

Holistic readings: from Chekhov to narrative medicine*

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The aim of this paper was to show how, in the short story "A Doctor's Visit," the Russian writer Anton Chekhov, himself a physician, creates a fictional narrative in which he draws attention to aspects of clinical practice that are rather overlooked today, namely: observation and evaluation of the environment in which patients live and aspects of their family, social and even sexual outlook, along with the crucial importance of the interpersonal dialogue-based relationship between doctor and patient. The attention indirectly drawn to this issue by Chekhov is here correlated with the current situation within the domain of clinical practice by invoking the concept of evidence-based medicine as the currently dominant paradigm in medical practice, and with the need for a complementary approach, namely by narrative-based medicine or narrative medicine.

Keywords: Anton Chekhov. Evidence-based medicine. Narrative-based medicine. Narrative medicine.

The Russian writer and physician Anton Chekhov (1860-1904) authored many famous short stories, among which "A Doctor's Visit", published in 1898, is the subject of the first part of the present article^(b).

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^(b) The short story was also published in Brazil, under the title "Um caso clínico"¹. For this translation I followed the English version, entitled "A Doctor's Visit," in Jack Coulehan's anthology².

For the benefit of those who are unfamiliar with the text, a brief summary is provided here. A prestigious physician in Moscow receives a telegram asking him to visit the factory owned by the Lyalikov family to attend the daughter of the factory owners. He, in turn, decides to send his assistant, Dr. Korolyov. However, his assistant is unable to detect any serious health problem in young Lisa, who has complained of anxiety, insomnia and palpitations. Seeing no more reason to stay, the assistant is ready to leave, but is then asked to stay overnight at the family house by the mother, who fears another night of insomnia and despair. Not being able to sleep, the physician wanders through the factory and adjacent areas at night. Then he has an “epiphany moment”, in which he realizes that there is a connection between the oppressive surroundings and the young girl’s illness. This perception of a social and spiritual malaise affecting that microcosm explains the patient’s symptoms to him and makes him deal with her in a different manner: from the distanced and professional viewpoint from which he had regarded the patient earlier, with no good results, to a more generous attention to the person and to Lisa’s situation, through engaging her in conversation. Now, in addition to the heart beats, he becomes attentive to the expression of her feelings, fears and anxieties, with which he sympathizes. She reveals to him that she is also convinced she does not suffer from any physical disease, while feeling restless and afraid. This conversation forms a turning point for the young lady, who comes to say goodbye to the doctor on the following morning, smiling and dressed in white, as if ready for a party.

I propose that we focus our attention on the opening paragraph(s). These are usually crucial for understanding what is truly at issue in the text; this aspect together with the identification of the most recurrent figures of speech are precious clues for interpretation^(c). Beginning with the opening of the narrative, we are told of a figure that will be absent from the short story: the anonymous Professor. We can immediately ask ourselves why, at the outset, to include a character with no interference in the unfolding events.

The Professor received a telegram from the Lyalikovs’ factory; he was asked to come as quickly as possible. The daughter of some Madame Lyalikova, apparently the owner of the factory, was ill, and that was all that one could make out of the long, incoherent telegram. And the Professor did not go himself, but sent instead his assistant, Korolyov.¹ (p.261)

Although seemingly inconsequent to the development of the story, mentioning the Professor’s attitude is, nevertheless, significant because he bases his decision not to respond to the appeal that is addressed to him on an interpretative act, i.e. through an act of reading. The fact that the telegram is “long” and “incoherent” devalues the person who wrote it, in his eyes, and thus he avoids the visit by delegating the task to his assistant.

^(c) About the importance of the so-called “incipit,” see, for instance, Andréa Del Lungo³.

