The Necessary Reconciliation between Evidence Based Medicine and Narrative Medicine

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Abstract

Analyzing a question about medicine (is evidence based medicine the best alternative in dealing with patients?), through an epistemological and hermeneutical approach the paper comes to an ethical answer. Patients are studied by clinicians as objects of a diagnostic investigation, while they are the subjects living their life and enduring illnesses. The paper argues that healthcare professionals (physicians, surgeons, nurses, etc.) should employ a more personalized approach in the way they provide care to patients. Scientific explanations of diseases should be integrated by human comprehension regarding what the disease entails for the patient's life. Rita Charon proposes the narrative method as an efficient and ethic way to provide care to patients, through human virtues such as understanding, empathy and attentive listening. The practice of such virtues encouraged by many pioneers of medicine since Hippocrates, will allow healthcare professionals to be touched and supported in their therapeutic tasks by their patients' desire for good.

Keywords: Medical humanities, Bioethics, Phenomenology, Evidence-based medicine, Narrative medicine, Empathy, Comprehension, Charon

1. Introduction

When investigating medicine's evolutionary path through history, it is clear that the methods of care used by the ancients were simple, but had already great wisdom behind them. Ancients considered the sick person in her psycho-physical integrity. The origin of this mode of treatment can be traced back to the Hippocratic paradigm. Hippocrates, in the fifth century, was able to combine semeiotic analysis of bodily fluids with the dialogic relationship with the patient. The anamnesis was guided by the understanding of the patient's experience: the dialogue was the key to finding – in cases of identical empirical observations – each patient's individual differences. The other crucial moment of the diagnostic process was the reconstruction of the patient's history, which allowed them to correlate individual signs with the classification of pathologies. The peculiarity of the Hippocratic approach was to comprehend the patient in relation to personal and environmental factors, together with the examination of empirical signs. Such a process allowed the subjective plane to cross over to the objective one. For us today, this approach may raise critical epistemological questions, but it was simple for the ancient man to reason in these terms because the consideration of reality in its correspondence with truth, as taught by Aristotelian theory, induced him to consider the object of study as an inseparable unity. The subject's separation or detachment from the object was in fact a cognitive-gnoseological operation of modernity. This is why today we find ourselves recuperating the narrative element of our being, in order to reconcile the threads of objective clinical data and the subjective and environmental pasts that make each clinical case different from the other. Over the centuries, the Hippocratic model has undergone numerous re-formulations. The West was influenced by Christianity's charitable ideals that animated leprosy and monastic infirmaries, in which technical competences were replaced by interpersonal solidarity expressed in the values of welcoming hospitality and care.

Later, the approach to illness became more and more technical and specialized, up to the point in which medicine - with Claude Bernard, in the positivist era - took a rank among the other sciences.

Bernard introduced the experimental method in the medical field. With Bernard, the laboratory became the preferred place for looking for new cures since it was deemed to be the most effective way to get to know the diseases' underlying anatomical structures and biological processes. The physician, then, abandoned the practice of care by the sick's bedside and devoted himself to research instead. For this reason Bernard's *Introduction à l'etude de la médicine experimentale* is the foundation for a scientific approach to medicine. Such an approach to medicine revolutionized medical practice, which consisted of three moments: the anatomical analysis of the human body, dead or alive, the logical-descriptive and statistical analysis of diseases through the compilation of medical records and nosological tables and, finally, physical-chemical analyses, which allowed the correlation of pathologies to drug use. These new clinical practices placed medicine under a new, objective light, allowing diseases' objectification. On the positive side, the field of medical science became more and more prolific and, since the mid-nineteenth century, began witnessing numerous discoveries, from the discovery of the microbes by Pasteur to the X-ray discovery by Röntgen.

The human being, the subject of medical science, began to be considered an agglomeration of single parcels, some of which affected by a pathology and subject to the analysis of ever-specializing medical disciplines. At the end of the nineteenth century, bacteriology, infectivology, parasitology, hygiene, serology and immunology were born. Even in the twentieth century, the blossoming of medical science was characterized by the succession of many advancements, including the invention of antibiotics, DNA discovery, the possibility of organ transplants, the use of CAT scans, magnetic resonance imaging, bio molecular engineering. Medical science could not, however, reduce the person to a mere organic machine. In the twentieth century, the tendency towards hyper analysis reached its climax. Augusto Murri, representing the mindset and methods from the positivist era, as well as Karl Jaspers later, was aware of the risk inherent to the fragmentation of the patient as clinical subject. Murri, seeing the answer to the needs of the ill as a true calling was able to combine an Aristotelian analytical approach to illness with the moral virtues of wisdom and prudence. The astounding development of scientific laboratory research in that period bore the risk of neglecting the other ethical as well as epistemological important foundation of the medical profession: that what is expected of the physician is to cure not merely individual pathologies, but rather to care for persons in their singularity.

