

# **The Body of Illness: Narrativity, Embodiment and Relationality in Doctoring and Nursing**

Ola Sigurdson

*This is a translation of a Swedish paper, “Sjukdomens kropp: Narrativitet, kroppslighet och relationalitet i medicinsk praktik och omvårdnad”, published in Sygdommens kropp: Kritisk Forum for Praktisk Teologi, 31 (123), 2011, p. 6–22. Translated by Rosemary Nordström for Proper English AB. Copyright for the English translation belongs to the author. This translated version is published digitally on April 2015.*

In this article, I will discuss the connections between narrativity, embodiment and relationality in the practise of doctoring and nursing. In particular, I will elucidate these connections by discussing the patient chart as a diagnostic tool that also determines the kind of relationship the doctor or nurse adopts vis-à-vis the patient and thus what kind of embodiment becomes the subject of examination. This becomes a way to seek the ill body; the body to which medicine devotes its care. The perspective is derived primarily from contemporary philosophy, the history of ideas and the medical humanities. The task of the article is critical in the sense that I aim to analyse the connections mentioned to shed light on their historical and philosophical foundations and thus be able to suggest possible alternatives to accepted practice. I will begin by discussing the narrative basis of diagnosis and showing the philosophical differences between the inanimate body and the lived body. I will thereafter discuss what may be called ‘bodily absence’ before returning to the patient chart and how the chart can stage various connections between narrativity, embodiment and relationality in doctoring and nursing.

## **The narrative basis of diagnosis**

As this article was being written (the summer of 2010), the staff at Kungälv Hospital near Gothenburg were working with a project aimed at changing the rounds system in the wards with focus on creating a patient-centred, interprofessional method.<sup>1</sup> In connection with this, the hospital will be remodelling the wards based on the shared method and attempting to devise a model for shared documentation in the patient chart. The goal of this documentation is for assistant nurses, RNs and doctors to jointly write

---

<sup>1</sup> See the internal document *Andra ronden: Nya väg(g)ar till ett patientcentrerat avdelningsarbete*, 7 November 2008.

admission notes and round notes. The problem with the current system, to put it simply, is that doctors only have to follow the patient's medical history and what other doctors have written about this history, while nurses need only to follow the nursing care given to a particular patient.<sup>2</sup> Owing to the options provided by the modern, digital method of charting, neither doctors nor nurses need to read what the other profession has written about the patient's condition. With a click of the mouse, they can hide the information they are not interested in. The results of a medical examination and various tests may thus be separated from a more general perspective on the patient's social history and the description of the habits that affect his or her health. If the purpose of a chart is to serve as a basis for care planning, such a system entails risk that important aspects of the patient's health will be lost in the gap between that defined as doctoring and that defined as nursing. At Kungälv Hospital, they describe this separation as a separation of 'body' and 'mind'. Where doctors take care of the body as an object explored through the medical sciences, nurses take care of the mind, meaning the personal and social aspects of human existence – in philosophical terms, our subjectivity and intersubjectivity.

This brief example illustrates a profound dichotomy in modern society that has a number of practical consequences. In relation to doctoring and nursing, it results in specialisation, wherein various aspects of human existence are regarded in isolation and thus the patient may be described as an arm or a leg or a heart, rather than a human individual with a unique history. On the caregiver's side of the equation, this metonymic talk about the patient – where a body part represents the entire person – corresponds to the specialist skills of doctors and nurses. There is often strong justification for such specialisation, in that a specialist should be able to provide the best and most precisely targeted treatment to the patient seeking care. Specialisation has burgeoned in pace with progress in scientific medicine and few people are distrustful of this progress. Still, we must not forget that one prominent justification for specialisation in modern societies has nothing to do with excellence, but rather with instrumental efficiency, where more patients seen per hour seems to mean more care for the money – but not necessarily better care. The reasons underlying this specialisation may be good or bad, but both carry a risk of exacerbating the fragmentation of the patient, where treatment of a particular illness is not related to the patient's more general physical, mental and social history.

Rita Charon, professor of clinical medicine at Columbia University, describes this specialisation as a 'reification of health' and emphasises that 'sicknesses declare themselves over time, not in one visit to the consultant'.<sup>3</sup>

---

<sup>2</sup> I refer here mainly to doctors and nurses. This picture of contemporary healthcare can of course be made more complex by including other professional groups and perspectives – both physical and psychological – that have become prevalent in healthcare.

