"The great human moment": Narrative Medicine and the ground of language

REVUE MÉDECINE ET PHILOSOPHIE

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ABSTRACT
In this paper we aim at reconsidering the challenges posed and the difficulties experienced by patients and physicians during clinical meetings, especially when the patient tells the doctor the history of his/er illness, i.e. anamnesis. Our approach is informed by Narrative Medicine and concepts imported from narratology and linguistics, namely Meir Sternberg's notion of 'exposition', Mikhail Bakhtin's 'double-voiced discourse', and Émile Benveniste's conception of language as discourse, subjectively charged. The time sequence in the patient's report, in/voluntary omissions, unperceived misunderstandings, the unsaid and the implied meanings may interfere disastrously in the doctor/patient's dialogue and delay or jeopardize diagnosis. By addressing their interchange through the lenses of narratology and linguistics, we hope to contribute to enlarge the scope and the potentialities of narrative medicine to doctors / carers in health care scenarios.

KEYWORDS : narrative medicine ; anamnesis ; doctor-patient communication ; narrative vs discourse.
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"Ce moment où mon corps va suivre ses propres idées – car mon corps n'a pas les mêmes idées que moi"

Roland Barthes, Le Plaisir du texte

The human element in the art of medicine

In the clinical encounter the importance of the moment when patient and doctor cooperate so as to overcome the disease has been emphasized since Hippocrates[1] : the doctor questions the patient about the latter's illness while the patient tells the doctor the symptoms that led him/her to look for the physician's help. Dialogue between the two has always been of paramount importance as the symmetry and cooperation evidenced in the Hippocratic formulation has made manifest. In modern times, however, the clinician must be able not only to attentively note all the information transmitted by his/her patient but also to interpret it by means of a sort of translation into another language – a decoding into a scientific typology. Thus, the unique story that was heard first is transformed into a case, which is an illustration of a typified disease, thus combining two contradictory impulses : to singularize and to categorize. This much has been recognised by Rita Charon when she argues that the act of diagnosis implies two contradictory drives : "the effort to register the unique features of that which is observed and the simultaneous effort to categorize it to make it 'readable'." (2006, 46) In this sense, we would say that the doctor becomes a hybrid being – both interpreter and translator and this (maybe for some) unexpected and complex professional profile is particularly demanding since it implies a medical performance that involves not only increasingly demanding scientific knowledge but also a clearly humanistic (not to say humane) component[2].

1. We have in mind here the famous 'Hippocratic triangle,' as manifest in the following passage : "The [medical] Art consists of three factors, the disease, the patient and the physician. The physician is the servant of the Art. The patient must cooperate with the physician in combating the disease". Hippocrates. *Epidemics* 1st, 11.

2. Hurwitz, writing on modern clinical case reports, calls attention to the fact that they are "problem-solution accounts of how an individual's felt experience of illness have come to be understood in terms of disease categories" (2017 65) and he explores the ways in which "clinical case reporting generally privileges a medical perspective, which muffles patients' voices" (2017 70).

This may well be the reason why there have been those who have emphasized in the physician those very features we normally associate with the literary scholar, namely, the reading and critical skills. Anatole Broyard, for instance, in his posthumously published work entitled *On Doctoring* (1991) writes : "What *do* I want in a doctor ? I would say that I want one who is a *close reader* of illness and a *good critic* of medicine" (175 – emphases added) [3].

Similarly, though from a doctor's perspective, Edmund Pellegrino, in his work, *Humanism and the Physician*, recognised medicine's epistemological hybridity : "Medicine is the most humane of the sciences, the most empiric of the arts, and the most scientific of the humanities" (17).

More recently, the Portuguese neurologist João Lobo Antunes, in *Ouvir com outros Olhos* [Listening with Other Eyes] (2015), admitted that in the exercise of his clinical activity "humanistic culture" had made him more capable of "attuning his ear to apprehend other voices, of understanding the hidden meaning of words and of being able to engage in dialogue with anybody in such a way as to raise to that common ground that enables a horizontal look, eye to eye" [4].

We wonder why Lobo Antunes is so concerned about "raising" the doctor's eyes to level them with the eyes of his patients. The fact is that the exercise that allows the physician to translate into a precise diagnosis and an exemplary case a story which is so often diffuse, uncertain and stuttering, may, on the contrary, invite him to retreat from the pathetic figure before him – a vulnerable being, frightened by the indecipherable symptoms of a disease unknown to him/her. Moreover, the gulf here is not simply the one that separates two languages that bear no resemblance to each other – the lay narrative of the patient uttered in the 1st person and the doctor's diagnosis, a scientifically informed narrative in the 3rd person, so often obscure to the former [5]. There is an experiential and epistemological gap that can easily turn into a situation of epistemic injustice, such as those denounced by Miranda Fricker [6], and, in the case of health scenarios, this may result in the patient's narrative being discredited [7].

Michel Foucault, in *Naissance de la Clinique* (1963), called attention to the essential gap separating the phenomenological experience of illness and its understanding as by the doctor. The experience of illness by a particular patient, he termed "historic" experience, and the doctor must attend to it in the first place. However, there is also its "philosophical" counterpart, whereby the former is projected on to a rational grid of intelligibility based on the analogies among diseases afterwards translated into taxonomies that do away with all trace of singularity (Cf. Foucault 20-28).