As Jaspers would have later realized, Murri saw the inherent risk of specialization that doctors of his time ran: they were becoming increasingly focused specialists, yet unable to see the patient as a whole, focusing their attention solely on the pathological aspects of illnesses. Oftentimes therapeutic decisions were made away from the patient's bed, while Murri reiterated the need to look at the patient as a single concrete case. For Murri, the clinic, that is, the sick's bedside was a place of scientific research as much as the lab was. In the face of an unclear clinical picture, Murri believed that the doctor should use his scientific skills bearing in mind the value of the sick person in front of him, whose life could never be sacrificed to the search of alleged causes or logical connections. Murri condemned the uncritical use of logic, and in this we can trace the Aristotelian background of his thought, both from a gnoseological point of view, for his invitation to rigor, as well as from an ethical point of view, for encouraging an education of doctors to moral virtues. Murri, though well in the positivist era, had noticed the danger that medicine would have faced in further analyses increasingly pressing towards a separation: in fact, the specialties are now - just provisionally - one hundred and fifty. Nowadays, unfortunately, the increasing analytical capacity has not been matched by a deeper consideration of the synthetic-humanistic skills of medical science, which are instead left to the good sense and personal qualities of the physician. Care as techne should be understood as confined to the role of the way, while its end should be the human being.

As Jaspers taught us, the technicalization of science, which progress has brought along, is revealing itself to be a double-edged weapon. Jaspers, first psychiatrist and then philosopher, knew these risks well and knew that science would have needed support and guidance. He believed that science could not and should not only target particulars. Science had to refer to the unity of the Being and, if it had not maintained that tension, would have lost its value. Jaspers, in *The Spiritual Condition of the Age*, reflected upon functionality as the criteria guiding technical evolution.

The human being would have had to become aware and responsible, both at the ethical as well as the gnoseological level, that is to say, aware of the possibilities and the limits that scientific discoveries and technological innovations brought with them.

Often it happens that there are innumerable tools available, but doctors are helpless in finding the best therapeutic approach suitable for the single patient, suffering from various pathologies interacting with each other. Such post-positivist reductionist mode was described by Jaspers as an arrogant attitude bringing us to believing to be the ultimate rulers of the world.

In contrast to the increasing specialization of technique, Jaspers emphasized the need for a return to the understanding of man and reality in all its complexity and multidimensionality. In the medical profession, the clinical view on the illness of the person should always be accompanied by a human gaze towards the sick person, who is first and foremost a person, a singularity, just as much as the doctor responsible for his care. Jaspers, in *General Psychopathology*, studied the methodologies of treatment of psychic phenomena. The first factor to take into account was the irreducibility of the individual to his psychological characteristics. The need for orientation towards methodological pluralism was born in the very recognition of this limit of psychopathology. Jaspers, in the scientific investigation of psychic phenomena, noted that it was not possible to remain confined into the mere explanation of causal relations. Surely, it is possible to identify causal relations in psychic phenomena, but because of the singularity of each person, such relations never assume the characteristics of laws, as it might happen in the study of other phenomena subject to natural sciences, such as physics and chemistry.

In psychopathology, it is necessary to grasp, that is, to understand the relational meaning of psychic experience. These types of connections are investigated through an objective criterion, as the data available is objective. Nonetheless, the method of understanding could collide with the limit of what goes beyond the objective data of the psychic phenomenon: what is called the *psychic substratum*, that part of our unconscious that cannot be observed or studied. Jaspers thus undertook the task of reiterating the need for the various methods of psychopathology to interact, in order to bring the understanding always directed to the whole, that is, to the human being in its inexhaustible totality. The important legacy of technical evolution is that young doctors approach patients with more and more specialized knowledge - this can be viewed as the positive factor of medical progress. However, such progress does not eliminate the need for humanity in the medical-patient relationship. The condition necessary for care perhaps has been overlooked for too long: a fully human ethic so that the physician can empathize, be patient, and listen to the patient. In *Ethics and infinity*, Levinas writes: “The tie with the other is knotted only as responsibility, this moreover, whether accepted or refused, whether knowing or not knowing how to assume it, whether able or unable to do something concrete for the Other. To say: here I am [me voici]. To do something for the other. To give. To be a human spirit, that’s it”[1].

Today's doctors should be able to know how to reconcile their technical and scientific expertise with the understanding of the human beings they are caring for, preventing an interference of machines in their relationship. Objective data emerging from machines should not remain figures or abstract indicators, but means of interpretation of the underlying human reality. Doctors should learn anew how to stand by the patient's bed, to meet her, to empathically understand his overall condition, preventing technology, a positive and fertile aspect of scientific research, from sterilizing the clinical relationship. The *object* of medical practice is the human being. But a man who falls ill is not a mere object to investigate with technical means in order to address its pathology. The human being is a person first, the *subject* of his own life. The patient should be considered as a psychophysical unit, as a human totality that completes that of the physician. Edith Stein, in *On the problem of empathy* (1929), addressed this exact kind of *unity*. This issue has also become the subject of scientific debate: there are neuroscientists who have tried to demonstrate the biological integrity of the emotional, cognitive, and psychological mechanisms of our being. Rita Charon, reflecting on her own experience of physician, noticed the importance of considering the patient in his psychophysical globality, and for this reason she deemed appropriate including the narrative element in medical practice so that it could be accompanied by human qualities such as empathy and understanding. Edith Stein begins her reflection by affirming the experiential continuity between what is given to us through our physical body and what forms and informs our consciences. The unity of body and soul can be inferred from the unity that is attributed to our empathic experience of the other. Our pure “I” cannot ignore the stream of consciousness. What constitutes in unity the pasts and the streams of consciousness of our pure “I” is the soul.

[1]Levinas, E., (1985) Ethics and Infinity, Conversations with P. Nemo, Pittsburgh: Duquesne University Press.

