The Intersubjective and the Intrasubjective in the Patient-Physician Dyad: Implications for Medical Humanities Education

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Abstract:
At the heart of Medicine is the patient, and the fundamental relationship in medicine is the patient-physician dyad. Smith’s argument for the intersubjective creation of knowledge, which is itself indebted to Bakhtin’s notion of the utterance and of the necessity of ‘the other’ in the development of meaning, enables an exploration of the creation of meaning during the patient-physician encounter. The analysis is enriched by Haraway’s concepts of partial perspectives and of dispersion, which expose the many roles and voices in which the physician and patient may interact. This approach emphasizes the use of the medical humanities as a tool to teach medical students about the ambiguities of clinical practice, in which there is often no ‘right answer’ except that which is appropriate for the individual patient.

Key (Indexing) Terms:
Physician-Patient Relations
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Medicine is often taken up in Western culture as a science. Despite the deeply non-scientific aspects of its nature, it publicly presents itself only as science, with scientific journals, scientific meetings, and a public reification of the scientific method. The legitimizing goals of this commonly presented discourse for the place of Medicine in society are, however, not the primary concerns of this article. Rather, it will problematize the impact of the public scientification of Medicine on the dissonance faced by those who join the profession as they encounter the disjunction between this discourse and the realities of practice. It will theorize the unexplored post-modern nature of the central patient-physician dyad with a grounding in both clinical practice and critical theory.

Given the position that insight into this dyad and the role(s) of the physician within it is fundamental to a coherent medical praxis, it will advocate for the introduction into medical training of intellectual tools necessary for this understanding.

Physicians undergo many years of science-based pre-clinical training. They learn that the science available to them has its limits, that Medicine still cannot always predict outcomes, promise cures, or even guarantee correct diagnoses. This does not, of course, necessarily mean a failure of Science as a paradigm. Perhaps scientific progress, in its modernist march forward, has not moved sufficiently quickly. Perhaps the patient in question couldn’t remember their symptoms well enough to supply a useful account of them. Perhaps the physician erred in some way. Nonetheless, once clinical training begins there develops an intuitive understanding that some things are not so clear-cut, that sometimes there is no one correct answer – even that sometimes the correct answer...
must be individualized. These physicians start to practice medicine, whether as trainees or as licensed professionals, and quickly realize that often the right answer depends on an individual other than themselves: the patient.

Let us take a banal example from routine primary care medical practice. Diabetes mellitus, or what is commonly known as ‘diabetes’, is a common illness with serious consequences and no cure. The hallmark of the disease is an elevated blood sugar level. It is known (in the scientific way of knowing) that average blood sugar levels which are higher than ‘normal’ (i.e., non-diabetic) levels are, over many years, associated with more complications, and that these complications can be devastating: blindness, kidney failure, heart attacks, strokes, etc. It is known that very high blood sugar levels can, over hours or days, make someone so sick that they can become comatose and possibly die. It is also known that very low blood sugar levels, even for a few minutes, can make someone faint, have a seizure, develop brain damage, or die.

The textbook treatment for diabetes, then, is to artificially lower the blood sugar to non-diabetic levels at all times without ever letting it dip into the dangerously low range. The ‘best’ treatment entails the person with diabetes testing her blood sugar levels (by pricking her finger with a tiny needle and dropping blood onto a testing strip which goes into a machine and is read automatically) at least four times per day. She uses those levels (plus calculations involving the amount and type of food she is planning to eat at a particular time of day) to decide on doses of insulin, the hormone that lowers blood sugar, with which to inject herself (which she also does four times per day) to keep her blood sugar levels in the non-diabetic range, neither too high nor too low. It is obvious that this process requires numeracy and some mathematical sophistication, as well as the
literacy required to check food information and organize blood sugar records, on the part of either the person with diabetes or a dedicated caregiver. It requires reasonable corrected vision and manual dexterity. It may not be so obvious that it requires access to refrigeration (for the insulin) and a clean environment in which to test and inject but in which needles are allowed. It requires sobriety for the complicated process of dose calculation and injection. It usually, depending on the country, requires money for testing strips and ancillary equipment, and for the insulin itself, over and above the money needed for the range of foods recommended for a diabetes-appropriate diet. Finally, it requires significant, ongoing motivation, and a frustrating understanding that even the most meticulous attention will not always result in perfectly normal blood sugar.