Such linguistic discontinuity and the lack of a common ground and perspective have become apparent and have deepened with the advent of modern medicine, increasingly more objective and scientific, since the last decades of the 18th century, but more clearly so in the following century with the emergence of clinical science [8] and specialization [9]. This was paralleled by a tendency to neglect the patient's narrative, both by doctors and patients, often complicit in the belief that images and test results are more eloquent in revealing the patients' condition than his/er own words.

Notwithstanding these developments, in the mid-20th century, a physician and writer, the Portuguese Miguel Torga, has made clear his own regard for this particular moment in the clinical encounter. In one of the entries of his *Diary*, one reads : "The one moment in the exercise of my profession that has always fascinated me is the history. The recitation of his woes the patient makes in response to the doctor's inquisitive cordiality. That is the great human moment of the medical transaction" [10].

In the following sections we will be using notions and concepts from the field of narratology in order to promote a heightened awareness in health care professionals of the centrality of the patient's anamnesis and the specific difficulties and pitfalls attending this crucial moment of interaction between patients and doctors. We do this in the hope it may contribute to enhance both the potentialities, challenges and subtleties inherent in the interrelation component of the clinical encounter and their impact upon diagnosis. We will address these issues by exploring in particular Meir Sternberg's notion of exposition, Mikhail Bakhtin's concept of double-voiced discourse and Émile Benveniste's emphasis on a dynamic conception of language.

From exposition to anamnesis

When addressing that "great human moment" of the clinical encounter from the perspective of narratology, the first thing that seems to be obvious is that the role of the doctor in view of that report of the history of the patient's ailments is no other than that of a reader. It is his/her job to listen attentively to and to absorb and register that history in all its nuanced meanings. This moment requires attention as the most decisive skill. As part of the Narrative Medicine triad [11], attention is, according to Charon, fundamental ; an attentive ear is what gives doctors the capacity of "close listening," in correspondence

3. Kathryn Montgomery Hunter also makes the case for the patient to be seen as text and the doctor as reader and even literary critic (Cf. 8).

4. In the original : "apurar o ouvido para captar outras vozes, compreender o significado oculto das palavras e ter a competência para falar com qualquer pessoa num diálogo que nos eleva àquela altitude comum que permite o olhar horizontal, olhos nos olhos" (Antunes, A Nova Medicina, 44 - our translation).

5. Cf Carel on the differences between these two types of narrative (10 ss). On this "narrative incommensurability" see also Hunter's chapter 7, "Patients, Physicians, and Red Parakeets" (123-47).

6. In her book *Epistemic Injustice*, Fricker argues that, in addition to social or political injustices especially faced by women and minority groups, there can be two types of *epistemic* injustices : testimonial injustice and hermeneutical injustice. Testimonial injustice consists in prejudices that cause one to "give a deflated level of credibility to a speaker's word" (1). Hermeneutical injustice describes the kind of injustice experienced by groups who lack the social resources to make sense of their experience. One consequence of such injustice is that such individuals might be less inclined to believe their own testimony.

7. Carel uses Fricker's concept of epistemic injustice in the clinical setting and, more specifically, for exploring the doctor / patient relationship, where she identifies the occurrence of "testimonial" and "hermeneutic injustice". Cf. Carel, xvii.

8. Diego Gracia calls attention to some important features in the modern clinical encounter, namely the distinction between the 'subjective' symptoms as told by the patient and the objective *facts* valued by the doctor. On the importance of facts for the clinical transaction, see his "On Clinical History", in Fernandes et al., eds., *Creative Dialogues* 11-15.

9. On the growing specialisation in Medicine, see Hurwitz, "Medical Humanities," especially 14-19.

10. The original reads : "Há um lance no exercício da profissão que sempre me apaixonou : a anamnese. O relato dos padecimentos feito pelo doente à cordialidade inquisidora do médico. É ele o grande momento humano do acto clínico." From the entry written in S. Martinho da Anta, 26th December 1960. In Torga, Diário, vol. IX, 55-56. Some entries of Torga's *Diary* have been translated into English by Iain Bamforth and included in his anthology *The Body in the Library* (2003) as is the case with the one quoted above, which occurs in Bamforth 271.

11. On the Narrative Medicine triad, see Charon, *Narrative Medicine*, chapter 7, "Attention, Representation, and Affiliation."

with the “close reading” method elected as Narrative Medicine’s central practice and presented as its “signature method” [12]. A trained ear requires, still according to Charon, the practice of close reading, a method of reading stemming from the classes of I. A. Richards in the early decades of the 20th century [13].

