; the history is always written *up*.) In this linear history, Western medical discourse postulates that illness can be, at least momentarily (long enough, that is, to study, classify, and pass judgment on it), dissociable from the ill person. This dissociation takes place through the objectified sequencing of bodily events that the physician seeks to elicit from the patient and to impose in the history. Disease is described and understood as something on which it is possible to act; indeed, the history serves as the arena from which the action will emanate. The history's discourse, then, is technical and materialist.³⁰

Still, this discourse follows many of the patterns that narrativist historians and theorists of historiography have brought to our attention.³¹ Corporeal experience, like other experience, comes to us *seriatim*, and the historian's task is to synthesize meaning from an assemblage of these serial moments and to serialize and prioritize the simultaneous. Narrative in history writing is itself a form of explanation because it reconstructs a course of events.³² Any assertion of causality, then, results, especially in medical narrative, in a story of improvement, of deterioration, or of oscillation between the two. Narrative history also implies continuity and isolatable causality; but while historical writing elides competing versions of the past, the medical case history aims at a differential diagnosis leading to several possible disease agents that might explain all symptoms, even as one singular explanation always represents the efficient ideal.³³

That narration is enlisted at all in a scientific discipline as a major problem-solving technique itself raises questions. The right to narrate, the intellectual historian Hayden White remarks, always hinges on some defined relationship to authority, but its use in science is suspect because science is "a practice which must be as critical about the way it *describes* its objects of study as it is about the way it *explains* their structures and processes."³⁴ Louis Mink, a philosopher, draws a related conclusion,

arguing that science, unlike inherently narrative disciplines such as history, can produce what he calls “detachable conclusions,” whereas historical assertions are “*represented by the narrative order itself . . . exhibited rather than demonstrated. . . .*”³⁵ The case history, as a genre of writing, conceives of human experience in a particular way and seems to assume, as the literary critic Steven Marcus has argued in a discussion of Freud’s history of Dora, that a healthy life embodies a connected narrative, a story with a proper linear sequence, whereas disease signifies, in part, an inability to give an adequate account of oneself and produces a narrative of disjunction.³⁶

Because the physician is constrained to elicit and produce an account that can yield at least a differential if not a firm diagnosis, the case report can never be read merely as a simple source of information, as an analytic description; it always implicitly interprets in the process of its narrative structure. In translating the patient’s experience into a clinical *text*, the physician must also interpret that experience to produce a diagnostic explanation, then persuade readers that this diagnosis is correct on the basis not only of evidence, but also of rhetorical appeal—the ways in which ruptures in the experience are filled in and in which reconstructions build a clinical picture whose mysteries have been solved. It is important to point out that only diagnosed disease that is fully understood in its physiological progression operates in this way—that is, runs an expected course—and even this expectation can at any time be disrupted in an individual case. Narrative truth rests not on evidence or actual events alone, but on closure as well. One of the rules for producing the history is a rule that has been called *clinical parsimony*. That is, “the smaller the ratio of explanatory cause to subsequent effect, the better the interpretation,” or, one cause is better than many.³⁷

A theoretical problem of narration is that it ceases to be stable, to be simple, unfraught, and autonomous storytelling, as soon as we try to detach the told from the telling and thereby open up new epistemological questions.³⁸ Edward Gibbon, for example, writing about his composition of *The History of the Decline and Fall of the Roman Empire*, commented on the falsifications to which problems in the telling may lead the historian. “I owe it to myself, and to historic truth,” he wrote, “to declare, that some *circumstances . . .* are founded only on conjecture and analogy. The stubbornness of our language has sometimes forced me to deviate from the *conditional* into the *indicative* mood.”³⁹ Unlike Henry Fielding, who repeatedly interrupts what he calls his “history” of the foundling Tom Jones with admonitions such as “Reader, take care,” Gibbon admits the artificiality of his stance.⁴⁰ He does not have

the temerity of a Fielding, who justifies his new form of writing (the novel, paradoxically)⁴¹ by arguing, "I am not writing a system but a history, and I am not obliged to reconcile every matter to the received notions concerning truth and nature."⁴²

The physician-historian cannot get away with this; "every matter" (what the patient had for breakfast, the chemical composition of the patient's urine) must be reconciled in the diagnostic process. Historical discourse, Roland Barthes has remarked, is uniformly assertive, certified or certifiable, established and verified. It is a discourse of facts that ignores its own linguistic material, that presumes that it represents a pure and neutral copy of the real. It is as though the facts targeted by the historian's account of them have an existence outside the text that embodies them. That text is always double in medical case histories because it is both a written object and the representation of an inhabited body.⁴³ This doubleness produces a tension that derives from the case history's *sui generis* inwardness and that can be located in the contradictions among its presentational modes.