It is painfully clear that, while there are some people with diabetes for whom this sort of routine is possible, there are many people for whom it is not. With this in mind, there are patients to whom multiple daily dose insulin therapy can be suggested and those to whom it can not be, for whom less intensive insulin regimens or oral medications are usually prescribed. The man with alcoholism who lives on the street corner would not be a candidate for this treatment. This is not an indictment of his lifestyle, but a recognition of the possibilities available within his reality. The elderly blind woman living on her own would also be unlikely to be safe with intensive insulin therapy; she might also not be interested in its long-term benefits. The anxious patient might be willing to try it with the right words of encouragement from the family doctor he’s been seeing for years, but not at the behest of his new endocrinologist. All of this is overwhelmingly obvious to physicians in practice – and quite unnerving to students as they begin their clinical time.
It isn’t very scientific. There simply is no right answer, except in the context of the individual patient-physician dyad.

This is a crude example, but a realization of the existence of multiple ‘truths’ in multiple patient-care contexts is taken for granted within the medical community. It is surprising only to outsiders, who still believe in the hegemonic discourse of Medicine as science. What the medical community has not done, however, is to theorize this multiplicity in such a way as it can be explored and explicitly taught to students. Such theorizing moves far beyond the realm of science, however, and outside the bounds of what is traditionally taught in pre-medical education. It would probably shock the medical profession to learn that, in the era of patient-centred care, medicine as it is practiced is actually, and must remain, decidedly post-modern.

The Patient-Physician Dyad and the Intersubjective Creation of Meaning

At the heart of Medicine is the patient, and the fundamental relationship in medicine is the patient-physician dyad. It is within this encounter that meaning is created. Physical reality is not determined by the encounter; an individual patient either is, or is not, subject to a particular pathophysiological disease process. However, the meaning of that disease (or lack thereof) to her, her illness state, is mediated at that moment both by her own standpoint and by her interactions with the physician diagnosing and treating her. This is most glaringly brought to the fore in the diagnosis of psychosomatic illness, in which physical symptoms are linked by one member of the dyad to underlying psychosocial problems rather than to biological diseases.[1] These contested situations, in which shared meaning is not reached, are distressing both for physicians and for patients. However, the creation of illness occurs constantly, in a straightforward, relatively
uncontested manner, in daily clinical practice. A patient’s chest pain, which he has been experiencing for weeks, ‘becomes’ heart pain as soon as his family doctor hears the all-too-familiar story. Another patient’s swollen legs ‘become’ heart failure, or kidney disease, or ovarian cancer following the review of her test results at a follow-up visit.

The process of the development of meaning in such encounters can be theorized using Dorothy Smith’s argument for the intersubjective creation of knowledge.[2] As part of her case for “a fully social, dialogic account of knowledge and truth” (Smith D,[2] p 127), Smith writes: “This account of knowledge and telling the truth represents them [...] as dialogic sequences of action in which the coordinating of divergent consciousnesses is mediated by a world they can find in common” (Smith D,[2] p 127). Further in the same text she posits that knowledge is brought into being by the encounter between two subjectivities (Smith D,[2] p 128). This move away from knowledge as the product of an individual is emphatically not a denial of individuality or individual subjectivity, but rather an emphasis on the need for two separate subjectivities in order to create meaning. It thus acknowledges the necessity, indeed the joint centrality, of the patient to the patient-physician encounter, and thereby empowers the patient.

The two subjectivities are, however, not necessarily two living human individuals. Smith points out that referring, the “concerting of consciousness through symbolic communication [...] in the emerging course of a social act” (Smith D,[2] p 115) occurs not only within a spoken dialogue but also between “texts and readers” (Smith D,[2] p 128). Within the medical context, this allows for other arenas of knowledge-creation surrounding and extending the patient-physician dyad. For example, the physician can, in certain circumstances, interact with the patient’s chart as a textual object even before
their initial physical encounter; the knowledge thus created in the former interaction can significantly inform the physician’s perspective on the latter. Meaning generated within the patient-physician dyad is then transmitted as new texts – pages added to the patient’s chart, letters sent to other physicians, forms filled out for insurance companies and government agencies – that generate further, different meanings in other contexts, with or without the repeated dialogic presence of the patient.

