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# Structural Racism and Practices of Reading in the Medical Humanities

Olivia Banner

The notion that race is biological has been exhaustively refuted in both the humanities and the social sciences, and over the past two decades increasing numbers of scientific and medical experts have joined the attack. In 2000, the Human Genome Project (HGP) was applauded for providing definitive evidence that race has no biological foundation. Around the same time, medical journals called for increased scrutiny, if not outright dismissal, of racial classification and profiling in the clinic and in research.<sup>1</sup> Yet even as race has been delegitimized by these authoritative voices, its use in the clinical setting is still common, with rationales ranging from its adequacy as a tool for categorizing people to the exigencies of prescribing race-based pharmaceuticals.<sup>2</sup> It is also still alive in the well-documented conscious and unconscious forms of race bias that play out in clinical interactions. In its less-recognized incarnation, biological concepts of race that reigned in earlier decades persist in how medicine conceives of the organs and disorders of African Americans as differing from those of other groups.<sup>3</sup> Science's delegitimizing of race has not, in other words, brought an end to race's life in medicine, where its continued presence has material effects on how people of color are diagnosed and treated.

In the late 1990s and early 2000s, health care responded to problems of bias by issuing cultural competency guidelines. Medical school education boards followed suit, issuing their own sets of objectives for a cultural competency skill set that would counteract "evidence of racial . . . disparities in health care."<sup>4</sup> Such skills are intended to help medical school students understand that patients of diverse cultural backgrounds "perceive health and illness and respond to various symptoms, diseases, and treatments" differently, and to "recognize and address gender and cultural biases in health care delivery" toward the goal of improving

physicians' interpersonal skills with patients of diverse backgrounds.<sup>5</sup> Yet for all their noble intentions, cultural competency courses and the skills they aim to impart do not get at the root of racial disparities in health care—that is, structural racism. Racism is not simply enacted in select interpersonal interactions; it is inscribed in the institution of medicine, and no amount of re-training individual physicians will fix an institution. Additionally, when we examine whether cultural competency curricula are achieving their stated goals, it is hard to see their effect. As John Hoberman argues, there is little evidence that cultural competency courses have been ubiquitously integrated into medical school curricula; there is less evidence that such courses are having an effect on the culture of medicine; and there is no evidence they are reducing students' bias.<sup>6</sup> Perhaps most significantly, cultural competency courses do nothing to enlighten physicians-in-training about structural racism, which causes the very diseases and conditions they observe in their patients.

What role have the medical humanities and narrative medicine fields played in this situation? In general, the fields have promoted a pedagogical agenda based on “fixing” poor interpersonal skills through engagement with discrete literary works. Hoberman, for one, has vociferously criticized both the privileging of the single work and the aim of fostering identification, asserting that this approach should be replaced with sociological or anthropological analyses that illuminate social context.<sup>7</sup> This article argues instead that literary studies (and the study of single works) do have a place within an anti-racist medical humanities and narrative medicine practice, provided the fields shift toward methods of interpretation that foster *structural competency*.<sup>8</sup> An idea elaborated by Jonathan Metzl and Helena Hansen, structural competency recognizes that bias in the clinic derives from the stereotypes and stigmas health care professionals learn from the culture at large, stigmas that are themselves the product of structural racism. In other words, “stigmas are not primarily produced in individual encounters but are enacted there due to structural causes,” and so it “follows that clinical training must shift its gaze from an exclusive focus on the individual encounter to include the organization of institutions and policies . . . if clinicians are to impact stigma-related health inequalities. . . . [M]edical education needs to more systematically train healthcare professionals to think about how such variables as race, class, gender, and ethnicity are shaped . . . by the larger structural contexts in which their interactions take place.”<sup>9</sup> A structural competency program would enable students to identify and consider how structural racism informs

everyday living (and thus has a direct effect on the bodies and minds physicians treat), their own interactions with patients, and the medical institution itself. Such a program would shift the reparative focus from individual interactions between physicians and patients to the institutions and structures that delimit those interactions.

Medical humanities and narrative medicine could be enlisted for the aims of structural competency if the fields were to foster textual readings that elucidate how ideologies of race, gender, and disability inform social, political, economic, and institutional structures, which then inform health and illness. I argue that such readings become even more necessary when we scrutinize the cornerstone principles often said to undergird the fields: empathy and listening.<sup>10</sup> Those skills, whatever their value, can do little to overcome the racist practices and biases embedded in medicine, which are institutionally reproduced, not intrinsic to interpersonal relations. That orientation, I show below, is in part a result of the body of literature the fields' scholarship has chosen to analyze, for it is authored in the main by people who do not experience the daily visible and invisible insults of racism. It is questionable, then, whether principles derived from such texts are relevant to people of color. When cultural competency is joined to these principles and their union framed as a sufficient response to racism in health care—where the individual physician learns the skills necessary to listen to patients and to respect cultural differences—the locus of anti-racist endeavor becomes the individual, rather than institutions and structures.

To illustrate a mode of interpretation that illuminates structural racism, I return to texts that medical humanities and narrative medicine consider more or less exemplary at representing a patient's desire to be listened to and empathized with, and I analyze them using a mode of analysis attuned to structures. Both works were authored by African Americans—one of them, Audre Lorde, explicitly African-American identified; the other, Anatole Broyard, a writer who passed as white—yet readings of their works by medical humanities scholars contain little consideration of race. By foregrounding race, I show that their works implicitly and explicitly decry structural racism and that medicine in particular is figured within that indictment.

The import of this re-reading of the works is twofold. First, by highlighting that Lorde's explicitly political critique of medicine has been neglected, I demonstrate that the accepted interpretive approach's focus on the individual has had the effect of obscuring other available approaches. My analysis of Broyard buttresses this claim. Broyard's

works have typically been considered emblematic expressions of the patient's desire for a good and empathic listener, but I show how we must consider them emblematic of passing narratives. Passing, by its nature, proves that structural racism keeps people of color from living full lives, and passing narratives, which operate on multiple layers of signification, ask that readers consider their own assumptions about race and how those assumptions play out in acts of reading. Once we consider them as narratives that in their very masking of race reveal structural racism, Broyard's works allow us to examine the medical humanities' own role in maintaining that structure, and to consider what the field could do better to hurry its demise.

### The Scholarly Elision of Race and Structural Racism

In this section, I trace two histories: first, the historical neglect of African-American literature in seminal scholarship in the field, and how that literature, when it does appear, is framed and interpreted; second, the history of how Lorde's work has been received by her interlocutors.

