Doctors as Wounded Storytellers: Embodying the Physician and Gendering the Body

VARPU LÖYTTYNIEMI

My recent reading of Arthur Frank's *The Wounded Storyteller* (1995) brought back to me some of the feelings of surprise and wonder I remember experiencing during the 16-month period when I was conducting life-story interviews with young doctors. In these interviews, I asked my colleagues to tell me their life stories, to narrate their personal and professional life, in the way they themselves wanted to share their stories with me. Of the 30 interviewees, 13 incorporated their own illnesses or other forms of bodily necessity (Radley, 1988: 99) in their life trajectories. I felt puzzled hearing these stories, some of which made the restriction of the body a central foundation for the narrated self or for the rhetoric of self-change (Frank, 1993). I realized I had not expected to hear them.

Yet we are all wounded storytellers (Frank, 1995). Frank notes that the illness story becomes 'the common bond of suffering that joins bodies in their shared vulnerability' and reaches across the abyss that opens up between the ill person and others (1995: xi). Facing together the limits of human existence should bring me closer to the narrator – why, then, these feelings of strangeness and distance? Of course, the stories I have collected are not really illness stories. That is, the

reason I have interviewed doctors is not that they have illnesses, but that they are doctors of my own medical generation who graduated in the mid-1990s, in the aftermath of the economic crisis that swept Finland in the early part of the decade (Löyttyniemi, 2001). Illness was not such an acute or recent phenomenon for any of the interviewees that it would have turned their whole life story into a story of illness. Perhaps this is why there is so very little indication of suffering, even in the episodes that do describe illness – there is no need, no space really, for sharing the pain. Yet in the midst of present health, there are the experiences, memories, possibilities and threats of illness, physical disability, infertility. This is my excuse for taking the liberty to listen to the stories as if they were illness narratives.

Embodying the Physician

The topic of the doctor's own vulnerability and illness is a discussion that takes place quietly but continuously within the medical profession. A recent dissertation draws attention to the reluctance of doctors to seek occupational health care (Mäenpää, 2000), and it is a well-known professional anecdote that doctors are reluctant to treat their own diseases properly (which often means seeing another doctor). I do recognize the voice noting how the healer's own illness experience is the ground for her creating empathic bonds with her patients (see Frank, 1995: xi; Kleinman, 1988). And empathic is what the healer is supposed to be. At the same time, inside the doctor's white coat, there is really no body (Gothill and Armstrong, 1999). In an ill physician, two different (are they exclusive?) worlds and languages meet. The patient side of the split seems to dissolve all that is physicianly in the physician; her/his authority, the mythical omnipotence, even the collegial support (Edelstein and Baider, 1982; Hahn, 1985). Dependency, helplessness, vulnerability and shame are perhaps not so much derivatives of joining the patient world directly, but of the absence of words, inner as well as collective, collegial silence (Frank, 2001; Spiro, 1987).

The subject matter of my article is the variety of meanings given to a doctor's vulnerable body. However, my present interest in the doctor's body has other roots in feminist theory and the endeavour to bring the body (back) in (Zola, 1991). To me, this means taking seriously the way our bodies give shape to our stories and selves (Frank, 1995: 27). Further, it means embodying myself as a performer of research, which is usually taken to be an activity conducted by the intellectual mind even when the research is *about* the body. Embodied theory might open up where embodiment is used as a theoretical and epistemological resource (Davis, 1997: 14). The theorist and the researcher is present as a

body-self (a concept I have adopted from Kleinman, 1988), analysing as a body and writing through the body. My doctor's body-self is the one that is evoked to embarrassment, wonder, and curiosity when she came to share her colleagues' vulnerability. Now I want to pause where I feel confused; I want to make my embodiment my epistemological resource and my wondering my method.

In and through my body I am a collection of meanings given to illness both in the professional culture of medicine and in Western culture in general. I have lived out some of those meanings myself; I am a physician. I was surrounded by chronic illness in my childhood home, and now I am a mother of small children who are at a high risk of developing such illnesses. For the moment, however, my personal polyphony seems to be conducted by more recent and critical voices of narrative and feminist theory that have made me challenge the meanings of illness and ask if it is possible to reconsider (bodily) difference. Luce Irigaray is the feminist writer who affects me most.

Luce Irigaray (1993) envisions a world where wondering is the mood of dialogue and where the sexual difference is lived out between men and women who are not opposites of a symmetrical difference or dichotomy, but two different identities each of which has its own cultural narratives, concepts, metaphors inscribed in their bodies and whose relation is no longer hierarchical. The sexual difference repeats itself in other hierarchies, and I will try the method of wondering in order to suggest the ethics of difference between the researcher and the interviewee, and the healthy and the ill. The former is what I intend to do theoretically and methodologically when I read and write about others' life stories from the vantage point of difference. The latter is more about my results after this kind of reading. As my difference-marked reading identifies the inscription of gender (Miller, 1988: 57), I will finish my article wondering how to read personal stories for ethical sexual difference, too. *The body* is where the three pathways of writing come together; my feeling body-self and my method of wondering, and illness and gender that are both unthinkable without a body carrying them.

Wondering as a Method

The main purpose of my article is methodological: I ask what could it mean to realize the ethics of (sexual) difference claimed by Irigaray when analysing the doctors' personal stories? Wondering as my mode of relating unfolds the stories as otherness and difference instead of sameness and narrative identity.¹ It is in wondering that the dialogical space opens up where I can meet with the other in a way that does not attempt to know him, but lets him be mysterious and

unexplained, different from me or my prejudice. Wondering as the mode of a relationship means turning the *who are you?* question back on myself: *and who are you?* (Irigaray, 1993: 74). After fleetingly touching my interviewee, I cannot know her. I can only ask: who did I become after meeting her, what did she teach me (Frank, 1995: 159)? 'Listening for the other, we listen for ourselves' (Frank, 1995: 25; see also Sparkes, 1996). We think with stories.

According to Sara Heinämaa (2000), Luce Irigaray's wondering has its dual roots in the first emotion of wonder in Cartesian philosophy and the phenomenological method of reduction. They both indicate pausing, eventually changing course, but in different ways. While the emotion of wonder comes spontaneously and precedes all appreciation or refusal, the phenomenological method is more like an effort. It requires that we put aside our customary conceptions and familiar theories about illness or gender or whatever it is we are wondering, and it requires that we suspend our natural flow of feeling, moving and observing (Heinämaa, 2000).

