

## Narrative in the Doctor-Patient Relationship

### *La narrativa en la relación médico-paciente*

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What does it mean *to be* a physician? And here, saying to be a physician not only includes the use of the medical technique according to the prevailing knowledge. Contrary to the statement “one *is* a doctor”, in which the rest of one’s being is excluded, in the physician, the art of the technique -definitely an art because each patient is a unique sculpture to model- must be complemented with the other propositions that involve not only being but also should be. And this *should* implies that the physician honors his profession beyond his knowledge and honors. It presupposes imbuing himself with the “human factor”.

In this positivist, materialistic, technically organicist medical society, this paradigm should change towards other facets of thought. We are what the cultural situation of society lets us be. To break down this premise has always been a feat in human history. In Medicine, we have built our actions based on the last three centuries of Positivism and Enlightenment. We work with this teaching method and exclude the inductive aspect (enlightening principle in science) from our thoughts, always returning to the mechanistic postulates. The human factor -basic and key principle in Medicine- was relegated to the intimacy of the physician, subdued by the mechanistic system.

The *curriculum vitae* of teaching provides concepts that do not allow us to move from it, as is the case of Gödel’s incompleteness theorem, at the risk of not understanding what is instituted. Thus, the human factor was gradually withdrawn behind medical companies, pharmaceutical industries, and technology. Thought and language are not enough to transfer knowledge; human action is needed for learning. It is necessary to set text and context on the practical fact of a sick person inserted in a society, in a culture.

Medical learning was built with the Rationalism of the 17th century and the Positivism of the 19th century, and is today deeply imbued with these movements. What science worked in other fields, such as Philosophy, Anthropology, Ecology, Psychology of the Subconscious, Physics, Sociology, and Logotherapy, had little influence on the Medicine that is taught today in university faculties.

All this happens at a time in history that, for the first time since the beginning of the industrial revo-

lution, abandons the great chronicles (England, 18th century). Gradually, progress proved inadequate to advance on humanism, and ended up excluding the human factor in Medicine. This peregrination has led us to Postmodernity, which poses a serious situation for the human condition, leading post-structuralist philosophers [Michel Foucault (1926-1984), Jacques Derrida (1930-2004), and Gilles Deleuze (1925-1995)] to discuss about “*the death of man*”. Great stories are left behind, and the world camouflages itself. It is the success of Enlightenment, which Theodor Adorno (1903-1969) refers to in his *Negative Dialectics*. Physicians should understand that the human consciousness is somewhat different from entities. It knows about time and death, and if physicians are unaware of that distress in their patients, they are avoiding the human factor, essential foundation of their art.

Descartes and Positivism come together in the concept of separating the subject from the object. According to Immanuel Kant (1724-1804), the subject appropriates the object, transforms it, and makes it possible until he possesses it with the *logos*. However, between subject and object there are attitudes and emotions that bias this appropriation. In addition, the subject’s behavior can enter into non linearity and remove certainty from prediction. Learning should occur by doing, but at the same time, doing means wanting, being able, and knowing. In Medicine, reality shows us an object of study -the patient- that becomes extremely fragile when considered external to the human factor.

Man faces reality by imagining. There is a bias that cannot be neglected because the patient is surrounded by fear and distress. He assumes this behavior due to ignorance and also due to intention, conscious or not. This patient’s psychic behavior plays a key role in the course of illnesses. Our representation of the morbid is still a symbolism of the real. With the information and culture received, our psychic apparatus creates a truth of knowledge, whose authentic reality remains hidden. The meaning of reality is thought and represented as we can. Technique certainly provides the tools to try and decipher reality up to the symbolic truth of knowledge.

Objects for learning are constructed in this way, but this task does not include the patient’s personal

fact nor his changing bias with his own behavior, that is, the manifestation of the human factor. Thus, the constructed object is a symbolic and inadequate approximation of the reality that we intend to treasure. Not everything in behavior is conscious, neither in the subject-physician nor in the subject-patient. Unconscious factors are like a swell that is continuously changing the path of what we want to understand. Kant argued that the universe is an illusion of reason, since it cannot be subjected to any experience.