Hoberman has already provided information on the lacuna around race by looking at the medical humanities' key journals: in the first fifteen years of *Literature and Medicine* and the first thirty of the *Journal of Medical Humanities*, about 1 percent of articles examined race. I extended Hoberman's analysis, which concluded with the journals' 2009 issues, and found that the trend continued. *Literature and Medicine* contained no articles that considered race. (It did, however, include one special issue on world literature and global health, and those articles took up issues of colonialism.) The *Journal of Medical Humanities* evinced a greater interest in race in the United States context: 7 of 134 articles since 2009 concern either writers of color or questions of race/ethnicity in medicine.<sup>11</sup>

This lacuna in the fields' key journals is mirrored in the fields' foundational works: Howard Brody's *Stories of Sickness* (1987), Arthur Kleinman's *The Illness Narratives* (1988), Arthur Frank's *The Wounded Storyteller* (1997), Anne Hawkins's *Reconstructing Illness* (1999), and Rita Charon's *Narrative Medicine* (2006). Each in its own way honors fairness and equality in health care, and some are explicit about framing their work in relation to social justice efforts. Yet none contains a sustained conversation about race; nor, moreover, do any of them draw significantly on works by writers of color. By no means does this omission

detract from these authors' professed desire to address socioeconomic and racial disparities in health, and neither does it mean that they presume universality from the white authors they examine. But it does mean that the now-canonical scholarship in medical humanities and narrative medicine has prioritized authors of the race category whose privilege insulates them from questions about how race informs illness, health, and/or the patient-doctor relationship. The narratives upon which they elaborate their arguments, in other words, are authored out of social locations little troubled by the realities of racism.

What relation, if any, does this lacuna bear to the claims that literature and literary analysis can inspire empathy and the ability to listen and to witness? Generated out of a limited set of texts, are these claims generalizable to all groups of people? We find one answer in an application of the reading-for-empathy model. Delese Wear and Julie Aultman devised a syllabus intended to expose medical school students to issues in families that diverge from that of the middle-class norm typical of most students' backgrounds. Drawing on the basic tenet that reading literature can improve students' empathy skills, Wear and Aultman hoped that students would gain insight into people of backgrounds and value sets unknown to them by reading literature about such families. Instead, they found that their students resisted understanding or empathizing with characters whose cultural, social, or economic experience was far outside theirs, or with those who rebelled against social norms (for gender, race, family, sexuality, and so forth). Because students may empathize only with those characters (and, potentially, patients) whose life experiences and values mirror their own, Wear and Aultman suggest moving away from a medical humanities praxis focused on the individual, and moving toward fostering an understanding of how social, economic, and cultural forces impact health.

Analyzing work by writers of color for its representation of empathy provides another window into whether such claims are generalizable. Rebecca Garden, for example, scrutinizes a text by Dominican writer Junot Díaz that includes moments of empathy. Rather than presenting empathy as something to be desired, Díaz's text depicts empathy, when directed at people of color, as wrapped up with judgment. Put another way, the presence of structural racism means that empathy depends on the very model of authority and paternalism it is presumed to negate. Díaz's text thus cautions readers to examine empathy critically, and it suggests that "empathy may be of limited benefit."<sup>12</sup>

Audre Lorde's works similarly problematize notions that the reading process should inspire empathy. In *Burst of Light*, published years after her earlier work *Cancer Journals*, Lorde looks back over the earlier text and writes that its "power doesn't lie in the me that lives in the words so much as in the heart's blood pumping behind the eye that is reading, the muscle behind the desire that is sparked by the word—hope as a living state that propels us, open-eyed and fearful, into all the battles of our lives."<sup>13</sup> Reading, for Lorde, should not inspire the reader's empathy; it should incite activism toward change. Later in the text Lorde depicts an encounter with her physician in which he displays the sort of paternalism for which medicine has been roundly criticized; she then offers her version of how she wished he had treated her. "[W]hat he said to me was, 'if you do not do exactly what I tell you to do right now without questions you are going to die a horrible death,'" while "[w]hat that doctor could have said to me that I would have heard was, 'you have a serious condition going on in your body and whatever you do about it you must not ignore it or delay deciding how you are going to deal with it because it will not go away no matter what you think it is.' Acknowledging my responsibility for my own body."<sup>14</sup> In the alternate response Lorde envisions, the physician would not empathize with or witness her; rather, he would acknowledge her autonomy. When that autonomy is not acknowledged, Lorde writes, she "feel[s] the battle lines being drawn up in [her] body," employing the trope recurrent throughout her work of the battle women of color wage daily against white capitalist patriarchy.<sup>15</sup> What Lorde wants is basic respect for her agency and autonomy; when she does not receive it, she reads it as the failure not of an individual to understand her but rather of a series of structures that allow that miscomprehension to occur in the first place, and her personal response is to engage in battle against the structures that buttress and legitimate his practice—racism's intersection with patriarchy, homophobia, and capitalism.

Perhaps the clearest exposition of what drives Lorde's "battles" can be found in the *Cancer Journals*. Toward the end of that volume's third essay, Lorde explicitly condemns Western medicine's emphasis on curing and treating cancer rather than advocating against the environmental pollution that causes cancer, and which disproportionately affects communities of color. Such environmental racism, for Lorde, exemplifies the intersection of capitalism with racism. Lorde also denounces the heteronormativity inscribed in the medical treatment of breast cancer, which assumes post-mastectomy women will—and should—want their

breasts reconstructed in order to conform to heterosexual imperatives about female desirability. These are not, Lorde makes clear, criticisms aimed at specific hospitals, doctors, or organizations: they are criticisms aimed at medicine that institutionally reproduces structural racism, patriarchy, and socioeconomic injustices.<sup>16</sup>

Lorde's structural critique of medicine has been elided in influential discussions of her work from medical humanities and narrative medicine, suggesting those fields' discomfort with that critique. In the typology of illness narratives that Hawkins presents in *Reconstructing Illness*, for example, she categorizes Lorde's *Burst of Light* with other works in which patients seek alternatives to Western treatments. In *The Wounded Storyteller*, which contains perhaps the longest discussion of Lorde's work, Frank describes the *Cancer Journals* as a "manifesto," and so of all these scholarly volumes Frank's does the most justice to her works' political valence; still, he does not mention her urgent condemnation of the medical establishment as enabling environmental racism to go unchecked. Thus while he does describe the work as political, the content of those politics does not receive full airing. Charon's influential *Narrative Medicine* (published about a decade after Frank's book) overlooks the manifesto aspect of Lorde's work. Charon writes,

Who [Lorde] is and not what she has is what marks her illness. . . . In her *Cancer Journals*, this feminist lesbian African American poet writes, "Each woman responds to the crisis that breast cancer brings to her life out of a whole pattern, which is the design of who she is and how her life has been lived." Although an illness might trigger dissociation from life, it can also distill the life, concentrate all its deepest meanings, heighten its organizing principles, expose its underlying unity.<sup>17</sup>

In framing Lorde's work as important for offering an individual's unique perspective on the meaning of an illness, *Narrative Medicine* elides Lorde's political argument. In one of the latest scholarly works to bridge narrative medicine scholarship with literary studies (Ann Jurcic's *Illness as Narrative*), Charon's understanding of Lorde is repeated: "[P]oet Audre Lorde refuses to accept breast cancer and mastectomy as a loss; instead, she writes about her illness as an opportunity to redefine her body, her self, and her voice."<sup>18</sup>

In moving toward the view that canonizes Lorde's work as concerning the development of an individual's voice, the fields have denuded the text of its excoriation of Western medicine as an indus-



try that colludes with structural racism, homophobia, and patriarchy to affect the health of women of color. So denuded, the text is easily slotted into typologies organized around the illness narrative rather than the politics of illness. In light of the paucity of attention the fields' scholarship has paid to works by writers of color, this is perhaps not surprising—one needs a quorum of works before another “type” can be established. On the other hand, one also needs some sense of the qualities being sought in order to add works to a possible quorum, and, as my next section will suggest, that the field has additionally missed the critique of structural racism present in another canonical text implies a blind spot around race.