Unlike some theorists, Smith accepts the biological reality of the human body, as evidenced by her understanding of the creation of meaning “implicating and relying on the humanly shared senses of participants, their bodily being and activities of looking, touching, smelling, hearing, etc” (Smith D.[2] p 128). If the body exists in the physical sense, then it can also be taken up as a text, allowing the possibility of interacting directly with the body as the subject. This is particularly helpful in theorizing the interaction between the physician and the unresponsive patient. The examination of the patient who is unconscious, or who is unable or even unwilling to communicate, must, morally, still be theorized as an intersubjective process. Otherwise there would be no difference between examining such a person and studying a plastic mannequin, obviating the need for respect and compassion in the encounter. This reminder of the subjectivity of the body being thus examined, being interacted with, protects against it being conceived, and

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1 While an existing chart is not often currently available for new clinic patients, previewing the chart prior to seeing the patient is the norm for inpatient consultations. With the impending advent of the centralized electronic health record in many jurisdictions, this practice will inevitably become increasingly common in the outpatient setting as well. This process is more efficient for health care personnel as it provides details that patients often do not remember. Patients also often prefer it in order not to have to keep retelling the same ‘story’ to multiple practitioners, and ‘experienced’ patients may tell physicians to ‘read the chart’ instead of answering repeated questions.
thus treated, solely as an object. Such protection can also be extended to the ultimate
manifestation of the unresponsive body – the corpse.

**Language, Naming, and the Medical Diagnosis**

Smith, then, connects knowledge to physical reality and thus to the body, but she also
connects both of these to language. She writes that knowledge is “grounded in the
foundational moments in which the social comes into being through language and
through the sensory ground which human organisms share” (Smith D.,[2] p 128). That is,
language, which in itself is limited by the possibilities permitted by the human body,
shapes and limits the knowledge that is intersubjectively created within the dyad. As
Smith herself acknowledges,[2] her ideas about language and meaning in particular owe
intellectual debt to the writings of Mikhail Bakhtin, whose work in this area is another
fruitful source of insight into the patient-physician dyad.

Like Smith, Bakhtin endorses corporeal reality, linguistic structure, and intersubjectivity.
In his introduction to Bakhtin’s influential *Speech genres and other late essays*, Michael
Holquist explains that Bakhtin’s work is “everywhere informed by a stern awareness of
necessity’s central place in the biological limits of our perception, the structure of
language, and the laws of society. Our very status as the subjects of our own lives
depends on the necessary presence of other subjects.”[3] This importance of the
intersubjective in the establishment of meaning weaves its way through Bakhtin’s
writings.[4] He focuses on the way it is “reflected in the forms that verbally express our
thought” (Bakhtin MM,[4] p 92), exploring it through a particular division of language,
the utterance, and in its relationship to speech genres. For Bakhtin, the utterance is the
fundamental unit of communication. It is delineated functionally, by the change between
one speaker and another, rather than structurally, as are sentences or phrases. It can be oral or textual, and can comprise anything from a mono-syllabic sound to an entire novel. The utterance must also permit a response. “As we know, the role of the others [emphasis in original] for whom the utterance is constructed is extremely great […]. From the very beginning, the speaker expects a response from them, an active responsive understanding. The entire utterance is constructed, as it were, in anticipation of encountering this response” (Bakhtin MM,[4] p 94). The dialogue, of which the utterance must therefore be a part, may be neither verbal nor immediately apparent; the response may be to carry out a barked order or to use a text to inform one’s own written work. Nonetheless, for an utterance to exist there must be another subject, present or implied.

Utterances are, in turn, created within one of many normative speech genres, which are relatively constant, generic forms of speech that are used in particular contexts. “Both the composition and, particularly, the style of the utterance depend on those to whom the utterance is addressed […]. Each speech genre in each area of speech communication has its own typical conception of the addressee, and this defines it as a genre” (Bakhtin MM,[4] p 95). Note again that, whether she keeps silent or responds verbally or in some other way, the listener (the patient, the physician) is always an active participant in the conversation, a subject rather than an object. The speaker’s utterance, however monologic it may seem, is tailored to her and to her anticipated (non-)response.