I have taken the two steps of wonder. First, I stopped where the episodes of doctors' bodily vulnerability left in me curiosity and wonder – I didn't know why these episodes were being conveyed to me – and then I followed the natural flow of (e)motion and thought that came pouring in, in order to then reduce the flow and give space to new and different ideas. That is, I listened to the thoughts and emotions that each story evoked in my body and mind, regardless of whether I recognized the origin of those reactions in my personal history or my (professional) culture, and then attempted to suspend them. I far from completed the phenomenological practice of non-thought, where the conceptual flow in me would stop and I would experience the most embodied moment of immediacy (Klemola, 2002). However, I think and feel that I was able to create in me some quiet space for the stories, for the difference of the other, to fill and change me. The break in my natural flowing does not mean silence, that is, 'repression, cutting it away, closing in – but *quiet*: opening out, shedding off, in peace', as Zali Gurevitch (1999: 536) writes and continues in a note:

Silence is in language: it comes as an order, a decree of limit, a break, abstinence from speech, or an abstract notion of no speech. Quiet is a state of body free from disturbance or noise. One sleeps quietly; the night is quiet. (Gurevitch, 1999: 539)

As I started to write the empirical part of my article, I found it hard to concretize my wondering method in my own writing about – or with – the stories I was analysing. I solved the problem in the same way as Marja Kaskisaari did when reading the life stories of non-heterosexual women (Kaskisaari, 1995; see also Irigaray, 1985: 205–18): I decided to write my part of the dialogue and address the narrator as a *you*. When I write *you* it is as if the space re-opened

where the story was told between you and me. *You* emphasizes the dialogic, contextual and embodied nature of knowledge (Kaskisaari, 2000: 35). *You* emphasizes the relation that continuously reforms both you and me. Writing *you* concretizes the dialogic position that I as the author am willing to take with regard to my heroes, that is, my interviewees so that their internal freedom and indeterminacy is affirmed (Bakhtin, 1984: 63). From that position, Bakhtin writes, the hero 'is not "he" and not "I" but a fully valid "thou", that is, another and other (...) "I"' (Bakhtin, 1984: 63).

Writing *you* in a journal article does not re-create the dialogues that once took place between my interviewees and I. If there is a two-person dialogue going on in my writing, it is between my reader and I, and in that relation my addressing the doctors as *you* means turning away. Please show tolerance. What I hope writing *you* will do is expose the dialogic nature of myself and my knowing. I am trying to reconstruct what happened in me while reading my interviewees' stories. In that process the voices of other doctors and the voices of my own past meet in me. Luce Irigaray writes:

The subject does not produce meaning alone (...). However, it does not follow that interaction with another subject or other subjects has to be immediate; it can be mediated in various ways. I can be in a relation (...) with a woman or a man who is not present, who never has been or never will be present. I can be determined by a man or a woman who is no longer here, by the historical relevance of what he or she says. (Irigaray, 1996: 126)

The doctors I have interviewed are no longer present when I address them as *yous*. *You* is written to the narrator who once said the words that have relevance to who I am now and what I now know about doctors' illness experiences.

My purpose in this article is two-fold: through my dialogue with the stories I intend to show *how* I came to change some of my previous conceptions of the physician's body and gender, and I reflect on those conceptions: *what* they were and what they could become. I then conclude by reflecting on the implications of wondering for the notion of narrator's gender. I hope I can offer some glimpses of the ethics of sexual difference (Irigaray, 1993), that is, the possibility of meeting the other as sexed without fixing that other to the dichotomy of gender.

What can I come to know by listening to my own bodily reactions pertaining to thought? The method of wondering challenges conventional notions of (social) scientific knowledge which take the view that those who are being studied are those who are known about. In narrative research, too, either the narrator or the story told is often thought to be an object, data to be analysed, even if the impartial and subjective nature of knowing and the transitory and contextual nature of truth are accepted and often welcomed. Wondering is one

step further in the direction suggested by Lorraine Code (1993) where knowing other people becomes the epistemological paradigm. In knowing other people, Code writes, 'a knower's subjectivity is implicated from its earliest developmental stages; in such knowing, her or his subjectivity is produced and reproduced' (1993: 38). I know *you* or your story not as an entity detached from myself, but through the meanings of your words to my emotional and conceptual existence. The divide between subjective and objective is no longer as crucial since the words and meanings are inherently shared and knowing takes place in between. Following Code, I suggest that knowing the other can be a paradigm of scientific knowing as well, and that is why I call my wondering a *method*, thus reaccentuating that word I have taken, to paraphrase Bakhtin (1981: 294), from 'other people's mouths, (from) other people's contexts (where the word is) serving other people's intentions' that are often very different from my own.

What Did You Make Me Become? What Did You Teach Me?

I now turn to five of those 13 doctors who spoke about their illness, handicap or infertility. In precisely these five narratives, the theme of bodily necessity is a central dialogue of the narrated Self – in one way or another.

Petra's Asthma: Your Chronic Disease Passing By

How should I introduce you, Petra, to my social scientific audience? You are a young female physician; you were working in a hospital at the time I interviewed you but still not sure what specialty you wanted to pursue. You say that your decision on where you would want to work might depend more on the working environment than on the specialty.

In your story, Petra, my sense of familiarity instead of strangeness is most palpable, and I think this has to do with your analytical aptitude. Our mutual sense of understanding was co-constructed at the beginning of the interview. We had both conducted a research project, the advanced studies project for our pre-graduate medical training, using qualitative methods, which is not very common, and I suppose that I, as the intended listener of your story, am one who will expect from the narrator the analytical aptitude of an analyser of qualitative data.

You did not know whether you wanted to tell your story in chronological order, and I asked what the alternative would be. You then started with motives. 'The most determining motive' in your life, you say, and the yardstick of evaluation in your story, is the motive of increasing your autonomy. Whatever happens to you and whatever choices you make can be evaluated against your feeling 'tight' or your being able to leave and to do something else. When you

narrate to understand yourself, I hear your mental and verbal experience take place in your body. The same goes for your metaphors that first invited me to read your story for traces of your embodiment.² You feel 'tight' or 'stuck', you are used to continuous 'pressure' and would 'choke' if that pressure is too suddenly lifted. Or you feel 'handless or footless' if you are forced to passivity and reactivity instead of agency.

You say your doctor's work is sometimes more reactive than active, that is, the impulses to activity come from outside yourself rather than from within, and again I want to add: from within your body-self. I can feel the tightening around me in a situation where I do not feel satisfied and cannot escape, and it is a bodily experience.

The theme of illness comes up twice. First, you make your symptom-giving body the marker of a turning-point that was needed for you to take an interest in medicine. You were not very serious about school when you were a teenager. You were more serious about sports and doing what young people do. It was only after you began to have trouble with your back and had to take three weeks' sick leave – it was severe lumbago and spinal instability – that you settled down, started dating and started studying. As the time had come to think about career choices after school, you concentrated on the application guides and found that medicine was a broad enough field so that you could retain your freedom of choice for the future. That is, you do not think that your suffering from back pain or your having to give up your serious investments in sports evoked the interest you developed in medicine. Your back just stopped you and forced you to reorientate.