### Reading Anatole Broyard: Toward Structural Competency

Having established that the fields' foundational texts reflect an insufficient engagement with literature by writers of color, I turn now to consider a writer who is enormously popular with scholars in the fields but whose race has never factored into their scholarship. In 1990 Anatole Broyard published an article in the *New York Times Magazine* (subsequently republished as “The Patient Examines the Doctor” in his *Intoxicated by My Illness*) that has been cited frequently in the fields' literature, and for good reason.<sup>19</sup> Sentences such as “I want [a doctor] who is a close reader of illness and a good critic of medicine”; “I want to be a good story for [my doctor], to give him some of my art in exchange for his”; and “[t]he technicians bring in the raw material. The doctor puts them into a poem of diagnosis” pose the physician-patient relationship as one of reader-story, and in describing the physician's practice as an art, they call out to scholars and physicians who see doctoring and literature as noble pursuits.<sup>20</sup> Yet none of these scholars has incorporated the knowledge, offered publicly by Henry Louis Gates in a 1996 *New Yorker* article and repeated in Broyard's daughter Bliss's 2006 *One Drop: My Father's Hidden Life—A Story of Race and Family Secrets*, that Broyard, of Creole descent, passed, once he left his childhood home, as white.<sup>21</sup> In light of those revelations, it seems important that we return to his writings not only, as scholars have done, to understand their relationship to racial passing, but also to understand how passing figures in his writings *about medicine*.<sup>22</sup> This overlooked aspect of Broyard's popular texts can illuminate the value of literature to advancing structural competency.

Broyard's works most often discussed in medical humanities and narrative medicine literature are "The Patient Examines the Doctor" and "Doctor Talk to Me," the first delivered before an audience of medical professionals at the University of Chicago Medical School in 1990, then published in his posthumous collection *Intoxicated by My Illness* (1992), and the second, a distillation of that talk, published in the *New York Times* in 1990. Both of these short pieces describe Broyard's ideal doctor and his vision of an ideal doctor-patient relationship, and they have proved invaluable for medical humanities scholars because they draw parallels between that relationship and that of reader-interpreter and text. These writings, for example, have borne ample fruit for Arthur Frank, who has tirelessly returned to Broyard's "Doctor Talk to Me" for evidence that patients want physicians who can "read" well. In *The Wounded Storyteller*, Frank employs "Doctor Talk to Me" to demonstrate that patients want their physicians to enter into a relationship with them, one in which the physician becomes a witness for the patient and therefore assumes an ethical stance of reciprocity, and Broyard has continued to occupy a central place in Frank's personal canon; Frank used Broyard to introduce an article about "Why Doctors' Stories Matter" as recently as 2010.<sup>23</sup>

In none of his writings does Frank mention that Broyard passed as white, and he is not alone in overlooking this fact. In articles addressed to ethicists (in the *Hastings Center Report*) and those targeting literary critics (in the journal *Narrative*), writers have used "Doctor Talk to Me" to illustrate that patients want their physicians to be skilled readers who can empathize and witness—without mentioning Broyard's race.<sup>24</sup> Sayantani DasGupta refers to Broyard in a piece about physician humility for the British medical journal the *Lancet*. She writes, "[B]y entering into a stance of narrative humility, the physician is fostering a state in which, as Broyard has observed, even as the physician examines the patient, the patient is able to examine the physician. The witnessing function, so crucial to doctoring, becomes a mutual one, supporting and nourishing both individuals, while enabling a deeper, more fruitful clinical relationship."<sup>25</sup> Felice Aull employs Broyard's work for an article in the journal *Narrative*, writing that Broyard thinks a "doctor should 'enter' his condition and 'figure out what it feels like to be me.'"<sup>26</sup> For Aull, Broyard's essay supports Rita Charon's project: "Her model is one of partnership, reflection, and affiliation; there is greater likelihood that the physician will acknowledge the patient's (and the family's) suffering, since the model allows the meaning of illness to be articulated and provides space for the physician's subjectivity

by encouraging reflective practices. Broyard's ideal doctor is 'a storyteller who can turn our lives into good or bad stories, regardless of the diagnosis.'<sup>27</sup> Here, as in Frank's work, Broyard is understood to extol storytelling's virtue as a means to deepen the patient-physician relationship. A central Internet resource for medical humanities and narrative medicine, the *Literature, Arts, and Medicine Database*, does not mention Broyard's ethnic origin as it does for other authors (such as Audre Lorde, whom the site labels as African-American).<sup>28</sup>

There is nothing inaccurate in these readings of Broyard's work. "The Patient Examines the Doctor" explicitly exhorts doctors to "make contact" with their patients, to engage in "empathetic witnessing," and to "read" the patient's illness.<sup>29</sup> Yet Broyard's other works (his posthumously published memoir; his book reviews; his essays) are characterized by the recurring tropes of misidentification and imposture—that is, moments when "reading" fails; and so the emphasis his illness writings place on "reading" calls out for contextualization within a larger corpus that consistently returned to this theme. In his earliest writings, Broyard foregrounded issues of identification. "Portrait of the Inauthentic Negro" (published by the influential literary magazine *Commentary* in 1950) argued that African Americans were plagued by an inability to establish a true self. In this essay, Broyard laid out five types of inauthenticity he said were characteristic of African Americans. Some of them include a performative aspect ("minstrelization" and "the rejected attitude"); in all of them, a person's style, attitude, and actions are responses to racist assumptions about people of color rather than generated out of an authentic self. For Broyard, that authentic self would arise once "Negroes . . . proved themselves fundamentally 'different' only in appearance."<sup>30</sup> As other commentators have noted, in this early piece Broyard seems to have been justifying his own passing, portraying his refusal to identify as African-American as a project of achieving authenticity.