Particular attention should be given to the act of reading as that which precedes and accompanies our actions and decisions and which, as we will see, signals the type of knowledge and decisions inherent to the clinical act as a deliberative act. That is, the clinical act is not merely cognitive, given that it is not limited to equating facts, but also involves emotions and values, as well as weighing up duties. Thus, the text indirectly draws attention to the complex hermeneutic character of medical practice as well as to its deliberative essence^(d). For there to be no doubts, the following passage describes what Korolyov sees on his way to the factory:

And now when the workpeople timidly and respectfully made way for the carriage, in their faces, their caps, their walk, *he read* physical impurity, drunkenness, nervous exhaustion, bewilderment.² (p.174) [my emphasis].

Chekhov is obviously committed to presenting physicians as readers, and as decoders of the signal systems that surround them, an aspect the text will address.

The central rhetorical device of the story is the simile. Indeed, comparisons are inescapable, not only because they are the most repeated figure of speech, but also because they inform the compositional structure of the narrative, as will be shown later on. For instance, as early as in the second paragraph, there is a reference to the coachman of the carriage that awaits Korolyov: "the coachman had wore a hat with a peacock's feather on it, and answered every question in a loud voice *like a soldier...*"¹ (p.261) [my emphasis]. Here, the first contact with a local inhabitant indicates, by means of comparison, a military-oriented world and its inherent discipline and power relationships, characteristics that will be echoed in the presentation of the factory.

The essence of comparisons (which, as is well known, are the basis of all metaphorical constructions) consists of bringing together different objects or planes in an integrative effort that, according to Percy Bysshe Shelley in his renowned *A Defence of Poetry* (written in 1821, but published posthumously in 1840), characterizes the poetic form itself. Starting from his affirmation regarding the difference between reason and imagination: "Reason respects the differences, and imagination the similitudes of things", Shelley goes further and argues that poetry, as the expression of the integrative power of imagination, has a language that is "vitaly metaphorical; that is, it marks the before unapprehended relations of things and perpetuates their apprehension"⁴ (p. 227).

^(d) I am here adopting the terminology and concepts used by Diego Gracia on the 31st. of March 2014, in his lecture "Bioethics and Humanization," at the International Congress Humanidades e Humanização em Saúde, organized by FMUSP, in São Paulo, Brazil. Any misreading or mistake is, however, entirely my own fault.

It is significant that comparison is the most notable and recurrent rhetorical device in the story. Comparisons show the need for an integrative view or attitude towards the forces and multiple relationships that rule our existence as human beings and, more than ever, at critical moments such as a crisis or a disease, as is the case in this text.

Besides, in less microscopic terms, the story progresses by means of other comparisons or approximations, although not of a rhetorical-stylistic nature, but more in terms of its composition. The text is constructed and developed by means of successive comparisons among characters and between them and the environment. At the beginning, we are presented with the comparison between the housekeeper and the employers, followed by the comparison that assimilates Lisa to her mother, and finally the comparison between the physician and Lisa. In this latter case, the characters are united by a conspicuous and unexpected "us", which, more than being merely a symptom of a common generational sensibility, goes deeper and signifies the sharing of human vulnerability, which ultimately unites physician and patient.

By correlating these two factors, i.e. the beginning of the text and its central rhetorical device, we can venture to say that Chekhov was interested in presenting to us a physician, whom we will consider to be an interpretive or competent reader, and a way to carry out clinical practice that considers the person of the patient in his/her domestic, familial and social context. In sum, instead of medicine that dissects or separates, he presents to us an integrative form of medicine that restores an overview of the patient *in situ*^(e).

Let us see how this is done in the story under analysis. The story is a narrative with an omniscient heterodiegetic narrator, i.e. a third-person narrative, in which the point of view is given to the young man Korolyov: it is his view and his consciousness of the world that we follow^(f). This choice is significant: the invitation for the reader to share the young physician's point of view signals his type of behavior and his type of vision as being worthy of attention, or, in other words, this choice invites empathy between the reader and this character^(g).

^(e) Here I am echoing the Sartrean expression: "être en situation," in the sense that human beings are the result of a bunch of circumstances and allegiances but not in any way totally determined by them.