You give your pre-graduate research project the meaning of another turning-point in your story. You took your time with the project. You lived through a personal crisis of a patient you were writing about and at the same time you lived through a personal crisis of your own: during the years at medical school you felt you had lost your freedom and acted on motives that came from outside your (body-)self. Now that you made your project your own way, you re-found your sense of autonomy. The project was about psychosomatics and you came to widen your own paradigm from a strictly physical understanding to a more holistic one where the patient's problem could only be processed in the context of their life situation, its past and present, taking the somatic symptoms as a part of the whole.

You are talking about the patient of your research project, but at the same time you are theorizing about your own life and illness as a part of the whole. I do not know whether you would accept the concept of *body-self* as an implication of the self that your story constructs. Anyway, I identify your embodied

existence throughout your story, and in psychosomatics I find a conceptual frame for it. Yet it seems that you get into trouble with a threatening illness. After telling me about the patient you had been able to help by widening your paradigm in the direction of psychosomatics, you associate to your own symptoms, your back that 'snapped' and became a turning-point in your life (story) and bronchial asthma that '(you) came close to getting'. I quote your own words:

Well I've had my back that snapped and at one point I came close to getting bronchial asthma ... and never at any point have I considered the option of becoming a chronic case with any illness ... the way I see it is that the disease becomes chronic when the problem does ... you fail to see the main thing, so it can't get better.

Through your paradigm of psychosomatics, the chronicization of an illness can (only?) imply a failure in unravelling the problem that the somatic symptom represents in bodily language (Hyypä, 1997). Being chronically ill is like giving up, or like voluntarily staying where you feel imprisoned.

At this point in the interview, I asked about the connection between the chronicization of illness and loss of autonomy, which is so pivotal to you. You readily conceded. To you, having a chronic illness bears the meanings of decline and dependence, even though you are now a doctor and can partly treat it yourself. Listening to you now, I feel uncomfortable. In my childhood family, chronic disease and asthma *do* embody lives that are marked by both decline and dependence, and I am talking about how I have experienced seeing those people conduct their lives, with no choice. So I think I know what you mean, what you are afraid of. This moment of knowing impresses my body, but it suppresses my feeling of wonder; instead of creating a quiet opening for difference and change, it is noisy with meanings that my body so naturally attaches to illness. At the same time, I am shaken by the need to find other ways of being ill, perhaps not so much for myself as for my small children who are at high risk of developing asthma or diabetes later on. In your story about the desire for autonomy, there is no space for asthma, which after all – according to my medical knowledge – is a chronic disease. You narrate it out of your story and self, and I remain wondering if you can narrate it out of your body as well.

What you taught me is that the scientific paradigm with which you once chose to conceptualize your patient's problem is dissolved into the way you now experience and understand your own body-self (see Frank, 1993: 44). Adapted to my own situation, you changed my question about how I have grown into and shaped my process of research to the question of how, in what ways my research has grown into me (West, 2000: 5). In this sense I needed your story to realize how untrue the scientific claim of distant, disembodied knowing is, not only to those who are known about, but also to those who know.

Timo's Stomach: A Mystery in You

You, Timo, are a male physician in your late twenties, organizing your time into phases between research and clinical work at the time of the interview. You say surgery is your future field, you find it more motivating to do something concrete rather than to continuously study some field of expanding knowledge. Paediatrics was the last to be eliminated from your list of alternatives. To summarize, you say that you have always 'put real effort' into things you really wanted to achieve, and you have achieved them.

Your illness story, Timo, was the one that resonated in me least and that I think changed me most. From the outset I was taken aback by the self-explanatory way in which you made your chronic illness the turning-point of your life, the starting-point of your career, and your way of existing as a body-self. This is how you started your life narrative:

I was six years old when I went to school . . . basically I did quite well until puberty when I was 14, 13, then things turned all pear-shaped . . . and then at some point I started to improve again. . . . I got this [chronic inflammatory, VL] disease at the age of 14, before that my average grade was something like seven, six or seven, that's how low it had dropped when my puberty was at its worst. I then got [the disease] when I was 14 and I spent six months in hospital and when I came back my average grade went up beyond nine. So this was really a great turning-point and really the basis why I ever applied to medical school.

I myself have lived in a (family) culture where illness always had a flavour of shame. It was not made explicit, but implied by the heavy emphasis on keeping illness a family secret. Whenever someone's illness was discussed, whether it was of someone in our own family or gossip about someone we knew, the tone of voice was lowered, made almost a whisper, even if there was no one near who might have overheard the discussion. *You must not talk about this to anyone, this is no business of outsiders.* Illness was secrecy, and at the same time, it was always there, an unavoidable burden of life, a plague that quenched all sacred gusto and joy.

In your story, your illness is no shame, no secret to be hidden from me or my medical audience. Quite the contrary, you bring it up from the start, and do so with pride: you are proud of the courage you showed when in the sensitive years of teenage you got this illness and it miscarried your serious commitment to sports and put you into hospital for months. You turned it all into a steadier grasp of life, you were now more serious about school, and you took an interest in biology and medicine.

In my experience, I can trace both my personal and professional history. My feeling of bewilderment and surprise about your story is and was evoked in my body-self, who has learned to associate secrecy and shame with illness and

vulnerability; my medical education has done little to dilute that sense. Anyway, I did not meet you as a doctor meets her patient; my body is evoked differently with a patient and with a colleague. In our professional culture, there is really no space for sharing vulnerability (West, 2000). I was surprised to read in the results of a major national follow-up study on young physicians' attitudes about their training and their career plans that as many as 7 percent indicated that their own or a family member's illness was among the reasons why they had chosen a career in medicine (Hyppölä, 2000). I do not remember this topic being raised once, at least officially, during my own medical training. In Hahn's words, 'medical training does not encourage either introspection or its public disclosure' (1985: 88).

It is only after turning down the noise of customary conceptions and cultural prejudice of the physician's disembodied and invulnerable nature that I can live with your story, Timo. Your illness is not there just as a major turning-point of your personal past. Your stomach is still your sensor today, a part of you, your sensitive point: it is by your upset stomach that you know you are being stressed, and it is your upset stomach that embodies your feeling of deep disappointment in your artistic career, to which you are committed as seriously as you are committed to medicine. You know that there is an expectation of making *feeling* a more mental or spiritual phenomenon, and I recognize that expectation in myself when reading your story and wondering how you define yourself as a figure who does not think about things very much but represses them, letting your stomach express negative things instead. Yet, after reading feminist theory so much that I want intensely to free the body from its cultural subordination to the mind, and after reading your story now, I want to respect your feeling stomach. In your story, you express no need to change it. Even though your disease will probably be a life-long mode of your body-self, your stomach is not so much a source of suffering as it is an indicator of that suffering.