Now, which part of the story does anamnesis correspond to, when does it occur in the context of a literary narrative ? Since what the patient is expected to tell the doctor upon their first encounter is the story of his/her symptoms and their development up to the point of consulting, we might look at this type of material as that part of a narrative text that tells the reader about the antecedents of the action proper. In this regard, two important time-laden notions emerge and here the doctor - patient relationship helps us : the antecedents belong to a past time in relation to the present of the doctor - patient meeting. In what concerns the present, in the case of the clinical encounter, it starts when doctor and patient meet. In the case of a narrative text, how do we identify the beginning of its present ? Here we had better resort to Meir Sternberg’s ground-breaking work on the manipulation of time in narrative in the 1970s. He speaks of the “fictive present” when talking of what others have termed simply and vaguely “action” [14]. According to Sternberg, we can identify the beginning of the fictive present or action of a narrative by the occurrence of the first “discriminated occasion,” a concept borrowed from Henry James, and which is generally marked by the use of dialogue between or among the characters in the book, but always “copious, comprehensive, and accordingly, never short” (James, 323). However, in order for the reader to understand what is at stake in this first occasion, where s/he for the first time “meets” these characters in action (just like the doctor when s/he first meets his/her patient), s/he has to be given some sort of information relating to these characters’ background. Sternberg calls exposition to the set of information concerning the past of the characters involved in the story. What type of antecedents or data are these ? The reader needs to know at least some of the following : the time and place where the story takes place, the characters’ identity, their social whereabouts, how they relate to one another, their psychological features, their beliefs, their occupation, their physical appearance, what they have done recently, etc. So, one would be led to believe that the best place for the exposition to be located in a novel or a short story would be the very beginning of the text, before the first discriminated occasion.

However, as every experienced reader knows, things are not that straightforward. Depending on the authors, the literary genre, the literary period, and the intended reception impact, the location of the exposition varies considerably. It may occur right at the beginning, immediately before the first discriminated occasion, in which case, Sternberg terms it “preliminary exposition” (35 ss) or it may be delayed until after that first occasion when the characters interact and/or talk. In this case, some suspense will be generated, spurring the reader’s curiosity, and postponing the information needed for a full understanding of what is going on. According to Sternberg, we call this type of account “delayed exposition”. Indeed, writers may decide to manipulate the reader’s interest and this involves playing with time [15].

Beyond these two narrative locations for the exposition to occur, relevant information about the antecedents of the action proper and its characters may appear in two different ways : either all of them together, as a block, or else given gradually throughout the narrative. Still according to Sternberg, the first is an instance of “concentrated exposition,” whereas the second he calls “distributed exposition.” In order to understand these concepts better, we offer an example from a well-known biblical episode to illustrate a preliminary and concentrated type of exposition [16] :

1"There was a man in the land of Uz, whose name was Job ; and that man was perfect and upright, and one that feared God, and eschewed evil. [17]

2 And there was born unto him seven sons and three daughters.

3 His substance also was seven thousand sheep, and three thousand camels, and five hundred yoke of oxen, and five hundred she asses, and a very great household ; so that this man was the greatest of all the men of the east.

(...)

6 Now there was a day when the sons of God came to present themselves before the LORD, and Satan came also among them.

7 And the LORD said unto Satan, Whence comest thou ? Then Satan answered the LORD, and said, From going to and fro in the earth, and from walking up and down in it.

8 And the LORD said unto Satan, Hast thou considered my servant Job, that there is none like him in the earth, a perfect and an upright man, one that feareth God, and escheweth evil."

The boundary that in this case separates expositional matter form the beginning of what Sternberg terms the fictive present seems clear enough. It coincides with the mention to a specific point in time, the time of the first “discriminated occasion :” “Now there was a day when the sons of God came to present themselves before the LORD...” Here the reader is aware that this segment is different in nature from the previous paragraphs, since it refers to a particular moment in time, where a specific action takes place. We have the impression that time itself expands so as to accommodate a dialogue between the two main characters (the Lord and Satan), whereas the previous paragraphs summed up Job’s situation and background, his qualities, family, habits, etc. and thus paved the way for an understanding of the events to take place immediately afterwards. Indeed, in only five paragraphs the reader gets a summary of several decades in Job’s life as well as recurrent actions testifying to Job’s and his family’s virtue and faith (references to these routine actions appeared in paragraphs 4 and 5, which were ex-

12. “As our signature method, close reading reflects and articulates the foundational principles of narrative medicine.” Charon et al., *Principles and Practice*, 8. The expression is also used in the title of chapter 7 of the same work : “Close Reading : The Signature Method of Narrative Medicine,” 157.

13. For more on this, see Fernandes et al. eds., Creative Dialogues, 22-25, and see also Charon et al. Principles and Practice, 158-64.

14. On this author’s notion of fictive present see Sternberg 19-23. Action is a term more appropriately used in relation to drama and that hardly accounts for the complexities of the narrative text (such as the subtleties in manipulating time/s, and phenomena such as illustrative scenes or pseudo-scenes). See Sternberg 23-30.

15. For exploring the origins of this methodologically relevant distinction : the chronological course of events of the story and the actual way in which they are reported to the reader, see how it featured in the famous Russian Formalists’ dichotomy between *fabula* and *sujet*. It was afterwards renamed and reworked by others, as for instance by Gérard Genette, who refers to three entities : *histoire*, *récit* and *narration*. (Genette, 1972).

16. Sternberg also uses this biblical episode in his work, though in a more detailed manner. See Sternberg 23-26.

17. The Book of Job, Jb 1, 1-8. *The Holy Bible*.

cluded here for economy's sake). These repetitive actions, however, are qualitative in character and they do not belong to the plot of this story, whose beginning coincides with the dialogue between the Lord and Satan. This dialogue, in contrast, corresponding to a brief moment in the plot, occupies six paragraphs. The time ratio governing expositional material and the fictive present is, therefore, significantly different.