"This substantial unity is "my" soul when the experiences in which it is apparent are "my" experiences or acts in which my pure "I" lives"[2]. And the soul is "always necessarily a soul in a body"[3]. What guarantees such unity between body and soul is the sensations which pertain to both the body, as they are spatially localized in the five senses, and to the soul as elements contained in consciousness.

"As the substantial unity announced in single psychic experiences, the soul is based on the living body […] and […] forms the "psycho-physical" individual."[4]. The unity of soul and body is therefore demonstrated by Edith Stein on the basis of the fact that we experience certain data simultaneously in the soul and in the body and by the fact that there are causal relations between physical and mental processes. The common denominator of soul and body, where they constitute a unity, is the spirit, which is the consciousness as it is a "correlate of the object world"[5]. This reflection is very important for the analysis of relationships within a person's care of another: the knowledge of the person other than me is essential to a self-knowledge aiming to be, Stein writes, *self-awareness* and *self-assessment*. In this sense Charon consideration assimilates doctor and patient on the basis of human essence. Both are finite and relational beings, and based on these qualities, the physician can empathically approach his / her patient, making the relationship more fruitful both from a human as well as a functional point of view. Analyzing empathy one can deduce that we can know the other through us, through the knowledge of ourselves and, conversely, know ourselves through the knowledge of the other. The physician cannot and should not reduce his wisdom and action solely to a technique which is objectifying, ignoring the subjective and inter subjective aspects of the relationship with her patient. As far as medicine is concerned, it should be considered that - unlike other sciences - there is never a pathogenic phenomenon ever equal to itself. Bernard knew very well that in medicine there are wide uncertainty intervals in medicine. Today's medicine begins to perceive the operational inefficiency of the reductionist approach that utilizes technical-scientific development to the maximum of its potential but does not take into account all the factors of the patient involved in the therapeutic dynamics. This is why, in recent decades, the need for a medical approach to the person as a whole has begun to surface (physical, psychic, emotional, family, social, etc.).The doctor is expected to come into the care process with all of his heart to learn and understand the patient, unique and unrepeatable subject, in his physical and mental complexity. There are two epistemological models of the medical science that have followed one another over time. The classic tradition is that of an *inductive* approach, while the second position adopts the *deductive* method. As for the inductive paradigm, the position supported by positivist physicians such as Maurizio Bufalini, common practice initiated with the neutral observation of phenomena, followed the formulation of the hypotheses and, finally, by the deduction of the consequences from the confirmed observations. Instead, with regard to the deductive paradigm, the process is reversed.

Claude Bernard, first exponent of this current, argued that the general assumptions at the beginning were always uncertain and correctable. The benchmark of such hypotheses produced deductively had to be the laboratory that replaced both the classroom and the clinic. However, just as Bernard recognized the uncertainty factor in medicine, he acknowledged the need to re-humanize medicine, even though he was convinced that progress would have eventually erased the category of uncertainty from medical science. Both of these two currents of epistemological thought have shown partial approaches to medicine. Indeed, modern epistemology has sought to include in a categorical and a logical-mathematical paradigm the ill human being, which, precisely because of its subjective nature, cannot be enclosed in reductionism schemes. The mistake of modern epistemology in the medical field, therefore, consisted in considering the patient as a mere object outside the physician, her observer. In the 1900s, the discoveries of relativity and the principle of indetermination dismantled the linear causal logic and the *reductionist* epistemology associated with it, as they revealed that the category of reality appertain to what was not perfectly quantizable. In the various fields of science, reality understood as *complexity*, singularity and disorder was given ontological dignity. Medicine has suffered too, albeit with a slight delay, the effects of this event. However, the medical paradigm that has been adopted with greater functionality to the therapeutic goal has been - and, to date, is - for a long time the one based on populations' sample statistical evidences. Thus, the effectiveness of a treatment is verified through scientific and statistical demonstrations, not through the experience of the individual patient. This methodological paradigm of medicine produces a dual effect.

[2] Stein, E., (1964) On the problem of empathy, Dordrecht: Springer Science+Business Media. p. 38.
[3] Stein, E., (1964) On the problem of empathy, Dordrecht: Springer Science+Business Media. p. 38.
[4] Stein, E., (1964) On the problem of empathy, Dordrecht: Springer Science+Business Media. p. 46. .
[5] Stein, E., (1964) On the problem of empathy, Dordrecht: Springer Science+Business Media. p. 83.

On the one hand, studying the pathogenic phenomenon, observing it and measuring it in detail, has sometimes brought any possible genetic causes to the attention of researchers. On the other hand, however, it has given way to processes of depersonalization of the patient and to an anonymous therapeutic relationship, with the result that it is customary to study diseases rather than patients.

2. EBM

Despite advances in medicine, it is often difficult to identify the root cause of a pathology as well as the proper cure to deal with it. Fortunately, science and technology allow us to undergo more and more precise investigations. The means, chemical or physical, used to cure diseases are more and more accurate and advanced. In the therapeutic field pharmacology, microbiology, surgery, endoscopy, etc. continue to make enormous leaps forward. Even in imaging the accuracy of the equipment used to make the necessary quantitative and qualitative surveys is more and more refined. The core activity of the clinic is therefore the achievement of a good diagnosis, which opens the door to the appropriate therapeutic path. The anamnesis process is defined as *hypothetical* and *deductive* because on the basis of the first summative observations of certain signs of the patient, the physician - based on her cognitive and experiential knowledge - already knows how to address the questions to the patient in the anamnesis phase as she already has a hypothesis regarding the nosology of the symptoms. The patient then undergoes *objective* examinations. A doctor's expertise is verified in two moments. First, to know the possible links between the patient's symptoms, which constitute the subjective elements of the disease, with obvious, objective, and measurable signs, by putting them in relation to a given nosography. Second, the physician should be able to *deduce* other symptoms and other signs, which should then be verified with further diagnostic tests. Even in choosing the objective examinations to administer to the patient, the physician must be able to discern the ones most appropriate to the patient's situation (i.e. age, sex, weight, and/or type of work). The physician directs her scientific judgment on the basis of the experimental studies carried out on the populations which are then elaborated through statistical tools, and from them guidelines and international protocols are derived.