Alan Radley (1988: 90) writes that when a person is able to locate an illness or injury within a bodily part, 'the balance is struck across the dimension of body versus person' instead of illness versus being all right. However, body versus person is your story only to some extent, Timo. You do not tell a story of how you have struggled with your illness while leading a normal social and professional life (though being turned down by the army did mark an exception to normality). Instead, you tell about a life in which you are about to settle down in a surgeon's career, and your stomach is there with you, ready to react if the going gets too tough. I do not hear in your story a battle between the two, or an ideological dilemma that seeks resolution in vain (Radley, 1988: 91). Somehow, your stomach is part of you, beloved and yet always unknown. It is a *dialogue*

in you, where the dialogue grows up out of the ground of wondering and never knowing the other (Bakhtin, 1984; Irigaray, 1993). Your stomach is your personal mystery.

During the process of writing this article, something has happened to my emotional flow. While my original wondering at your story used to be followed by the embarrassment of not knowing whether you were seriously proud or whether my feeling of being ashamed was the dark side of your story (instead of being the dark side of me), I now enjoy your original way of narrating a hero whose illness is no disgrace.

Mirja: Material Necessity as Freedom of Choice

To you, Mirja, medicine is a second career, a second chance that captivated you with the 'euphoric tempo' of the very first year in medical school. When I interviewed you, you were working at a primary health care centre, and you planned on staying in general practice: 'this is really me'.

Your story, Mirja, is one of the most touching life narratives in my interviews. Even now when I listen to your story, I start crying when you describe the nice house you and your husband bought, with enough space for three children. And you had none.

Throughout your story, you comment on how (your own and others') life choices are made: it is *both* about choice, about freedom, *and* about material necessity. I think you are addressing these comments to me and my locating my study at a critical period of Finnish society. In your own experience, you do not recognize society – the scale is different – or you only recognize it afterwards. You know now that woman's role in society was embodied in your first career choice, but at the time of making that choice, the decision came 'from your own navel', from your own experience, from the lacking encouragement to ambition. You were never told you were 'a smart girl' even though you would have deserved this on account of your school success. So you didn't, perhaps do not, feel like one. But you still chose a job with which you were happy.

And you got the chance to make a second choice. Your story, as you restate in the coda at the end, is one about studying and working. You have always been able to do a job you really wanted to, you have always felt that things turned out right for you. That, to you, is a privilege, something you think is far from something that can be taken for granted, especially by women. While other women balanced between work and family, you could re-live the freedom of choice.

You chose medicine, but only after a turning-point that was not chosen but dictated by the material body: after years of tests, you and your husband were told you could not have biological children of your own. In your story, you do

not come out with this epiphany directly. I hear it now that you are rather sounding things out, that you want to try first how it feels to share your suffering with me in the interview. You first leave the door open for yourself so that you do not have to touch where the body hurts and only allude to the 'decisions [that] have come about differently' from having the courage to choose what you wanted. Your phrasing was:

I've had the chance to make choices, not all women do, they're more closely tied to the family or to where they live or anything. . . . And I perhaps consider the opportunity more important than the courage, because I don't consider myself a particularly courageous person, in the sense that I would have been all prepared to make major decisions. They've come . . . my decisions they've come about differently.

You come back to those decisions a little later and tell about the crisis that you and your husband lived through as a couple, as a shared body that could not have a child. The period of mourning lasted 18 months, you 'have measured it with a tape-measure'. You describe it as 'a black river that carried [you] alone and [you] together' and finally 'thrust [you] to the shore where [you] awoke and knew [you] had survived'. All the way down the river, you had had your previous job that you enjoyed. However, now that you were in a position to redefine your childless future as a new freedom of choice, you knew you wanted something more. You had never thought about going into medicine before, but as soon as someone suggested it to you, you knew it sounded right. You wanted to have a go, and you made it all the way to graduation and your job as a primary health care physician.

What I wondered and still wonder when listening to your story is the courage with which you share the wound of your body with me. You tell your story about and around that wound, naming it as one, and that is the difference between your story and Timo's where *suffering* is not the issue. What I learned from Timo was how to contradict my association between illness and shame. In those parts of your story, Mirja, that are so different from mine, so other than me, I think I face the question that Clarissa Pinkola Estés (1992) says is the most important decision psychologically that a woman (because Estés is writing about a woman's psyche in a culture that represses what is wild in the feminine) will have to make: is she going to be bitter or not? You have decided not to be. You have followed your destiny without becoming subordinate.

I am writing this two days after I was told my little son has antibodies against pancreatic islet cells in his blood for the second time, and the number is increasing. We know this because upon birth he was found to be genetically predisposed to type-I diabetes and we were asked to join a research project known as DIPP (Type 1 Diabetes Prediction and Prevention Project) where predisposed children

are followed up in order to see whether they develop islet cell antibodies. In most cases they do not, and they are as healthy as any children; but if they do, this often indicates that the process leading to diabetes has started. In our case, the chances are now 50-50. During the past two days I have been going through much of my own burden of meanings, which has made me question whether I can talk about this to anyone, or whether I want to share it with anyone (that is, will I be harming my little boy if I try to alleviate my own situation in this way, will I carve into his tiny body the marks of the shame of illness?). And I have been completely lost for words when trying to explain to my 3-year-old what will happen on Friday when he will be going to the 'big hospital' to have the glucose tolerance test done. I do not know the words, or the story, with which it is possible both to meet his fear or suffering, meet him in his suffering *and* promote his (future) freedom of choice, even if being a diabetic will be his material necessity.

It is your story, Mirja, that bothers me most now that am I sitting in my office with this foggy feeling of bereavement. My son's eventual diabetes is not the only thing I am bitter about, but it is the terminus for the either-or experience that culture has inscribed in me. I have been wondering at your survival story, but it is only now that I *believe* you and *know* it is possible to feel *both* free *and* unfree, both 'an agent with free choice and an object which is determined by a bodily materialism' (Radley, 1988: 99). It is possible to follow your bodily fate without feeling too tight. It has to be.

Riku: No Man Made of You

Riku, you are a male physician with a first degree and several years' experience of clinical practice before you graduated as a medical doctor the year before the interview. You have already settled down in a surgical career, and you work long hours. However, with your working style you 'perhaps steep [your]self too deeply in work' and want to keep your options open so that you can change directions.

Timo, to whom I wrote above, taught me that carrying an illness does not have to be loaded with shame, and you, Riku, take it further still. In your story, you make your (past) illness almost a joy; your voice has both a serious and playful tone. Or is it irony?