The patient enhances his existential distress in the face of illness. This causes an emotional upsurge that the physician will have to understand to neutralize its negativity and redirect it to the healing process. We should not ignore the fact that the human being, a fragile and distressed figure, rushes into a psychic state that enhances the morbid. This behavior is also present outside the strictly health context. Socially, in the face of inequities in the resources of civilization, man accumulates a growing search for lenitives in some cases and violation to norms in others. Therefore, it is essential that the patient's historical context be linked to his medical record in order to obtain a broader result: his biography.

Medical thinking is key to understand these tools and use them at the patient's bedside. We must create the frame of mind in medical students that their knowledge of each patient is neither fixed nor invulnerable, but that it shows a continuous fluctuation that will be interpreted in the context of the patient's progress.

According to the Cartesian theory, to believe that there is a subject (physician) and an object (patient) in Medicine is to start an anomalous relationship, because we will be putting the *res cogitans* (mental substance) on one side and the *res extensa* (what is thought about) on the other. In fact, we should talk about the thinking subject and the thought subject in the same space-time, bringing us closer to the human factor. It is certainly very difficult to know who "the other" is, but we must advance on his emotions to tackle the medical problem, and not turn it into a mere treatment of concrete elements such as the organs. Actually, subject and object belong to the same phenomenology. The cosmos "is" to the extent that man can adjectivize it and make it "observed" in his thought and language. There is no way to practice Medicine without this subject/subject of priestly disposition, as "fervor to others". This fundamental point at the beginning of the physician-patient relationship has a weak aspect: the dialectic of understanding, which makes a fundamental difference between the two. It is this gap that the physician should bridge to be effective with the message of language.

Since the historical process of Rationalism and Positivism, the physician has not stopped thinking about a linear concept of cause-effect. Randomness, transformation, and multiplicity of causes and ef-

fects brought about by the knowledge of physics also have active participation in the subject and his morbid process. And the fact that the patient is subject to a changing behavior of his illness means that the physician should analyze the process and the random behavior of the patient-illness system, knowing the necessary permanent correction of the course of action. For that purpose, leaving the inductive approach aside exclusively in favor of the hypothetical-deductive approach has been a mistake, since it overrides the complementarity of the methodological with the observational.

There are clear examples of this intuitive observation throughout the history of the evolution of medical knowledge. The following are a few examples:

1) **William Harvey (1578 - 1657)** One of the predecessors in observation who strongly influenced Harvey regarding blood circulation is Girolamo Fabrizi d'Acquapendente (1537-1619), who was his professor of Anatomy in Padua. Effectively, d'Acquapendente wrote the book *De venarum ostioliis (On the Valves of the Veins)* in 1574, which was published in Padua in 1603 with nice engraved copper plates. The book fully describes the venous valves, an anatomical structure that had been dealt with by other authors. Despite this description, d'Acquapendente, still impregnated with the Galenic spirit, ignored their real meaning, their true function. He believed they were meant to prevent excessive flow to periphery. These were his words:

My theory is that Nature has formed them to delay the blood and to prevent the whole mass of it, like a river, from flooding either the feet, or hand fingers, collecting in them with the ensuing disorders: while the upper parts of the extremities would work with scarce nutrition, hands and feet would be oppressed by perpetual swelling.

What Harvey learned from his master about venous valves was a key observational contribution to the idea of blood circulation. Robert Boyle (1626-1691), with regard to this topic, wrote:

[...] I remember having asked our renowned Harvey, shortly before his death, which were the reasons that had suggested him the idea of blood circulation. He answered that this idea came to his mind when he noticed that the valves in the veins of many parts of the body were so placed that they gave free passage to the blood towards the heart, preventing its flow in the opposite direction. This led him to imagine, that provident Nature would not have placed so many valves without design; as blood cannot flow in the veins towards the limbs because of the interposing valves, the purpose of these valves would seem to be that blood flowing through the arteries returned by the veins, whose valves do not oppose its course in this sense.