IV. Diagnosis, Historiography, and "Thick Description"

The tension in a case narrative derives also from the necessarily incomplete relation between objective data and subjective complaints: the case historian's representation of disease rarely duplicates the patient's sense of inhabiting a symptomatic body, and generic nosological description rarely mirrors in an exact way the experience of given suffering human beings. These relations between what can loosely be designated *objective* and *subjective* accounts determine the nature and form of the clinical history and raise the fundamental question posed by any case history: does the disease derive from the life of an individual, or is the individual life constructed by disease? In a classic article on the case history, Walther Riese argues that the clinical history starts with subjectivity and that objective diagnoses and therapeutic plans derive from the signification of subjective signs. Riese proposes that "*it is not the history of the disease which leads to an understanding of the life history but the latter which may induce an understanding of the former.*"⁴⁴

The interaction between objectivity and subjectivity, or between external and internal factors, is not only a modern problem; it emerges as a central theme in a well-known work of 1733, *The English Malady; or, A Treatise of Nervous Diseases of All Kinds, As Spleen, Vapours, Lowness of Spirits, Hypochondriacal, and Hysterical Distempers, etc.*, by George

Cheyne. Cheyne, like Johnson and Brodal an autopathographer, presents his own case most thoroughly, apologizing for his apparently "*indecent and shocking Egotism*" in making himself his own subject.⁴⁵ In the final section of the work, "The Case of the Author," Cheyne comments on the case history as narrative. "I have," he writes, "written *this* in a plain *narrative* Stile, with the fewest Terms of Art possible, without supposing my *Reader*, or shewing *myself*, to have look'd ever into a *physical* Book before."⁴⁶ In Cheyne's case, the pages of case histories that conclude his book serve as proofs of his theories about certain kinds of disorders and anchor his controversial proposals for therapy.

Cheyne discusses case-history writing in relation to the eighteenth-century social context of clinical diagnoses. He remarks that composing the third section of his work, titled "Variety of Cases that illustrate and confirm the method of cure," was "*the most difficult and unpleasant Part of my Work*."⁴⁷ Some of his patients are still alive, and he worries about incurring their wrath:

The *Distempers of Patients are sacred*, (*Res sacra miser*) and *nervous* Distempers especially, are under some kind of *Disgrace* and *Imputation*, in the Opinion of the *Vulgar* and *Unlearned*; they pass among the Multitude, for a lower degree of *Lunacy*, and the first Step towards a *distemper'd Brain*: and the best Construction is *Whim*, *Ill-Humour*, *Peevishness* or *Particularity*; and in the *Sex*, *Daintiness*, *Fantasticalness* or *Coquetry*.⁴⁸

To counteract these superstitions, Cheyne argues vigorously that "nervous distempers" are as much bodily ills as are fevers and smallpox, though he goes on to reveal medicocultural assumptions himself when he writes that such distempers virtually never occur "to any but those of the liveliest and quickest natural Parts, whose Faculties are the brightest and most spiritual, and whose Genius is most keen and penetrating," even arguing he has "seldom ever observ'd a *heavy, dull, earthy, clod-pated Clown*, much troubled with *nervous Disorders*."⁴⁹ The cultural anthropologist Clifford Geertz provides one theoretical model for locating the interpretive role of extraobjective factors of the sort that trouble Cheyne. He elaborates what he calls, borrowing from the English philosopher Gilbert Ryle, "thick description."⁵⁰ Geertz takes an essentially semiotic approach to his own disciplinary practice, ethnography, and argues that this discipline's object is to sort out its data into structures of signification that explain, not the ontological status of human behav-

iors and rituals, but their import.⁵¹ Data thus interpreted—that is, thickly (intelligibly) described within a cultural context—become another order of interpretation within anthropological writings. Such writings, Geertz argues, are fictions, not because they are unfactual or false, but because they represent imaginative acts of representation. Ethnographers turn events and behaviors into narrative or expository accounts; they inscribe actions, and it is within and from these accounts that conclusions are drawn.