<sup>3</sup> Rita Charon, *Narrative Medicine: Honoring the Stories of Illness*. Oxford/New York: Oxford University Press, 2006, p. 7.

Charon suggests what she calls ‘narrative medicine’ as a remedy for such fragmentation. What narrative medicine can do is bridge the divides prevalent in medical care today: between the giver and the receiver of care, between the medical diagnoses of what kind of illness has affected the patient and the patient’s own experience of illness, etc. Medicine, according to Charon, inevitably has a narrative component that seeks to tell a story about how the patient became ill, what kind of illness has affected the patient and what kind of restoration of health is possible – and how. Medical care can thus be analysed as a narrative with a plot that is revealed in a patient chart – which is a type of literary genre, although it differs from other types of literature in that its primary purpose is descriptive rather than reflective. As Charon describes it, ‘clinical practice is consumed with emplotment. Diagnosis itself is the effort to impose a plot onto seemingly disconnected events or states of affairs’.<sup>4</sup> The main purpose of the chart is to shape a structure based on the results of clinical examinations, the doctor’s observations and the patient’s own account of his or her sufferings – a structure that makes the patient’s condition comprehensible and thus treatable.

A medical diagnosis is, in other words, an interpretive act and just as every good novel is open to many interpretations, but not any and all interpretations, the patient’s condition may also be open to multiple interpretations. Not all of them will be productive, but determining the one that is the most productive is probably up to the doctor or nurse who has good judgement, schooled in medical research and clinical experience.<sup>5</sup> Some kinds of illness are more easily interpreted than others, but the habit of interpreting certain symptoms as obvious indicators of a certain illness may cloud the understanding that this time – in the hundredth case – it something entirely different. In other words, critical vigilance over one’s own interpretation process is an element of good judgement. This is a matter of interpretive skill, which constitutes an intersection between the medical sciences and the humanities disciplines such as comparative literature, philosophy and theology. In one sense, the latter may be defined as exercises in and reflections on the art of interpretation, but medical diagnosis may also and opportunely be described as an act of interpretation and thus something upon which these humanities disciplines can shed light. To once again quote Charon, ‘What literary studies give medicine is the realisation that our intimate medical relationships occur in words’.<sup>6</sup> And words are never innocent, not even in a patient chart. This is evident in that how a patient is described in a chart by necessity conveys a

---

<sup>4</sup> Op. cit., p. 50. Contemporary examples of similar perspectives are found in, for example, physician and journalist Lisa Sander’s book *Every Patient Tells a Story: Medical Mysteries and the Art of Diagnosis*. New York: Broadway Books, 2009, and novelist Siri Hustvedt’s book *The Shaking Woman or A History of My Nerves*. New York: Henry Holt and Company LLC, 2009.

<sup>5</sup> See Jerome Groopman, *How Doctors Think*. Boston/New York: Houghton Mifflin, 2007.

<sup>6</sup> Rita Charon, op. cit., p. 53.

particular attitude towards the patient. Various charting methods thus communicate various attitudes towards the patient, not least among them how the chart understands the patient's body. This argument on the narrative basis of diagnosis thus leads us to the matter of the ill body.

### **The inanimate body and the lived body**

What body does medicine study? What is the ill body? The very possibility of asking such questions in a meaningful way is predicated upon the body's capacity to manifest itself in myriad ways, or perhaps upon that our view of or interest in the body allows various dimensions of our embodiment to become apparent to us. A relatively simple distinction between various perspectives on the body is brought to the fore by the philosophical tradition of phenomenology in its distinction, as made by German philosopher Edmund Husserl, between the body as lifeless physical object (*Körper*) and the Body as living and animate (*Leib*).<sup>7</sup> The latter conceptualisation of the Body means that the body is not primarily an object, but rather constitutes our relationship to the world we constantly live in and experience. The Body becomes an instrument of communication and the perception of embodiment an experience of participation in the world rather than separation between self and world. Take for example the experience of reaching for a coffee cup with one hand. The hand is not merely a thing that my 'self' somehow steers towards the coffee cup. My embodiment in this case is, rather than a thing, a particular way of being in the world, where all my bodily attention (if I am not reaching as an act of pure distraction) is directed at the object of my desire rather than the body as such. Certainly, my hand can become an object when my attention is shifted from the cup to the hand ('What is that odd spot on the back of my hand?'), but such an experience actually clarifies the paradoxical and intriguing human ability to be at once the object and subject of experience – as when I use the fingers of one hand to move the other.