You, too, suffered a serious illness when you were a teenager. You recovered, though, and your illness is no longer a clear marker of your body-self. Nevertheless, you make it part of your story. You bring it up first as the only negative event that enters your memory of an otherwise 'happy childhood and adolescence'. Although your illness happened 15 years ago, it was only last year

that the diagnosis was finally specified. You laugh and promise to come back to this enigma later on; in the chronological course of your life story you just wanted first to make the point that your illness experience may have evoked your interest in medicine, too.

I lead you back to the subject 23 transcribed pages later. Prior to this you have finished a sub-narrative about two patients that illustrates both the continuity and breadth of your narrated self: out of your childhood interest in reading you now construct a professional self who does not reconcile himself to the dichotomy between operative and non-operative, or manual and intellectual, medical practice. You are the 'philosopher-surgeon' who sometimes loses himself in books or Medline in order to gain knowledge that cuts deeper than your instrument. To make your philosopher-self come true you tell about an operation where a sensory nerve was exposed when you excised a tumour. You knew you should douche the operation area with a solution containing formaline in order to prevent a tumour relapse, but you also knew it would be disastrous to the bare nerve:

The senior physician asked whether the solution was applied, so I said I'm not going to, I mean there would be no sense perception left at all. Well then someone there said yes you can, you can. . . . The same afternoon I happened to have some time off so I must have looked up some 80-odd summaries on Medline and I didn't find a single one that dealt with this. So I just thought ok, I've now read 80 summaries that do not say a single word about it, no one's taking a stand so I'm not going to use it until someone proves to me you *can* use it. Eventually I did get my answer, a friend (. . .) who's the same sort of nitpicker as I am, one day a couple of weeks ago he said he'd seen this article in the paper that the nerve can tolerate 30 seconds of the solution and it won't cause any damage if it's rinsed afterwards. So I said thanks, from tomorrow on I'll use it.

Then you willingly accept my request to revert to your own diagnosis and now take it as another example of your being such a pedantic 'nitpicker'. When you were about to graduate from medical school you knew you would have to do your national service. You happened to mention this to your grandmother who, without any medical knowledge, wondered whether you might not be exempted on account of your serious illness. You started out on detective work to find out what the exact diagnosis had been and whether an exemption would indeed be possible. After going to quite a lot of trouble you eventually found a specialist who wrote a statement saying that if you had to suffer the hardships of military service, that could well cause a relapse. 'So I have not been in the army and I am pleased about that', you say in the coda of the episode.

Is it an illness narrative you are sharing with me? It is certainly not about the suffering you must have experienced when you were a teenager and seriously ill. I hear a warm self-irony in your voice and wording; you are using this irony to

find your way to your listener, to me (Booth, 1974). That is, you draw upon our shared understanding of what is unexpected and what should not be taken literally as a description of your true self. You are slightly ironic about your being such a 'nitpicker' and you point to the 'amusing avenue' – via your *grandmother* – to the decision you took. However, I do not recognize irony where I feel it is most urgently needed: in your efforts to justify skipping the army in the first place. You proudly present a man who did not go where *they make men of boys*.

This is not to say I am an army lover, quite the contrary. Yet my culturally inscribed body refuses to resonate. I find your story doubly wonderful: you narrate a body-self by including your own illness and excluding the army, both acts that are culturally unexpected from a decent man. Why, then, do I still know you are a man, and further, why do I feel respect for your true way of being one? I must be listening to your story not asking how you (have) become a man, but instead taking it that you *are* a man and wondering how you tell your story in order to ground the subjectivity and identity appropriate to your male gender (Irigaray, 1996: 107).

I think that both you and Timo recognize the cultural narrative about how military service 'Will Make A Man of You' (Morgan, 1990: 37). David Morgan notes that while we live our lives as gendered throughout, some situations are more gendered than others, and exploring themes of men or masculinity through autobiography might well start by focusing on these moments of personal history. I imagine these are the moments where inscribing difference into the body is strengthened, just as mothering is for women, and a wound remains where the narrative cannot motivate enforced or unconstrained denial or diversification of the norm. Neither Timo nor you, Riku, have been in the army because of your illnesses. So you both risk telling stories and body-selves that are not masculine enough, not so much because you did not go to the army but because you *could* not go because of your illness. Your bodies were too vulnerable.

In a splendid way you, Riku, turn this into a story that provides the foundation for a subjectivity and identity appropriate to *your* male gender. You changed my view of masculinity by turning your vulnerability, explicitly, into a man's story that illuminates your self, your 'nitpicker nature' that professionally makes you question the truth you have been given by your older colleagues, to challenge therapeutic conventions and to find out for yourself. You do not respect conventions or customary conduct too much, and to me that is the implicit point in your army tale.

Timo, on the other hand, only had the meaning of *being turned down* for his

lacking army experience, and it thus remains a scratch in his body-self in my reading it now.

*

What thrills me in these stories, as much as they differ as illness narratives, is the way they turn the physician's own experience of bodily necessity almost into everyday talk by making it explicable and shareable with a colleague – me – who would probably not have dared to ask the question in the first place. Illness may remain as a dilemma in the story, as it does in Petra's, or it may provide some kind of narrative merriment, as in Riku's story, but it is not associated with societal shame. Bodily necessity may be the point of deepest pain and sorrow, as in Mirja's story, or it may be the narrator's way of creating a self who cannot not feel suffering other than bodily pain, as it is to Timo, but it is not something that should be excluded from life story.

The stigma of illness or other bodily necessity is not carved into a doctor's self as an overall reluctance to accept one's own vulnerability; my interviewees convinced me of this much. If a doctor's illness is a taboo or stigma, it is more about dialogic repression (Billig, 1999) and narrative unconscious (Freeman, 2002): there is no story of a wounded professional that would be attached to a *professional* context or could create a *professional* identity. Life story can include the vulnerability of the body, while there is little space in the professional culture for a doctor's life story to exist. Perhaps creating space and time for sharing personal stories could make (us) doctors more loving towards our own differences, on the one hand, and more willing to construct our ability to help and heal on our own fragility and occasional need for help on the other.

There is one story that makes me wonder whether it would make a difference if the illnesses and other bodily necessities touched more the professional part of the story, the professional body-self. None of the four narrators carry markers that are visible to others (as far as I understand, it is only Timo who will occasionally have to take sick leave because of his illness), and they can choose not to share their pain with colleagues unless they want to. Eija's private pain, on the other hand, is also a public pain (Sparkes, 1996).

Eija: The Public-Private Bodily Necessity

You, Eija, are a female doctor, working as a primary health care physician when I interviewed you. You 'associate [your] future very much, or mostly, to work', but you were not going to stay in general practice. You liked the job, but the more you gained experience, the more strongly you felt that you wanted to know your future field thoroughly, in a way that was not possible in the vast field of general practice.