Acts of interpretation—literary, cultural, or diagnostic—always raise distinctions between description and explanation. In so doing, interpretations make clear that to offer an account of images, or rituals, or symptoms is to systematize and order. Geertz uses medicine to demonstrate this problem in his discussion of “clinical inference,” or generalization within cases. “Symptoms,” he writes, “are scanned for theoretical peculiarities—that is, they are diagnosed”; put differently, clinical inference “begins with a set of (presumptive) signifiers and attempts to place them within an intelligible frame.”⁵² In another essay, Geertz argues that “there is more to diagnosis, either medical or sociological, than the identification of pertinent strains; one understands symptoms not merely etiologically but teleologically—in terms of the ways in which they operate as mechanisms, however unavailing, for dealing with the disturbances that have generated them.”⁵³ The case report, if we read it within Geertz’s model of interpretive writing, produces a context around groupings of symptoms and signs and findings, and articulates these data into a narrative whose goal is to move toward explanation, therapy, and resolution. In the end, ethnographic expositions and patient histories disclose prevailing explanatory schemes and the social ideologies inevitably subscribed to by their authors, and these writings are thereby anchored in particular times and places as well as in particular evolutions of knowledge about their content. This context production, the development of a framework of knowledge and assumptions on which to attach a patient’s symptoms, is at the heart of the diagnostic process. Aristotle reassured the insecure poet that “the error is less if the artist did not know that female deer have no horns than if he failed to draw a recognizable picture.”⁵⁴ The physician cannot be so blithely reassured. The genre of case reporting itself postulates a discursive practice that constrains an ostensibly scientific proceeding within a rhetorical structure. This structure, in its formal positioning of narrative elements, regulates the evaluation of evidence.⁵⁵ Professional medicine has created and codified a clinical discourse with its own governing rules and its

own vast vocabulary. In the clinical case record, language mediates bodily experience so that such experience can be made available for interpretation.

I have not been concerned with therapeutics in this essay, but rather with medical practice's inaugurating gesture: to know and to record status changes in the human body. It has been my contention that if we want to understand the primary discourse of medical knowledge—the medical case history—we need to position that discourse in relation to other explanatory uses of narrative language. Physicians act as ethnographers, historians, and biographers when they take patient histories and when they write up case reports. Recognizing these historiographic functions of the diagnostic process in the context of other kinds of historiography allows us to recognize as well the way medical practice participates in the production of cultural discourses.

NOTES

1. This term has been popularized by Oliver Sacks in *The Man Who Mistook His Wife for a Hat and Other Clinical Tales* (New York: Summit Books, 1985) and in "Clinical Tales," *Literature and Medicine* 5 (1986): 16–23. Harold L. Klawans also uses this formal concept in *Toscanini's Fumble and Other Tales of Clinical Neurology* (Chicago: Contemporary Books, 1988). In addition, see Arthur Kleinman, *The Illness Narratives: Suffering, Healing, and the Human Condition* (New York: Basic Books, 1988), and a sequence of essays in *Literature and Medicine* 5 (1986): Joanne Trautmann Banks, "A Controversy about Clinical Form," 24–26; David Barnard, "A Case of Amyotrophic Lateral Sclerosis," 27–42; Eric Rabkin, "A Case of Self Defense," 43–53; David H. Smith, "The Limits of Narrative," 54–57. The notion of a relation between stories and bodies is also discussed in Philip Mosley, "The Healthy Text," *Literature and Medicine* 6 (1987): 35–42; Larry R. Churchill and Sandra W. Churchill, "Storytelling in Medical Arenas: The Art of Self-Determination," *Literature and Medicine* 1 (1982): 73–79; and James Hillman, "The Fiction of Case History: A Round," in *Religion as Story*, ed. James B. Wiggins (New York: Harper and Row, 1975), 123–73. Kathryn Montgomery Hunter has recently published a definitive ethnography of the case report in *Doctors' Stories: The Narrative Structure of Medical Knowledge* (Princeton, N.J.: Princeton University Press, 1991). The psychoanalytic narrative raises different though theoretically related kinds of questions, but will not be discussed in this essay. For an especially useful account, see Roy Schafer, "Narration in the Psychoanalytic Dialogue," *Critical Inquiry* 7 (Autumn 1980): 29–53.

2. For theoretical discussions of these questions, see Frank Kermode, *The Sense of an Ending* (New York: Oxford University Press, 1967), and Terry Eagleton, "Ideology, Fiction, Narrative," *Social Text* 2 (Summer 1979): 62–80.