The scientific heritage at disposal of the physician always communicates with the evidence found in the patient following the examinations conducted through biomedical technologies. The physician approaches his subject, i.e. his own patient, with quantitative surveys based on scientific evidence, which, however, often do not take into account the humanist ethos, identifying the true good for the patient's health. The biggest problem that has arisen is the distance between the treating subject and the patient subject. This distance has been created because of conditions that have negatively influenced the creation of ethical and efficient therapeutic relationships. The market logics affect the time of medical work, everything becomes faster. The lack of time is one of the problems that most affect the medical profession. It is true that there is not much time left to devote to listening, but perhaps that little time could be optimized. The corporatization of healthcare facilities has affected the medical profession by anonymizing and bureaucratizing therapeutic relationships, increasingly lacking in empathy and understanding. There is a risk of a technical interpretation of the therapeutic function of health professions. In this sense, the physician risks hurting her patient, or not even advising her at all, offering therapy based solely on a predefined protocol without taking into account the singular aspects of the individual patient. Considering that each of us is a unique psycho-physical unity, a medicine that only adheres to general reasoning and predefined protocols without considering the specificity of each one gravely lacks in attention to the person. It is on the basis of our singularity and uniqueness that we can think of effective therapeutic pathways. Mortari writes: “respect is primarily an intellectual operation, consisting in not locking the other’s singularity within a general framework of concepts and ideas in which the other’s uniqueness becomes invisible”[6].

In certain situations, for example, for patients with particular genotype - that is, a certain genetic kit - and a particular phenotype (i.e., all the morphological and biochemical aspects of an organism resulting from its development, resulting from the interaction between the genotype and the environment), conservative therapy may be deemed preferable to an interventionist approach or vice versa. This is because the infinite possible interactions between genotype and phenotype make us, in physiological terms, unique and unrepeatable. Only a physician who knows how to relate to her patient through a holistic approach is able to evaluate the most appropriate therapy, based on the single case, which also includes the context in which the patient lives, the work he is doing and all the variables that affect his life.

[6] Mortari, L., (2015) Filosofia della cura, Milano: Raffaelo Cortina Editore. p. 162.

The technical-scientific medical approach, without human comprehension, is a legacy of the positivistic paradigm which deemed the full knowledge of an object as a reality separate from its observer as possible. However, in medicine, the problem of the discrepancy of clinical conclusions has an incidence in 50% of cases. This means that, faced with the same pathology, two physicians will agree on the diagnosis only in one in two cases.

Throughout history, medicine evolved from the attention to a single patient to a *standardized* care. That is why defining some semantic concepts of medical practice becomes necessary. Firstly, one asks what can be *considered evident*. *Evidence-Based Medicine* has had to define its range of action on the basis of guiding principles that integrate clinical practice. Doctors use bibliographic research to relate evidence with the clinical picture, taking into account the protocols provided by major international organizations. The introduction of such quantitative paradigms in the work of the physician has begun to bring out many uncertainties. We wonder what can be considered as evidence, how we should define it, and who should set the parameters for such evaluations. These issues relate to the conciliation between the singularity of the patient and the protocols defined on the basis of the class of events. Thus, there are oscillations between overly scientific and extremely subjectivist notions leading to two equal and opposite risks: on the one hand, generalization, on the other, subjectivism. This is why it is important to redefine medical practice through an approach that is complementary to the objective criteria of clinical protocols, through the empathic understanding of patients past, which can bridge the gap between objective practice and subjective practice, quantitative methods and qualitative methods. Therefore, the EBM's interpretative modalities are not sufficient to evaluate the probability that a patient may be subject to a particular pathology and the habit of bringing it back to a particular therapeutic protocol. It is essential to associate to the patient's symptoms the historical elements, that is, family, cultural and social specificities. As Charon writes, in the face of the wealth of technological advancement, a degree of indifference has been added to the medical profession harmful to relationships of care. EBM is not an exhaustive tool for medical practice as the disease does not coincide totally with the scientifically classified data in the nosographic framework. To fully understand pain, conceptualization is insufficient if disregarding the emotional dimension, as physical illnesses also have emotional, psychological and social implications. The gap between the clinical case and the individual patient can be bridged by a therapeutic relationship experienced in his human fullness.

We humans express, as Ricoeur wrote, through storytelling. According to Rita Charon, it is precisely the narration the bridge, the magnet capable of "attracting and uniting diverse fields of human learning "[7]. *Evidence based medicine* should be integrated by *narrative medicine*. Physicians should be educated to consider the patient in the totality of his being, not reducing her to mere quantifiable and manageable entities by means of predefined protocols. It is possible, and more and more established today, that the value of evidence based medicine, in many specialties, even surgical ones, can be further enriched by *narrative medicine*, not only to deal better with the effects of the disease but also to define more correctly the therapy to offer to the patient, based on her own living conditions. EBM is a fundamental tool for dealing with what can be done scientifically, but the relational aspect of the sick person also requires other approaches. Narration is an important tool available to the treating physician to supplement scientific evidence with the clinical experience and the evaluation of the individual patient, respecting the uniqueness of her value system and the particular situation in which her disease begins. "From patients' pathographies and caregivers' stories from practice to ethicists' written cases, what unified this early efforts was the recognition of the centrality of narrative in the work of health care. Although illness is indeed a biological and material phenomenon, the human response to it is, indeed, neither biologically determined nor arithmetical"[8].

Rita Charon realized that the value of diagnosis and therapy formulated from the interaction between the qualitative and quantitative aspects of the disease, while neither mechanistic nor deterministic approaches have proven to be fully explanatory of the meaning of the relationship between health and illness. The narrative medicine program developed by Rita Charon was born out of the awareness that physicians, thinking that diagnostic technologies could be enough, forgot the meaning of attentive listening to their patients, believing that their words and stories were not essential in the diagnostic and therapeutic process.

[7] Charon, R., (2006). Narrative medicine. Honoring stories of illness. New York: Oxford university press. p. 11

[8] Charon, R. and Montello, M., (2002). Stories matters: the role of narrative in medical ethics. New York: Routledge New York London. p. 9

Illness is, as Jaspers would say, one of those life-limiting conditions that highlight the need for sense-seeking for what happens in one's own life. Building a good history record of illness helps the patient in terms of greater acceptance of their condition, and therefore also in living in a more constructive and collaborative way their own disease and the therapy offered by the doctor. In addition, it helps the physician to improve her understanding in the diagnostic phase and to research the most suitable path for that unique patient.

In the field of medical science, it is crucial to point out that a method based exclusively on *explanation* cannot be adopted, as in any other science having as an object of research quantizable entities. The method of medical science requires a cognitive mode that renders itself available to *understanding* the ill person in its psycho-physical totality, that is, also in its latent and mysterious component - to say with Kant, noumenal, and therefore in its entirety. Ricoeur's phenomenology can provide a useful contribution to science in this regard. As he writes in *Oneself as Another*, the identity of the person is a narrative identity: the person is a subject of a tale that is constantly being told. Our person builds up as a story, based on a weaved plot. The human being needs to talk about themselves to give a unitary dimension to their life, to find the conjunction rings between the light zones and the shadow areas of life. In this sense, the narrative dimension is for Ricoeur preparatory to ethics, and that is why he refers to the pragmatic dimension of the text. It is in the narration that we understand the meaning of our life experiences. The tale's fabric is woven of several possible combinations, and it has the function of organizing and unifying the contradictory aspects of existence. The narration is a plot of several possible combinations, and it has the function of organizing and unifying the contradictory aspects of existence. Ricoeur's theory of interpretation invites us not to censor neither the moment of explanation nor the one of comprehension, which are two complementary moments of our knowledge and our being in the world. Explaining and understanding thus forms a fruitful plot, in which the first moment is inclusive of the second, and vice versa. A gnoseological attitude can prove to be very fruitful in the medical profession: the patient is for the doctor as a text full of interweaves to be understood. Ricoeur writes that the human being is a "type that is neither repeatable nor divisible without alterations"[9]. Understanding is a necessary approach to studying the sick person in her entirety since the human being has the traits of unrepeatable uniqueness. It is precisely for this reason that Ricoeur defines the identity of the person as a narrative identity as telling a story is the act that allows us to discover something more on the mystery that we are: "the self seeks its identity on the scale of an entire life"[10], and this may be very important in the study of a particularly complicated clinical case. This is why it would be important to grant greater dignity to the anamnesis phase, to consider thoroughly, that is, to understand the story of the patient's disease.

The interactions between a physician and a sick person concern both information on the disease in the biological sense, that is, on the objective condition of the disease, as well as include interactions on the past and significance of the *illness*, i.e. any subjective perception of pain and suffering irrespective of the presence of obvious organic alterations. There is then another dimension of suffering: sickness is, in fact, the social representations of the illness. Narration is in this sense the most appropriate method for knowing the self and its reality. Narration is an intrinsically reflective act, and it is through reflection that we are able to understand how we are building the knowledge of an event that is happening to us, focusing it in its entirety, including its foresight and the way in which it affects us. As Gadamer has taught us, it is not possible to pursue a pure, objective and exhaustive knowledge of a phenomenon. Every interpreter, in this case the doctor with his scientific knowledge, does not address a patient in the way of a *tabula rasa*, but with their *foresight* and with their past care experience with other patients. "Interpretation begins with fore-conceptions that are replaced by more suitable ones"[11]. It is on the basis of such foresight that the physician sketches a preliminary diagnostic significance of the pathology that the patient presents. "A person who is trying to understand a text is always projecting. He projects a meaning for the text as a whole as soon as some initial meaning emerges in the text"[12]. But as Gadamer explains about the interpretation of a text, it is inevitable that on the basis of the *clash of experience*, that is, the mysterious and unpredictable events that can be manifested in the human being, in a physiological and existential way, we face the need for a "*constant process of new projection*"[13].