In your story, Eija, it is not the *presence* of your body but its *absence* that makes me wonder. You had mentioned on the phone when we made our appointment that your story was not a usual one, which I did not quite understand until you came to see me after working hours in the hospital where you worked. That I understood as soon as I saw you made me think how much the body matters. I did not know, that is, before I met a body marked by difference. You had a physical handicap.

Now that I read your story, I still recognize my own confusion about expecting your handicap to make a difference in the story, on the one hand, and about not being able to ask about it, on the other. It feels as if your story should be *about* it, and the feeling is there even now that I read the text and know it will come up, but not as determinatively as I expect. Your handicap can be read as *one* plot of your story, but my eagerness to do so in the first place does not originate in the story or the narrating subject I fleetingly touch. It originates in my context of reading, where I notice that I expect your disability to become a master identity, as Charmaz (1994) says visible disability typically does. You resist this, and you start telling your story about becoming a doctor without first granting your handicap any explanatory power in your identity.

Radley and Billig (1996) say that those who are ill or who have some disability face the task of denying the extent of disability and displaying enough healthiness to gain social value. In the interview between you and me, however, the situation was weird. I could see your handicap, so we both knew your eventual exclusion of it from your story would have its limits. On the other hand, the only one of us whose social worth and ability to work as a doctor was self-evident from the beginning was *you*; I was just an interviewer who said she was working on a doctoral thesis, but my life story method gave little evidence for my scientific value in medicine.

The first time you point to your handicap evokes your body as gendered. You say that when you were choosing your career, you didn't initially have the courage to apply to medical school, but you 'yielded' (your word) instead to the words of an older man and physician you knew and spent several years studying something else.

It was [he] who said it was nonsense, an older doctor, he said women can never become doctors, especially you, referring to my handicap.

Later on, your disability and gender become intertwined in your need to prove that you can do what others can, and that need is emphasized in situations where you feel (or felt before) young and inexperienced as a physician. So there are at least three differences that co-create your bodily wound: gender, (professional)

age and physical disability. It is as if your handicap made even your female body visible in a special way, and at the same time you think that a doctor should be – and that you usually are – neutral; it is just ‘excess tension that you can create in a situation by being gendered’.

I think the most wonderful moment in our conversation, Eija, was your sending of the narrator’s evaluative task back to me. You were talking about the reluctance of (some) other physicians to tolerate difference, different working styles and work organizations, and you asked me whether any other interviewees had made this same comment.

I recall my embarrassment at that moment, a repertoire of episodes and fragments of my own doctor’s story pouring into my body and mind. You asked about the interviews I had conducted, but I thought I knew what you were talking about from my own experience. I knew, so that was not a moment of wonder or living out the difference between you and me that makes all dialogue possible. This is perhaps the reason I was so confused: in your experience, I came too close to my own, and I answered by referring to some distant others instead. That is, I told about my previous clinical jobs where I had met several colleagues who, in one way or another, deviated from the expected pattern of being a doctor, something that was anything but esteemed.

I did not have the courage to share with you my own vulnerability that had made it both necessary and possible for me to choose an unusual doctor’s career and become a feminist auto/biographer (Stanley, 1990, 1992). It was quite soon, after just a relatively short spell of clinical work, that I knew I needed and wanted to reorientate. I could not cope with the need to know for sure in the midst of all the constant uncertainty, or with the heaviest responsibility when working with patients, and had I not given up at that point my body or mind would have made it necessary sooner or later anyway.

As happy as I am now, doing what I feel is in harmony with my bodily rhythm, I do recognize the cultural (and I am talking about the professional culture of medicine in particular) embarrassment and distrust when facing difference. In conversations between doctors and others, as well as in my own personal dialogues, it is perfectly clear what I mean when I say that I don’t have a *real job*, even though my experience of the research I am now doing is as real as life can be. Anyway, the fact that I am not *really* a physician silenced me when you, Eija, asked me about professional attitudes to difference. Had I replied to you with my own story, I would have called into question your ability to work *really*, even if I had not meant it that way – I had no doubt about your being a competent and empathic physician. That, though, is the persistent wound in your body-self: the threat of being suspect. That is why your bodily necessity is a dilemma in

your story more than in the others presented above: it marks your professional self in a visible, unavoidable way.

How did you change me, then? You made me write about my own vulnerability (Sparkes, 1996, helped you in turning my head). I understood that my pain does not lie in having to give up my clinical career – it lies in being different. I would not suture my wound by carving out a successful career, and judging by how your story resonates in me, nor can you. I can only gain a self and identity appropriate to my body and my experience if I can write a story over it that includes my fragile, my ever unknown, mysterious and special nature. Whether it is my heart, mind, leg or stomach that is my sign, I must love the difference in me.

I suppose the same wondering that I visioned between myself and my interviewees and their stories at the beginning of my article will happen in *me* if and when I meet my own otherness with curiosity – that is what I heard Timo do with his bodily mystery, his symptom-giving stomach.

Gendering the Wounded Body

I have used the word *wound* in two very different senses: first, I quoted Arthur Frank, who says we are all wounded storytellers and refers to the fragility of the human body. I then adopted an Irigarayan idea of the wound that is cut into a self by someone who does not respect the otherness of that self, but claims to have the rule of identity. Timo, for example, is definitely vulnerable in Frank's sense, but his bodily otherness – his stomach – is not a wound in his narrated self, I hope not even after my wondering at his story.

I will conclude by figuring the implications of the two kinds of wounds for research on narrative and gender. To Luce Irigaray, cherishing the moments of wonder is both an ethical and an epistemological claim. I suggest that what I have called a method of wondering might open up a way of listening to other people's stories in a way that does not cut off but creates dialogue and knowledge. In this article, I have portrayed the knowledge about doctors' wounds and vulnerability that I was able to create by toning down my previous conceptions and sentiments and wondering at the illness stories that first appeared surprising or strange. The method of wondering protracts the narrative approach to the direction of phenomenology through Irigaray's writings. It recognizes *both* the embodied and emotional nature of experience *and* the importance of language and stories for facilitating and maintaining communication (cf. Honkasalo, 2000).

While Irigaray writes that 'the relation between man and woman seems to be the one where language is most needed because they cannot be reduced to one

another' (1996: 125), I have tried not to reduce to myself, to my prejudice, narrators of both sexes. I took the difference between the healthy and the ill as my starting point, and I do not mean myself as healthy and the interviewees as ill but the cultural dichotomy that determines what can easily be thought about our own and others' bodily wounds. And I often ended up deliberating sex. As I understand Irigaray, she means that sexual difference is both a universal difference between women and men and, because of that, representative of other differences, the whole notion of difference. We are always dealing with sex even if we focus on other differences, for example that between the healthy and the ill.