^(f) We are dealing with the dialogic device which F. K. Stanzel calls 'reflectorization' and which gives rise to what he calls a 'figural narrative situation,' where a character is used as a reflector-character, or, to use a Jamesian expression, a 'vessel of conscience'⁵.

^(g) According to Stanzel, 'figural narrative situation' invites empathy towards the reflector-character, the character whose point of view is adopted⁵.

The climactic moment occurs when, at night, walking first around the perimeter of the factory and then in the adjacent areas, the physician becomes aware of the hostile and infernal environment, similar to that of a prison – an inescapable comparison that is communicated to us significantly in the monologue cited below^(h), in a sequence of descriptions in which the character's senses of hearing and seeing are invoked, in witnessing the following scenario:

Near the third building he heard: "Zhuk... zhuk... zhuk..." And so near all the buildings, and then behind the barracks and beyond the gates. And in the stillness of the night it seemed as though these sounds were uttered by a monster with crimson eyes - the devil himself, who was controlled the owners and the workpeople alike, and was deceiving both.

Korolyov went out of the yard into the open country.

- Who goes there? – someone called to him at the gates in an abrupt voice.

"It's just like being in prison," he thought, and made no answer.¹ (p. 268)

But it is not only the surroundings of the factory that negatively affect the physician. The interior of the Lyalikov family's house with its questionable taste and new-rich pretentiousness has the gift of irritating him. Moreover, the first impressions that he has of Lisa also induce his intuition that something is amiss at the level of the young lady's sexuality, which makes him think: "It's high time she was married"¹ (p. 264).

We then become aware of the senseless enterprise that benefits no one: neither the workers, who are severely exploited and alienated, nor the owners, who also fall victim to their mechanized and insensitive system and their unhealthy environment, as shown through the premature death of Lisa's father and the current suffering of the mother and daughter. The only and ironic exception to this irrational state of affairs seems to be the housekeeper, Khristina Dmitrievna, who knows how to take advantage of the good bed and food available to her.

Over the course of the story, Korolyov's qualities become apparent, regarding his capacity for observation, listening and interpretation, as well as his general sensibility. He is an open-minded person, who knows how to listen, see and decode what he observes, as well as being affected by the absence of beauty and life around him.

His diagnosis of the industrialized microcosm that he observes leads him to a new and eloquent comparison: in the same way that factory life is to him enigmatic, so are certain incurable diseases, whose causes are revealed to be obscure but unavoidable. No matter how much distraction and entertainment is offered to the workers, this will not cure them of the diseases that affect them, similar to what happens with treatments applied in vain to cases of incurable diseases.

^(h) Dorrit Cohn uses the term 'quoted monologue' to refer to this narrative device, in third person narratives⁶.

But if the physician's assessment and diagnosis of the social and family context is accurate and decisive for what follows, it is the dialogue with Lisa, the patient, which provides the turning point that leads to the outcome. This dialogue shows the mutual need between the "I" and the "other," which has been explored among thinkers such as Paul Ricoeur⁽ⁱ⁾ or Mikhail Bakhtin. The latter, for example, in an eloquent step in *Art and Answerability* (perhaps one of his lesser known works), draws attention to the complementary nature of views that characterize any encounter between individuals, without which comprehension of the whole picture would be impossible:

When I contemplate a whole human being who is situated outside and over against me, our concrete, actually experienced horizons do not coincide. For at each given moment, regardless of the position and the proximity to me of this other human being whom I am contemplating, I shall always see and know something that he, from his place outside and over against me, cannot see himself: parts of his body that are inaccessible to his own gaze (his head, his face and its expression), the world behind his back, and a whole series of objects and relations, which in any of our mutual relations are accessible to me but not to him. As we gaze at each other, two different worlds are reflected in the pupils of our eyes. It is possible, upon assuming an appropriate position, to reduce this difference of horizons to a minimum, but in order to annihilate this difference completely, it would be necessary to merge into one, to become one and the same person.⁸ (p. 23)

