Vulnerable Medicine
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Here are the tears of things; mortality touches the heart. (Virgil, 1917, p. 462)

People need heart as much as they need people listening to their hearts. That’s why, when you want suggestions, I can only come up with my shame, as I remember it, and its sources; and I can only say: let’s have some heart-to-heart stories to tell each other, the folks who teach medicine and the folks who are learning it. (William Carlos Williams, cited in Coles, 1989, p. 104)

Did you ever wonder what happens when the white coat comes off and the doctor looks in the mirror? What does she see? How does she size herself up? What gives her life of doctoring meaning? In Narrative Medicine: Honoring the Stories of Illness, Rita Charon (2006) paints an original and humane portrait of what it can mean to be a doctor, to live a life immersed in sickness and dedicated to wellness. Rita Charon drops the veil, inviting readers to look at the secret, subjective, emotional face of medicine, a zone of self-censored feelings and desires cloaked in secrecy as if they were a source of shame and embarrassment.

Rita Charon allows, even encourages, her readers to peek into the personal side of medicine, where they can glimpse what may be going on inside the doctor who treats them. The picture she shows is not an x-ray, but it is a representation both unfamiliar and inaccessible to the untrained eye. The doctors on these pages aren’t the doctors most of us know. These doctors are committed not only to the health of their patients, but also to the health of their relationships with patients. They suffer guilt and remorse; they cry; they express grief openly; they feel obligated to achieve an intersubjective closeness to their patients; they are taught to listen, not to judge, to bear witness and honor the stories of illness by acknowledging that they don’t necessarily know what’s
causing a patient’s sickness. They substitute genuine listening and being fully present for templates of standardized questioning, allowing themselves to get in touch with the vulnerability so many sick patients feel instead of shying away from, or avoiding entirely, the delicate emotional textures on which doctor/patient relationships turn. They know the difference between managing a diagnostic protocol and getting to the heart of a patient’s suffering. These are full bodied, deeply subjective, feeling, breathing, moving, vulnerable human beings who are being taught that authentic primary care can’t be carried out exclusively from the head up. Medical knowledge may be necessary, but it is not sufficient in dealing with disease, and certainly not for exercising the caring function of medicine. Intellectualizations can’t calm anxiety. That’s the trouble with modern medicine—too much head, not enough heart.

Rita Charon is performing heart surgery on medicine and medical education. The patient has poor circulation and a weak pulse. She may not survive if she doesn’t get help immediately. Nothing less than a complete paradigm shift will suffice. Not a simple bypass or transplant, this is radical surgery—narrative surgery! Medicine needs a new storyline; a different plot structure; fresh metaphors; distinctive characters; modified scenes; a new moral to the story—medical education with a conscience and a concern for the interior lives of doctors.

What strikes me as the most unique quality of narrative medicine is its vulnerability. Narrative medicine is vulnerable medicine. It can be healing and comforting, but it’s also heartbreaking for many of these young physicians—and older ones too. Don’t get me wrong, I don’t think heartbreaking necessarily is a bad thing—not if it brings you into authentic contact with the pain and suffering endemic to the human condition, the kind of reflexive relatedness that makes it possible to be there vividly, ethically, in the presence of a person on the edge of oblivion, “joined in authentic regard,” as Charon (2006), p. 35) puts it, (able) to face the unknown with courage, justice, and hope.”

I’m reminded of Ruth Behar’s call for an “anthropology that breaks your heart” (Behar, 1996, p. 161). In The Vulnerable Observer, she questions orthodox practices that idealize objectivity, suggesting that by objectifying the people we study, eventually we betray them. Behar wants to make it possible to realize George Devereaux’s (1967) dream “to do social science more subjectively so it will be more objective” (p. 29). Observers are vulnerable because the emotions and worldviews of the researcher cannot be entirely separated from the interpretations and conclusions they draw from research evidence. Vulnerable observation and vulnerable writing ushers in a new era of social science where, as Behar (p. 33) observed, “new stories are rushing to be told in languages we’d never used before . . .”

Narrative medicine is one of these stories. It’s a tale that tells truths previously hidden, truths doctors were afraid to disclose; truths that sometimes are a source of shame and guilt and vulnerability; truths that made it difficult for doctors to get to know themselves because they deprived themselves of the opportunities to get to know the other characters in the story of doctoring—the sick persons—as persons, and to reflect deeply, subjectively, on what the sick person’s experience opens up to the doctor, what the doctor can learn if she allows herself to be examined by the patient. What does the doctor have to offer the patient other than, or in addition to, diagnoses
and medications? Can my doctor, can any doctor, know what he needs to know about me if he has shut himself off from himself?