Awareness of my embodiment in this sense cannot be reduced to awareness of an object that may, in theory, be expected to remain the same over time; it is empirical knowledge in the genuine sense, where my perceptions of being (and not merely owning) a body are communicated over time. Talking about the body as an inanimate physical object – as *Körper* rather than *Leib* in Husserl's terminology – thus becomes a kind of abstraction that selects certain aspects of my experience of my own embodiment and omits others. The body as lived and animate cannot be examined independently of how I physically experience the world, while the body as inanimate physical object becomes

---

<sup>7</sup> For a more detailed discussion of phenomenological concepts of the body including references, see my book *Heavenly Bodies: Incarnation, Gaze, Embodiment*. Translation: Carl Olson. Grand Rapids: Eerdmans, forthcoming.

something separate from the self. Philosopher Stephen Crites argues therefore that narrative is the proper form for examining lived embodiment: ‘Neither disembodied minds nor mindless bodies can appear in stories. There the self is given whole, as an activity in time’.<sup>8</sup> How we choose to talk about the body thus determines which dimensions of our embodiment become manifest at the moment. It is thus not only the doctor who reduces my bodily existence to the knee she is happens to be about to operate on; I can also become a knee to myself when the knee is demanding my attention. Unlike the doctor, who moves on to the next knee when she is finished with mine, my attention usually wanders between different parts of my body or, at least as often, outside my own body.

It may therefore be accurate to say that the patient chart differentiates between body and mind, provided we understand that this involves an attempt both to separate and to hold together. On the one hand, there is a conscious desire to separate insofar as the clinical observations are intended to winnow out a medically significant detail in the process of the organism so that the outcome of an appropriate intervention can be predicted. There is an endeavour here to ignore what may seem – albeit for the moment – medically insignificant in order to sharpen the focus on what seems to be the cause of an illness. As I will return to soon, this is consistent with customary scientific method: to reduce as many factors as possible in order to better predict the outcome. On the other hand, the chart is also an expression of a desire to hold together, in the sense that the medically significant details are seldom or never entirely independent of either the actual course of the illness (the time aspect) or the patient as a single biological organism rather than numerous cooperating but independent organisms – or of the patient’s ‘general condition’ (including her personality) beyond the purely biological. The emphasis I have placed above, with Charon’s assistance, on the narrative dimensions of the patient chart has to do with these particular aspects; the reduction of the patient to a physical body (or body part) is inadequate to understand the human experience of being a physical being. When we reduce our embodiment to the physical body, dimensions of our state of illness and our state of health are lost.

That this reduction often occurs is not particularly surprising though. Modern medical science – including many of its advances – is based precisely upon such a reduction. Rather than tracing back to a Classical philosophical or theological influence and the propounded dualism between body and mind, we instead find it at the gates of modern history. German medical historian Klaus Bergdolt argues that the sharp distinction between body and mind made by French philosopher René Descartes (1596-1650) was ‘an event of enormous

---

<sup>8</sup> Stephen Crites, ‘The Narrative Quality of Experience’, *Why Narrative? Readings in Narrative Theology*. Stanley Hauerwas and L. Gregory Jones (eds). Grand Rapids: Eerdmans, 1989, p. 85.

consequence for European theories of health'.<sup>9</sup> Descartes viewed the body as an 'extended thing' (*res extensa*) that could be likened to a machine and studied through mathematics and geometry, while the soul (or mind/consciousness, as we would say today) was a 'thinking thing' (*res cogitans*) that was independent of the body and was the human being's actual self. Consciousness was autonomous, the body purely material. Where the body was previously seen as a mirror image of the greater cosmos, Descartes considers it comparable to a mechanical automaton. Philosopher and physician Drew Leder thus says, in reference to Cartesian philosophy, that 'the living body is not fundamentally different from the lifeless; it is a kind of animated corpse, a functioning mechanism'.<sup>10</sup> The mechanical understanding of the body originated by Descartes has, as Bergdolt has pointed out, played a critical role in the history of ideas, not least due to medical progress. When the body was represented as a mechanical automaton, it also became accessible to study the body in another way, in that it could be measured. As Bergdolt says, 'The healthy body seemed to have no secrets to hide; the unknown was regarded as the *not yet* known'.<sup>11</sup> And so certain groups of doctors began to apply Cartesian theories to concrete medical problems by measuring the body's pulse, temperature and perspiration in an attempt to systematise medical knowledge. They polemicised against the old Aristotelian and Galenic medicine and advocated state-organised public health care.