3. Approaching medicine as a *text* with its own special discourse and scrutinizing the role language plays in medical knowledge have become accepted practices, from F. G. Crookshank's "The Importance of a Theory of Signs and a Critique of Language in the Study of Medicine," in *The Meaning of Meaning*, ed. C. K. Ogden and I. A. Richards, 3d ed., rev. (New York: Harcourt, Brace, 1930), 337–55, to G. S. Rousseau's call to articulate an adequate methodology for the discipline of "literature

and medicine," in "Literature and Medicine: Towards a Simultaneity of Theory and Practice," *Literature and Medicine* 5 (1986): 152–81. For a particular application of the notion of *the patient as text*, see Kathryn Montgomery Hunter's comment on the Barnard-Rabkin debate in her "Making a Case," *Literature and Medicine* 7 (1988): 66–79. Also pertinent is Laurence B. McCullough, "Particularism in Medicine," *Criticism* 22 (Summer 1990): 361–70.

4. Only partial work has thus far been done on the origins and history of case recording, and in *The Care of Strangers: The Rise of America's Hospital System* (New York: Basic Books, 1987), 382, Charles E. Rosenberg remarks on the need for a study of the history of medical records. I have written a longer essay on this subject, titled "Observation in Physic: The Literary Genealogy of the Medical Case History," but include here only a brief sketch of the major issues raised by the history of case reporting. Some important studies on the development of modern hospital records are Stanley Joel Reiser, "Creating Form Out of Mass: The Development of the Medical Record," in *Transformation and Tradition in the Sciences: Essays in Honor of I. Bernard Cohen*, ed. Everett Mendelsohn (Cambridge: Cambridge University Press, 1984), 303–16; Guenter B. Risse, *Hospital Life in Enlightenment Scotland: Care and Teaching at the Royal Infirmary of Edinburgh* (Cambridge: Cambridge University Press, 1986); and John Harley Warner, *The Therapeutic Perspective: Medical Practice, Knowledge, and Identity in America, 1820–1885* (Cambridge, Mass.: Harvard University Press, 1986). See also John D. Stoeckle and J. Andrew Billings, "A History of History-Taking: The Medical Interview," *Journal of General Internal Medicine* 2 (March/April 1987): 119–27.

5. See especially Giorgio Baglivi's *The Practice of Physick, reduc'd to the Ancient Way of Observations containing a just Parallel between the Wisdom and Experience of the Ancients, and the Hypothesis's of Modern Physicians* (London: Andrew Bell, 1704).

6. John Bellers, *Essay Towards The Improvement of Physick* (London: J. Sowle, 1714), and Francis Clifton, *Tabular Observations recommended as the plainest and surest way of practising and improving Physick* (London: J. Brindley, 1731).

7. In a discussion of Hermann Boerhaave's case writing, the historian Thomas W. Laqueur relates the evolution of truth claims in early medical case reporting to the development of other quintessentially eighteenth-century literary forms: the novel, the parliamentary inquiry, and the autopsy report. See Thomas W. Laqueur, "Bodies, Details, and the Humanitarian Narrative," in *The New Cultural History*, ed. Lynn Hunt (Berkeley and Los Angeles: University of California Press, 1989), 176–204.

8. See Roy Porter, "Lay Medical Knowledge in the Eighteenth Century: The Evidence of the *Gentleman's Magazine*," *Medical History* 29 (April 1985): 138–68.

9. This is Norman Jewson's widely accepted theory. See Norman Jewson, "The Disappearance of the Sick Man from Medical Cosmology, 1770–1870," *Sociology* 10 (May 1976): 225–44, and "Medical Knowledge and the Patronage System in Eighteenth Century England," *Sociology* 8 (September 1974): 369–85.

10. For a discussion of these ideas as they held sway in an earlier period, see Andrew Wear, "Puritan Perceptions of Illness in Seventeenth-Century England," in *Patients and Practitioners: Lay Perceptions of Medicine in Pre-Industrial England*, ed. Roy Porter (Cambridge: Cambridge University Press, 1985), 55–99. See also Lucinda McCray Beier, *Sufferers and Healers: The Experience of Illness in Seventeenth-Century England* (London: Routledge and Kegan Paul, 1987).

11. "Eloge de Foubert" (1768), in Antoine Louis, *Eloges lus dans les séances publiques de l'Académie Royale de Chirurgie de 1750 à 1792*, ed. E.-F. Dubois (Paris, 1859), 125. The translation is by Toby Gelfand, who cites this passage in *Professionalizing Modern Medicine: Paris Surgeons and Medical Science and Institutions in the Eighteenth Century* (Westport, Conn.: Greenwood Press, 1980), 105.