The editor's note introduced that essay as an "analysis of the situation of the American Negro, which [the author] knows at first hand."<sup>31</sup> This was the one instance in his career where Broyard's African-American heritage was mentioned in print. By the time he was hired as a book critic by the *New York Times*, which maintained a de facto whites-only policy, Broyard was no longer identified, in his author's descriptions or elsewhere, as black. For literary audiences, then, Broyard was effectively rendered white, but, as will become clear below, it is important to note that the African-American community knew Broyard was black, as did many of the New York intelligentsia (white and otherwise) with whom Broyard associated.<sup>32</sup>

Forty years after "Portrait," Broyard delivered the talk that would enter the medical humanities and narrative medicine canon without referring to his own race, but his opening line strikingly echoes that 1950 piece. "I want to begin by confessing I'm an imposter," Broyard began, which, in light of his passing, tantalizes with the possibility of a confession about race and imposture, authenticity and inauthenticity.<sup>33</sup> Instead, the paragraph goes on to explain this imposture as a matter of whether he can legitimately address an audience of physicians: he has little experience with doctors and thus is posing as someone with in-depth knowledge of the doctor-patient relationship. And so, as Alisha Gaines and Brett Kaplan have noted, the opening statement must have seemed fairly mundane to his audience, its clarification slotting Broyard into their expectations for what a speaker addressing a room full of physicians would logically say. At the same time, whether knowingly or not, Broyard was offering his audience—both those gathered in the University of Chicago auditorium as well as those reading the *New York Times*—a chance to consider that other kinds of imposture might figure in his success at attaining this forum.

This is not the sole mention of imposture in the speech. The trope recurs when Broyard visits a urologist. Shown into an office to await the physician's arrival, Broyard

subjected the doctor to a preliminary semiotic scrutiny. Sitting in his office, I read his signs. The diplomas I took for granted: what interested me was the fact that the room was furnished with taste. There were well-made, well-filled bookcases, an antique desk and chairs, a reasonable Oriental rug on the floor. . . . On the walls and desk were pictures of three healthy-looking, conspicuously happy children, photographed in a prosperous outdoor setting of lawn, flowers, and trees. . . . [O]ne of the photographs showed a sailboat. From the evidence, their father knew how to live—and, by extension, how to look after the lives of others. His magic seemed good. Soon the doctor came in and introduced himself. Let's go into my office, he said, and I realized that I had been waiting in the office of someone else. I felt that I had been tricked. Having already warmed to the first doctor, I was obliged to follow the second man, this imposter, into another office, which turned out to be modern and anonymous.<sup>34</sup>

Broyard was obsessed with style; throughout his writings he returns to style as the essential element of living, and so it is in keeping

with that general worldview that he would judge a man by his style. In this passage, though, style takes on an additional meaning, as the office's style—its furnishings and decorations—communicates something about the *quality* of the professional, a quality that can be determined through the sort of “semiotic scrutiny” to which literary critics (of which Broyard was one) subject texts. The doctor fails to pass this initial scrutiny in two ways: first, by himself conducting a sort of imposture on Broyard with the “lie” of the front office; second, because his actual style (modern, anonymous) does not match Broyard's expectations about the style a competent, if not “magical,” physician should have. Those expectations are fulfilled by decorations notable for their indications of class status—the sailboat, for example, and “well-made” furnishings. In this light, what turns Broyard off about the actual office is that its homogeneity, in not offering any personal information, does not allow a precise identification of the doctor's social status. Indeed, other details Broyard notes suggest the truly troubling aspect of this urologist is that he does not properly occupy the role of the esteemed and highly compensated physician. For Broyard, the urologist

was such an innocuous looking man that he didn't seem intense enough or willful enough to prevail over something powerful and demonic like illness. He was bland, hearty, and vague, polite where politeness was irrelevant. I felt that he would be polite even to my illness, whatever it might be. He reminded me of a salesman, with nothing to sell but his inoffensiveness. I didn't like the way he spoke: it struck me as deliberately deliberate, the speech of a man fixed in a pose, playing doctor.<sup>35</sup>

The comparison to a salesman, a middlebrow profession, suggests that a true doctor should occupy a social class of some prestige.

This emphasis on style recurs later in the piece, when the doctor performs a cystoscopy on Broyard while wearing two surgical caps on his head. “[T]he moment I saw him in these two caps, I turned irrevocably against him. He wore them absolutely without style, with none of the jauntiness that usually comes with long practice. . . . He wore [them] like an American in France who affects a beret without understanding how to shape or cock it. To my eyes this doctor simply didn't have the charisma to overcome or assimilate those caps, and this completed my disaffection.”<sup>36</sup> These passages seem, on first reading, to continue Broyard's emphasis on style: he wants a doctor who

is forceful, assured, charismatic, with a personality strong enough to overwhelm his uniform's awkwardness. Yet if we read these passages in light of Broyard's own successful passing, they take on additional meaning. The terms "overcome" and "assimilate" in the final sentence stand out for their race connotations (both figuring prominently in civil rights discourse), and the wearing of "two caps" seems to echo, if not signal, Broyard's own "wearing" of "two hats," spending much of his professional and personal life as white, while also moving fluidly through African-American settings. In this reading, Broyard judges the doctor's attempt to wear two hats through the prism of his own successful navigation of two worlds.

If we follow the tacit contrast between the doctor failing to inhabit two hats at once and Broyard succeeding to pass, and consider it in light of the fact that Broyard may have been toying with the idea of revealing his passing to his children at about this time, we might take this passage to figure Broyard's African-American identity in relation to the image of a failed physician he gives us.<sup>37</sup> Just as his initial semiotic scrutiny of the physician indicated a physician with good magic, so to the world's initial semiotic scrutiny, under which Broyard was assumed to be white, Broyard would appear to be a writer of good magic—a writer whose whiteness imbued him with the cultural legitimacy to assess and evaluate establishment culture. Passing as white, Broyard could live in the wealthiest county in Connecticut and be a member of its country club; passing as white, he could publish his assessment of culture in the most esteemed literary outlets in the nation. From this perspective, what Broyard feared was that if his passing were revealed, that magic would evaporate, leaving in its place only someone "playing" at being a writer of value.<sup>38</sup>

Certainly the passage can be read as gesturing to Broyard's success at assimilating by fluently adopting the "styles" of different cultural and social worlds. But it also gestures to a previous scene of a urologist and a cystoscopy in Broyard's own corpus, and this almost uncanny repetition deserves attention. Such attention is especially important because the first iteration of such a scene appeared in a story Broyard published in 1954—just four years after the *Commentary* piece that named Broyard as African-American—and thus Broyard must have assumed while writing it that the story's audience might know that he was passing. First published in the literary magazine *discovery*, the story, "What the Cystoscope Said," seems to present a fairly generic story of a father's death through his son's eyes, and, with no mention of those characters' race or that of the author, it can be read as a tale

of a white family. Nevertheless, it is entirely possible to make out the contours of a passing narrative under its generic cloak.<sup>39</sup> Once we become aware of that passing narrative, we will be in a better position to consider how passing functions in Broyard's later illness narratives.