To start out from sexual difference means taking it that gender is very much part of both the context of narrating and the story itself. Yet it also means not knowing how, not having the rule of man's or woman's identity, and it sometimes means stopping where my first reaction is wonder and disbelief (*Is it really a man who is speaking? What kind of woman could possibly say so?*). Rather than assuming that men tell their stories in similar ways, because they are men, and rather than looking for (dis)similarities in men's stories in order to justify (a challenge to) the masculine norm, starting out from difference means emphasizing the context of reception and asking what factors in the text tempt the reader to name gender, and why (Mills, 1995: 39). Paraphrasing Nancy K. Miller's arachnology, a theory of text production where the narrator leaves traces of his/her material, embodied, gendered existence in the text, so that the reader can 'recover within representation the emblems of its construction' (1988: 80), I think that where the body becomes tangible in the story I will be able to identify (with) how that body is marked by difference and by gender. I name sexual difference through my own body resonating.

Kathy Charmaz (1994: 270) writes about the identity dilemmas that *men* face when serious illness reminds them of their vulnerability: risking activity vs. forced passivity, remaining independent vs. becoming dependent, maintaining dominance vs. becoming subordinate. Of the five narrators presented above, though, only Petra – a woman – tells a story that clearly turns the possibility of chronic illness into this masculine dilemma. From where I stand with my interviewees' stories, I agree with Frank (1993: 43) who says that demographic explanations are inadequate in specifying the style of an illness narrative. Therefore what troubles me about Charmaz's sensitive analysis of men's (and women's) accounts of chronic illness is how much weight she gives to gender as an *explanatory* factor. She equates man with masculine, and then measures the distance between *a* man and masculine. Preserving the masculine identity of control sneaks in as an expectation against which every man's story is heard. At the same

time, other non-masculine identities regain their meaning of shame and their implication of belonging to a woman or a child (Charmaz, 1994).

It might be more threatening to gendered stereotypes, and more respectful to the uniqueness of the stories and body-selves, to ask how (and if) narrative identity and self are constructed in a particular story so that identity is appropriate to the narrator's gender. From the vantage point of sexual difference the question is, what kind of woman is Petra/Mirja/Eija giving voice to? Speaking as? What kind of man is embodied in Timo/Riku telling his story and my reading it? I accept that the narrator is a man or woman, *but I still do not know how*: how has culture marked this (fe)male body, with or without a wound (Irigaray, 1993: 75; see also Irigaray, 1996: 107)?

Or: I accept that the narrator is a physician, but I still do not know how. The same fondness of difference has made it easier for me to suspend my/the customary conceptions of what a physician's body, self, or career should be like and to listen to different doctors' stories. Those customary conceptions come close to normative masculinity. What I have called elsewhere (Löyttyneimi, 2004) *the mythical doctor* – that is, the cultural character that doctors seldom accept as their personal ideal as such but that seems to be evoked every time the word 'doctor' is uttered – is one characterized by independence and invulnerability. Irigaray's notion of sexual difference can challenge the myth in two ways. First, the notion claims the independent value of the feminine (that is, of what is referred to as feminine in the Western culture): the embodied – and thus wounded – and interdependent threads of any identity. If vulnerability is not considered the dark or negative side of professional autonomy but, instead, coexistent with that autonomy, doctors, too, can more easily be wounded storytellers. Second, the notion of sexual difference suggests an orientation to the other sex as different, and to the other as sexed and different. The myths of woman, man and physician are deliberately denied the status of norm or of expectation about any single story or identity.

What, then, would a story that is inappropriate to one's gender be like, if gender does not explain what is told in the story and how? If a man's story is not heard and evaluated against the cultural stereotype of masculinity? If anything goes for a woman or a man? I hear some inappropriateness in Petra's story: when she refers to her female body, her body-self is marked by a threat to her autonomy, that is, to the ground of her narrated subjectivity and identity. Having a partner, getting married, and having children are all unmade decisions in her story, and they all carry the meaning of adaptation and subordination, just as eventual illness does. On the other hand, in Mirja's story her female body is the home for the deepest sorrow, but she narrates an identity that heals the wound.

Both stories make the cultural association between woman's body and mothering, but the dissonance between this culturally constructed difference and a woman's body-self only remains in Petra's. Her potential to become a mother creates a story of a dilemma, whereas Mirja who cannot mother a biological child tells her woman's story of and through her childless body.

Masculine storylines are certainly more familiar to a man in a culture where gender makes difference, just as feminine storylines are to a woman, but they are inscribed in and retold through every body a little bit differently and more or less crosswise (Stanley, 1992: 247). So the fact that I am a woman explains my story and experience only to some extent, and if we want to coax out stereotypes I suppose the part of my story that is not explained by my gender but constructs *my* female gender is of interest. That part of my story can probably be shared with *you* only if you stop where you do not understand, where you intuitively resist, where you cannot believe, where you can only wonder. Where your body does not easily resonate. Where you can let my story live with you and change you.

Notes

1. I want to thank Marja Kaskisaari for highlighting the pivotality of otherness in Irigarayan wondering and the antithesis that otherness makes to the concept of identity as sameness.
2. The Finnish metaphors are '*ahdas*', '*juuttua*', '*prässi*' and '*tikahtua*'.

References

- Bakhtin, Mikhail (1981) *Discourse in the Novel*, pp. 259–422 in M. Holquist (ed.) *The Dialogic Imagination: Four Essays by M.M. Bakhtin*. Austin: University of Texas Press.
- Bakhtin, Mikhail (1984) *Problems of Dostoevsky's Poetics: Theory and History of Literature*, Vol. 8, ed. and trans. C. Emerson. Minneapolis: University of Minnesota Press.
- Billig, Michael (1999) *Freudian Repression: Conversation Creating the Unconscious*. Cambridge: Cambridge University Press.
- Booth, Wayne C. (1974) *Rhetoric of Irony*. Chicago: University of Chicago Press.
- Charmaz, Kathy (1994) 'Identity Dilemmas of Chronically Ill Men', *Sociological Quarterly* 35(2): 269–88.
- Code, Lorraine (1993) 'Taking Subjectivity into Account', pp. 15–48 in L. Alcoff and E. Potter (eds) *Feminist Epistemologies*. London: Routledge.
- Davis, Kathy (1997) 'Embody-ing Theory: Beyond Modernist and Postmodernist Readings of the Body', pp. 1–23 in K. Davis (ed.) *Embodied Practices: Feminist Perspectives on the Body*. London: Sage.
- Edelstein, E.L. and L. Baider (1982) 'Role Reversal: When Doctors Become Patients', *Psychiatra Clinica* 15: 177–83.
- Estés, Clarissa Pinkola (1992) *Women Who Run with the Wolves: Myths and Stories of the Wild Woman Archetype*. New York: Ballantine Books.