Rita Charon’s version of narrative medicine shifts the plot of medical practice, making it possible to envision a different moral to the story of doctoring. A doctor normally enters the personal story of a sick person as a stranger. As Richard Zaner (2004, p. 36) says, “Illness itself is a strangeness.” But this strangeness need not be either frightening or distancing. At one time we were all strangers to our lovers and close friends. In one of his “conversations on the edge,” a story of an exchange with a 28-year-old man, born with spina bifida, and now refusing dialysis, Zaner (p. 36) asks “[W]hat should I say? Standing bodily, boldly, before you as someone who may well be dying, and I don’t know you. What can you do to help me help you? Or do you want my help at all?”

The sorts of edgy conversations and active listening promoted by Zaner, a medical ethicist and philosopher, and Charon, a clinical physician who also holds a PhD in literature, are a far cry from the canonical story of the illness experience characterized by Arthur Frank (1995, p. 6) as “narrative surrender,” in which the sick person is not only expected to comply with prescribed medical and physical regimens but also to capitulate to the medical narrative of the meaning of illness. It is the physician who becomes the spokesperson for the disease. “The scope of modernist medicine,” writes Frank (p. 6), “—defined in practices ranging from medical school curricula to billing categories—does not include helping patients learn to think differently about their post illness worlds and construct new relationships to those worlds.” But Frank is concerned primarily, if not exclusively, with the patients’ experience of illness not the doctors’ or the connection between the two.

One of the first strategic moves necessary to change the plot of medical practice is to introduce a decidedly relational view of medicine. The subtitle of Dr. Charon’s book is “honoring the stories of illness”—not stories of patients or stories of doctors, but stories of illness. The doctor and the patient are intimately and inextricably linked in stories of illness. Each has her or his own story, and a story of the other’s story. The doctor is nearly always included in the illness story that a patient tells. But what about the doctor’s story? Is the patient’s narrative a distinctive part of the physician’s story of himself? “The patient’s biography is always braided with the [physician’s] autobiography,” writes Charon, and thus the goal of narrative medicine is “to recognize more fully what patients endure and to examine explicitly the physicians’ own journeys through medicine” (pp. 156–157). Thus, for the narrative physician, narrative medicine is autoethnographic medicine (Ellis, 2004).

Medical students socialized into narrative medicine are asked to write about “their deep attachment to patients, their awe at patients’ courage, their sense of helplessness in the face of disease, their rage at disease’s unfairness, the shame and humiliation they experience as medical students, and the memories and associations triggered by their work” (Charon, 2006, p. 156). Narrative medicine presumes that the more physicians know about their own emotions and subjectivity in the context of their doctoring, the better prepared they will be to understand their patients and to treat them ethically and effectively.

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I have this fantasy that I move to New York in the hope that Dr. Charon will accept me as a new patient. I’m 62 years old and all my recent blood work suggests I’m in reasonably good health—for now. In my fantasy, I promise not to make unreasonable demands on her time or expertise—not yet. My motives are pure; honestly they are. Unlike Madame Bovary, I don’t want a love affair with my doctor, only a relationship akin to good friendship. She and I would take our time getting to know each other—to build the trust, respect, and commitment on which good friendships are grounded, but relationships between doctors and patients only rarely achieve. I feel as if we already have a good start. I’ve read most of Dr. Charon’s published articles and books. Until a few weeks ago, though, I’d never met her. Yet I felt as if I knew her, the way you might know a character in a good novel. Anne Lamott (1995) says that when you write stories you learn to love some of your characters, because they represent some facet of you. The same can be said for a reader. You’re drawn to a character when the writer touches something deep inside you, makes you stop and question yourself, the way you’re living your life, urges you to scrutinize contradictions, inconsistencies, and incongruities, makes your blind spots visible. This is how I know Dr. Charon. She taps into these cravings of mine.

In my fantasy I allow my ethnographic curiosity to get the best of me. I hang out near Dr. Charon for a while, immersing myself in the culture of narrative medicine at Presbyterian Hospital, where I witness first hand sessions of Dr. Charon’s “Parallel Chart” seminars in which her students express candidly the human side of what they go through caring for patients. I restrain myself from asking a few pointed questions running through my mind about the pedagogy of parallel charting. When I get back to my apartment, I write notes feverishly into my journal. I start by asking Dr. Charon why she insists on calling her students’ “stories” charts.