The conspicuously optical nature given to this defining matrix-like scene of intersubjective relationships makes us aware of the interdependence of the irreducible points of view that intersect here, thus indicating that for an adequate topographical recognition of any situation, we must invariably change our point of view. Transposing this interdependence to the clinical encounter, it can be seen that there is a need for the doctor's view to be complemented by that of the patient, so as to bring the context of his/her situation into the picture and thus reach an adequate diagnosis.^(j)

On the other hand, for Lisa to become fully aware of her situation, and given her relative isolation, she needs other people's viewpoints, which in this case is represented by the doctor's view. However, the doctor himself is not completely confident of being able to deal alone with the enigmatic malady that affects Lisa and, especially, of being able to deal with his own conclusions, unless she interacts with him. It is interesting to observe that this crucial dialogue **between** doctor and patient is, against our expectations, verbally sparse and not very long.

(i) See, for instance, his *Soi même comme un autre*.⁷

(j) This indispensable interdependence and collaboration reminds us of the famous Hippocratic triangle: "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"⁹ (p. 1).

Moreover, it transmits a level of insecurity from Korolyov: the technical language of medicine does not make it easier for him or ensure access to the intimacy of this person, who is in fact revealed to be intelligent and sensitive. Thus, he must resort to another type of language. Almost instinctively, the physician sits on the edge of the bed, holds Lisa's hand, and uses the first-person plural, thus implying that he is sharing with her what she feels she has to transmit, even without knowing how. In other words, this is a true dialogue, given that the interlocutors respect each other, place each other on the same level, and reposition themselves as the conversation unfolds, seeking a true exchange of points of view and an authentic understanding.

There is no paternalism here, nor does the doctor seek refuge in his pedestal of technical knowledge. Rather, he admits feeling embarrassed and uncomfortable, as can always happen in a true encounter between two human beings in which both parties seek a shareable truth. Thus, signs of interdependence emerge between them, which are not limited to the clinical relationship, but rather, surpass it since Lisa admits that what she truly lacks is a friend, someone whom she trusts and can talk to. The capacity to generate trust, the opening up to the imponderables of what the other person has to tell us, the availability of an attentive listener and his empathic presence constitute the scene that is portrayed in this dialogue and which is insinuated to form the indispensable ingredients in a productive encounter that is worthy of this name. In this dialogue, the doctor eventually reveals that he is in tune with the patient, but as her equal. Meanwhile the symptoms of the disease (insomnia and tachycardia) become signs of a healthy reaction to the hostile and unhealthy context and indicate an instinct for life that both share:

Your sleeplessness does you credit; in any case, it is a good sign. In reality, such a conversation as this between us now would have been unthinkable for our parents. [...]; we, our generation, sleep badly, are restless, but talk a great deal, and are always trying to settle whether they are right or not.¹ (p. 272)

It is not important whether what Korolyov says regarding differences between generations is true or not, but rather this is an access route and ensures the necessary trust that will enable honest and open dialogue. The physician temporarily waived scientific language, thereby putting himself at risk in the uncertain frailty of his own humanity, in trying to create a bridge towards the other person^(k).

In the end, everything connects and is leveled: the physician with the patient, the housekeeper with the factory owners, the owners with the workers and, ultimately, the natural elements with the human universe.

^(k) The only character in this story to use an allegedly scientific language is the governess, who mimics the medical jargon, thus trying to play the role she thinks is expected from her. We have here another comparison (between governess and doctor) but, in this case, an ironic one.

Everything here is presented in close interdependence: by assessing the ecosystem that involves the patient, the physician is led to a diagnosis that, as so often happens, exceeds his clinical competence and scientific knowledge. The mechanized, unhealthy and irrational life produced by industrialization reflects on the body and soul in a general manner, particularly among more sensitive people. This requires a holistic approach that considers the person as a whole, in the multiplicity of their belongings, constraints, commitments and circumstances.

