MEDICAL HERMENEUTICS:
WHERE IS THE "TEXT" WE ARE INTERPRETING?

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ABSTRACT. The present paper is a commentary on an article by Drew Leder [1]. Leder identifies a series of 'texts' in the clinical encounter, emphasizes the central role of interpretation in making sense of each of these texts, and articulates ordering principles to guide the interpretive work.

The metaphor of clinical work as textual explication, however, creates the expectation that there is a text somewhere to be found. Such an expectation invites doctors and patients to search for the text and runs the risk of conceptualizing patients as more static than they are. If one is to use the textual metaphor, one must appreciate the radical extent to which the clinical encounter is a mutually produced and shifting entity. The qualities of mutuality and indeterminacy are not those one usually associates with texts. One might ultimately be better served by a different metaphor based more directly on uncertainty.

Key words: clinical interpretation, doctor-patient relationship, hermeneutics, medical practice

I

Drew Leder [1] sets out an ambitious set of tasks for Medical Hermeneutics. He would have us recognize the basic role of interpretation in medical practice and thus acknowledge directly the necessary role of subjectivity in medicine. Practicing physicians are said to confront a series of 'texts', defined as "any set of elements which constitutes a whole and takes on meaning through interpretation" ([1], p. 11), in the clinical encounter, and then we are asked to be more explicit about the role of interpretation in the construction of these texts. Leder sees "the person-as-ill" as the "primary text", but he describes "a complicated series of secondary texts" of which he addresses four: "experiential", "narrative", "physical", and "instrumental". Leder explicates the complexities of these texts in an articulate and thoughtful way and shows a significant interpretive component in each of them. He remarks on the incompleteness of the experiential text, both in a felt sense – the patient, after all, comes to the doctor because of uncertainty as to the meaning of various signs and symptoms – as well as in a sense of the opacity of embodiment itself which renders invisible and obscure the "workings" of the body to experiencing consciousness. Leder
argues that the “narrative text” is jointly authored by the patient’s body, the patient, and the doctor – a “collaborative product”. The interpretation of the “physical text” is the challenge of physical diagnosis, the effort of the trained physician to read on and within the body unimpeachable evidence of disease and disorder, blocked at every turn by the body’s very physicality – obesity or ticklishness, for example, frustrating the deft examiner’s effort to explore the abdomen’s temple of mysteries. The instrumental text is then the contribution made by various machines – X-rays, cardiograms – to the interpretable record.

Having explicated the form of the various texts, Leder turns to “the set of goals which ... orient the writing and reading of these texts” ([1], p. 16). He finds “coherence,” “collaboration,” and “clinical effectiveness” to be ordering purposes for interpretation. Then he concludes by arguing that medicine, in its pretense of objectivity – and consequent denial of any necessity for interpretation – is living in an anti-hermeneutical “false consciousness”, one based both in the “perceptual ideal” (that which is seen has truth) and the “mathematical ideal” (that which can be counted has truth). Leder perceptively observes that “medicine’s flight from interpretation” has led to paradoxical results”, noting that preoccupation with “secondary and tertiary texts” makes the “person-as-ill” – the really legitimate ‘thing itself’ of medical practice – harder and harder to find ([1], p. 21). Referring to Whitehead’s fallacy of misplaced concreteness, Leder argues that medicine’s effort to “expunge interpretive subjectivity” leads to repeated violation of the hermeneutic telos of coherence, collaboration, and clinical effectiveness. He urges that for medicine to realize its full potential it must focus not on the eradication of interpretation but on a more rigorous examination of how interpretation works, that is, on hermeneutics.

II

Certainly this is a provocative and wide-ranging analysis. Yet it seems to me that there are a number of problems with the approach. One familiar with medical practice will recognize in Leder’s secondary texts the more mundane “History”, “Physical”, and “Lab”, with the “experiential text” seen by doctors as the merely subjective world of the patient. These texts are not, in themselves, all that distinct. Their differences arise from separate intentionalities rather than any quality belonging to themselves. That is, it is the purposes of the physician in organizing and recording the medical encounter that create these categories. Their distinction is in that sense provisional, depending on the needs and skills of the textual “reader”. The sharp distinction we make between signs and symptoms has not always been so clear in medicine. Consider Dr. Thomas Watson’s definition of a ‘symptom’ in his 1858 textbook of medicine: “Every