[9] Ricoeur, P., (1992). Oneself as Another. Chicago: University of Chicago Press. p. 28.
[10] Ricoeur, P., (1992). Oneself as Another. Chicago: University of Chicago Press. p. 114.
[11] Gadamer, H. G., (2004). Truth and Method. New York: Continuum Publishing Group. p. 269.
[12] Gadamer, H. G., (2004). Truth and Method. New York: Continuum Publishing Group. p. 269.
[13] Gadamer, H. G., (2004). Truth and Method. New York: Continuum Publishing Group. p. 269.

In the interpretative process, "every revision of the fore-projection is capable of projecting before itself a new projection of meaning"[14]. Gadamer exhorts us to maintain a constant openness to experience, precisely because of our awareness of our limit, of our ontological and gnoseological finitude. “A person who is trying to understand is exposed to distraction from foremeanings that are not borne out of the thing themselves”[15].

The physician, a finite human being as well as a scientist, will never be able to be completely exhaustive in his knowledge of the patient, since the sick human being with whom he is in relation is at the same time a finite and infinite being. Gadamer often reminds us that we must be "aware of our finitude and limitedness”[16]. For this reason, as far as the narrative method used in medicine is concerned, it is useful to refer to the *primacy of wonder*. “It is clear that the structure of the question is implicit in all experience. We cannot have experiences without asking questions”[17]. For Gadamer, the cognitive process develops in the form of the *hermeneutical circle* as it is realized in the constant dialectics between the interpreters, since it is constitutive of the human being to express herself *linguistically*. In the hermeneutical circle, the interpreter must remain in an open state: "this openness always includes our situating the other meaning in relation to the whole of our own meanings or ourselves in relation to it.”[18]. Such openness should be adopted in medical practice as human reason lacks the ability to find definitive solutions, and even more so in the awareness of the frailty and infiniteness characterizing each ill person. Thus writes Mortari, "to be the right fit in difficult questions means keeping them open, avoid persisting in looking for definitive solutions that do not belong to the power of human reason.”[19]For these reasons, it is important that the physician learns to collaborate with her patient the and the patient’s disease history. "In the process of understanding a real fusing of horizons occurs.”[20]

3. NBM

As Charon explains, narrative medicine is a medical practice that uses the narrative skills of *absorbing*, *interpreting* and *responding* to disease stories, leaving the possibility of direct *involvement* by the physician open to the patient expressions. This is a *bidirectional* and *circular* process in which the patient's and the attendant's pasts interact with each other, enriching themselves in order to build a good history of illness. We talk about *building* a history of illness, as if it were a never-ending search, because the patient is not finite, and totally measurable: the hypotheses about the patient's illness are not totally objective. The doctor and patient must co-build hypotheses together, building the best history of illness: the truth about the disease is never fully uncovered and can always be deepened. Such approaches bring, as Charon writes, to a more *humane*, more *ethical* and, nevertheless, more *effective* contribution to medical work and, in general, to the work of nurses and all health-care providers. On a theoretical level, the human relationship is anything but contrary to the efficiency criteria. The most pressing need that Rita Charon reports is the urgency of *personalizing* patient care[21]. Charon is convinced of the highly enriching value of the narrative method, both from an ethical-existential and medical-scientific point of view. “A scientifically competent medicine alone cannot help a patient grapple with the loss of health and find meaning in illness and dying. Along with their growing scientific expertise, doctors need the expertise to listen to their patients, to understand as best they can the ordeals of illness, to honor the meanings of their patients’ narratives of illness”[22].

In the face of an ever more specialized technique, the authentic meaning of care has gradually been lost, abandoning patients in the lack of sense of disease and death. And it is in the context that Charon uses the verb to honor, referring to the act of accompanying the life of the sick. To bring the attention of medical science to its human nuance, becomes necessary not only for the elaboration of a more complete diagnosis. By virtue of a fully human understanding of the patient, it will be possible to proceed with greater ethical rectitude, hence with greater effectiveness from the operational point of view, even in terms of the usefulness of the cure.

[14] Gadamer, H. G., (2004). Truth and Method. New York: Continuum Publishing Group. p. 269.
[15] Gadamer, H. G., (2004). Truth and Method. New York: Continuum Publishing Group. p. 269.
[16] Gadamer, H. G., (2004). Truth and Method. New York: Continuum Publishing Group. p. 356.
[17] Gadamer, H. G., (2004). Truth and Method. New York: Continuum Publishing Group. p. 356.
[18] Gadamer, H. G., (2004). Truth and Method. New York: Continuum Publishing Group. p. 271.
[19] Mortari, L.,(2015) Filosofia della cura, Milano: Raffaelo Cortina Editore. p. 105.
[20] Gadamer, H. G., (2004). Truth and Method. New York: Continuum Publishing Group. p. 306.
[21] Charon, R., (2006). Narrative medicine. Honoring stories of illness. New York: Oxford university press. p. VII.
[22] Charon, R., (2006). Narrative medicine. Honoring stories of illness. New York: Oxford university press. p. 3.

The doctor's narrative understanding of the patient is made up of attention to words, gestures, silences, as well as analysis, laboratory reports, and physiological changes. There is an aseptic way to carry out the medical profession, however just the narrative medicine can "answer many of the urgent charges against medical practice and training - its impersonality, its fragmentation, its coldness, its self-interestedness, its lack of social conscience,"[23] recovering the value for the *particular*, and learning to understand "the meaning of individuals' words.