Even though this text exemplifies only one type of exposition, a preliminary (since it comes before the beginning of the fictive present) and a concentrated one (given in block), it is nevertheless adequate as an approach to the clinical meeting. Indeed, it is desirable that the patient gives the physician at first the whole history of his clinical situation : symptoms, their development and any other relevant information pertaining to his current health condition. These are but the narrative exposition of the antecedents or the events that led him/her to the doctor [18].

It seems that at this stage one will willingly accept that there is a clear correspondence between narrative exposition (pertaining to the narrative action antecedents), as theorized by Sternberg, and clinical anamnesis, as has already been suggested above. The (generally) initial moment in the consultation when the patient takes a few minutes to report the story of his/her illness and its symptoms till the present moment aims at enlightening the doctor as to his/her specific health condition. One could therefore argue that in the clinical meeting the moment when the patient enters the doctor's office and both start their dialogue, that is, the here and now of that meeting, corresponds to what in a narrative is its first discriminated occasion. Moreover, narrative exposition (information concerning past events) corresponds to anamnesis. In the case of the clinical meeting, the target recipient of this information is no longer the reader (as in a narrative) but the doctor. He is now the one in charge of making sense of the case he has before him [19].

Now, it may happen, as is so often the case when reading a narrative, that not all the elements that will prove important for diagnosis are transmitted to the physician at first, at the outset of the first meeting, thus compromising a quick and precise diagnosis. In this case, we may speak, adopting the typologies governing Sternberg's narrative exposition, of a delayed and distributed anamnesis, if we assume that the missing relevant information will crop up on (a) subsequent occasion(s). Doctors will know that what happens most of the time (especially in cases that are not typical or straightforwardly identifiable) is an instance of this latter type of anamnesis. Indeed, there is never total convergence between what the doctor views as relevant clinical facts and what the patient considers as important in his experience of the illness, unless the two are both physicians. Normally, what we have are two not easily reconcilable perspectives. Narrative Medicine is also about bridging this gap and promoting its awareness ; to achieve this goal, it conjures up narrative tools and concepts such as the ones we here propose.

Exemplifying the difficulties of anamnesis from a clinical case report

In order to identify and illustrate some common difficulties and challenges posed by anamnesis and in particular a case of a delayed and dispersed illness recitation, we will refer to the clinical case report by John Launer, published in 2005 as an article entitled "Dialogue and Diagnosis" (subsequently included in his *How not to be a Doctor*, 2007).

Launer, a GP at the time, tells us about a woman in her late thirties whom he saw with peculiar neurological symptoms, serious enough for him to direct her to an urgent neurological outpatient appointment. Since the woman normally saw another doctor, Launer was only vaguely aware that there had been a miscarriage about a year before and dismissed this information as irrelevant in view of the information given in their first meeting – the severe worrying symptoms [20].

The neurologist asked for some imaging, which turned out to be normal, an information he imparted to the patient a month later. At this stage, the symptoms had become vaguer and more suggestive of muscular fatigue. The neurologist therefore sent her back to Launer and suggested she consulted a rheumatologist or someone equally interested in such cases. It is now worth quoting what happened at this moment :

So I saw her again and went back to square one. This time I got an entirely different story. The symptoms were now mainly aches and pains and exhaustion. She had more or less forgotten the numbness and paraesthesia that had brought her to me in the first place and caused such concern. (I wonder if they were amplified from the original consultation onwards as a result of seeing doctors, and then dispelled by the normal scans. We sometimes forget that we make our own contribution to the construction of symptoms). When I asked her to date her problem, she told me this time that she had had them about a year—considerably longer that she had said at first. This timing took us back precisely to her miscarriage. (321)

What the doctor gets this time is "an entirely different story," not the strictly biological report (doctor and patient somehow colluded in) but a biographical one, where the time reference led to the extremely traumatic experience of the miscarriage of a much desired but no longer expected pregnancy. This time she talks freely about incidents in her past personal life that punctuated a story of loss, grief and hopelessness ; and she cries [21]. The cathartic flow of tears goes hand in hand with the flow of words – a much-needed overflow of deep-seated feelings.

18. It would be relevant to try to identify the role of tests, scans, imaging of all sorts and other additional diagnostic means, which today complement anamnesis in the clinical encounter. We would argue that, in the context of Sternberg's theorization, their role would fall within the "indirect expositional accounts" category, in contrast with the "direct exposition" encapsulated in the patient's report. Cf. Sternberg 90 and ss. As in the example given by this author (Ulysses seen by the reader only through the eyes of other characters until book 5 of the Homeric poem), its valuable role notwithstanding, this type of complementary information may, in some cases, overlap and obstruct a direct access to the person of the patient and the way in which s/he experiences his/her condition.

19. George Rousseau acknowledges that the meeting between patient and doctor can be seen in terms of a literary experience, since "every time a patient enters a practitioner's office a literary experience is about to occur : replete with characters, setting, time, place, language and a scenario that can end in a number of predictable ways" (10).

