‘CLINICAL COUSINS: INTERPRETERS OF MALADIES’ NARRATIVE MEDICINE: A SUPPLEMENT TO MEDICAL PRACTICE

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“As sicknesse is the greatest misery, so the greatest misery of sicknesse is solitude” -John Donne

The battle-cry of Kant - sapere aude (Dare to know or have the courage to use your own reason) in his essay “What is enlightenment?” (1784), echoes in the scientific endeavor of humankind in the last two hundred years. We have been immensely benefited by scientific advances, though a blatant indifferent progression in the shadow of capitalistic framework has led to some drastic consequences, urging some to raise questions over the scientific pursuits. But it is widely recognized that science is neutral in terms of value and it is human intervention which decides the consequences.

Medicine is one among the scientific fields, which has extended great solutions to the humanity in its perennial fight against sickness. Despite tremendous achievements, persistent efforts and researches to evolve remedies for the sick, it is consistently observed that it has somehow failed to become holistic and meet the reasonable expectations of hopeful humanity. One of the inadequacies can be attributed to its ‘dealing’ with human beings, keeping aside the less-reported-but-much-known malpractices of the profit-driven corporate healthcare industry. Medicine, primarily, functions under the aegis of positivist paradigm. Hence, the practice is empiricist or evidence-based. On non-human entities or the physical matter, it commands a convincing and ‘triumphant’ standing. It even explains its inaccuracies, such as the embarrassing deviations in meteorological predictions, with the Chaos theory. But when it comes to deal with human beings, its evidence-based and generalized approach meets its limitations, quite conspicuously in medicine. It is because, medicine, in principle and in conduct too, excludes the patient’s narrative- his/her inevitable making sense and telling of life/sickness/time in a story. It has failed to recognize the healing effect of listening ‘completely’ and is ill-equipped to extract not-so-clinically-evident illnesses. These illnesses may lie hidden in the existential, experiential or unconscious realm but can be discovered and accessed in language. Language which is never transparent, as medicine treats it to be. The illness needs to be discovered in the ambiguities, metaphors, silences, gestures, allusions, et cetera, as the patients recount the stories of their illnesses. To a great extent, healthcare professionals ignore the stories of patients in their fixed ‘disciplined’ functioning patterns. Patients often complain of
not being listened to properly or carry a nagging feeling of not being able to describe their illness completely. These complaints are dispelled as trivial and insignificant issues. Narrative based practice highlights that such problems are significant and must be attended with precision. With some philosophical inputs and insights, this paper attempts to support the narrative based practice as a supplementary method to bring improved results in the medicine. Though, it is an honest submission that this practice cannot make for an ‘absolute’ knowing. The limits of knowing, as here in the empiricist practice of medicine, were foregrounded by Husserl, in his rigorous scientific method of investigating the subjectivity of knowing and the objectivity of the content known. “natural science gives itself over to the world of the natural attitude in an unspoken and unquestioning assumption that it exists independently and is an authority in all matters of fact. It puts to one side questions concerning the experience of the world and simply takes reality at face value. It asks about the objects that are given, not about the nature of their ‘givenness” (2007:73)

Narrative based practice in medicine has grown up enough from its naiveté childhood to assert a name for itself- narrative medicine. Columbia University’s college of medicine offers programs, conducts workshops and seminars on narrative medicine, training healthcare professionals in blending literature and medicine. Dr.Rita Charon, founder Director of the college, is the leading name in this field. She is a seasoned physician with PhD in English. This paper is indebted to her. She has developed a model of writing ‘parallel charts’ for doctors, illustrated a large number of cases where narrative medicine reoriented the mode of treatment and fetched remarkable results and framed revised formats and ways of medical interviewing. This paper will confine itself to philosophically justify the narrative features of medicine, as proposed by her. These features are peculiarly given to human’s temporal existence, inevitable pervasiveness of story-formation and telling, emplotment as productive act of an individual and intersubjective selfhood. Narrative medicine strives to train and equip the medical professional with narrative competence. It can transform their routine practice. They get skilled to listen, absorb, interpret and internalize the stories of the patients. They learn to understand, feel and assimilate their metaphors, allusions, genres, flashbacks, gaps, silences and gestures. Narrative medicine is an authentic turn to revive the primary aim and nobility of this profession.