In an accurate diagnosis of the current state of affairs in the field of healthcare, João Lobo Antunes, in his recent work entitled *A Nova Medicina* (The New Medicine), describes the following picture:

One surprising fact is that progress in biomedicine has come to paradoxically increase the uncertainty of medical decision-making. [...] Even today, the practice of clinical diagnosis begins with gathering the patient's history and conducting a physical examination (now somewhat undervalued due to the abundance and rigor of imaging techniques), followed by auxiliary diagnostic examinations. In the New Medicine, imaging has almost abolished the narrative of the disease, partly because the doctor has less time to listen [...], and because the patient himself has difficulty in explaining his complaints and thinks his disease is clearly revealed in the images that were obtained.

The prevalence of auxiliary diagnostic examinations and, especially, imaging has led to a tendency to neglect the verbal, or better, the narrative aspects that are inherent to clinical practice: the patient is heard less and less space is given to him during his consultation because his verbal testimony has been devalued.¹⁰ (p. 29-30)

From this context, characterized by this difficult balance between objectivity, scientific rigor and recognition of the need for words and a verbal report, Narrative Medicine or Medical Humanities¹⁰, as it is also called, has emerged. This is a field of study that over the past decades has drawn attention to the need to refocus on the intersubjective relationship that characterizes clinical practice, thereby addressing and improving the communicative competences and humanistic preparation of paramedical personnel and physicians, for them to place the relationship with the patient at the center of care. To do this, Narrative Medicine, which is deeply interdisciplinary, explores the contribution of different fields within the Humanities, namely, Literary Studies, Philosophy, Ethics, Anthropology and Sociology, among others. The 1980s witnessed the emergence and almost unchallenged affirmation of Evidence-based Medicine (EBM), which will be discussed later.

¹⁰ Terminology varies: the US privilege "Narrative Medicine" (MN) while other countries, such as the UK, prefer to use a more encompassing term: "Medical Humanities," which in France corresponds to "humanités médicales." Thus, for instance, the name of the pioneering North-American project: "Program in Narrative Medicine," based at the New York's College of Physicians and Surgeons of Columbia University.

On the other hand, the appearance of this new area of investigation, i.e. Narrative-based Medicine (NBM) or Narrative Medicine (NM) has been less of a protagonist within the scope of medical sciences, although it is no more recent^(m). Publication of papers and conducive initiatives became noticeable especially during the 1980s and 1990s. Today, the movement is manifested at a global level, but more particularly in the Anglo-Saxon world. The emergence of academic programs such as those of the University of Columbia, founded in 2000, and published papers such as those by Richard Zaner, Tricia Greenhalgh, Brian Hurwitz or Rita Charon can be cited.

Narrative Medicine, in the words of its main proponent, Rita Charon, “[is] medicine practiced with the narrative competency to recognize, interpret, and be moved to action by the predicament of others”¹² (p. 83).

In a later and more complete definition, Hurwitz takes into account the crucial difference between biological singularity and the patient’s individuality (this latter being favored in NM):

[a] Narrative Medicine is a practice and an intellectual stance which enables physicians to *look beyond the biological mechanisms at the centre of conventional approaches to medical practice*, towards domains of thought and ways of telling that *focus on language and representation, on the emotions and relationships* which illuminate health care practice.¹³ (p. 73) [my emphasis]

This is said to be “the most developed platform we have for practicing with the sensitivities and skills needed *to combine clinical and scientific knowledge with interpersonal understanding* of the many and varied accounts encountered in the health care of individuals”¹³ (p. 84) [my emphasis].

The central issue that we face today consists of balancing the extraordinary advances achieved in medicine as science, or rather, in the medical sciences, and the tendency towards a certain neglect of the interpersonal relationship in clinical encounters, in hearing the patient’s story attentively and taking his social and family environments into consideration. These matters, as we have seen, are understood by some to be a consequence of the unchallenged and (almost) exclusive belief in the decisive value of auxiliary diagnostic exams and tests and, especially, the rigor of imaging techniques.