20. For Launer this was the primary information received from the new patient and he, therefore, attaches himself to it. This phenomenon of the prevalence of the first impression or information over the subsequent one/s has been explored and explained in psychological terms by A. S. Luchins in his chapter "Primacy-Recency in Impression Formation," in Hovland ed., *The Order of Presentation.*

21. In literary narratives, the narrator tends to focus more sharply on some expositional data that are more directly relevant to the sequel ; in the same way, one could argue, the patient tends to emphasize closer antecedents to his symptoms than to focus on facts which are more distant in time, as happens in the case under scrutiny here – the woman does not refer at first to the miscarriage, which had happened one year before.

It is clear that she needed "someone who was capable of hearing both kinds of story—the biological and the biographical one—and who did not find it at all surprising that human beings live in both worlds at the same time" (322). Diagnosis is now corrected by a new chronology [22], and the inclusion of new biographical and biological data related to the miscarriage.

It is worth considering what has happened in terms of the report of the patient. Let us call her first narrative, the one that coincides with the first consultation, narrative A. And let us call narrative B the one which occurs in her second visit to the doctor (after the imaging had proved that nothing was amiss in neurological terms). Narrative A omitted any reference to the miscarriage (which proved crucial for the right timeline and diagnosis) and alluded only to symptoms occurring in the recent months, whereas narrative B goes backwards in time, aligning the beginning of the symptoms with the occasion of the miscarriage one year before. The time design is strikingly different now and gives the doctor the right sort of clue. Clearly, this is a case of delayed and dispersed anamnesis, which involves withholding pertinent data until disclosure at a later stage and therefore demands greater decoding and interpretive skills than those required by a preliminary and concentrated type of anamnesis, in which all relevant information is imparted by the patient to the physician during the first /stage of the meeting. However, this seldom occurs and, as with literary texts, the demands made upon the reader / physician are greater in such instances.

Something else however differentiates both narratives, which is also worth considering. When Launer is confronted by narrative B he brackets a significant hypothesis : "(I wonder if [the symptoms] were amplified from the original consultation onwards as a result of seeing doctors, and then dispelled by the normal scans. We sometimes forget that *we make our own contribution to the construction of symptoms*)" (321 – Emphasis added). This means that some significant sequence of events, medically motivated, may act as a cause that impacts upon the increase or decrease of symptoms on the patients' part. It is as though a contextually motivated sort of subterranean dialogue takes place : in the first case, the successive clinical meetings and exams suggested to the patient the gravity of her condition as though someone was telling her that her situation was serious, thus contributing to a state of anxiety leading to more acute symptoms. The normal results of the subsequent scans, on the contrary, may have contributed to a decrease in anxiety levels, as if someone was whispering into the patient's ear : "nothing really serious is going on!" thus leading to less specific and feebler symptoms. These are not actually uttered speeches; rather they are implicit or internal/ised, but no less effective, for that matter, and not to be neglected. A simple scheme may succinctly represent what happened :

Seeing different doctors = "something serious is going on!" »»» anxiety increases – amplification of symptoms »»» narrative A

Normal scan results = "everything is ok!" »»» anxiety decreases – feebler symptoms »»» narrative B

In both cases we are faced with non-uttered, invisible dialogues, but they have nonetheless powerful effects upon the patient. More often than not, we harbour such internal dialogues very often at a subliminal level, not necessarily on a conscious one, but they condition nevertheless our response to our interlocutors and to our surroundings. It is as though these invisible utterances are part of the surrounding context and have the force of implicit presuppositions thus actively motivating what we say and do not say. The most prestigious authority on such forms of dialogism (not just in literary narrative) is undoubtedly the 20th century Russian theoretician Mikhail Bakhtin. In cutting-edge works such as *Dostoyevsky's Poetics* (originally published in 1929) or in the essays included in *The Dialogical Imagination*, he has shown how dialogue and, in particular, unexpected, hidden forms of dialogue permeate and condition not only the novel form but also our daily social interchanges. For him it is not so much what is said and heard when two people talk that is relevant but rather everything that is implicit in that conversation, and particularly the specific context where it takes place; it is as though the surrounding atmosphere were saturated with hardly audible messages, which however condition the ostensible dialogue going on. This is what he terms heteroglossia [23]. As S. Petrilli has rightly noticed, it is as if the "rustle of language," of which Barthes spoke in a writing of the same title, of 1975 (*Le Bruissement de la langue*), is always present while we talk even though we no longer notice it :

Barthes speaks of the 'rustle of language' (. . .) with reference to that system of verbal and communicative automatisms which make language comparable to a running motor, such that the noise it produces is similar to a rustling noise which nobody notices. (232)

Consequently, still according to Petrilli :

Bakhtin claims that every utterance is an "enthymeme" because something always remains implicit (. . .).

As emerges (. . .) in Bakhtin, "additional meanings" understood as "implied meanings" are related to values. More exactly, what is implied are values shared by partners in the communication relation. (231)

This type of phenomenon is what Bakhtin terms in general double-voiced discourse, the incorporation of another's word or perspective into our own speech [24]. This incorporation of another's voice or view point may adopt several forms as happens, for instance, in the so-called "hybrid constructions" [25] of which one possible example is the pseudo-objective motivation or the incorporation of the common sense perspective into the speech of the third person narrator that characterizes, for instance, Dickens's comic prose. In this instance, the narrator incorporates into his prose a belief he does not share, thus giving rise to an ironic twist such as in this short but eloquent sentence on one of the characters of *Little Dorrit*, quoted by Bakhtin : "Mr. Tite Barnacle was a buttoned-up man, and *consequently* a weighty one" (*Dialogic Imagination*, 305).