- Frank, Arthur W. (1993) 'The Rhetoric of Self-change: Illness Experience as Narrative', *Sociological Quarterly* 34(1): 39–52.
- Frank, Arthur W. (1995) *The Wounded Storyteller: Body, Illness, and Ethics*. Chicago: University of Chicago Press.
- Frank, Arthur W. (2001) 'Can We Research Suffering?', *Qualitative Health Research* 11(3): 353–62.
- Freeman, Mark (2002) 'Charting the Narrative Unconscious: Cultural Memory and the Challenge of Autobiography', *Narrative Inquiry* 12(1): 193–211.
- Gothill, Matthew and David Armstrong (1999) 'Dr No-body: The Construction of the Doctor as an Embodied Subject in British General Practice, 1955–97', *Sociology of Health and Illness* 21(1): 1–12.
- Gurevitch, Zali (1999) 'The Tongue's Break Dance: Theory, Poetry, and the Critical Body', *Sociological Quarterly* 40(3): 525–42.
- Hahn, Robert A. (1985) 'Between Two Worlds: Physicians as Patients', *Medical Anthropology Quarterly* 16(4): 87–98.
- Heinämaa, Sara (2000) *Ihmetys ja rakkaus: Esseitä ruumiin ja sukupuolen fenomenologiasta* [Wonder and Love: Essays on Phenomenology of the Body and Gender]. Helsinki: Nemo.
- Honkasalo, Marja-Liisa (2000) 'Chronic Pain as a Posture Towards the World', *Scandinavian Journal of Psychology* 41: 197–208.
- Hyppölä, Harri (ed.) (2000) *Lääkäri 1998. Raportti kyselytutkimuksesta vuosina 1987–1996 valmistuneille lääkäreille ja vertailu tilanteeseen kymmenen ja viisi vuotta aiemmin* [Physician 98. Report on a questionnaire study about Finnish physicians graduated in 1987–1996 and comparison with the situation ten and five years earlier. English summary]. Helsinki: Ministry of Social Affairs and Health.
- Hyypä, Markku T. (1997) *Tunteet ja oireet: Uusin psykosomaattikka* [Emotions and Symptoms: The Latest Psychosomatics]. Tampere: Kirjayhtymä.
- Irigaray, Luce (1985) *This Sex which Is Not One*. Ithaca, NY: Cornell University Press.
- Irigaray, Luce (1993) *An Ethics of Sexual Difference*. Ithaca, NY: Cornell University Press (French original *Ethique de la différence sexuelle*, 1984).
- Irigaray, Luce (1996) *I Love to You: Sketch of a Possible Felicity in History*. New York: Routledge.
- Kaskisaari, Marja (1995) *Lesbokirja* [The Lesbian Book]. Tampere: Vastapaino.
- Kaskisaari, Marja (2000) *Kyseenalaiset subjektit: Tutkimuksia omaelämäkertoista, heterojärjestyksestä ja performatiivisuudesta* [The Subjects Called into Question: Studies on Autobiographies, Hetero Order and Performativity]. Jyväskylä: SoPhi.
- Kleinman, Arthur (1988) *The Illness Narratives: Suffering, Healing and the Human Condition*. New York: Basic Books.
- Klemola, Timo (2002) 'Filosofian harjoitus – harjoituksen filosofia' [The Practice of Philosophy – The Philosophy of Practice], *Niin&näin* 9(3): 13–20.
- Löyttyniemi, Varpu (2001) 'Doctors Drifting: Autonomy and Career Uncertainty in Young Physicians' Stories', *Social Science and Medicine* 52(2): 227–37.
- Löyttyniemi, Varpu (2004) *Auscultatio Medici: Kerrottu identiteetti, neuvoteltu sukupuoli* [Auscultatio Medici: Narrating Identity, Negotiating Gender]. *Acta Electronica Universitatis Tamperensis* 347, University of Tampere. Available online: <http://acta.uta.fi>.
- Mäenpää, Eliisa (2000) *Sairaalalääkärin jaksaminen työterveyshuollon näkökulmasta* [Hospital physicians' well-being viewed from their occupational services]. *Acta Universitatis Tamperensis* 729. Tampere: University of Tampere.
- Miller, Nancy K. (1988) *Subject to Change: Reading Feminist Writing*. New York: Columbia University Press.
- Mills, Sara (1995) *Feminist Stylistics*. New York: Routledge.
- Morgan, David (1990) 'Masculinity, Autobiography and History', *Gender & History* 2(1): 34–9.

- Radley, Alan (1988) 'Health and Illness', pp. 84–99 in M. Billig, S. Condor, D. Edwards, M. Gane, D. Middleton and A. Radley (eds) *Ideological Dilemmas: A Social Psychology of Everyday Thinking*. London: Sage.
- Radley, Alan and Michael Billig (1996) 'Accounts of Health and Illness: Dilemmas and Representations', *Sociology of Health and Illness* 18(2): 220–40.
- Sparkes, Andrew C. (1996) 'The Fatal Flaw: A Narrative of the Fragile Body-self', *Qualitative Inquiry* 2(4): 463–94.
- Spiro, Howard M. (1987) 'When Doctors Get Sick', *Perspectives in Biology and Medicine* 31(1): 117–32.
- Stanley, Liz (1990) 'Moments of Writing: Is There a Feminist Auto/biography?', *Gender & History* 2(1): 58–67.
- Stanley, Liz (1992) *The Auto/biographical I: The Theory and Practice of Feminist Auto/biography*. Manchester: Manchester University Press.
- West, Linden (2000) 'Doctors on the Edge. Gender and the Cultural Psychology of Healing and Lifelong Learning. An Auto/biographical Study', paper presented at the 'Biographical Methods and Professional Practice' Conference, The Tavistock Clinic, London, 19–21 October.
- Zola, Irving Kenneth (1991) 'Bringing Our Bodies and Ourselves Back In: Reflections on a Past, Present, and Future "Medical Sociology"', *Journal of Health and Social Behavior* 32: 1–16.

Varpu Löyttyniemi is a post-doctoral Fellow at the School of Public Health, University of Tampere, Finland. In her doctoral dissertation 'Auscultatio Medici: Narrating Identity, Negotiating Gender', which she defended in May 2004, she develops dialogical and gender-marked ways of reading doctors' personal stories. In her future project she is especially interested in combining narrative theory and methodology with the notion of sexual difference to create a notion of medical profession that is both gender sensitive and sensitive to intraprofessional differences. Her own educational background is in medicine, she graduated as a medical doctor in 1994. However, in her scientific work she draws upon her studies in discursive social psychology and feminist theory.