The manifest narrative of "What the Cystoscope Said" succeeds in veiling its passing narrative in part because its manifest content is so conventional to 1950s short fiction. The story can easily be read in relation to Beat generation literature depicting discontented youth alienated from the values of their parents; it can be understood to represent its narrator's psychological state, as a grieving son confronts his father's legacy; it can also be read as a narrative critical of health care.<sup>40</sup> In these understandings, which I will map out below, the story describes a father's sickness and eventual death through his son's eyes, employing images and tropes that indicate fears and fantasies about masculinity, emasculation, impotence, and death; the son copes with contradictory feelings of admiration and distaste for his parents; and the son attempts to compensate for the poor treatment his father receives during his painful illness by authoring a story as a tribute to his memory.

The story begins by detailing the father's physical degradation, when physicians prescribe an awkward-looking collar to treat a stiff neck. When it fails to work, the son, father, and mother return to the hospital, where the father is further degraded by an unpleasant cystoscopy. The attending physician introduces the procedure: "We want to get *the inside story* on you, so we're going to give you a cystoscopy. They can sometimes be unpleasant, but I don't think that will bother an old soldier like you."<sup>41</sup> The son goes to retrieve his father after the procedure and observes: "[M]y father wasn't in there. Sprawled on the table, incredibly out of place, lay a plaster Prometheus, middle-aged and decrepit, recently emptied by an eagle. . . . Or perhaps . . . what actually lay there was only an eviscerated old rooster, plucked white, his skin shiny with a sweat more painful than blood. . . . Whatever it was, it wasn't my father."<sup>42</sup> The urologist gives him six months to live, and, explaining that the hospital does not take incurable cases, advises the son, "'There are nursing homes. . . . Your father's a nice man,' he said, and he walked off down the corridor"; the son is outraged by these words: "Damnation is faint praise. . . . 'A nice man!' Can that phrase, or praise, penetrate an inch of eternity? Is that all sixty-two years achieve? Is that *what the cystoscope said*? A nice man be damned! He's a prick! He's a saint! He's a hero, a clown, a Quixote."<sup>43</sup> The passage emphasizes how much modern health care dehumanizes

its patients, with its procedures that strip away a person's dignity and then fail to recognize the complexity of a person's being. What the cystoscope "says," in other words, is inaccurate, because modern medicine's instruments do not exercise the powerful "semiotic scrutiny" of the storyteller or the true critic.

The story continues to depict the medical establishment in a harsh light. Turned away from this first hospital, the father is eventually placed in Kings County, which the son describes as "a hospital with too many sick people and too few well ones to take care of them"; his father's room, for example, contains seven beds, and he often goes unattended by staff.<sup>44</sup> When he arrives one day to find his father rigid with intolerable pain, the son hurries to fetch the nurse and demands she medicate his father. Her unempathetic manner is rendered in vivid terms: "Unceremoniously pulling down his left arm like a vandal destroying a statue with a club, leaving the other grotesquely widowed in the air, she jabbed the needle unerringly into his vein, as you would flip a switch to turn off a motor, and put him to sleep."<sup>45</sup> On top of her cruel treatment of his father, the nurse also laughs at the son, who rarely leaves the ward, for his devotion. Repulsed by her coldness, the narrator determines to enact his own form of revenge through a campaign to charm, then seduce her. He plies her with sweet talk:

"You know, Miss Shannon . . . I think that your presence and your spirit does more for these men than the doctors' medicines. . . . Even the doctors admit . . . that the will to live often means the difference between life and death. To these old men in this gray ward you are an advertisement for life. Your warm smile and your yellow hair remind them of the sun that once seemed to shine especially for them, your blue eyes just naturally suggest the sky on a perfect day, your youth calls up a picture of the girl they knew, or married, forty years ago."<sup>46</sup>

He convinces her to come to his apartment, using the somewhat odd seduction tactic of promising to loan her French author Céline's *Journey to the End of the Night*. The description of their sex act employs metaphors that connect sex to death, and they imply that for the narrator, the sex act, with its relation to vital forces, is tangled up with both his own fears of death as well as an identification with his father's dying.<sup>47</sup> "I let the book fall and seized her in a death grip and bore her backward to the bed. . . . Working with feverish haste,



I nailed the coffin, dug the grave, and dropped my previous load."<sup>48</sup> Later in the night the sex act is repeated, although this time without its intended conclusion.

I woke and impatiently pulled her clothes off under the bright light, exposing her pastel body like a calendar painting in its inhuman healthiness. Taking up my task again, I bore the pall, trod the tread of the dead, bowed my head, and tamped down the ruffled earth. I put all my strength into pounding it, pounding it flat, but it remained stubbornly round, heaving against me. I tried, I tried, but flowers sprang up under the blade of my shovel, and I dropped it.<sup>49</sup>

Falling into a dream state, he sees himself "in a hospital, in bed, and a nurse was standing over me, smiling. Where was the needle in her hand? I wondered, and then, as my head began to clear, she spoke. But I couldn't make out what she said, and before I could answer she was gone."<sup>50</sup>

The story's familial and Oedipal themes are woven together in this metaphor-dense scene. The son's father, a carpenter by trade, was an expert user of tools, so the appearance of nails and a shovel in this scene associates the son's actions with his father's work to suggest that the son is enacting a skill inherited from the father. In fact, at an earlier point in the story, the son leans over his delirious father to hear what the son expects will be significant last words, but all his father tells him is the now-distant date when he last had an erection. Thus the son's obsession with having sex with Nurse Shannon stems from the desire, however unconscious, to revive the father's impotent masculinity and to remedy his illness, of which the nurse's vibrant radiance seems a rebuke. With the first sex act, the son manages to partly achieve this goal—by "nailing a coffin" and "digging a grave" he has momentarily contained that energy—yet with the second one the son fails to arrest her fecundity, suggested in the "stubborn roundness" of the earth. When "flowers" spring up, it is clear that her vibrancy—and, possibly, her own pleasure—cannot be extinguished at all. And so, although the son cannot restore the masculinity and potency that his father lost to a cystoscopy that rendered him a plucked rooster (i.e., an impotent cock) and to the nurse's phallic needle jabs, the son does feel himself less threatened by the nurse's power, for in his oneiric vision she no longer holds the castrating instrument, her threat dissolved.

In addition to the clear Freudian undercurrents of that dream, the oneiric vision is also suggestive about power and communication in the medical context. Just at the moment when it seems real communication between the nurse and the son is on the horizon, it disappears; meaning is deferred. This figuring of failed communication could be read as a commentary on the elusiveness of understanding between medical professionals and those they treat. In his dream vision, just as he is rendered visible to her his ability to understand her vanishes. In this reading—one that reiterates the core principles of medical humanities and narrative medicine, that patients want to be witnessed—the author intends to show us just how harmful negative interactions with patients are, for they prohibit the real exchange of understanding toward which the dream vision reaches.

That is one possible reading of this scene. But a radically different reading of this scene, and of the entire story, becomes available if we consider how race—and its absence—figures in them. In the story's first pages, the son explains that, on his first visit to a hospital, none of the attending physicians said that his father had cancer; instead, the father was told he needed heat treatments and the collar for his sore neck. Perhaps, the son realizes in retrospect, the family should have figured out the real diagnosis, for "[e]veryone knew Memorial Hospital was for cancer cases. Everyone but Peter Romain, his wife, Ethel, and his son, Paul."<sup>51</sup> That second sentence is the only instance in the story where the narrator refers to himself in the third person. Its singularity draws attention to the proper names and their function as signifiers, reminding us that proper names typically convey some quality of the person named—often, an ethnic or racial identity. Yet the generic quality of these names frustrates an attempt to identify their race or ethnicity (at the most, the names may indicate a Catholic family with a French background; they also seem white). Something about this particular family's culture has kept them from knowing what another culture takes as common knowledge. By presenting this through a grammatical choice that draws our attention to language as a signifying system, the story alerts us to the possibility of multiple meanings; with that grammatical shift pivoting on the names of people, it alerts us to the possibility that their identities may not be clear cut.

This is the only time the story even tentatively invokes the family's race. It is more specific about other characters. The nurse's skin color is identified multiple times: "Her complexion was so fair, . . . her eyes so blue, that she reminded me of a patriotic image in pastels, the winner of some title such as Miss American Flag."<sup>52</sup> An-

other passage emphasizes her whiteness to the extent of doubling up on its layers: "Going up the four flights, my eyes were so intent on the pink beneath her white stockings . . . that I stumbled and had to steady myself."<sup>53</sup> While the nurse is marked for her skin color, the skin color of the son's own family members is never mentioned; instead, their racial identity remains vague, marked only by what it isn't. For example, while one of his father's doctors is ethnically typed, and his father is contrasted to that ethnicity, his father is still not identified by any kind of ethnic or racial marker. "The doctor in charge of his case was Jewish. Although [my father] was a halfhearted anti-Semite, he much preferred a Jewish doctor because he believed the Jews had a better grip on life."<sup>54</sup> While we know the father is an anti-Semite, the only information we can glean from this is that he is not Jewish.

At what will be his final destination, Kings County, race is explicitly named. "[T]hey wheeled another bed into the room. The room was long and narrow, so they situated it below the foot of my father's bed. Lost in the sheets and the pillow, I saw a dark spot, apparently a Negro patient to keep my father company in death's antechamber here outside the ward."<sup>55</sup> This specificity about his new companion's race has two effects: first, it marks out the family as not-black; second, it signals to readers operating on the assumption that the family is white the extent of the father's degradation, that he would have to share space with a black man. Other readers, however, may understand this scene differently. Published in 1954, "What the Cystoscope Said" appeared at a time when hospitals were segregated. It was not until 1964, with the passage of the Civil Rights Act, that its Title VI extended equality to all federal programs, among them Medicare, and thus forced integration of all hospitals. If the men are consigned to the same space on the ward at Kings County, a public institution, the father could therefore be in a section designated specifically for African Americans; if the hospital did not maintain segregated wards, then this passage works to indicate that the hospital itself caters to a local African-American population. A reader attuned to the story's doubled modes of signification will therefore understand that the father and son have been categorized by the medical profession as black.<sup>56</sup>

In that light, the story generates entirely new meanings. It is no longer simply a story about one man's degradation by the brutal process of dying or through the dehumanizing treatments of modern medicine: it is a story about how racism affects medical care. When the first doctor they see tells the son the hospital cannot treat his father due to the late stage of his disease, a knowing reader will rec-

ognize the good chance this is a lie told to hide the real reason: the hospital's legally sanctioned refusal to treat African-American patients. Nurse Shannon may neglect to humanely treat his father and other men on the ward because she is a mean person or because modern medicine is inhumane, but it is just as likely that she is a racist who saves her acts of compassion for those with skin as fair as hers. The story's opening passage also holds radically different meanings once we understand the father as black. "When I saw my father with the horse collar around his neck," it begins, "I knew immediately. . . . Some people are just stopped dead in their tracks . . . but my father was demoted down the evolutionary scale into nothingness. He lost position after position in interminable retreat."<sup>57</sup> Certainly, this could be read as describing how illness and its treatment diminish his father, but the passage also uses images and discourse associated with slavery: a horse collar that yokes; people constrained from moving; a eugenics-based discourse of degeneration. The phrase "he lost position after position" draws not only on eugenics discourse but also on the ladder of social mobility, which his father—a successful carpenter—had been able to climb during his professional life. Here, the medical establishment, having identified him as black, erases that success—or rather, once categorized as black, his father undergoes medically racist treatment, his social class providing no protection.<sup>58</sup>

The climactic sex scene also transforms once we consider how race figures in it. When the son attempts to subdue the "inhuman healthiness" of the nurse's "pastel body," the revenge he seeks is not just for her cruel treatment of his father but also for the racism that fuels her manner of care. Thus the tropes of stamping out the healthiness contained in her body stage a contest among disability (here figured as the threat of debility), gender, and race. In its initial scene aligning the father's treatment of being collared to the yoke of slavery, the story constructs a relation between blackness and debility. This pivotal sex scene can be seen as a struggle between the son's black masculinity, which is always threatened under racism, and white femininity, which is here figured as endlessly renewing, like a calendar. The dream vision is a conclusion to this struggle where neither party is tamed or conquered but instead both vanish in a draw ("as my head began to clear, she spoke. But I couldn't make out what she said, and before I could answer she was gone"). In this reading, the sex act is an attempt to reduce the threat of the power her whiteness gives her by diminishing her bounteousness. And there is another reading of the intersections among gender, race, and disability

available to us: since the story neither mentions the son's race nor indicates how Nurse Shannon perceives him, the sex act, in which an African-American man copulates with a white woman, establishes the son's true "assimilation," one predicated on his successful disavowal of the debilitating position of black masculinity.<sup>59</sup>

I admit that this is not a very generous kind of semiotic scrutiny; it seems to support Henry Louis Gates's view that for Broyard the pinnacle of assimilational success was seducing a blonde.<sup>60</sup> Nevertheless, this reading illustrates how the multiple meanings lurking in the story can prompt and sustain a humanities interpretive practice in line with Metzl and Hansen's structural competency. Metzl and Hansen propose, for example, assigning medical students to observe medical institutions as structures and to imagine structural interventions. Students could begin by thinking about the cultural and professional institutions of Broyard's career—literary publishing and established newspapers—and their interactions with structural racism. What was it about these institutions that spurred Broyard to pass? In 1954, the *New York Times*, where Broyard would eventually work as a book reviewer, effectively maintained a whites-only hiring policy, and so a young man considering a future as a professional writer might take seriously the limitations to his professional prospects that being seen as black would create. Furthermore, to be identified as an African-American writer would have, as Gates and Brent Staples have pointed out, consigned Broyard to the ghettoized category of the "Negro writer" and thereby affected how the literary establishment would receive his writings. In recognizing that only through concealing his African-American heritage—that is, by evading the negative effects of structural racism—could Broyard shape a career where he would receive the professional stature granted to white writers, students could be encouraged to reflect on whether passing as white conveys similar privileges today. By considering a historical moment in which structural racism made passing a reasonable way to ensure the same privileges accorded white people, students might then consider whether our moment, when white patients receive higher quality care, still makes passing a viable strategy, and acknowledge that perhaps light-skinned people of color might choose to bury their own African-American background within clinical settings. This could lead to discussions about the impossibility of identifying race visually, which could launch discussions about its illegitimacy in scientific and medical institutions.

The story could also be pressed into service to interrogate whether historical changes have been substantial enough to weaken

structural racism and the bias it engenders. Considering whether such racial dynamics still prevail in hospital settings could be an important exercise for medical students, especially because many of them do not recognize that the structural racism explicit in segregated institutions in the United States prior to 1956 is still in play in today's integrated institutions. For example, if students trace the nurse's neglect to adequately address the father's pain to the color of his skin, they could be directed to the many studies documenting that today, people of color, long after desegregation and even in anti-racist contexts, are still given much lower doses of painkillers than are whites.<sup>61</sup> Students could also consider the locations and the private and public status of the hospitals mentioned in the story, in order to think about how socioeconomic status affects what sort of health care is available.

A reading of this story oriented toward structural competency would also emphasize how structural racism interacts with structural sexism. The son's pseudo-revenge on the nurse through sex is troubling, to say the least, but it can be understood as partly produced out of the differing positions the two occupy in relation to hierarchical systems of privilege. The complex realities that feed into the white woman being used as object of desire, sign of success, and target for the son's anger would be understood as his misrecognition of where power lies, a misrecognition that the structure of patriarchy itself creates. It would allow students to consider that the story places a large burden of symbolic responsibility on the actions of one individual, the nurse, when in fact she may simply be fulfilling institutional protocols. One of the goals of structural competency is to move away from the current emphasis on individuals learning to behave better and instead toward individuals understanding how institutions and structures condition that behavior. Such a reading attenuates the ungenerous nature of the reading I offered above by identifying how the nurse is also denied agency in this story, that denial produced out of complex interactions between racism and patriarchy. Reading this story to foreground how race and gender structure its characters' interactions moves the onus of responsibility from individuals and onto institutions themselves.

### Conclusion: Attending to Structures

How does this reading reflect back on Broyard's "The Patient Examines the Doctor" and "Doctor Talk to Me," published in the early 1990s, which have proven so useful to the fields of medical

humanities and narrative medicine? In those two pieces, Broyard imagines the very model of an empathetic and witness-ready physician that has become the academic ideal, and he foregrounds the dyad of the patient and physician as the primary point of contact between individual and medicine. In this model, medicine consists of two individuals communicating with each other, and it also elevates the doctor-patient relationship to one of collaborative artists engaged in creating meaning out of the endeavor of illness. It is that elevation itself that, in my opinion, has made these pieces so attractive to the fields. They are not about structures; instead, they are about the meeting of two individuals, both of them endowed with the magic that comes from style and powerful charisma, both “geniuses,” who operate beyond the anonymizing and generic forces of institutions and structures, who overcome the stifling weight of those forces and proclaim their unique selves.<sup>62</sup>

This model of privileging the atomistic and self-determining individual is not uncharacteristic of the literature of passing. There have traditionally been two dominant understandings of passing: poststructuralists applaud that it shows race to be an empty category constituted only by the meanings attached to it; those interested in racial solidarity criticize passing as a disavowal of the African-American community through the use of a personal attribute for individual gain. In work that aims to go beyond these views, Kathleen Pfeiffer has argued that passing is an example of that most valued of American traits, individualism. In her analysis of American literature, individuals who pass refuse their background, social context, and even family in order to successfully navigate through American society and refashion the self to achieve social mobility. From this perspective, the persona Broyard announces for himself—and the one he values in his ideal physician—is simply the American success story: a person of taste and means who has gained those qualities by the strong application of self-determination. It is therefore not at all surprising that this essay has proved so popular among physicians, who themselves hew to this most valued of American types. Just as Wear and Aultman discovered that their students could empathize only with those characters whose values and belief systems mirrored their own, so too physicians and medical students encountering Broyard’s ideas may see their own ideal selves and ideal profession reflected in his descriptions of the best physicians as magical and their work as a kind of art.

The 1990 essay, I have argued, serves as cover for (and projection of) Broyard’s own successful passing, which he had, early in his

career, described as an instance of an individual proving himself to be self-determining and “authentic.” His passing, too, enabled him to live beyond the confines of structural and institutional racism, a mark of his individual strength. He then exports this individualism to the physician’s realm, suggesting that a good physician is one who elevates himself above the dehumanizing confines and constraints of the institutions in which he is trained and practices. And it is precisely because he worked so hard to shed his African-American identity that the adequacy of Broyard’s model for people of color should be questioned. The model that Broyard’s essay lays out was developed from the social location of someone who chose to live his life accessing the privileges accorded people with white skin, in other words, someone who was able to evade structural racism; but that choice simultaneously identifies just how constraining structural racism is. Indeed, as Gayle Wald points out, all passing narratives “remind us through their very contradictions, that it is the nature of any ‘strategy’ that we do not get to choose either it or the circumstances in which its desirability is manifested. . . . [E]ven when racial passing is predicated on conscious choice, such choice occurs within the context of a negotiation of categories that are authorized by racial ideology and quite literally mandated by the state.”<sup>63</sup> Once we consider the fact of Broyard’s passing—why it happened; how it appears, however masked, in his writing—we come to a clearer understanding that the particular argument he made, and that has been repeatedly endorsed in the medical humanities, was enabled by the social location of white privilege, which allowed Broyard to ignore whether “empathy,” “listening,” and “witnessing” have the same bearing on those whose lives are contained by a structural racism they cannot choose to evade, and that the argument may itself continue to authorize medicine’s racial ideology.

The case can be made, as some scholars have, that passing narratives provide examples of what it would mean to exist “post-race”—in Broyard’s case, that his writings and his career inscribe a manner of self-fashioning that resists affixing markers of race, where ambiguity about race delegitimizes it by undermining the sign systems on which it depends.<sup>64</sup> And perhaps such ambiguity or refusal of race markers may at some point in the future be how we can usher into being a world beyond race. But before we can get there, we must first attend to how our structures—economic, social, institutional, educational—make race very much still matter. It is urgent that we scrutinize our interpretive practices and pedagogical aims for whether they strengthen those structures or loosen their foundations.



## NOTES

The author would like to thank Therí Alyce Pickens for comments on an early version of this article and the editors of *Literature and Medicine* for their work.

1. The HGP received that public acclaim at the nominal announcement of its completion, by then-President Bill Clinton in a Rose Garden speech. See “Remarks”; Bhopal and Donaldson; Schwartz; Kaplan and Bennett; Ellison; Braun; Fullilove; and Stolley.

2. See, for example, Satel. On the desperation of physicians for remedies to the crisis in African-American health that makes race-based pharmaceuticals a good-enough option, see Pollack.

3. Hoberman, especially chapter 3.

4. Association of American Medical Colleges, *Cultural Competence*, 1.

5. *Ibid.*

6. Hoberman, 216.

7. *Ibid.*, 228.

8. I employ the common terms for the fields in this article to ensure it stays in conversation with the fields as they are currently constituted. Other choices were “health humanities” or, as developed within literary studies, “humanities and health.” These two other terms attempt to disentangle the fields from being embedded within or focused solely on established medicine. While I prefer the latter term, here it seems appropriate to use terms that more readers will recognize.

9. Metzl and Hansen, 126–27.

10. See, e.g., Charon; Boker, Shapiro, and Morrison; Frank, *Wounded Storyteller*; and the idea appears sprinkled throughout Crawford et al.

11. See Russert; Reitmanova; Atkinson; Mani; Long; Garden; and Berry.

12. Garden, 448.

13. Lorde, “Burst of Light,” 106.

14. *Ibid.*, 133.

15. *Ibid.*

16. Scholarship in feminist, queer, and disability studies, however, focuses on these aspects of her works. See, for example, Alexander; Herndl; Jain; and Pickens.

17. Charon, 96.

18. Jurecic, 8.

19. Broyard, “Doctor Talk to Me.” This piece is quoted, for example, in Frank, *Wounded Storyteller*, “Reclaiming an Orphan Genre”; Shapiro; Charon and Spiegel.

20. All quotations are taken from the version of the article and talk distilled into the piece “The Patient Examines the Doctor,” in Broyard, *Intoxicated by My Illness*, 40, 45, 41.

21. Gates, 180–214; see also Bliss Broyard.

22. See Kaplan, “Anatole Broyard’s Human Stain”; and Gaines.

23. See Frank’s “Illness as Moral Occasion”; “Experiencing Illness through Storytelling”; “Five Dramas of Illness”; and “Why Doctors’ Stories Matter.”

24. Frank, “How Can They?”; Aull, “Telling and Listening.”

25. DasGupta, 981.

26. Aull, “Telling and Listening,” 286.

27. *Ibid.*

28. Felice Aull has discussed her own thinking regarding Broyard’s biography in a blog post for the database. Writing about Broyard in relation to race-based medicine, Aull explains that after learning about Broyard’s passing from Gates’s article in the *New Yorker*, she changed the entry to identify him as African-American, even though she was troubled that he would not have self-identified as such and had not made public his “race”; “in addition, his ethnicity had nothing to do with the work I had annotated.” In light of this, she deleted an ethnic origin for Broyard,

thus leaving his race/ethnicity unmarked (and, by implication, white). In the following years, the Database's Editorial Board instituted a policy: "The decision was, for the time being, to categorize a limited group of authors who self-identify their ethnicity publicly and whose work reflects their interest in that ethnicity." With Bliss Broyard having publicly outed her own father, Aull believes the issue has become more complicated, as his race is now a matter of public discussion. Still, she writes, she has left the category blank. See Aull, "Medical Humanities Perspective."

29. Broyard, "Patient," 44.

30. Broyard, "Portrait."

31. Introduction to Broyard, "Portrait," *Commentary*.

32. See Gates, "Passing," and Bliss Broyard, *One Drop*.

33. Broyard, "Patient," 33.

34. *Ibid.*, 35–36.

35. *Ibid.*, 36.

36. *Ibid.*, 38–39.

37. In her memoir, Bliss Broyard includes information suggesting he was indeed considering it at this point in his life. Even when pressed by his wife during the final stages of his illness to do so, he never did. See Bliss Broyard, *One Drop*, 441.

38. Gates makes this argument in "Passing"; Bliss Broyard makes a similar argument in her memoir.

39. This story, according to Gates, brought Broyard acclaim throughout the literary establishment.

40. Broyard's other name-making short story was included as the first piece in an edited collection of seminal Beat Generation writing, called *The Beat Generation and the Angry Young Men*. The one-sentence introduction to that story, "Sunday Dinner in Brooklyn," frames it as an example of generational differences defined by differing values about the nature of work and life's meaning. See Feldman and Gartenberg, eds., 21.

41. Broyard, "Patient," 96, emphasis added.

42. *Ibid.*, 97.

43. *Ibid.*, 99, emphasis added.

44. *Ibid.*, 102.

45. *Ibid.*, 109–10.

46. *Ibid.*, 112–13.

47. According to letters from his lovers that his daughter found, this rather odd gambit—offering women Louis-Ferdinand Céline's *Journey to the End of Night*—was high on Broyard's list of seduction ploys. There is no space to consider the interesting fact that in Céline's novel, the main character is a physician—as well as a misogynist, anti-Semite, and general misanthrope—and that the son in the story considers this book appropriate for this nurse. See Bliss Broyard, *One Drop*.

48. Broyard, "Patient," 120.

49. *Ibid.*, 121.

50. *Ibid.*, 120–21.

51. *Ibid.*, 92.

52. *Ibid.*, 105.

53. *Ibid.*, 120.

54. *Ibid.*, 103.

55. *Ibid.*, 117–18.

56. Granted, it was only in the southern states that segregation was policy, and there is a chance that Kings County Hospital was integrated at the time of the story. However, this does not change the claims I am making. By 1954, Civil Rights leaders were fighting for civil rights in medical care as elsewhere, and discussions about how structural discrimination sanctioned African Americans to lesser quality of care were in the air. The detail would still indicate, especially to African-American readers who understood the subtle ways in which segregated care could

still be exercised even in integrated settings, that race is operating within the story and that the story has something to say about how race affects medical practice.

57. Broyard, "Patient," 91.

58. It is relevant here that when the Broyard family moved from the more racially integrated New Orleans to Brooklyn, for the sake of obtaining work as a carpenter Anatole's father passed as white. This passage could be read, therefore, as describing a moment when, for Anatole, the collar and its connotations of slavery visually called up his father's African heritage.

59. This scene could also be read as building on other moments in Broyard's writings that allude to passing in reference to love. In *Kafka Was the Rage*, Broyard explains that he wanted to be "transfigured" by love, which commentators have aligned with his other recurring themes of reinvention and self-fashioning (51). Reading this passage in light of that, we might see the sex act as enabling a kind of transfiguration, at least in the sense that it seems to ensure or legitimate Broyard's passing. See Kaplan, "Anatole Broyard's Human Stain."

60. Again, it is not only Gates who argues this; Bliss Broyard as well makes a similar argument in her memoir.

61. See for example, Bonham, "Race"; Balsa and McGuire, "Prejudice"; Meghani et al., "Advancing."

62. Broyard uses the term "genius" in reference to his ideal doctor in *In-toxicated*, 19, 43.

63. Wald, 187.

64. See Kaplan, "Anatole Broyard's Human Stain."

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