In this case, we are dealing with the unsignalled and implicit quotation of someone else's point of view in the

22. On the importance of hindsight for diagnosis, Hurwitz argues : "It is not just that diagnostic reports benefit from hindsight : cases unfold as re-formulations of clinical appearances that commence at time T1 under a description D1 and are supplanted by subsequent descriptions D2 at T2, which significantly were not available at T1" ("Narrative Constructs," 71). This aptly applies to Launer's case report under consideration.

23. For more on the concept of *heteroglossia*, see Bakhtin, *The Dialogic Imagination*, 276 and ss.

24. For this concept, see Bakhtin, *Problems of Dostoyevsky's Poetics*, 106.

25. According to Bakhtin, double-voiced discourse, as opposed to single-voiced discourse, adopts several guises such as : stylisation, parody, incorporated genres, character zones, hybrid constructions, etc. (Cf. Fernandes, "Dialogism,").

narrator's speech : the perspective of current opinion dominant in Dickens's time that lightly takes a respectable external appearance for true respectability and importance. Such incorporation distorts and inflects the narrator's meaning opening up a space for suspicion, since the reader is invited to notice that he is before a case of irony ; indeed, the narrator's voice implicitly distances itself from the opinion he is incorporating into his speech. By this very device, the latter reveals itself as being actually double-voiced. In everyday life and communication, however, cases of incorporating current presuppositions and implied meanings related to values do not usually reflect such ironic distance, on the contrary, they are uncritically (and often unconsciously) reproduced.

Another important observation made by Launer is also worth considering in this context. In his second meeting with the patient, when the symptoms were no longer acute, he asks the woman to date her problem :

When I asked her to date her problem, she told me this time that she had had them about a year—considerably longer that she had said at first. This timing took us back precisely to her miscarriage.

Miscarriage. Childlessness. Late thirties. Suddenly I knew that I was going to hear quite a different story from the clipped, clinical one that I had elicited and possibly promoted at our previous meeting. *And indeed, an entirely new story now came to light. The miscarriage had been, in effect, a cruel caesura in her life. (321 - Our emphasis)*

With laudable humility, Launer admits having possibly contributed to the "clipped" clinical story he obtained from the patient in their first meeting. It is as though what the physician is ready to receive, with no need to verbalize it, will condition the kind of report he will get from his/her patient. How is the doctor's un/availability indirectly communicated to the patient ? The type of language (more technical, more fact-oriented) used, his behavior (pose, gesture) and other elements in the context of the interchange may act as a sort of rustle of language, with an encrypted message to the patient, as though whispering to him/er : "Keep to the facts ! Be objective. Avoid sentimentality" [26]. This again illustrates a case of double-voiced discourse, where the dialogue is hidden from view but is nonetheless responsible for an implicit suggestion to the patient, conditioning his/her report and the doctor and patient type of communication that ensues. In the case under scrutiny here, the "clipped" clinical story obtained at first corresponds to "the one in which we all colluded", according to Launer. But this type of report is clearly unable to bring forth and to illuminate the patient's full experience of his/her illness and thus may disastrously interfere with a correct diagnosis, as was the case here. It is in the last meeting reported by Launer that the doctor / patient relationship changes : "She began to cry, and then she told me more." The cathartic irruption of her tears replicates and accompanies the corresponding word flow and signals a radical change of affairs and a sort of epiphany for the doctor. We might even compare this moment to the epiphanies at the end of Joyce's short stories [27], or even to that stage in classical tragedy Aristotle calls the reversal, or abrupt change in fortune, which in the best tragedies is accompanied by the discovery of the truth by the protagonist, also called recognition (Cf. Aristotle 54 and 56) [28].

Narrative *in* language

Due to its embodiment dimension and the body/language reciprocity, the medical encounter furthers our understanding of narrative and interpretation by obliging us to go beyond the texture of the 'story' (its shape and structure) and by highlighting the importance of context, what Émile Benveniste calls "the human reality of dialogue" (1971, 100). Indeed, together with Bakhtin's dialogical theories, Benveniste's argument on the centrality of language as discourse in context can also be useful and enlightening in the case of the doctor – patient communication.