Silences, and behaviors"[24]. Only narrative attention, focused on content not strictly evident, may be able to understand the importance of "connections among body, mind and self"[25], so that the treatment of the disease can proceed as completely as possible, with due care to the triadic unit of the patient. In our deeper being, our *mind* and *soul* live inseparably. What often we tend to ignore is that the *body* plays a fundamental role in building our person. As we recall, Stein wrote: "This substantial unity is "my" soul when the experiences in which it is apparent are "my" experiences or acts in which my pure "I" lives"[26]; And regarding the body: "the soul is always necessarily a soul in a body"[27]. The physician, having to deal with the patient's body, also has to do with their mind and spirit at the same time, so it is important to set the healthcare going in the direction of an attention to the patient in the globality of their history of life and illness. "The body is the passport, the warrant, the seal of one's identity"[28].

The body is just one side of our person, behind whose signs are the unexplored vastness of our mind and soul. A certain wasting of our body is a physiological process, natural and human: we are subject to time, and as such, the physician is certainly not expected to cure them with elixirs of eternal life. Death is part of our humanity. It is also true that some pathogenic conditions can accompany us from conception. However, it cannot be said that all the pathologies that may arise between the time of birth and that of death are totally random and independent of our choices of life and the context in which we live. The genotype, unique and unrepeatable, always corresponds to a phenotype, equally unique. The physician must be able to express himself in a non-technical manner. He must be able to dedicate an attention to the patient allowing her to perceive what resonates in her inner reality during the communication of the diagnosis, and at the same time being able to interpret the emotions triggered in them. "These practices share a theoretical orientation that values narrating as an avenue toward consciousness, engagement, responsability, and ethicality"[29]. The goal of narrative medicine, says Charon, is to extend *empathy* and *effective care* through *community* building among doctors and patients[30]. These are two actions that a careful physician performs simulatenously: on the one hand, using own scientific knowledge and cognitive skills to interpret data for the formulation of hypotheses and diagnosis - an active moment triggered by his judgment. But in this action, there is also a second moment characterized by a passive and receptive posture, which consists of absorbing all that the patient exposes, both in objective and subjective terms, suspending every judgment and foregoing any preceding notion.

The doctor, therefore, can take care of the patient in a passive way. Rita Charon writes that the physician at this stage behaves like a ventriloquy that is pervaded by all the patient's emanations[31], both subjective and interior, as well as from objective observations. Charon compares the physician to an amphora, who has to listen to and welcome the patient, accepting them "being accepted as a *mystery*, a *singularity*, a self"[32], and not just as an object. This way of looking at the patient promotes the ability and ethic to have a deeper and more up-to-date knowledge of a person. Such an inner posture by the physician can only be acquired if she has to empty her own self, accepting the patient's perspective, understanding the patient's needs and deeper desires. When a doctor welcomes this attitude of attention and listening it means that she is available, as Levinas would say, to the patient's call.

[23] Charon, R., (2006). Narrative medicine. Honoring stories of illness. New York: Oxford university press. p. 10.
[24] Charon, R., (2006). Narrative medicine. Honoring stories of illness. New York: Oxford university press. p. 10.
[25] Charon, R., (2006). Narrative medicine. Honoring stories of illness. New York: Oxford university press. p. 67.
[26] Stein, E., (1964) On the problem of empathy, Dordrecht: Springer Science+Business Media. p. 38.
[27] Stein, E., (1964) On the problem of empathy, Dordrecht: Springer Science+Business Media. p. 38.
[28] Charon, R., (2006). Narrative medicine. Honoring stories of illness. New York: Oxford university press. p. 87.
[29] Charon, R., (2006). Narrative medicine. Honoring stories of illness. New York: Oxford university press. p. 131.
[30] Charon, R., (2006). Narrative medicine. Honoring stories of illness. New York: Oxford university press. p. 131.
[31] Charon, R., (2006). Narrative medicine. Honoring stories of illness. New York: Oxford university press. p. 132.
[32] Charon, R., (2006). Narrative medicine. Honoring stories of illness. New York: Oxford university press. p. 134.

Charon writes: "we are *summoned* by our patients' suffering, their needs, their plight, their authentic selves"[33]. Charon speaks of the physician's ability to represent the condition of the patient. This attitude recalls Edith Stein's concept of empathy. Empathy is that cognitive and emotional ability that allows us to resonate within us the experience of others. The etymology of this word is, in fact, indicative: *en* (inside) and *pathos* (feeling / suffering). Thus writes Mortari: "To act with care is essential, the ability to feel the other, and to feel the other's feeling, which is empathy, that is, the ability to grasp the experience of a stranger"[34]. In this sense, Mortari also refers to the concept of Stein's empathy.

"A single action and also a single bodily expression,such as a look or a laugh, can give me a glimpse into the kernel of the person"[35]. The human being is relational and such empathic representation ability is one of the qualities that can and must be developed for a full blossoming of our human essence. In this sense, empathy is a true ethical virtue, Charon indicates, whose *habitus* a physician can not do without in his profession. Mortari defines empathy as "letting your own being vibrate from feeling the quality of the other's life"[36]. This ability is essential for those who bend to the bed of a suffering person or for those who have to listen to a history of illness and know how to interpret it to find the right therapy. For Mortari it is an act of proximity to the other, which reduces the formal distance but is never intrusive and where a small distance remains: "It is a delicate but vibrant way to meet the other"[37]. Stein describes in this way empathy:

"While I am living into the other's joy, I do not feel primordial joy. It does not feel primordial joy. It does not issue live from my I. Neither does it have the characther of once having lived like remembered joy. But still much less is it merely fantasized without actual life. This other subject is primordial although I do not experience it as primordial. In my non-primordial experience I feel, as it were, led by a primordial one not experienced by me but still there, manifesting itself in my non-primordial experience."[38] Empathy allows us, therefore, to transpose, hear, represent, acquire, albeit non-originally, the experience that the other person lives in an original way. As Mortari writes, empathy never creates an ontological fusion[39], but rather allows one to approach the other and to stay with him, while remaining another. Empathic experience for Mortari is a "thinking that lets you touch the other's being."[40] Allowing oneself to be touched by the other's being and sensitivities is a basic disposition which completes other habits, such as understanding and attention. Physicians who bear towards their patients make a better use their cognitive and scientific ability during the investigation and in the rational explanation of pathogenic phenomena. Mortari believes that what generates empathy consists precisely in the "disposition of the mind to concentrate intensively on the other to seek an understanding that goes to the heart of his experiences."[41] Narrative medicine can enrich the clinical practice commanding doctors to empathy and understanding, even though it seems to run the risk of abandoning the scientific dimension of care. In actuality, it is about seeking a balance between the humanization of the therapeutic relationship and medicine based on scientific evidence.

4. Conclusions

This study was originated in a problem that today concerns medical practice. Following the evolution of scientific paradigms, even for medicine, there was a need to raise it to the rank of science. To date, a biomedical model based on evidence is in effect. The outcome of this process is twofold: on the one hand, there have been many scientific and technical discoveries that have implemented the efficiency of medical practice; on the other hand, however, a process of distancing between the figure of doctors and nurses and the figure of the sick person has been caused by this development. We embarked on the problem of suffering and death according to a criterion almost exclusively based on operational effectiveness and, in a sense, on utility.

[33] Charon, R., (2006). Narrative medicine. Honoring stories of illness. New York: Oxford university press. p. 135.
[34] Mortari, L., (2015) Filosofia della cura, Milano: Raffaelo Cortina Editore. p. 195.
[35] Stein, E., (1964) On the problem of empathy, Dordrecht: Springer Science+Business Media. p. 99.
[36] Mortari, L., (2015) Filosofia della cura, Milano: Raffaelo Cortina Editore. p. 195.
[37] Mortari, L., (2015) Filosofia della cura, Milano: Raffaelo Cortina Editore. p. 196.
[38] Stein, E., (1964) On the problem of empathy, Dordrecht: Springer Science+Business Media. p. 11.
[39] Mortari, L., (2015) Filosofia della cura, Milano: Raffaelo Cortina Editore. p. 196.
[40] Mortari, L., (2015) Filosofia della cura, Milano: Raffaelo Cortina Editore. p. 197.
[41] Mortari, L., (2015) Filosofia della cura, Milano: Raffaelo Cortina Editore. p. 198.

But such an approach had an unrepeatable human cost; this has brought by this reflection that has its beginning in the epistemological premise that the object of medical science is a person, and therefore a subject first. And, from a question that was on the epistemic level (*Is an evidence-based medicine the best alternative in dealing with patients?*), we have come to an ethical reflection that has moved to the question of what is the root of care and what is lacking in the current approach of *evidence-based medicine*. The passion for the others' good is what should always guide actions, especially clinical ones. To summarize - with respect to the starting question - *evidence-based medicine* is a fundamental but not a sufficient means to carry out the medical profession. Medicine cannot rely solely on thinking based on the gnoseological process of explanation. The human being is not an entity between entities: it is a being that first needs to be understood and comprehended. Understanding is a broader way of reasoning capable of embracing both the immanent and transcendent aspects of the sick person: the body in unity with his psychic and spiritual being.

As Mortari writes: "Care refers to a specific other person, and their good is what the other needs in the precise moment in which they ask. Life is not a system, life needs not general architectural systems. Rather, it needs attention and dedication, for that very gaze, in that precise instant. We live within time, and our soul is nourished by instants of good(ness)"[42]. Charon has noticed the need to integrate the clinical eye with a gaze founded on attention and empathy that allows the physician to join the patient to understand his real need for good in his unique therapeutic needs. Narration can dissolve the conflicts and distances that have arisen in the relationship between physician and patient. A physician acting with narrative skills will be more aware of their own medical being and of the being of the patient. A good physician cannot act with the technical and theoretical skills in the care of the patient without an emotional posture that makes them attentive, responsive and understanding about of the need for the good that every human being has in himself. From this emotion for the other, for her or his need for good one can rethink a more human and effective medical practice. When patients feels loved, looked after and treated for the inestimable value they bear as persons, they feel better and, even if they cannot heal, they can be positively accompanied during the course of their suffering.

Bibliography

Charon, R., (2006). Narrative medicine. Honoring stories of illness. New York: Oxford university press.

Charon, R. and Montello, M., (2002). Stories matters: the role of narrative in medical ethics. New York: Routledge New York London.

Gadamer, H. G., (2004). Truth and Method. New York: Continuum Publishing Group.

Levinas, E., (1985) Ethics and Infinity, Conversations with P. Nemo, Pittsburgh: Duquesne University Press.

Mortari, L., (2015) Filosofia della cura, Milano: Raffaelo Cortina Editore.

Ricoeur, P., (1992). Oneself as Another. Chicago: University of Chicago Press.

Stein, E., (1964) On the problem of empathy, Dordrecht: Springer Science+Business

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[42] Mortari, L.,(2015) Filosofia della cura, Milano: Raffaelo Cortina Editore. p. 219.