The concept of speech genre is in itself interesting to explore in the medical context. Bakhtin suggestively explains that while there are a multitude of general speech genres that are unconsciously assimilated as we learn to speak and as we master language(s), other genres are only used within certain groups of people or fields of activity and so are
unavailable to the uninitiated. In speaking within and to such specialized knowledge communities, “accounting for the addressee (and his apperceptive background) and for the addressee’s influence on the construction of the utterance is very simple: it all comes down to the scope of his specialized knowledge” (Bakhtin MM,[4] p 96). This manipulation of language is played out within the patient-physician encounter, wherein the physician must change her speech genre from the genres which she uses with her colleagues, with the allied health professionals with whom she works, and with her students, to account for the lack of specialized medical knowledge among laypeople. Unfortunately, a physician may perceive himself to have switched to a genre that will be more comprehensible to someone with his patient’s apperceptive background, but his thorough acculturation within the medical world may distort his perception of the average non-physician’s medical knowledge. The resultant use of speech genres which assume an unrealistic degree of biomedical understanding, and which are perceived as being jargon-laden, can lead to frustrated incomprehension for patients and their families.

Putting aside these moments of miscommunication, Bakhtin’s focus on language also allows us to delve further into the way meaning is made between two different subjects. If meaning is dialogic, and is contained in language, then the act of naming (encompassed in Smith’s act of referring) shared among two people allows them to create meaning between them. This requires that attention be paid to the meaning, both denotative and connotative, that each of them ascribe to the name being used. Medicine abounds with examples of careful naming, allowing denotation without connotation. A physician may, for example, tell his patients about ‘growths’, ‘lumps’, ‘masses’, or even ‘tumours’ before they have a definite pathologic cause, despite his own knowledge of the nearly
certain diagnoses. He may reserve the word ‘cancer’, with its connotations of painful treatments and possible death, until the final possible moment. Patients may guess or even know that by growth or mass, their physician means cancer, but until the word is actually used, its connotative meaning may be held at bay. Most of such clinical examples are anecdotal, based on individual physician and patient experience. However, this phenomenon is beginning to be looked at more systematically in the biomedical literature.

For example, in a recent study published in the Journal of the American Board of Family Practice, 459 patients read nearly identical scenarios in which the symptoms of viral bronchitis were described. The scenarios differed only in the diagnosis – the name – attached within them to the ailment being described: ‘viral upper respiratory infection’, ‘chest cold’, or ‘bronchitis’. These are, within a clinical framework, equivalent diagnoses, although ‘chest cold’ is not considered a technical term. Despite equal written (and appropriate) reassurance that an antibiotic would not make the infection get better any faster, 26% of patients whose scenarios had named the disease in question ‘bronchitis’ said they would still have been dissatisfied if they had not been prescribed an antibiotic, while 13% and 17%, respectively, of the ‘chest cold’ and ‘viral upper respiratory infection’ groups said they would have been dissatisfied with that result.[5] Not surprisingly, the authors of this study focus only on its implications for unnecessary antibiotic prescriptions, without presenting a context for theorizing around these results. Nonetheless, this is an intriguing illustration of the importance of naming for the establishment of shared meaning (or lack thereof) in the patient-physician dyad.
The Impact of the Intrasubjective

Up to this point, my theorizing of the patient-physician dyad has operated under the assumption, common to both Smith and Bakhtin, that the intersubjective encounter exemplified by this dyad occurs between two individual unitary (or at least strongly dominant) subjectivities. There is some allowance made for the existence of other subjectivities that are somehow suppressed during a given encounter (particularly in the notion of multiple speech genres for different addressees), but these do not enter into the creation of meaning in the intersubjective space. This is, however, problematic both for the physician and for the patient. It implies that both of their subjectivities are entirely subsumed within their roles in this encounter. There is, of course, a great deal of literature about the professional role of the physician and how professionalization can take over all other aspects of an individual’s life, but this cannot adequately represent a reality in which a physician can also be functioning in his or her own life as a parent, a child, a lover – and in which the physician can be a teacher and/or a student at the very same time as he is interacting with the patient in front of him. Nor does it allow the patient to escape the sick role, to separate any other aspect of her life from her ailing or healing body, while under the medical gaze. It also does not permit the interaction of the patient and physician in any plane other than that of illness, and forces them into a position of constant dichotomy. Such intersubjectivity is therefore not enough.