^(m) It should be noted that the appearance of the Balint Groups in the 1950’s was the symptom of unease and of the need to correct this state of affairs. By recognizing that the clinical encounter is, above all, a relational act, these groups aimed at supporting doctors, by inviting them to share with their peers the dilemmas and difficulties experienced with particular patients. The goal was to stimulate a more empathic and more self-conscious attitude, thus enabling the establishment of a bond of trust between doctor and patient¹¹.

This new interdisciplinary field that focuses on language and/or representation does not reject scientific advances, but rather, it depends on them. However, NM combines these advances with other disciplines, deriving intellectual support from domains beyond the scope of strict science, namely the domain of arts. NM acts as an interpretative and provisional activity, inalienable from the situational context in which it is practiced¹³.

Although NM does not signal any particularly new concern in clinical medicine, it is, nevertheless, an innovative field in the sense that, for the first time, medical practice is combined with research fields beyond its scope¹³. NM also responds in a modern way to the growing prevalence of a positivist-based scientific paradigm, combined with a somewhat narrow professionalism in clinical practice. NM has appeared as the necessary complement to the institutionalization of this “hard” paradigm in practicing the art of medicine, based on technology, which became established at the beginning of the 1980s and was materialized through the aforementioned EBM¹⁰ (p. 33).

What should we understand EBM to be? In the words of one of its advocates:

[a] Evidence-based medicine, or factual medicine, is defined as the conscientious and judicious use of current best evidence in clinical investigation, thus addressing the specific care of individual patients.¹⁴ (p. 71)

This evidence comes from systematic clinical trials consisting of extensive randomized tests, meta-analyses, cross-sectional studies or reliable follow-up studies. EBM recommends the use of systematic reviews of the best available medical literature (subject to scientific peer review), risk/benefit analysis and randomized controlled tests. Thus, EBM consists of basing clinical decisions not only on theoretical knowledge, judgment and experience (the main components of traditional medicine), but also on scientific evidence. This means knowledge that can be deduced from systematic scientific investigations, carried out especially at the levels of diagnosis, prognosis and disease treatment, and which is based on validated results that are applicable to current medical practice.

Even if the advocates of EBM claim that they do not dispense with medical judgment and experience and affirm that EBM is complementary to traditional medical practice, the truth is that this paradigm has increased the rigidly scientific approach of “new medicine”. This then invites doctors to adopt a defensive attitude⁽ⁿ⁾ and make excessive use of all those types of results and corresponding statistical data, of a multiplicity of tests and auxiliary diagnostic techniques, which gave rise to an exponential increase in the number of examinations (often unnecessary), with additional risks to patients and significantly higher healthcare costs^(o).

⁽ⁿ⁾ The expression “defensive medicine” is used by Antunes, in a similar context¹⁰.

^(o) On this subject, besides Antunes¹⁰, see also David H. Newman^{15,16}.

Despite all this, I believe that we should not encourage contradictory views between EBM and NBM/NM, but rather, as advocated by Parker¹⁷, affirm that EBM, properly conceived and complemented by NM, can constitute the necessary condition for the conscious practice of clinical freedom today.

NM does not recommend simply that healthcare professionals should be solely attentive and available to register in the clinical report the most prominent information from the story the patient tells them. They should also be receptive to and able to register and decode the peculiar language used for narration, which may occasionally even conflict with the ostensive story being told. Inspired by the New Criticism reading method, 'close reading', Charon likes to use the expression 'close listening' to refer to the type of attention that the doctor should provide regarding what the patient transmits. Healthcare professionals will better perceive the particular psychosomatic situation of the patient at hand, and will diagnose it more fully through their capacity to register the types of metaphors that are used, the insistent repetition of certain expressions, the adopted point of view and time frame and even the ambiguities and silences, among other discursive characteristics attending the patient's utterance. This is only achieved through training. Charon states that "narrative training in reading and writing contributes to clinical effectiveness,"¹⁸ (p. 107) and adds that: "the kind of therapeutic decisions we make can be remarkably different from conventional decision-making as a result of narrative deepening of doctor-patient relationships"¹⁸ (p. 108).