12. Gelfand, *Professionalizing Modern Medicine*, 134.

13. See Richard Harrison Shryock, *The Development of Modern Medicine: An Interpretation of the Social and Scientific Factors Involved* (New York: Knopf, 1947); David Riesman, "The Rise and Early History of Clinical Teaching," *Annals of Medical History*

2 (Summer 1919): 136–47; and David M. Vess, *Medical Revolution in France, 1789–1796* (Gainesville: University Presses of Florida, 1975). John Harley Warner briefly discusses the mid-nineteenth-century evolution and use of case records at the Massachusetts General Hospital, which opened in 1821 (its effort to keep systematic records was an exception), in *The Therapeutic Perspective*, 107–8.

14. See Erwin H. Ackerknecht on the importance of Cabanis and philosophical sensualism for medical therapeutics in *Medicine at the Paris Hospital, 1794–1848* (Baltimore: Johns Hopkins University Press, 1967), especially pages 4–11. Ackerknecht traces the development of a hospital-based medical practice in Paris.

15. Erwin H. Ackerknecht remarks on the contemporaneity of votive inscriptions and the *Corpus Hippocraticum* in *A Short History of Medicine* (Baltimore: Johns Hopkins University Press, 1982), 49.

16. This is, of course, Michel Foucault's thesis in *The Birth of the Clinic: An Archaeology of Medical Perception*, trans. A. M. Sheridan-Smith (New York: Pantheon, 1973). For a modification, see Toby Gelfand, "Gestation of the Clinic," *Medical History* 25 (April 1981): 169–80.

17. This history is outlined in more detail in Othmar Keel, "The Politics of Health and the Institutionalization of Clinical Practices in Europe in the Second Half of the Eighteenth Century," in *William Hunter and the Eighteenth-Century Medical World*, ed. W. F. Bynum and Roy Porter (Cambridge: Cambridge University Press, 1985), 207–56.

18. Letter to Mrs. Thrale in Bath (19 June 1783), in James Boswell, *Life of Johnson* (1791), ed. R. W. Chapman (London: Oxford University Press, 1970), 1241–42.

19. For discussions, see Macdonald Critchley, "Dr. Samuel Johnson's Aphasia," *Medical History* 6 (January 1962): 27–44, as well as Sir Humphry Rolleston, "Samuel Johnson's Medical Experiences," *Annals of Medical History*, n.s., 1 (September 1929): 540–52, and Peter Pineo Chase, "The Ailments and Physicians of Dr. Johnson," *Yale Journal of Biology and Medicine* 23 (April 1950–51): 370–79.

20. Heberden wrote his case notes, titled *Index Historiae Morborum*, in Latin: "vox subito perit in viro nato LXXIV, mente et membris illasis; quae intra paucos dies fere restituitur. 17 Jun 1783." Cited by Lawrence C. McHenry, Jr., "Medical Case Notes on Samuel Johnson in the Heberden Manuscripts," reprinted from *The New Rambler: Journal of the Johnson Society of London*, Serial B.15 (June 1964): 2, in a pamphlet in the Historical Collections of the Library of the College of Physicians of Philadelphia. This article was also reprinted in *Journal of the American Medical Association* 195 (17 January 1966): 89–90 (quoted material appears on page 89). McHenry wrote extensively on Johnson's various maladies and his interest in medicine. See also his "Mark Aken-side, M.D., and a Note on Dr. Johnson's Asthma," *New England Journal of Medicine* 266 (5 April 1962): 716–18; "Samuel Johnson's 'The Life of Dr. Sydenham,'" *Medical History* 8 (April 1964): 181–88; "Louis Morin, M.D., Botanist, and Dr. Johnson," *New England Journal of Medicine* 273 (5 August 1965): 323–25; with Ronald MacKeith, "Samuel Johnson's Childhood Illnesses and the King's Evil," *Medical History* 10 (October 1966): 386–99; "Samuel Johnson's Tics and Gesticulations," *Journal of the History of Medicine and Allied Sciences* 22 (April 1967): 152–68; "Dr. Samuel Johnson's Emphysema," *Archives of Internal Medicine* 119 (January 1967): 98–105; "Art and Medicine: Dr. Johnson's Dropsy," *Journal of the American Medical Association* 206 (9 December 1968): 2507–9; and "Samuel Johnson: A Medical Portrait," *Jefferson Medical College Alumni Bulletin* (Winter 1969): 2–9.