The writings of Donna Haraway, particularly her astonishing text A Cyborg Manifesto,[6] offer a theoretical solution to the potential trap of dualistic intersubjectivity. Contemplating the struggles of feminism and feminist science, she posits the need for multiple partial perspectives, and uses the metaphor of the part-human part-machine
cyborg as the embodiment of the non-unitary subject. She envisions a world “of permanently partial identities and contradictory standpoints” (Haraway DJ,[6] p 154) and advocates the “partial, contradictory, permanently unclosed constructions of personal and collective selves” (Haraway DJ,[6] p 157). This allows, for example, the re-imagining of the physician role. Haraway’s notion of dispersion (Haraway DJ,[6] p 170), which she applies to the many functions of women in society, can also be fruitfully used to analyse the multiple roles of professionals. At the level of the individual, there is the dispersion of the self among the many partial perspectives and roles of the human (man or women) who is also a professional. Within the professional self there is yet another layer of roles that require each other and yet fragment the unitary body of professional competence, and in Medicine these roles are often formalized for educational and evaluative purposes. [7, 8] Such a multiplicity of roles, of ‘spaces’, can also be applied to the individual who has among his roles that of patient. Thus, in “so far as we know ourselves in both formal discourse […] and in daily practice […], we find ourselves to be cyborgs, hybrids, mosaics, chimeras” (Haraway DJ,[6] p 177).

Such intrasubjectivity need not stand in opposition to the intersubjectivity of Smith and Bakhtin. These approaches can be complementary, allowing new possibilities for theorizing patient-physician relations and giving new meaning to the ongoing discourse (within Medicine and other Health Professions) of patient-centred care. That is to say, there can still be a patient-physician dyad within which meaning is created, but each member of that dyad is, like a cyborg, “a kind of disassembled and reassembled, postmodern collective and personal self” (Haraway DJ,[6] p 163). If the more conventional dyad is envisioned as
then this new conception of the dyad can be represented as

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<tr>
<th>Physician Subject</th>
<th>Patient Subject</th>
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<td>Other Partial Perspectives (Parent, Child, Lover, Body, etc.)</td>
<td>Other Partial Perspectives (Parent, Child, Lover, Body, etc.)</td>
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<td>Physician ↔ Subject ↔ Person</td>
<td>Patient ↔ Subject ↔ Person</td>
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In order to integrate these two theoretical perspectives, then, we must accept that each of these subjects can simultaneously embody all of these multiple roles and partial perspectives while interacting with, and creating meaning with, the other. This allows the subjects to interact while enabling the patient ongoing agency as a human being.

This enabling of partial perspectives also allows a re-imaging of the role of the body in the patient-physician encounter. When the patient is seen as a unitary subject, the body can only be foregrounded in the absence of another aspect of subjectivity. Hence the need, as earlier in this text, to focus on the unresponsive patient, for whom the body becomes the subject. In the presence, however, of the intrasubjective, of the multiple subject, the body can speak without silencing (or requiring the silence of) the rest of the patient. The body can be taken up as both dialogical and material, contributing to the intersubjective creation of knowledge while remaining the unchanged embodiment of pathophysiologic processes. This is a much more accurate reflection of the uses of the body in daily medical practice. On the one hand, the body is the (material) site of contestation between health and sickness, between the alliance of the patient and the physician against the disease process lurking within it. On the other hand, it is a (dialogical) source of meaning, manifesting obvious and more hidden signs of disease.
The body becomes a text, rather than the text, of the patient’s sickness. In this role it is complementary to other aspects of the patient’s being, as the history (told by the patient) and the physical exam (told by the body) jointly narrate the story of disease and illness. Often, the body provides information of which the rest of the patient is not aware, such as through signs only visible to the trained, equipped eye (e.g. spots on the retina, in the back of the eye) or audible to the trained ear (e.g. a murmur caused by a leaky heart valve) which, combined with non-specific historical symptoms (e.g. chills, feverishness, loss of appetite) enable the rapid, and potentially life-saving, establishment of a meaningful diagnostic hypothesis (e.g. endocarditis, an infection of the heart valve).