Being able to read body language must be combined with the ability to decode patients' narratives and other verbal and non-verbal clues, as well as an awareness of the ethical and sociocultural issues involved. This demands a particular cognitive predisposition that only a background in the Humanities, combined with scientific knowledge and clinical experience, can promote^{19,20}. This understanding and decoding of the specific human situation that, at a particular time, characterizes the patient and leads to a diagnosis will be the more capable and efficient if the tools for analysis and interpretation will be made available to the healthcare professional thus enabling him /her to make the most of the report s/he listens to. Some of these tools can be provided by literary studies in general and, in particular, by more recent contributions from the field of narratology²¹.

This recognition of the need for complementarity between scientific knowledge with the attending tendency for generalization, which is characteristic of the biological sciences, and an attentive and open approach to the peculiar resonances of the concrete case history that are revealed during the clinical encounter and through the clinical history, echoes the differences established by Aristotle, in *Nicomachean Ethics*, between two types of knowledge. Here, I have in mind the pairing of philosophical knowledge and practical knowledge, which are very different in nature, even though both are part of the rational side of the soul. Practical knowledge is guided by action and is not concerned only with establishing universal rules, as is characteristic of philosophical knowledge, but rather, deals with immediate particular facts that become known

through experience. This is the type of knowledge that allows correction of reasoning and leads to excellence in deliberation, which is the desired outcome for the clinical act^(p).

Recognizing the importance of the interdependency between scientific knowledge, which is objective and has universalizing value, and another type of knowledge, which is attentive to the particular context situation and, in this sense, temporary and dependent on a complex hermeneutic act, was what, at least partly, led Lennard J. Davis and David B. Morris in 2007 to publish their manifest in favor of what they call "biocultures", in which they state:

To think of science without including a historical and cultural analysis would be like thinking of a literary text without the surrounding and embedded web of discursive knowledge that is active or dormant at particular moments. It is similarly limiting to think of literature [...] without considering the network of meanings that might be learned from a scientific perspective. [...] The biological without the cultural, or the cultural without the biological, is doomed to be reductionist at best and inaccurate at worst.²³ (p. 411)

Through this term, "biocultures", these authors intended to validate and consolidate a multiplicity of interdisciplinary experiences that were already in play in several universities, going from "Medical Humanities" or "Narrative Medicine" to the history of medicine, including public health, bioethics, epidemiology, identity and body studies, medical anthropology, medical sociology, medicine philosophy, etc. Moreover, they contested the legitimacy of the traditional boundary between what is called hard science and the remainder, in stating that a "*community of interpreters across disciplines*" exists, comprising "interpreters who are *willing to learn from each other*."²³ (p. 416) [my emphasis]

In the current state of affairs, it would be advantageous for healthcare professionals and, in particular, for doctors, to see themselves as members of a "community of interpreters" and, thus, place value on the interpretative competences postulated by the demands of the "new medicine". However, this will only become possible through changes in attitudes, which in turn will only occur when the habits and mentality that are currently deeply rooted in the practice of medicine are abandoned. Trained to heal and convinced that the medical sciences and their undeniable progress are a guarantee of success, students at present-day medical schools are not prepared to admit that they do not know or that they were mistaken¹⁶ (p. 34). Thus, when confronted with situations that deviate from the typified format or the documented and statistically expected case, not to mention treatment failures, these candidates to become physicians go through situations of anxiety and despair that are utterly unjustified.

^(p) Cf. Aristotle, *Ética a Nicómaco*²². I thank Diego Gracia for calling my attention to the relevance of this Aristotelian distinction.