21. A. Brodal, "Self-Observations and Neuro-Anatomical Considerations after a Stroke," *Brain* 96 (1973): 675.

22. Elizabeth A. Kolin, "Stroke: A Sudden Discontinuation of Self," paper delivered in Kansas City, Missouri, on 2 October 1985, to the American Academy of Physical Medicine and Rehabilitation. Two recent books comment on this experience: May Sarton, *After the Stroke: A Journal* (New York: Norton, 1988), and Ilza Vieth, *Can*

You Hear the Clapping of One Hand? Learning to Live with a Stroke (Berkeley and Los Angeles: University of California Press, 1988).

23. John W. Stakes and Raymond A. Sobel, "A 55-Year-Old Woman with a Progressive Neurologic Disorder," *Case Records of the Massachusetts General Hospital*, Case 22-1986, *New England Journal of Medicine* 314 (5 June 1986): 1498. Subsequent quotations come from this page of the case.

24. Elaine Scarry, *The Body in Pain: The Making and Unmaking of the World* (New York: Oxford University Press, 1985). David B. Morris analyzes Scarry's book helpfully in "How to Read *The Body in Pain*," *Literature and Medicine* 6 (1987): 139–55. See also Julia L. Epstein, "Writing the Unspeakable: Fanny Burney's Mastectomy and the Fictive Body," *Representations* 16 (Fall 1986): 131–66.

25. Montaigne cites this proposal in his essay "On Experience": "So Plato was right in saying that to become a true doctor, the candidate must have passed through all the illnesses that he wants to cure and all the accidents and circumstances that he is to diagnose. It is reasonable that he should catch the pox if he wants to know how to treat it." In *The Complete Essays of Montaigne*, trans. Donald M. Frame (Stanford, Calif.: Stanford University Press, 1957), 827.

26. Jean Starobinski, "The Body's Moment," *Yale French Studies* 64 (1983): 276.

27. The significance of these three kinds of information has shifted, so that now data produced by technologically sophisticated diagnostic tools far outweigh the patient's narrative in importance (and in credibility). For a useful commentary, see Paul B. Beeson and Russell C. Maulitz, "The Inner History of Internal Medicine," in *Grand Rounds: One Hundred Years of Internal Medicine*, ed. Russell C. Maulitz and Diana E. Long (Philadelphia: University of Pennsylvania Press, 1988), 33–35. In the same volume, Stephen J. Kunitz analyzes the shifting functions of diagnoses in "Classifications in Medicine," 279–96.

28. For an exposition of this approach, see Lawrence L. Weed, *Medical Records, Medical Education, and Patient Care: The Problem-Oriented Record as a Basic Tool* (Cleveland: Press of Case Western Reserve University, 1969); Lawrence L. Weed, "Medical Records, Patient Care, and Medical Education," *Irish Journal of Medical Science* 6 (June 1964): 271–82; Lawrence L. Weed, "Medical Records That Guide and Teach," *New England Journal of Medicine* 278 (14 and 21 March 1968): 593–600, 652–57; and Lawrence L. Weed, "What Physicians Worry About: How to Organize Care of Multiple-Problem Patients," *Modern Hospital* 110 (June 1968): 90–94. Richard E. Easton also discusses this system in *Problem-Oriented Medical Record Concepts* (New York: Appleton-Century-Crofts, 1974).

29. Three modern textbooks present this teaching particularly lucidly: *Harrison's Principles of Internal Medicine*, 8th ed. (New York: McGraw-Hill, 1977), 1–12; Elmer L. DeGowin and Richard L. DeGowin, *Bedside Diagnostic Examination*, 3d ed. (New York: Macmillan, 1976), 11–32; and Paul Cutler, *Problem Solving in Clinical Medicine: From Data to Diagnosis* (Baltimore: Williams and Wilkins, 1979), 10–12. For older discussions, see John Southey Warter, *Observation in Medicine or the Art of Case-Taking* (London: Longmans, Green, 1865); George Dock, *Outlines for Case Taking and Routine Ward and Laboratory Work as Used in the Medical Clinic of the Washington University*, 3d ed. (Ann Arbor, Mich.: George Wahr, 1921); James A. Corscaden, *History Taking and Recording* (New York: Paul B. Hoeber, 1926)—Dr. Corscaden refers to the history as the *anamnesis*, an interesting term in the history of case reporting because it privileges the patient's recall and organization of events; Arthur F. Byfield, "Case History Taking," in *Practice of Medicine*, vol. 1, ed. Frederick Tice (Hagerstown, Md.: W. F. Prior, 1943), 551–94. Alfred K. Hills, in a pamphlet titled "Instructions to Patients How to Communicate their Cases to a Physician by Letter" (1870), in the Historical Collection of the Library of the College of Physicians of Philadelphia, offers a different angle on this question, as Dr. Hills suggests that patients write a narrative of symptoms "as they occur to the mind in reading," avoid "anatomical expressions," and "give a full history of their cases in their own way" (p. 1). Dr. Hills closes with the recommendation that, since

"different temperaments require different remedies," if the physician being addressed does not know the patient, the patient should enclose a photograph (p. 8).