The dualism of the material/dialogical body can be further disassembled with the foregrounding of the body’s multiple uses outside the medical context. The patient’s pain and other symptoms and the physician’s clues are important, but all of the other uses of that body by the patient – physical labour, marathon-running, sex, cartwheels, childbirth – can be identified and honoured. Other boundaries can be blurred by further dismantling the dichotomies of the patient-physician encounter. A physician body abused only by its time within the medical profession, by lack of sleep, too much caffeine, and excess stress, can morph into a patient body and, often, back into a physician body, marked but finally spared. This merging of bodies, and the shared partial perspectives it implies, is permitted by the cyborg perspective. As Haraway writes: A cyborg body […] does not seek unitary identity and so generate antagonistic dualisms without end (or until the world ends); it takes irony for granted. One is too few, and two is only one possibility” (Haraway DJ,[6] p 180).
Such a multiplicity of partial perspectives also allows the extension of Bakhtin’s notion of speech genres. As discussed earlier, Bakhtin maintains that the “utterance is filled with *dialogic overtones* [emphasis in original]” (Bakhtin MM,[4] p 92). He writes: “Unless one accounts for the speaker’s attitude toward the *other* [emphasis in original] and his utterances (existing or anticipated), one can understand neither the genre nor the style of speech” (Bakhtin MM,[4] p 97-8). By dismantling his notion of the unitary speaker and unitary other(s), we can reconceptualize these speech genres as the mechanisms of interaction between different individuals with multiple subjectivities. Thus the physician and patient might converse in one genre in the clinic and another if they bump into each other in the supermarket, and yet in another again if the patient is also the physician’s child’s kindergarten teacher and they are at parent-teacher interview night. Multiple subjectivities on the part of both the speaker and the hearer give them access to multiple speech genres, one of which must be chosen for use in that moment in that space.

This takes Bakhtin’s notion of polyphony one step further than he himself took it. As explored in David McNally’s *Bodies of Meaning*,[9] Bakhtin specifically uses this term to describe Dostoevsky’s multi-voiced novels. McNally writes that “the voices that enter a polyphonic novel are internally connected. […] Always in the process of responding to others, each unique voice resonates with the utterances and accents of others” (McNally D,[9] p 128), thus creating “a sort of dialogical realism which seeks truthfulness in the concrete and manifold richness of social interaction” (McNally D,[9] p 129). The author appears to be allowing the characters in the novel to speak in utterances, within speech genres appropriate to their nature, rather than seeming to be “orchestrating their utterances toward predetermined ends” (McNally D,[9] p 128).
Nonetheless, despite Bakhtin’s sympathy with the idea of the “open-ended and unfinalizable individual” (McNally D,[9] p 128), the polyphonic novel still maintains the unity of the self, however interdependent and dynamic. Polyphony, therefore, was for Bakhtin a manifestation of the interaction of multiple separate subjectivities. However, in light of Haraway’s insights, a truly polyphonic encounter would include voices creating utterances within multiple competing and complementary speech genres as different partial subjectivities interacted with one another. Thus even the superficially dichotomous patient-physician encounter could truly represent this re-definition of polyphony.