As advocated by Newmann, modern science and, especially, medicine “continues to treat the human organism as a cause-and-effect model, a Cartesian machine with predictable and measurable functions in the physical world.” This assumption is clearly inadequate and does not take into consideration the complexity of the “inner machinations of the human form,” most of which “have yet to be elucidated”¹⁶ (p. 34). Moreover, it also ignores another factor, to which quantum physics drew our attention: the importance of the observer. As Newmann argues:

[the] stoic model of the modern physician that we endorse - the objective and uninvolved observer - does not exist. Our presence alters the path of illness and impacts the human experience. We are not detached spectators nor should we be; we are an integral and powerful part of both illness and healing.¹⁶ (p. 223)

This is exactly what Chekhov's short story teaches us, through presenting a medical protagonist who, when confronted by an enigmatic and atypical situation, ends up being involved, allowing himself to become impregnated by the environment surrounding the patient and, thus, becoming “an integral part of healing.”

Jack Coulehan, an attentive observer of the use of narratives and metaphors in medicine, has shown how the prevailing language in clinical practice reflects a culture that transforms the patient into an object and the doctor into someone with power to approach this submissive patient-body²⁴. For example, considering the expression “history taking” also in its metaphorical form, the conceptual weight of “history” suggests that what the patient reports is objectified, while implicitly referring to an entity that we are able to find if we look for it in a sufficiently aggressive manner, as if searching for a black box among the wreckage of a patient's life. The verb “to take” suggests a violation of the patient. The doctor pulls the history from the patient, in the way that a tooth is pulled out or an appendix is removed. In Portuguese, the equivalent word “*colheita*”, another metaphor, also suggests an aggressive and rapacious act, thus underlining the passivity of the patient.

Coulehan also analyses the most recurrent metaphors in medical discourse and highlights the three most common ones: war (the disease is the enemy and the doctor, who commands the troops, has set out to beat it), paternalism (the disease is seen as a threat and the doctor as the protector) and engineering (the disease is a disorder and the doctor is the technician).

With the decreasing use of paternalist metaphors, which contemporary medicine has banished, the military and mechanical metaphors have gained strength. In both cases, however, the submissiveness of the patient and the reduction of the patient or his/her body to the dimension of an object are inescapable. This is concordant with the conception of the physician as an objective and distant observer, a holder of knowledge, who does not become involved.

At a time when we are constantly surprised by the recognition of our global interdependency, whether in climatic, political or economic terms, it might make sense, as has

already been suggested, to replace these metaphors with others that are more holistic. I have in mind environmental metaphors, which make assumptions referring to the interrelationship among the parties involved and between these parts and the whole, evocative of the dynamic integrality of either the social or the physical body.

Successful treatment of pain calls for more communication between patient and doctor, communication between the professions, and a view of medicine as something unfinished and integrative, rather than specialized, standardized, and technology based. [...] Perhaps the metaphors should shift from war to the environment. [...] Medicine has to look beyond isolated symptoms and aggressive solutions to the ecology of the larger system.⁽⁹⁾

Ultimately, what NM proposes is a change in the metaphors and, with that, a change in the whole culture that has characterized the way in which medicine is practiced today. We have no doubt this will be a slow process with many obstacles, but the good news is that it has begun. We also believe that literary studies, despite their recent history, characterized by antagonisms and schisms, and by successive movements of action and reaction, or, perhaps, precisely because of all this, have reached a level of maturity that is indispensable in interdisciplinary dialogue. This allows this type of study to make a decisive contribution, given judicious use of its best tools and methods. Furthermore, we should not forget, as has previously been highlighted, that: "more so than any other subject, literature lends itself to powerful teaching"²⁶ (p. 74).

⁽⁹⁾ The author continues: "Politically, thinking globally has become less an ideological option than a necessity. Borders protect no one. Our relationship to the earth has become more stark and unavoidable. It's the same with our health"²⁵ (p. 356-7).

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