Narrative medicine identifies that there is a baffling, poignant, nearly unbridgeable and fundamental divide between the sick and the doctor or rather the sick and the well. The news of a terminal or a serious disease brings about an agonizing awareness of mortality, decay and void. The person finds himself/herself enveloped with plethora of emotions of rage, fear, shame, blame, regret etc. The well remains, obviously, alien to his/her differing notions of mortality, contexts/ causality of illness and gamut of emotional upheavals. Here the positivist approach of medicine encounters, though it may not admit, its limitation. Human beings given to their ‘immortal’ transcendence cannot be confined to the ‘generalized’ treatment of science. Mishler points out that, “… the practice of medicine is not a
theoretical, but an applied science… its focus and stance are tied not to the disinterested stance of the scientific investigator but to the practical concerns of patient care and treatment.” (1986:128)

Wittgenstein, who denounced all philosophical problems to the problems of language, must have stood for a narrative/language based relationship between a doctor and a patient. He advocated sharing of social contexts, practices and concepts to have a meaningful dialogue. He characterized this process as a “language game” in which “meaning is embedded within a social context and so finds expression through the use made of particular terms”(1953:2)

Scientists, including doctors have remained, more or less, indifferent to the interpretive discourses. They tend to stay complacent in their ‘scientistic’ attitude. Hunter makes a very bitter statement that medicine “… shares its methods of knowing with history, law, economics, anthropology, and other human sciences less certain and more concerned with meaning than the physical sciences. But unlike those disciplines, it does not explicitly recognize its interpretive character or the rules it uses to negotiate meaning.”(1996:225)

Though there may be a few disciplines which include body in their curriculum, it is medicine which has an unparalleled privileged status in its essential access to the body. And a large number of discourses ranging from religious to psychiatry have grappled with the relationship between the body and the self. How can medicine bypass it! It is with the body only that one asserts, claims, justifies ones presence, expresses ‘itself’ and relates with the world. It is the locus of a person’s self. The body really matters because it is the ‘matter’, which though not much-acknowledged, provides for a metaphorical extension of the self. In a Heideggerian sense, it only matters when there is a ‘break in the everyday unmediated participation’ (as in the case of an ailment) or the ‘care’ for the self (as evident in the beautifying, fitness etc measures). Charon writes “The body is and is not the self. No wonder the telling of the self that occurs in the doctor’s office becomes complicated. Such telling follows the rules for autobiographical telling or writing in general: the teller splits into a narrator and a protagonist, generating the autobiographical gap” (2006:90). She further states “The autobiographical gap here is accompanied by another gap that we might call the corporeal gap. The teller of the self tells of the body of the self. The act of telling separates, momentarily, the teller-who-reports from the body-that-feels. The teller is called upon to become the voice of the body or the medium through which the body can convey its message to the listener” (90).

She proposes five narrative features of medicine – temporality, singularity, causality/contingency, intersubjectivity and ethicality. She finds these features intertwining and indiscrete as they make an organic whole of narrative. Singularity blends into intersubjectivity, temporality is required for causality and ethicality evolves from the intersubjective acts of listening or telling. She, explaining the temporal nature of narrative medicine, points out, “By respecting the beginnings, middles, and ends of human
events, narratives require, from each reader and writer, adherence to the human’s obligatory existence within the flow – and the buoyancy of time” (42). Healthcare professionals must understand the axial significance of time in diagnosis, prevention, palliation and cure. An insightful understanding of time and timeliness will help in realizing the distinct temporal experience of a sufferer and the ‘others’.

She finds singularity as a differentiating aspect of narrative from the universal or scientific knowledge, which ignores singular and incommensurable in its ‘obsessive compulsion’ with the general. The telling is not only reporting but also producing and configuring an original form. This form makes for singularity. The treatment of patients like items or numbers on an assembly line justifies their complaints for being deprived of their singularity. Human beings find, understand or invent a cause in a primary urge to make the state of affairs sensible and intelligible. Causality comes from human intervention as evident in the differing opinions of patients and doctors or among doctors governing the ‘same’ illness. A meaningful relation with an embedded causality forms the structure of narrative called plot. Diagnosis is nothing but emplotment of apparently disparate symptoms/signs, events or states of affairs. As Charon suggests, a narratively trained clinician will be inventive and open-ended to go beyond the obvious and look “generatively, creatively, hopefully in collaboration with patient- to construct a wide, deep and varied differential diagnosis.

Adam Zachary Newton in Narrative Ethics writes, “ a narrative is ethics in the sense of mediating and authorial role each takes up toward another’s story….storytelling lays claim upon all its participants, those circumscribed within the narrative as well as those …witnesses and ethical co-creators from without-its readers.” (1995:48, 24) The privilege of knowing, especially in the case of clinical practice, calls for a dutiful, trustworthy and responsible consideration. This entails an ethical relation between patients and doctors, a unique relation which does not find its origin in love, hatred, passion, friendship or familial affection.

Narrative medicine grows on the thesis that life and narrative are intertwined. Ricoeur is the most authoritative voice in this regard. He denies any conception of life without narrative. The book on Ricoeur, edited by David Wood, unfolds rich contribution of Ricoeur to narrative and interpretation. Ricouer finds narrative immanent to experience itself by virtue of life “being symbolically mediated with stories”. Narrative is a configuring act completed in reading, as, the doctor completes the patient’s story by ‘listening’ to it. Kevin Vanhoozer states that Ricoeur in his thesis of narrative theory fuses time and imagination together drawing upon Kant’s productive imagination and Heidegger’s existential temporality. Vanhoozer finds Ricoeur completing the respective projects of Kant and Heidegger with narrative. According to Kant, imagination plays a mediating role in schematizing the figures that shape time. Narrative “…gives an essential articulation to this schematization”. Vanhoozer further writes,

Narrative also functions for Ricoeur as a corrective supplement to Heidegger’s account of
temporality. If Heidegger could be said to have replaced Husserl’s direct inspection of essential structures of consciousness with a detour through the fundamental structures of Dasein’s existence, Ricoeur argues that Heidegger’s own route is in need of a further mediating detour, through narrative. The narrative approach not only allows greater analytical rigour, it allows us to turn away from the monadic concerns of Being-towards-death to a more fully public and social sense of our temporality (1991:12).

Therefore, the patient does not just experience a sequence of disparate symptoms. Human reality cannot be conceived in unrelated and discrete sequence of events. It would have reduced humans to robots or zombies. We make story of our self and our relation with the ‘world’ out there. The patient also does not attend to just ‘now’ when he tells about his illness. Husserl’s theory of time-consciousness makes it clearer. The ‘retention’ of past and ‘anticipation’ of future is embedded in the ‘present’. He argues, the remarkable and fundamental ‘horizontal’ structure of experience seems to bear an intrinsic and essential connection to temporality. The 'possible perceptions' that accompany perception at every turn are possible future experiences, or perhaps possibilities already realized in past experiences. This is even more clearly the case within the simple act of perception itself. I anticipate that further adumbrations of the physical thing will appear in a continuum as I move around the thing or the thing changes position. (2006: 128)

This unifying intentional act of patient is configured and articulated in a story. Ricoeur recalls Aristotle in forwarding the supremacy of narrative, “Aristotle said that story reveals the universal aspects of human condition….develop a sort of understanding that can be termed as narrative understanding and
which is much closer to the practical wisdom of moral judgement than to science, or more generally, to the theoretical use of reason.” (21, 22)

The doctor and the patient when come together, they ought not to be regarded in subject-object position. It is sharing which can be better termed as intersubjective situation. Analytical philosophers confined intersubjectivity to observation of an external thing by two subjects at the same time. But, as Charon suggests, Husserl and Heidegger undertook a more penetrating project of combining cognitive, perceptual and ontological accounts. Husserl did extend his solipsistic sphere to accommodate intersubjectivity. He even employed the phrase, Transcendental Subjectivity, which he elaborates as,”…the absolute and only self-sufficient ontological foundation. Out of it are created the meaning and validity of everything objective, the totality [All; cosmos] of objectively real existent entities, but also every ideal world as well.’(168). Charon places Levinas as a culmination in a sense that he replaces Husserl’s problem of knowledge and Heidegger’s problem of being, with the problem of ethics as “…primary, transforming philosophy into an enterprise committed to intersubjective human responsibility” (51). He is a very influential thinker in terms of ethicality involved in the clinical practice. According to him, listening to the other (as it happens in clinical practice) breeds responsibility.

Narrative medicine, thus, is a methodological application to bridge the gap that occurs between the healthcare professionals and the patients, which is nothing but manifestation of the ontological and epistemological beliefs of the professionals. With an upsurge in democratic pursuits across all disciplines particularly in literary theory, narrative medicine can assume a practically feasible and influential role, if properly undertaken. As narrative theory has ceased to be confined to the study of dead texts, it has widened its scope from cinematic studies to the living textuality like medicine. And more so, it has far reaching altruistic consequences.

Works Cited