**2) Lazzaro Spallanzani (1729-1799)** By chance and by observation, the visual verification of blood circulation should correspond to the priest Lazzaro Spallanzani, born in Scandiano, near Modena, in 1729. He was a professor in Scandiano and in Pavia. He wrote several books, including *Del azione del mori ne' vasi sanguigni* (Modena, 1768) and *De fenomeni della circolazione* (Modena, 1777).

In 1771, Spallanzani observed red blood cells circulating from the arteries to the veins in a chicken embryo. He described it in 1773 like this:

Since the room in which I found myself was insufficiently lighted, and I was determined at all costs to satisfy my curiosity, I decided to examine the egg in the open, under direct sunlight. After fixing it in the apparatus of Lyonet, I turned the lens upon it, and, notwithstanding the strong light that surrounded me, was enabled by focusing my eyes, to see plainly how the blood ran in the entire circuit of the arterial and venous umbilical vessels. Thrilled with unexpected joy, I exclaimed: Eureka, eureka!”

His quote, “The voice of Nature should prevail over Philosophy”, shows the inductive character of his research.

**3) William Withering (1741-1799)** He lived in Edgbaston Hall (Birmingham, England). In his office, patients suffering from dropsy showed poor treatment progress. The patients then turned to Mother Hutton, a folk healer, who in 1775, told Withering about the good diuretic results she obtained from a herb known as *digitalis*. In 1785, Withering published “An account of the Foxglove and some of its Medical Uses”, which included reports on clinical tests and articles on the toxicity of *Digitalis purpurea*. In this report, Withering stated that: “This drug has a power over the heart that has not been observed with any other medicine.”

In Medicine, *logos* implies more than knowledge; it means knowing the human factors in a subject. Although they are not directly measurable, these factors are concealed in the conformation of the disease. Objectivity is not measurable, since every human process is subjective. Science is not objective; therefore, close attention to patients should be paid regarding the ‘non-measurable’ factors such as emotional influxes, or hidden factors such as the ethological environment.

From the Cartesian doctrine of *res cogitans* separated from *res extensa*, the psychic foundation of the patient was relegated, particularly its hidden emotional aspect. Freud made a great contribution

to the interpretation of a total psyche in man, although this phase still remains distant from usual clinical offices as cause and concause of diseases. Already in the 5th century B.C., Hippocrates had warned us that “there are no diseases, but sick people.”

We have retrograded in using only a mathematical dialectic in which we construct material abstracts of the disease, and we disdain *aletheia* (disclosure in Greek), understanding that the active search for the occult forces Nature to reveal its secrets. In the same way, we should dig into the patient’s human factor to get closer to the problem that motivated the patient’s consultation.

The fragmentation of the patient based on the virtual construction of knowledge, leaving aside the multidisciplinary translational aspect, has led the physician to ultra-specialization, in which the patient’s integrity is lost. He is no longer a whole but rather the partiality, the fragment, taking the characteristics of the abstract model. He adopts a form and materiality in which the components absent in his format —such as the psychic, the spiritual, the emotional— have no place in the physician’s imagination of illness. The patient is overlooked, and emphasis is placed on the disease. Today, this medical position about the morbid is not only a utopia but it also goes against human ethics. The physician attends with the same immediacy as that of society compromising its existence. Increasing dehumanization has led to the abandonment of the human factor in any of the aspects that feed it.

Adjacent to the positivist world, which materialized a science with laws from a thought that constructs abstracts, and names them through the language, there are permanent observations that should not be discarded because they are out of the consideration of the current scientific law. As a result of observation, these opinions have fulfilled huge benefits to science (Pierce, 1877), and form a set of beliefs that are rejected, but that science incorporates many times, ignoring their mechanisms. These beliefs come from thought, and although they are out of the positivist laws of today’s science, they are based on deep truths that cannot be invalidated by mechanistic knowledge. Pierce mentioned tenacity, authority, metaphysics, and science as the methods to achieve sustainability in belief. Language does not respond to the intention that the logic of a certain understanding may have. Moreover, current knowledge does not adjust to strict reality but to the conveniences of beliefs, imaginations, and desires of human beings.