Consequent upon the mechanisation of the body and the accompanying quantifiability of health, physical health was isolated from and understood independently from other kinds of health, which brought about an epoch-making transformation of the understanding of embodiment and health alike. A more complete breakthrough of mechanically understood embodiment and the intimately related notion of health as quantifiable did not occur until the 19<sup>th</sup> century. Physical health unmistakably became part of the social differentiation process of modernity: economics, politics, religion and science are presumed to belong to different and distinct spheres, each of which heeds its own laws rather than being gathered under the same mantle. And so doctors become specialists in their own field, medical science, but are presumed (in theory) not to possess any particular skill in other spheres. A metaphorical superimposition of the individual body and the social body simultaneously occurs, in which the latter could also be described as a mechanical body and protected by the state as a defence against disease, most notably by English philosopher Thomas Hobbes (1588-1679). Social welfare and health comprised

---

<sup>9</sup> Klaus Bergdolt, *Wellbeing: A Cultural History of Healthful Living*. Translation: Jane Dewhurst. Polity Press. Cambridge: Polity Press, 2008, p. 202.

<sup>10</sup> Drew Leder, 'A Tale of Two Bodies: The Cartesian Corpse and the Lived Body', *Body and Flesh: A Philosophical Reader*. Donn Welton (ed.). Malden/Oxford: Blackwells, 1998, p. 119.

<sup>11</sup> Klaus Bergdolt, op. cit., p. 204.

– then as now – a political agenda. But we can also follow the cultural transformation of various illnesses and notions about health on another level; with regard for instance to how historical notions about melancholia, supported by a wealth of empirical knowledge, have been pathologised in our time, becoming the clinically diagnosable – but experientially that much poorer – disorder of depression.<sup>12</sup> The striking thing about this evolution is that there seems to be a constant tug-of-war between the endeavour to distinctly separate what belongs to the body and what belongs to the mind, and a movement that forever crosses and re-crosses the boundaries of these alternatives when illnesses are used to describe social conditions or melancholia is used to describe an entire culture. If phenomenological objections to the reduction of human embodiment to a physical mechanism are justified, this tug-of-war is hardly surprising; the reduction of embodiment to an inanimate mechanism is simply unable to do justice to our experiences of being physical beings.

### **Bodily absence**

The development I outlined above and which led to separation of the body as object and the lived body – or between ‘body’ and ‘mind’ – is often presented as a conundrum. One of the problems this separation is thought to lead to concerns how the caregiver relates to the patient: as a person with a will of his or her own or as passive object of medical and nursing care. One of the risks of the latter attitude may be that caregivers become guilty of a variant of what physician Jerome Groopman calls ‘confirmation bias’, seeing the patient’s symptoms as an indication of the statistically most likely illness and thus overlooking the aspects of the patient’s personal life history that might make the case unique.<sup>13</sup> But describing the development of modern medicine in this respect, in a more or less cut-and-dried manner, as a story of decline also entails a risk of conveying an oversimplified picture of the complex relationship between caregiver and patient and obscuring some of the reasons Descartes and the medical tradition that followed him came to regard the body as an object. Let me therefore unpack a dimension of human embodiment of profound significance, especially to the relationship of doctoring and nursing to this.

In *The Absent Body*, Drew Leder draws attention to what he calls ‘bodily absence’.<sup>14</sup> Bodily absence is a multidimensional phenomenon, but one of the phenomena that Leder notes in his book – and which few modern philosophers have discussed in any depth – is how several of our most vital bodily functions – breathing, blood circulation, digestion and, not least of all, sleep among them – must be understood as impersonal and thus more or less

---

<sup>12</sup> See Karin Johannisson’s account of this in *Melankoliska rum: Om ångest, leda och sårbarhet i förfluten tid och nutid*. Stockholm: Bonnier, 2009.

<sup>13</sup> Jerome Groopman, op. cit., p. 71.