“I recognize the political challenges of narrative medicine, but I’m not convinced they justify this choice of language,” I write. “When I think of a chart I see a diagram, a map, or a list,” I continue, “I imagine pie charts and scatter plots, bar graphs, and bubble charts. But these medical students aren’t charting illnesses; they’re not diagramming sickness; they don’t graph mortality. Instead, they bear witness to suffering; they testify to their feelings of powerlessness and frustration in the face of mortal illness; they grieve the loss of innocence they must endure when they realize how few illnesses medicine can cure; they awake to the therapeutic potential of doctoring, recognizing that if they can’t cure the suffering body perhaps they can help heal the tormented soul. They’re compassionate doctors practicing vulnerable medicine. The vocabulary they use is not the sort of medical discourse that so often alienates patients from doctors, which strikes me as one of the admirable strengths of narrative medicine. When I listen to these doctors I hear them speaking candidly of fear, isolation, sadness, and exhaustion. Shattered by lost illusions of medicine’s power, they express their anguish in a language of feeling, emotionality, grief, and powerlessness that expresses their nearness to the experience of pain and suffering. These young doctors sound to me like wounded healers struggling to come to grips with their own frailty and vulnerability in order to develop a moral sensibility largely omitted from their medical education. They haven’t lost faith in the importance of
their work, but they have begun to question how effectively they can perform their duties if they don’t acknowledge their own suffering and pain.”

An important challenge for narrative medicine is to invent linguistic structures that can accommodate the experience and expression of pain to which these young doctors speak, as Elaine Scarry (1985) observed, is normally inaccessible to language. “The success of the physician’s work,” writes Scarry (1985, p. 6), “will often depend on the acuity with which she can hear the language of pain, coax it into clarity, and interpret it.” Scarry goes on to say, however, that “many people’s experience of the medical community would bear out the opposite conclusion, the conclusion that physicians do not trust (hence, hear) the human voice, that they in effect perceive the human voice as an ‘unreliable narrator’ of bodily events, a voice which must be by-passed as quickly as possible so that they can get around and behind it to the physical events themselves” (p. 6).

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I admire the goals of narrative medicine and the humane values on which they are grounded. Still, I disagree with a few of Charon’s distinctions, which seem unnecessary, perhaps even detrimental, to the cause of narrative medicine. She dismisses venting sessions, support groups, and the whole realm of therapeutic communication, implying (or fearing) that such endeavors may be labeled “touchy-feely” or “soft,” which she has learned is “the death knell of any innovation in medicine or medical education” (Charon, 2006, p. 156). Yet one cannot read the stories in her book without sensing the therapeutic benefits of the writing exercises she assigns, which help to heal these wounded and vulnerable medical students. Sometimes you have to stand up and say, “This is wrong, we must not cave in the face of pressure to conform to orthodox, conventional practices that demean emotionality, subjectivity, and humane medicine.” I’m not buying into this condemnation of “touching and feeling,” and I don’t think Charon should either, regardless of the political pressure she may feel to bargain away the feminine or therapeutic dimension of narrative medicine. If you want doctors to show they have a heartbeat, you can’t sit back and accept this sort of negation of the emotional and subjective—the very things that make narrative medicine so unique and important. If you want to introduce a life of the heart into medical practices, I don’t think you can afford to reinforce categorical divisions between the weakness and neediness of medical students who might benefit from healing experiences and the strength and self-assurance of those who reject them. It is precisely the cold, mechanical, and unfeeling reason of orthodox medicine that narrative medicine can redress. If you want a life of the heart for medicine then you’re going to have to debunk the notion that emotion necessarily distorts judgment, reason, and diagnosis. The charge that narrative medicine may be soft or touchy-feely is a surreptitious expression of what feminist critic Jane Tompkins (1987, p. 178) calls “the trashing of emotion,” which she depicts as a war waged ceaselessly “against feeling, against women, against what is personal.” As long as stories of suffering bodies and souls can be stigmatized by association with neediness and weakness, they will remain in the darkness of the
alley. If you want to bring these stories into the light of day, you must be willing to transgress the institutional taboos against sentimentality in the name of the right to speak and the longing to be heard of people in pain (Bochner, 2001).

I also want to nudge Charon toward a more dialogic view of authenticity. In the text of *Narrative Medicine*, she pleads with doctors over and over again to become more authentic. Notwithstanding her reasonable appeals to physicians to express a more authentic regard for the plight of their patients, she leaves the impression that authenticity is largely rooted in the interior life of the doctor, as if authenticity were solely a personal possession and personal virtue. Yet I sense that what she’s trying to say, but doesn’t quite get to, is that authentic doctoring requires a commitment to a set of specific social obligations. As the philosopher Charles Guignon (2004) argues in *On Being Authentic*, authenticity is personal insofar as it entails a person’s own integrity and responsibility, but it also has a social dimension that entails “a sense of belonging and indebtedness to the wider social context that makes it possible” (p. 163). This wider social context is the heart of narrative medicine. Without patients, there are no doctors. How a doctor feels about herself, her doctoring, and her capacity to express those views candidly, is essential to her own self-respect and self-regard. Clearly, the practices of self-reflection proposed by Charon are crucially important to this process. But authenticity also rests on the doctor’s commitment to “an open and respectful exchange of views with a wider community” (Guignon, 2004, p. 164).

This relational account of authenticity is a commitment to what I call “authentic conversation,” a term missing from Charon’s *Narrative Medicine* (2006), though strongly implied. The rub is that authenticity as a social practice requires the doctor to move out of the center of the picture, releasing ego investment in the situation (Gadamer, 1989; Heidegger, 1962). Heidegger’s term for this activity has been translated as letting be, letting go, or releasement, suggesting that authenticity is contingent on giving up the desire to try to control everything. Thus, to actualize narrative medicine’s commitment to dignified care and authentic relating, medical education must give up its preoccupation with control and mastery. Charon shows how well she understands the complexity and contingencies of the relationships between doctors and patients in the sections of her book where she specifies and elaborates on the divides that must be bridged to make authentic dialogue between doctors and patients possible. A doctor’s sorrow is not a patient’s sorrow. Anatol Broyard (1992) expressed this cleavage between doctors and patients eloquently in his memoir, *Intoxicated by My Illness*. “To the typical physician, my illness is a routine incident in his rounds, while for me it’s the crisis of my life. I would feel better if I had a doctor who at least perceived this incongruity. ... Every patient needs mouth-to-mouth resuscitation, for talk is the kiss of life” (pp. 43, 53).

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If I did get an opportunity to converse with Rita Charon, I’d make it a point to express my deep appreciation for the attention she pays to the last chapter of life, the
struggle to bring meaningful closure to the end of a patient’s life both for patients and for doctors. “Thank you for naming these silences,” I would say.

The highest virtue of narrative medicine is its capacity to give voice to the gaping silence that surrounds the experience of death and dying in America. “Doctors may look upon death as a technical defeat whereas patients may see death as both unthinkable and inevitable” (Charon, 2006, p. 22). Death hovers over nearly every page of Narrative Medicine as well as every traumatic experience and encounter narrated in the students’ parallel charts. This is the storyline of conventional medical education most in need of change and most open to revision through narrative medicine. Medicine as a profession teaches doctors to delay endings. Our cultural commitment to develop technologies and medicines that prolong life as long as possible reinforces the canonical story that death is to be avoided or postponed as long as possible regardless of the circumstances. For the physician this storyline means every death is an untimely one, whereas for the mortally ill patient it means the end of life cannot be integrated coherently into her life narrative. In After Virtue, one of the books that inspired the “narrative turn” in the human sciences, Alasdair MacIntyre (1984) argued that it was crucial for human beings to achieve a sense of a narrative unity and continuity to their lives and this achievement rested on one’s ability to comprehend his or her own death. In the canonical life narrative, however, most patients experience illness as a breach, an interruption, or a rupture in their life story, and doctors comprehend death largely as a defeat, a source of professional suffering, or a reminder of both their own powerlessness in the face of their opponent, mortality—the enemy of medicine—as well as the fragility and uncertainty of their own health. Dr. Charon poignantly expresses this point: “Our warrant is that we have seen pain and seen death. Our warrant is that we have lived through a nearness to sickness so profound, so saturating that we fear daily for our own health and that of those we love” (2006, p. 235).

The moral of the story I am telling, the relational story of narrative medicine, is that doctors are not the only ones who need a new plot for their lives; patients do too. If patients haven’t been encouraged to think of their lives in a narrative way, in terms of beginnings, middles, and endings, a story that comes to an end one day, then there is very little a doctor can do to help a patient comprehend illness and death (Hauerwas, 1990). In the face of death, what the sufferer needs from her doctor is not false platitudes or easy comfort, but rather the sort of companionship and intimate connection expressed so tenderly by Nicholas Wolsterstorff (1987, p. 34) in Lament for a Son, “I need to hear from you that you are with me in my desperation. To comfort me you have to come close. Come sit beside me on my mourning bench.”

References