30. These ideas are discussed in André Arsenault, "Mutations du discours thérapeutique," in *Traité d'anthropologie médicale: L'Institution de la santé et de la maladie*, comp. Jacques Dufresne, Fernand Dumont, and Yves Martin (Québec: Presses Universitaires de Québec, 1985), 75–84.

31. The principal narrativists have been W. B. Gallie (*Philosophy and the Historical Understanding*, 1964), Arthur C. Danto, and Morton White. For commentary on their work, see Maurice Mandelbaum, "A Note on History as Narrative," *History and Theory* 6 (1967): 413–19; Richard G. Ely, Rolf Gruner, and William H. Dray, "Mandelbaum on Historical Narrative: A Discussion," *History and Theory* 8 (1969): 275–94; W. H. Dray, "On the Nature and Role of Narrative in Historiography," *History and Theory* 10 (1971): 153–71; and David L. Hull, "Central Subjects and Historical Narratives," *History and Theory* 14 (1975): 253–74. Louis O. Mink, in "History and Fiction as Modes of Comprehension," *New Literary History* 1 (Spring 1970): 541–58, also discusses the relation of narrative form to theories of historical knowledge. See also Maurice Mandelbaum, *The Anatomy of Historical Knowledge* (Baltimore: Johns Hopkins University Press, 1977); Arthur C. Danto, *Narration and Knowledge* (New York: Columbia University Press, 1985); David Carr, *Time, Narrative, and History* (Bloomington: Indiana University Press, 1986); and Paul A. Roth, "Narrative Explanations: The Case of History," *History and Theory* 27 (1988): 1–13.

32. See Georg G. Iggers, *New Directions in European Historiography*, rev. ed. (Middletown, Conn.: Wesleyan University Press, 1975), for a history of narrative history.

33. For a useful recent discussion of the dilemma of history writing and its insincerities, see Hans Kellner, *Language and Historical Representation: Getting the Story Crooked* (Madison: University of Wisconsin Press, 1989). Kellner's notes also provide a helpful bibliography of historiographical scholarship.

34. Hayden White, "The Question of Narrative in Contemporary Historical Theory," *History and Theory* 23 (1984): 1. This essay is included in White's recent collection of essays, *The Content of the Form: Narrative Discourse and Historical Representation* (Baltimore: Johns Hopkins University Press, 1987), 26–57.

35. Louis O. Mink, "The Autonomy of Historical Understanding," in *Philosophical Analysis and History*, ed. William H. Dray (1968; reprint, Westport, Conn.: Greenwood Press, 1978), 180–81; cited by Roger G. Seamon, "Narrative Practice and the Theoretical Distinction between History and Fiction," *Genre* 16 (Fall 1983): 203.

36. Steven Marcus, *Freud and the Culture of Psychoanalysis: Studies in the Transition from Victorian Humanism to Modernity* (Boston: George Allen and Unwin, 1984), 61. This notion has since been challenged, and Freud's text of Dora has become as overdetermined as its subject in a proliferation of literary analyses. See especially Charles Bernheimer and Claire Kahane, eds., *In Dora's Case: Freud—Hysteria—Feminism* (New York: Columbia University Press, 1985).

37. These terms come from an illuminating discussion in Donald P. Spence, *Narrative Truth and Historical Truth: Meaning and Interpretation in Psychoanalysis* (New York: Norton, 1982), 144–45.

38. See Sande Cohen, *Historical Culture: On the Recording of an Academic Discipline* (Berkeley and Los Angeles: University of California Press, 1986), 100, 323. See also Raymond Bremond, *Logique du récit* (Paris, 1973); Seymour Chatman, *Story and Discourse: Narrative Structure in Fiction and Film* (Ithaca, N.Y.: Cornell University Press, 1978); and Mieke Bal, *Narratology: Introduction to the Theory of Narrative* (Toronto: University of Toronto Press, 1985).

39. Edward Gibbon, *The History of the Decline and Fall of the Roman Empire*, 7 vols., ed. J. B. Bury (London: Methuen, 1900–02), 3:353, n. 184.