<sup>14</sup> Drew Leder, *The Absent Body*. Chicago/London: The University of Chicago Press, 1990.

beyond our conscious horizon. Unlike the external organ that can be used for a variety of things – the mouth can talk, sing, whistle, spit – the movements of the internal organs are predetermined. I do not need to form any conscious intention to continue the repetitive act of breathing; on the contrary, if I begin to pay attention to how it works, my breathing is more likely to be disturbed. As well, if I had to think consciously about breathing, it would leave precious little time to perform other actions. Most of our most vital bodily functions are therefore – as luck would have it – impersonal, inaccessible to introspection and more or less automatic.

The interesting thing about these functions is that we are reminded of them primarily through some kind of disruption: I am not breathing right; I am having a hard time digesting my food or sleeping. Disruption of these impersonal functions is a common reason for seeking medical attention. Leder emphasises that it is such experiences of the absence of the body – in this case the absence of experience of the body – that makes Cartesian mind/body dualism seem empirically credible; universal human experiences like pain, pregnancy, or age may be experienced as that the self is something separated from the body that is alien to the self, which is in some way holding me captive. I am reminded of my embodiment primarily in the experience of my internal alienation from the same; we say that health is silent and the same applies to the well body. Moreover, experiences of bodily presence and bodily absence are rarely distinct experiences; I am reminded of my embodiment when I am ill precisely because I experience a biological process that is beyond my voluntary control. It therefore becomes relevant to talk about more complex experiences of present absence or absent presence that show the tension of our relationship to our embodiment. To do justice to human experiences of the body, a philosophy of the body must be broad enough to also account for experiences of bodily absence (even in their more complex versions). If science and medicine have largely entailed a third-person perspective on the body and have thus reduced our embodiment to an object, such a perspective has in so doing nonetheless been able to illuminate dimensions of our embodiment that are quite simply inaccessible from a first-person perspective.<sup>15</sup>

These internal processes and functions that are essentially inaccessible to our direct, conscious intention are thus not entirely independent of our conscious functions. There is, as said, an interplay between bodily absence and bodily presence that can be illustrated with a few simple examples. On the one hand, it is clear that our conscious intentions can be affected by internal functions, such as when poor digestion puts us in a bad mood. Our overall perceptions of a certain situation may be tinged by what is going on inside of us, inaccessible to our direct intention. On the other hand, it is also true that we can affect our internal processes. Regular exercise, we are told,

---

<sup>15</sup> Op. cit., p. 7.



strengthens the heart muscle and counteracts stiffness in the joints and muscles. I can thus, through my lifestyle, affect these internal processes, which is indirectly confirmed by how dietetics – not only in terms of diet but more generally as a position-taking – has been closely associated with medicine into modern times.<sup>16</sup>

Similar examples can be multiplied and deepened, but let me instead briefly argue that one conclusion of this becomes that the bodily presence and bodily absence overlap and cannot be identified or picked apart. The overlapping of internal and external functions, but also the body as thing along with the body as existential project seem to constitute a basic structure for our embodied existence as human beings. I talk about this as an overlap rather than an identification or distinction deliberately, based primarily on French phenomenologist Maurice Merleau-Ponty's use of the rhetorical term 'chiasm', thus a 'crossing-over' or perhaps a 'reversal' to avoid using immediately contrastive terms to illustrate this phenomenon.<sup>17</sup> Our internal and external bodily functions cooperate, but that does not mean they can identify with each other, any more than the body should be understood as a contrast to mind or consciousness. Such overlaps, or chiasms, can be identified at several levels of human existence. And so Leder, for instance, argues that the desire to separate the physical body from our existential engagement is to draw a false distinction: 'in the lived body, the physical and existential always intertwine'.<sup>18</sup> This 'intertwining' does not, as I have noted, necessarily manifest as an obviously harmonious relationship between physical and existential, which is why I prefer the term 'overlap' as more expressive of tension. But this uncovers one of the reasons that reduction of the human body to an inanimate object discards important aspects of our embodiment: it obscures the complexity of the person, as biological organism and as existential being.

Translated to the practise of doctoring and nursing, criticism of Cartesian dualism need not entail a rejection of the insights achieved by modern medical research, nor the need in certain situations to study the body as an object of medical examination. To use a trivial example: if I arrive at Accident & Emergency with a broken leg, I might not be particularly interested in knowing that the A&E doctor emphasises in her practise that the physical and the existential always overlap and therefore wants to get to know me as a person before treatment begins. In this situation, I would most likely be happy to be reduced to a leg so that treatment with painkillers can start as soon as possible. But in the face of diagnoses that are less straightforward than a broken leg (and perhaps even in connection with this seemingly simple one – before it has been

---

<sup>16</sup> This becomes clear throughout Bergdolt's book.