This entails bypassing a strict narratological framework and adopting a complementary approach of language. Benveniste opposed "narrative" (*récit*), which does not imply the locutor commitment, with discourse (*discours*) which is personal : *how* the story is told, deployed in the real space and time in which one finds oneself immersed. "Enunciation" is the term he uses to describe the act that produces "utterances". Categories such as "I", "here" and "now" are then privileged in his theory as expressions of *subjectivity in language*. His central thesis is that "it is in and through language that man constitutes himself as a *subject*, because language alone establishes properly the concept of "ego", in *its* reality which is the one of the being" [29] (Benveniste, 1974, 259). Narratives are here not simply conceived as a system of signs, relations and functions – the approach prevalent among the Structuralists in the study of language and literature (Culler, 1975) – but as a singular and experiential activity [30]. In terms of Narrative Medicine it invites us to enlarge the scope of narrativity to encompass a more dynamic, plastic and inclusive dimension and to pay attention to voice, rhythm, silences, gestures through which is expressed our own and another's story. The narrative encounter, like all creative speech, is a mixture of story and embodiment, an in-between space of narrative meaning-making. In recent works, Rita Charon emphasizes the importance of the embodied aspects of the clinical encounter since "we are, finally, embodied selves and relational selves" (Charon, 2017 : 106). Assuming this embodied perspective implies the creation of habits of attending to more aspects than simply the story. This necessarily involves listening to the embodied story and hence the importance of discourse and of body-language reciprocity (Cabral

26. Interestingly, Jack Coulehan, at the end of his article on the use of metaphors in medicine, invoking William Osler, invites us to : "Consider the contemporary hospital - the white coats, stethoscopes, and beepers. The ritual of daily rounds. The ceremony of physical examination. Consider the nuclear magnetic imager as an oven-like oracle that sees inside the soul and one's emergence from this machine a type of resurrection." Thus, he calls attention to another important and positive message given by the hospital context : that of hope and faith. Osler notes how, "while his colleagues viewed the practices and paraphernalia that filled Johns Hopkins Hospital as objective and scientific "givens," patients inevitably experienced them as a vast network of symbols that promote healing" (quoted in Coulehan, "Metaphor and Medicine," 92).

27. One paradigmatic example would be Gabriel's epiphany experienced at the end of the short story "The Dead," in Joyce's *Dubliners*.

28. Notice how Berman P. and Horton R. argue that "the ideal Case Report will have an unexpected twist or detective element" (quoted in Hurwitz, "Narrative Constructs" 65).

29. In the original : "C'est dans et par le langage que l'homme se constitue comme *sujet* ; parce que le langage seul fonde en réalité, dans sa réalité qui est celle de l'être, le concept d' « ego » " (Benveniste, 1974, 259).

30. Accompanying this discursivity turn within Literary Studies (Meschonnic, 1982, Adams, 2012) a new attention is paid to reading as an ethically charged dialog and experiential process with benefits to health education (Cabral, 2020).

et al. 2017, 180). A reflection along these lines adds useful insights for adequately dealing with intersubjective data in the perspective of qualitative research in Narrative Medicine (Charon 2017, 257 ss).

As seen in the previously section, in the context of medical encounter, dialogues often include, surreptitiously, a number of relevant data, and they offer subtle, often unnoticed clues for interpretation crucial for a more precise diagnosis. However, very often these data and clues remain unspoken, hardly externalized and are therefore ignored ; yet they signal expectations, needs, and desires, independently of their verbal externalisation. In a vein somewhat similar to Bakhtin, Benveniste calls this form of internal language an *internalized dialogue* between a speaking I and a listening I. It comes under the arch of communication insofar as it discursively links two voices, even in the extreme form of the monologue :

The "monologue" should be posited, despite its appearance, as a variety of dialogue, which is the fundamental structure. The "monologue" is an internalised dialogue, formulated in "internal language" between a speaking self and a hearing self. Sometimes the speaking self is the only one to speak, but the listening self remains present nevertheless ; its presence is necessary and sufficient to render significant the enunciation of the speaking self. Sometimes, as well, the listening self-intervenes with an objection, a question, a doubt, an insult. (Benveniste 1974, 85-86).

The act of enunciation is indeed a *here and now* unique event, proceeding from an I, a speaker (thus inseparable from the concept of speech), towards a *you*. The meaning of an utterance ("instance of discourse") is evidently interdependent on the present of the speech situation, defined by the co-presence of the interlocutors. It was from this fundamentally dialogical foundation of discourse that Benveniste questioned the classic paradigm of the three pronouns I / You / He, concluding about its "non-linguistic nature" (1974, 225) :

As soon as the pronoun I appears in a statement, it evokes, explicitly or implicitly, the pronoun you *and the two together evoke and confront the* he*. In this moment, a human experience is relieved, revealing the linguistic instrument on which it is founded... The pronoun* I *is transformed from an element of a paradigm into a unique designation, which produces a new person each time. (1974, 67-68)*

In the sphere of discourse, the 'I' (enunciator in the terms of Benveniste) implies a 'you' (co-enunciator), and they are even reversible (as in the case of the monologue). Each one can pose himself as a subject only by implicating the other, the communication partner. That is why, according to Benveniste, the *he* does not exist in the discursive relation : it is a "*non-person*" [31].

From this perspective, the situation where the utterance takes place constitutes a space of mutual dependence : each speaker's position affects the other. As shown in Launer's case, this can be hugely important for the clinical encounter and can shift our understanding of the practice (and the theory) of doctor - patient relationship from a linear and directional process to a complex intersubjective act, from a standardized interview to an unpredictable event.

31. The entities that effectively take place in the communicational sphere are the "I" and the "you". This is not a grammatical logic (as the Saussure's structural linguistics taught) but an inevitable consequence of the *nature of language* : "language as an instrument of communication, whose expression is discourse" (Benveniste 1971, 110).

As far as discourse relates to history, the time that informs discourse is no longer the chronological time, according to Benveniste, but that of the present of the utterance, the time of its saying. This makes us aware that "events are not time, they are in time", as Benveniste remarked (1974, 70). Chronological time offers uniform measures and divisions, which harbor events, but such divisions do not coincide with the categories peculiar to the human experience of time (Benveniste 1974, 73). Time is internal experience. The time of speech compels the interlocutors to be in the present, to be listening to the other, accounting for the other. Switching from an objectifying conception of time - something divisible, with a beginning and an end - to a perception of time as intimately related to experience, immersed in feeling and sensation, makes it possible to operate an opening, an availability to the other and to foster the discursive sphere of relationships, of trust. From this point of view, the patient's narrative (and its listening) exceeds the coherence of the events reported (even though these remain important, of course). It becomes the place *par excellence* of the mixture, of the discontinuity, of ambivalence - thoughts, events, emotions, perceptions, half-felt, half-conscious. While the structural and narratological perspective compels us to methodologically separate the levels of narrative and discourse, what happens during the consultation reveals that such cleavages are not natural, but arbitrary, the product of an *a posteriori* delimitation for the sake of method.

Benveniste proposed another sort of time, which is linguistic time, allowing us to place the event in a linguistic perspective : "the time of language" ["le temps de la langue"] (Benveniste 1974, 73). And this dimension is particularly relevant to consider in the context of the consultation, because of the way in which time compels a forceful interrelatedness between the speaker and the listener. This resonates with the concept of dialogism, since it implies the dynamic incorporation of the other's words into our own speech. A shared, expanded, dialogical movement that is always present : "reinvented each time a man speaks because it is literally a new moment, not yet experienced" ["réinventé chaque fois qu'un homme parle parce que c'est, à la lettre, un moment neuf, non-encore vécu"] (Benveniste 1974, 74). Since that type of narrative, embedded in a performative speech act, is *fundamentally* embodied, fluid, dynamic, it presupposes a relation (the clinical relation) that is *actually*, actively embedded in its *hic et nunc* situation.

The "he" and the "us" (to refer to patient/s), often used in consultations, while allowing the doctor to protect himself in some way, effectively erases the discursive dimension of the subject (the individual's expression), and prevents a genuine interpersonal meeting between "I" and "you".

Launer's case report reveals the intimate connexion between dialogue and diagnosis, and invites us to explore the language/s dynamics at work in the clinical encounter. The "present" and the in presence (face to face) narrative allows us to take into account the qualitative data, to grasp and to interpret them, encouraging doctors - and patients - to attentively decipher the other's real needs, expectations, and limits – beyond unnecessary consultations and examinations (Launer, 2005, 322).

Conclusion

The case put forward by Launer is eloquent at more than one level and invites us to clearly perceive the double nature of the medical act, both diagnosis and interpretation. The doctor's role is not just deducing a diagnosis from symptoms to be confirmed by the physical exam, by the ancillary tests and exams and by the information provided by the *guidelines* and standardized procedures. The challenge is rather for the physician to be able to interpret those symptoms, signs and data in the light of the patient / doctor dialogue, that is, to test them in narrative, discursive and biographical terms, in the context of what Rita Charon has termed "narrative evidence based medicine" (Cf. Charon 2008, 296-97).

In other words, and to recall our opening argument : the physician is not simply a scientist, obliged by the logic of an objective analysis of verifiable data (according to the hypothetical deductive method). He is also a hermeneutist able to accommodate in his diagnosis a shrewd and sensitive interpretation of his patient's experience, as it is embedded in discourse, lived-in discourse. In this sense, he is also a reader and a humanist. This maybe the reason why the word "dialogue" is paired with "diagnosis" in Launer's article. The author may have wished not only to put them both on the same level but even to give symbolic and literal precedence to dialogue, as the needed condition for a good diagnosis ; hence the word order in his title : dialogue, first and diagnosis, second !

In his text, however, we also find the insightful perception of the importance not only of dialogue proper, but of everything that interferes with it, that conditions and threatens to thwart it, as most often happens in any dialogical encounter. As has been shown, anamnesis (understood in terms analogous to narrative exposition) may at first be delayed and missing in important data, thus postponing and compromising mutual understanding and a first-hand correct diagnosis. On the other hand, narrative does not exist in itself, it is formed, transformed through individual experience and mutual interaction. Understanding the meaning of the narrative requires in fact considering the concrete act of the discourse in which narrative takes place, where it becomes language in action and produces meaning.

This ascent from text to body involves discursivity, according to Benveniste, who emphasizes the inseparability between language and experience. Considering enunciation as an essentially creative act brings into play the personal, lived experience and becomes a relevant tool for developing deep and accurate attention to some implicit non-verbalized presuppositions concerning the doctor's and the patient's expectations, roles and interaction.

A good diagnosis is dependent upon the clinician's capacity of fully apprehending and ably decoding the lived-in experience of the patient and not simply his/her story. It demands "narrative deepening" (Charon, 2006, 108) : an increased awareness of the inherent discursive and invisible aspects, which permeate the dialogic interchange. The dialectic of text and body, of listening and response, promotes a natural and organic unity and may contribute to the great human purpose of Narrative Medicine : a "*Narrative Transformation of Health and Healthcare*" (Charon, 2017, 271).

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