40. Henry Fielding, *The History of Tom Jones, a Foundling*, 2 vols., ed. Fredson Bowers (Middletown, Conn.: Wesleyan University Press, 1975), 1:43. The passage reads: "Reader, take care, I have unadvisedly led thee to the Top of as high a Hill as Mr. *Allworthy's*, and how to get thee down without breaking thy Neck, I do not well know" (1:43–44). This kind of interruption is typical of Fielding's narrative strategy. Elsewhere, he writes: "we warn thee not too hastily to condemn any of the Incidents in this our History, as impertinent and foreign to our main Design, because thou dost not immediately conceive in what Manner such Incident may conduce to that Design" (2:524). Laurence Sterne, of course, also indulges in this sort of rhetorical tongue-lashing of the reader in *Tristram Shandy*.

41. See the famous "Author's Preface" to *Joseph Andrews*, in which Fielding outlines his new theory of the "comic-epic-poem in prose." In *Joseph Andrews*, ed. Martin C. Battestin (Boston: Houghton Mifflin, 1961), 7.

42. The quotation serves as an epigraph to Leo Braudy's book *Narrative Form in History and Fiction: Hume, Fielding, and Gibbon* (Princeton, N.J.: Princeton University Press, 1970), 3.

43. See Roland Barthes, "Le discours de l'histoire," in *Le Bruissement de la langue: essais critiques IV* (Paris: Editions du Seuil, 1984), 153–66, and Iggers, 23–24.

44. Walther Riese, "The Structure of the Clinical History," *Bulletin of the History of Medicine* 16 (December 1944): 442. The italics are Riese's.

45. Jacalyn M. Duffin has called these *autopathographies*, and Drs. Brodal and Cheyne are joined by Thomas Sydenham on his gout, John Hunter on his angina, and, more recently, Oliver Sacks in *A Leg to Stand On* (New York: Summit Books, 1984). See Jacalyn M. Duffin, "Sick Doctors: Bayle and Laennec on Their Own Phthisis," *Journal of the History of Medicine* 43 (April 1988): 165–82, and Harvey N. Mandell and Howard M. Spiro, eds., *When Doctors Get Sick* (New York: Plenum, 1987). The term *pathography* itself has been borrowed from Freud's essay on Leonardo da Vinci. Tom Conley analyzes the fictive nature of this narrative form in "Freud: Notes on Pathography and the Art of History," *Paragraph* 14 (July 1991): 115–22. For a more medicoliterary discussion, see Anne Hawkins, "Two Pathographies: A Study in Illness and Literature," *Journal of Medicine and Philosophy* 9 (August 1984): 231–52, and the subsequent commentaries in the same issue: Earl E. Shelp, "The Experience of Illness: Integrating Metaphors and the Transcendence of Illness," 253–56, and Anne Hudson Jones, "A Commentary on 'Two Pathographies: A Study in Illness and Literature,'" 257–60. The quotation is from George Cheyne, *The English Malady; or, A Treatise of Nervous Diseases of All Kinds, As Spleen, Vapours, Lowness of Spirits, Hypochondriacal, and Hysterical Distempers, etc.* (London: G. Strahan and J. Leake, 1733), 362. The italics are Cheyne's.

46. Cheyne, 363.

47. *Ibid.*, 259.

48. *Ibid.*, 260.

49. *Ibid.*, 262.

50. Clifford Geertz, "Thick Description: Toward an Interpretive Theory of Culture," in *The Interpretation of Cultures* (New York: Basic Books, 1973), 3–30.

51. This notion of ethnography as a kind of cultural code breaking and an interrogation of systems of meaning appears throughout an important collection of essays on ethnographic practice, James Clifford and George E. Marcus, eds., *Writing Culture: The Poetics and Politics of Ethnography* (Berkeley and Los Angeles: University of California Press, 1986).

52. Geertz, "Thick Description," 26.

53. Geertz, "Ideology as a Cultural System," in *The Interpretation of Cultures*, 204.

54. *Aristotle's Poetics*, trans. James Hutton (New York: Norton, 1982), 75. I am

indebted here to Murray Krieger's discussion of this idea in his "Fiction and Historical Reality: The Hourglass and the Sands of Time," in *Literature and History*, Papers Read at a Clark Library Seminar, 3 March 1973 (Los Angeles: William Andrews Clark Memorial Library, 1974), 45-77.

55. Dominick LaCapra discusses some of these questions in *History and Criticism* (Ithaca, N.Y.: Cornell University Press, 1985).