<sup>17</sup> Maurice Merleau-Ponty, 'The Intertwining–The Chiasm', *Lovtal till filosofin: Essäer i urval*. Translation: Anna Petronella Fredlund. Stockholm/Stehag: Brutus Östlings bokförlag Symposion, 2004.

<sup>18</sup> Drew Leder, op. cit., p. 44.

confirmed), it may be relevant to consider aspects other than the purely physical. Apropos the doctor's diagnosis, Gropman establishes the need to be able to both objectify and thus ignore the patient as a person and to acknowledge the patient as a person: 'We face a paradox: feeling prevents us from being blind to our patient's soul but risks blinding us to what is wrong with him'.<sup>19</sup> Problems arise when this tension cannot be maintained without the depersonalised objective body – in a nutshell: the Cartesian corpse – must constitute the model of human embodiment in general. In Leder's words: 'When the patient is not treated as living, desiring, suffering being, compliance is reduced, evidence is overlooked, inappropriate treatments are prescribed, genuine healing gives way to "fixing the machine"'.<sup>20</sup> The solution is then not found in allowing the tension to slacken in the other direction, so that the first-person perspective reigns supreme, but precisely in maintaining the tension between these two perspectives in the art of medicine, for they are, as I recounted above, rooted in the paradoxical structure of human embodiment. A good patient chart whose aim is the best interests of the patient should probably reflect the very complexity of embodiment in some fashion.

### **One reader, two stories**

Let us finally return to the relationship between the chart and the ill body of the patient. What I first want to establish based on the arguments presented thus far is that patient charts and embodiment are inextricably bound in the trinity of narrativity, relationality and embodiment that is the main focus of this article. This means that in a particular form, the chart can promote the separation of aspects of human existence that should remain together, while the chart in another form may promote affinity.

As I recounted in the introduction, the patient chart can easily become an instrument of separation. The body is treated by the doctor as an inanimate object, while the nurse must devote himself to the living person. I suspect that in general neither of these caregivers could manage without an approach that to some extent also considers factors other than those included in their own specialities. At the same time, it is hardly inconceivable that the chase after efficiency gains in the modern hospital institution reinforces a separation of body and mind or inanimate object from living person. When I, somewhat schematically, have talked about doctors and nurses as different skills that I have called doctoring and nursing, it is important to say that these discrete skills are not primarily reproduced by individuals and that a less productive relationship to the patient's embodiment might thus constitute an attitude problem. The truth is

---

<sup>19</sup> Jerome Gropman, op.cit., p. 59.

<sup>20</sup> Drew Leder, op. cit., p. 147f.

instead that such divisions are ‘bred-in-the-bone’, reproduced by the very social institution comprising medical education and research, hospitals, primary care centres and so on. If these divisions entail a separation, not only of the patient as physical body from the patient as living person, but also of doctors from nurses and doctoring from nursing, this can present a barrier to making it possible for the patient to receive optimal care because the tension that resides both in human embodiment and the relationship of medicine to the same ceases to be a tension and becomes a dichotomy: a splitting of two mutually exclusive parts.<sup>21</sup> Standardised templates in patient charts can inhibit the prerequisites for asking the patient open-ended questions and thus ignoring anything that does not fit.<sup>22</sup>

But the chart – which can at once be the result of an institutional dichotomisation and an inherent reproduction of the dichotomy – also holds, at least potentially, other resources. The chart writes the story of the patient’s illness, which follows the patient over time and contains observations of several types – based on both doctoring and nursing – and thus provides a more comprehensive picture of the patient in question. In some types of charts, probably such that belonged to family doctors in private practice in an era that only recently passed into memory, the description of the patient may be expanded to touch upon matters beyond the strictly medical and nursing account and thus approach a kind of rudimentary biography.<sup>23</sup> Charon argues that in our time, health care professionals often replace the confessors or spiritual advisors of former times and might be among the few trained confidantes available to individuals in ordinary life.<sup>24</sup> Even if the chart is not of the more exhaustive type, and even if it lacks the authorial ‘I’ that characterises more literary or autobiographical stories, it is at least inclined towards an understanding of human embodiment that goes beyond the physical object. With the quotation of Crites above, I submit that disembodied minds or mindless bodies can hardly be the subject of a story, for a story depicts a lived body.<sup>25</sup> Such a body is always unique because it belongs to a living person with a history of his or her own. A chart that retells at least part of a patient’s story is thus conceived in the overlap between the ambitions of scientific medicine to find the generalisable elements of certain symptoms of disease that make it possible to arrive at a particular diagnosis and prescribe a treatment, and the unique patient’s non-generalisable story. The point of recounting these unique elements is not, or at least not only,

---

<sup>21</sup> Rita Charon, op. cit., p. 19.

<sup>22</sup> Jerome Groopman, op. cit., p. 102.

<sup>23</sup> See Charon’s account of how her father, a family doctor, kept his office charts in op. cit. pp. 146-148.

<sup>24</sup> Op. cit., p. 78.

<sup>25</sup> A mindless body as the subject of a story is, of course, not inconceivable. In Hitchcock’s comedy *The Trouble with Harry* from 1955, the plot is driven by Harry’s dead body, which is buried and dug up four times during the film. Harry’s dead body is however a ‘MacGuffin’, a plot device whose function is to advance the story but which has little other relevance to the story itself.

to respect the patient's subjectivity, but that this life story may also contribute insights that are relevant to the care actually given. As an example, Groopman mentions how a doctor used the patient's biography to help a woman who had been repeatedly admitted to a hospital in Boston and was now in heart failure: the doctor realised that as an African-American woman who grew up in Mississippi in the 1930s, it was highly likely that the patient had never learned to read or write. And so it proved that she could not take her medications correctly because she was unable to read the labels on the medicine bottles.<sup>26</sup> Similar examples of how upbringing, family, religion and culture affect the success of caring treatment – and what constitutes success in general – can be replicated, but also regarding more personal factors such as shame, guilt and fear.

One way of emphasising the importance of seeing the lived body, and not only the body as physical object, is to talk about the need for a more 'holistic' perspective. Although such a holistic perspective may be a justifiable reaction to reductive theories and practices, I am not entirely satisfied with such a descriptor because it, too, can obscure the tensions and paradoxes characterising human embodiment that I have chosen to bring to the fore here. A holistic or whole-system perspective may lead to thoughts of an organic whole in which everything works together smoothly, but as we have seen above, there is reason to distinguish various aspects of human embodiment without requiring their utter separation or construal as contrasts. In line with the more complex perspective I am advocating here, Charon suggests that 'Illness occasions the telling of two tales of self at once, one told by the "person" of the self and the other told by the body of the self'.<sup>27</sup> Even though Charon is not discussing patient charts in this context, I believe this is also a fair model for what we should be able to expect from a chart. It is important that medical professionals are able to listen to or read these two tales simultaneously, the patient's own story of his or her symptoms and illness put into the context of his or her greater life story, as well as the story that the caring sciences have trained caregivers to listen to: the impersonal but crucial bodily functions that work for the most part in silence, unseen and unnoticed, when the body is functioning it should, but come out of the woodwork in the ill or aged body. When it comes to the latter tale, the care professions, by virtue of their training and experience, are gifted with literacy possessed by few laymen, but that does not mean they cannot make themselves illiterate in relation to the first-mentioned, more personal life story; there is reason for professionals to reflect about how they can build their skills in relation to this – a kind of reflection that is found in literary studies, philosophy, theology and other humanities, which is not to say that they apply this reflection with any regularity to the care sciences. For the sake of good

---

<sup>26</sup> Jerome Groopman, *op. cit.*, p. 95f.

<sup>27</sup> Rita Charon, *op.cit.*, p. 87.

judgement, the doctor or the nurse must be able to integrate both stories without confusing them and able to interpret both with a high degree of skill.

The ill body is not one body, but several. The question of how a chart should be structured in practice to correspond to this complexity is outside my area of expertise. Nevertheless, it does not seem too far a stretch to ask whether care should not be taken to ensure that the chart is not standardised to the point that it prevents doctors and nurses from approaching the patient with open-ended questions. I can also imagine that elements of a more discursive narrative in the chart would also lead to an approach that avoids reducing the patient's body to an inanimate object – which, again, should not involve any compromise of the doctor or nurse's medical/scientific expertise. The connection between narrativity, embodiment and relationality in the practice of doctoring and nursing would profit by a method of charting and care provision that in some sense reflects the complexity of the human being. The chart should hardly be called upon to take sole charge of this complexity; if the complexity is not permitted to imbue the entire health care sector, from education and research to practice, its chances of any general impact are slim.