This acknowledgement of the intersubjective and intrasubjective creation of meaning in a polyphonic patient-physician encounter fundamentally changes the nature of such encounters, shifting them from practice to praxis. Returning to the example at the beginning of this article, that of the care of people with diabetes, it presents us with a way forward in conceptualizing the care of the individual patient with diabetes in his individual human context. The body is allowed to speak, as are the subjectivities labelled ‘the patient’ and ‘the physician’, but other roles are also given voices in the dialogic interaction. For example, questions about economic status, employment, housing, education, and social supports are shifted from an ancillary ‘social history’, perhaps relegated to a practice nurse or social worker, and foregrounded as key to understanding the multiple partial perspectives with which the patient will interact with his physician. Addictions, disabilities, and co-morbid physical and psychiatric illnesses also move from a check-list of problems to be addressed at other visits to aspects of a patient’s life that impact on his illness experience. Only by engaging with all of the relevant subjectivities
can the physician authentically co-construct the meaning of the illness with the patient, allowing them together to formulate a plan for his own self-management with her ongoing support. The physician’s own partial perspectives also allow her to imagine the impact of disease and illness on the patient’s other roles, and thus to respond more meaningfully to both voiced and unspoken concerns. Such a polyphonic co-creation of illness, rooted in the patient’s disease and the physician’s biomedical knowledge but extending through multiple perspectives, can thus provide the basis for a truly patient-centred praxis of diabetes care.

Subjectivity, Post-Modernity, and the Humanities - A Way Forward

As this article has shown, the patient-physician relationship, which is and must remain at the heart of clinical medical practice, is fundamentally post-modern. It involves the creation of meaning through the intersubjective encounters of the multiple subjectivities inherent in both the patient and her physician; these subjectivities have access to situated speech genres which guide their utterances as they interact with other(s). The meaning created in their encounters acknowledges a basis in the physical, material reality of pathophysiologic disease processes and in the biological bodies we share as humans, but it allows subjectivities and agency to be honoured. So why is this conceptualization so surprising? Why is such an everyday occurrence, the meeting between the patient and her physician, not commonly theorized in this way?

Unfortunately, only those within the practice, too close to Medicine to be wholly taken in by its legitimating, self-promoting public discourses, are close enough to it to see it like this. As an artefact of our medical education system, the vast majority of these physicians will not have had the training required to approach their experiences using tools derived
from critical or literary theory. After a science-based undergraduate education and science-oriented pre-clinical years in medical school, they can not be expected to have either the language or the ontology to ask questions about individuality, patient and physician subjectivity, and ambiguity when they first encounter these phenomena on the wards or in clinic. The dissonance experienced as the Science of Medicine meets clinical practice soon dissipates, and the ambiguity and intersubjectivity of patient-centred medical care become too commonplace to even be remarked on. Therefore, if we want practitioners to be able to theorize and understand their own practice, transforming the medical patient encounter into praxis, we must give them some of the intellectual tools necessary for this understanding before they begin their clinical years. A wholesale restructuring of medical student ontology and epistemology would be neither achievable nor advisable given the other knowledges these students need to absorb. However, one might be able to introduce the ideas of ambiguous knowledge, of the body as text, and of the patient and physician as subjects into pre-clinical education through careful implementation of, or additions to, a medical humanities curriculum.

One of the classic articles in the field of literature and medicine presents a synopsis of its goals and possibilities in medical education that can inform this discussion. It presents several objectives for the study of literature in particular and of the arts in general. For example, illness narratives are hypothesized to be useful for teaching students about the experiences of their sick patients.[10] By presenting a sick person in a narrative centred on their experiences, as well as (potentially) the same character in other life roles, such stories could be used as a springboard for an exploration both of patient subjectivity and agency as well as of the multiple subjectivities inherent in the life of the patient within
and especially beyond the walls of the hospital or clinic. Similarly, texts about physicians could illustrate their multiple roles as professionals and as people. According to Charon et al, an understanding of narrative is also believed to help trainees develop the skills to create their own understanding of their experiences as nascent physicians. An introduction to literary theory is also advocated as a source of insight and of different perspectives on clinical practice.[10] Other texts published by members of the Literature and Medicine community also highlight the role of the patient body as text.[11] Still others endorse the role of literature in the teaching of ambiguity to medical students.[12, 13]

Literature and medicine curricula and other medical humanities curricula, some of which teach around each of these objectives, are become increasingly common in North American[10, 14] and British[15] medical schools. Perhaps, as they develop and become more sophisticated, they will be able to provide students – future physicians – with tools they will be able to use to analyse their subsequent realities. It might then become possible to engage medical students in a dialogue about intersubjectivity and intrasubjectivity that they could carry forward as physicians into a coherent clinical praxis.

References:


