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Narrative in Medicine: Pathways to Healing and Vehicles of Power—Based on the Work of Rita Charon and Amanda Caleb

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Abstract

This paper adopts Rita Charon's theory of "narrative medicine" and Amanda Caleb's critique grounded in Michel Foucault's concept of "biopower" as a dialogic framework to examine the dual roles of narrative within the medical field. It first analyzes Charon's approach, which positions narrative competence as a healing bridge that helps close the doctor–patient gap and fosters empathy and human connection. The paper then introduces Caleb's critical perspective, revealing how narrative also functions as a discourse of power—one that has historically operated through social structures and institutional practices to "medicalize" social problems and legitimize various forms of inequality. The argument advanced here is that Charon's constructive methodology and Caleb's critical examination together illuminate two inseparable dimensions of narrative in medicine: narrative serves not only as an essential pathway to healing in clinical practice but also as a complex vehicle of power. Ultimately, the paper contends that in today's mediated environment, an integrated narrative lens—one that combines empathic practice with sustained reflection on power—holds significant ethical value for cultivating a more inclusive, reflexive, and equitable medical humanities landscape.

Keywords

narrative medicine; discourses of power; doctor–patient relationship; biopower; medical humanities

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Scholar Introduction

Rita Charon is a physician, literary scholar, and Professor of Clinical Medicine at the Columbia University Vagelos College of Physicians and Surgeons. She is also the founder and Executive Director of the Program in Narrative Medicine at Columbia University, and continues to practice as a general internist at the Associates in Internal Medicine of Columbia Presbyterian Hospital.

A leading scholar in medical humanities, she first proposed the concept of "Narrative Medicine" in 2000, advocating for the use of close listening to and recording of patient stories to strengthen clinician-patient empathy and improve the quality of care. Her work integrates literary analysis with clinical practice, emphasizing the need for healthcare professionals to engage with patients' individual narratives to counterbalance the limitations of a purely technical medicine. Her book, Narrative Medicine: Honoring the Stories of Illness, systematically elaborates this theory and has become a foundational text in medical humanities education.

Amanda M. Caleb, PhD, is a Professor of Medical Humanities at Geisinger College of Health Sciences, where she also serves as the Director of the Family- and Community-Centered Experience.

She holds a PhD in English and an MA in Nineteenth-Century Studies from the University of Sheffield, as well as a BA in English with a concentration in Gender Studies from Davidson College.Her research focuses on the intersections of literature, medicine, science, and policy, with a particular interest in how patient narratives can influence healthcare practices and policies.

Introduction

With the advancement of modern medicine, scholars and practitioners have increasingly grown dissatisfied with the reductionism and limitations of the biomedical model. There is a growing recognition of the social and holistic dimensions of medical problems, as well as the influence of psychological and social factors on health. In this context, George L. Engel proposed a shift toward the biopsychosocial model, arguing that “a medical model must take into account the patient, the social context in which he lives, and the complementary system devised by society to deal with the disruptive effects of illness—namely, the physician’s role and the health-care system.” (Engel, 1977)

Against the backdrop of this paradigmatic transformation, life—understood as an organic integration of bodily experience, emotional and cognitive processes, and social relationships—offers a renewed humanistic and critical perspective on medical issues. Narrative, a conceptual tool originating in literary studies, can be mobilized in clinical settings to facilitate understanding of illness and foster empathy between physicians and patients; at the same time, it may also operate

within public policy and cultural production as a discursive instrument of medical authority. Drawing on the representative works of Rita Charon and Amanda Caleb, this paper seeks to construct a theoretical dialogue on the relationship between medicine and narrative, exploring the dialectical role of narrative as both a pathway to healing and a vehicle of power.

Rita Charon: The Theoretical Construction and Practical Pathways of Narrative Medicine

Narrative Medicine, proposed by Rita Charon, advocates for cultivating clinicians' narrative competence so that they may genuinely understand patients' suffering. Charon's extensive scholarly background grants her a distinctive perspective in this field: she holds an MD from Harvard Medical School and a PhD in English from Columbia University, and currently serves as the founding director and executive director of the Program in Narrative Medicine at Columbia University.

In her early work prior to 2000, Charon had already recognized the potential value of applying narrative approaches to medicine. She argued that, at their core, both literature and medicine are concerned with the origins and destinies of individuals. (Charon, 2000)

At that time, medical education suffered from a pronounced problem of dehumanization. Training emphasized technical mastery and efficiency, compelling medical students to reduce patients to "cases" requiring solutions rather than to view them as whole human beings. This process of dehumanization not only strained doctor–patient relationships but also distorted medical students' professional identity. (Charon, 1986)

Drawing on literary theory, Charon interpreted the medical chart not as an objective document but as the product of a clash between two narrative traditions—classicist and romantic. Physicians tend to pursue universality, defining illness through clinical language, whereas patients foreground individuality, expressing disordered bodily experiences through personal narratives. (Charon, 1992)

In response to this narrative rupture, she proposed integrating literary critical methods into medical education, piloting such practices in the curriculum at Columbia University's College of Physicians and Surgeons. Through humanistic training such as creative writing, she aimed to help medical students transcend technical thinking and re-recognize patients as individuals with emotional histories and lived contexts. Her analogy between the doctor–patient relationship and the reader–author relationship (Charon, 1989) laid the conceptual groundwork for what would later become Narrative Medicine.

In 2001, Charon formally introduced the concept of "Narrative Medicine" and subsequently refined its definition: Narrative Medicine is clinical practice grounded in narrative competence—the ability "to recognize, absorb, interpret, and be moved by stories of illness." (Charon, 2008) She argued that such competence enables clinicians to bridge divides between doctor and patient,

within the clinician's own self, among colleagues, and between medicine and society, thereby fostering care that is more humane, empathic, and effective. (Charon, 2001)

In practice, Narrative Medicine centers on three core components: attention, representation, and affiliation. (Charon, 2005) Practitioners must listen to patients' stories with care and responsibility, cultivate "a transmuting, reciprocally nourishing affiliation kindled by language" between clinician and patient (Charon, 2008), and translate patients' stories into written form to facilitate shared understanding of illness. This spiral process of narration and reflection enhances deeper connections among patients, clinicians, colleagues, and institutions.

Theoretically, Charon actively situates Narrative Medicine in dialogue with other paradigms—most notably traditional bioethics and evidence-based medicine (EBM). She contends that conventional bioethics assumes an inherently adversarial doctor–patient relationship, thereby overlooking the possibilities of trust, empathy, and collaboration. She therefore proposes using Narrative Medicine as a methodological lens to reconstruct ethical practice, redefining ethics as relational action embedded in clinical encounters rather than externally imposed rules. (Charon, 2004) Regarding EBM, Charon critiques its overreliance on measurable evidence, which risks marginalizing patients' lived experiences and clinicians' judgment. She advances the framework of Narrative Evidence-Based Medicine (NEBM) to encourage comprehensive attention to the dimensions of known/unknown (clinical evidence), universal/particular (clinical context), and body/self (patients' values). (Charon, 2008)

Practically, Charon and her colleagues have developed a robust methodological system for Narrative Medicine, including close reading (Charon, 2017) and parallel charting (Charon, 2008). These methods have been applied across diverse contexts—from doctor–patient communication to team building and institutional reflection—significantly expanding the reach of Narrative Medicine. At the 2021 Columbia University conference "Race | Violence | Justice: The Need for Narrative," Narrative Medicine practices were applied to address structural inequities in health care. (Charon et al., 2021) Moreover, she has promoted Narrative Medicine globally, framing it as a form of "international diplomacy practiced through health care." (Charon, 2008) Beginning with the Columbia program as the initial hub, the model spread through international workshops and faculty training, subsequently forming regional centers that now constitute a global network. (Charon, 2012)

Localized cases throughout Europe, Latin America, and Asia demonstrate that despite differences in medical systems and cultural contexts, the human need to understand suffering, seek meaning, and build connection through stories is universal. Narrative Medicine offers a methodology that resonates across these boundaries.

Amanda Caleb: Narrative, Power, and the Critical Reconfiguration of Medical Discourse

Charon's theory frames the encounter between clinician and patient as a domain of intersubjectivity. (Charon, 2002) This encounter is not a unidirectional observation of a subject by an object; rather, it is an ethically charged face-to-face engagement between two subjects, in which mutual recognition, response, and valuation co-construct an egalitarian and reciprocal clinical relationship. Within this framework, narrative functions as a transparent bridge, transmitting authentic experience and bridging differences.

However, the utopian vision of doctor–patient interaction filled with empathy and understanding that Charon portrays is inherently idealistic. Narrative is a constructively mediated tool, and Charon emphasizes the impact of formal elements—such as framing and metaphor—on the narrative effect ([Charon, 2015, p. 164]). She also highlights that both patients and caregivers participate in illness and treatment as integrated wholes—including their bodies, daily lives, families, beliefs, values, and experiences. (Charon, 2008) These considerations point to a crucial reality: narrative is not a direct reflection of experience but is told and interpreted within specific discursive systems; patients' stories are shaped by the social power structures in which they are embedded. Similarly, clinicians' representations of patients constitute a secondary encoding and interpretation of the original narrative, which may, often unconsciously, reproduce medical authority.

When we turn our attention to the broader social structures in which both patients and clinicians are embedded, the critical role of narrative in medicine becomes apparent. Narrative functions not only as a tool for recounting illness experiences but also as a discourse of power. Amanda M. Caleb is a representative scholar from this critical perspective. She is a Professor of Medical Humanities at Geisinger College of Health Sciences, where she also serves as the Director of the Family- and Community-Centered Experience. Her research focuses on the intersections of literature, medicine, science, and policy, with particular interest in how patients' individual narratives influence healthcare delivery and policy. In her work, narrative often operates as a discursive instrument for constructing social norms and legitimizing inequality.

Caleb's scholarship is grounded in Michel Foucault's theoretical framework, centering on the concept of biopower. Foucault argues that since the eighteenth century, modern states have increasingly governed through the management of life itself; power is no longer exercised solely through coercion or law but penetrates physiological and population-level processes via medical, statistical, educational, and other scientific discourses. Using historical documentation and critical discourse analysis, Caleb deconstructs how medical discourse and practice operate as instruments of power. She demonstrates, for example, that Nazi social policies were rooted in a "racial hygiene agenda," whose core involved the medicalization of social problems—framing societal issues as medical conditions, attributing their causes to individual responsibility, and emphasizing the need to treat or cure individuals. (Caleb, 2022)

This ideological foundation draws substantially from the early twentieth-century British eugenics movement. British eugenicists medicalized class issues, portraying the poor as "residuum" and associating social deviance with inherited intellectual deficiencies. The 1913 Mental Deficiency Act provided a precedent for the Nazis' institutionalized segregation of "defectives."

(Caleb, 2019) Such logic exemplifies Foucault's notion of the collusion between power and knowledge.

In her study of Victorian hospital wards, Caleb examines hospitals as sites of narrative conflict at the micro level. Drawing on Foucault's concept of heterotopia, she defines the ward as "a space that is simultaneously represented, contested, and inverted." (Caleb, 2019) Hospitals, through spatial arrangements, constrain patients' autonomy, while patients use writing to reconstruct ward spaces, thereby challenging medical authority. In Caleb's analysis, hospitals and patients engage in an ongoing struggle over narrative power—a struggle that itself constitutes a narrative about medical and health practices.

In this light, Caleb's research on health-related narratives can be seen as a critical complement to Narrative Medicine. Beneath the warm and therapeutic model of narrative as a vehicle for healing lie critical questions: Who has the authority to narrate? How are narratives encoded, decoded, and re-encoded? And what are their broader social implications? These questions highlight the inherently political and power-laden dimensions of medical storytelling.

Conclusion: The Dual Dimensions of Narrative—Healing Practice and Power Reflection

Synthesizing the perspectives of Charon and Amanda Caleb, their central concern converges on the humanistic qualities and value of narrative. Narrative serves not only as a crucial clinical tool but also as a social discourse carrying complex power relations. From a practical standpoint, the model of Narrative Medicine provides a methodological framework for improving doctor–patient relationships—how to listen, how to witness, and how to foster affiliation. Within the broader academic framework of health narratives, however, critical-oriented research reminds us that power permeates every interaction, requiring constant reflection on one's own positionality, privileges, and the latent power dynamics inherent in narrative exchanges.

The rapidly evolving media environment also poses new challenges for the study of health narratives. With the empowering potential of social media, Charon's concept of "writing life" (Charon, 2008) now encompasses a more diverse range of participants and practices. Patients, clinicians, and caregivers narrate their experiences and interact in decentralized online spaces, creating social connections and reshaping the definition and interpretation of health issues. At the same time, this development introduces new forms of discipline and stigma.

Accordingly, the future of medical humanities education urgently calls for integrating both the constructive and critical dimensions of narrative. It is not enough to cultivate clinicians' ability to "hear stories"; they must also develop the wisdom to "decode stories"—understanding how narratives are told, selected, amplified, and circulated within complex power networks. Ultimately, the highest ethical value of narrative lies in its capacity to allow us to reach others' suffering at the limits of technical mastery, to assert the right to speak under structural pressures, and to continually interrogate questions of justice, dignity, and what constitutes a life worth living. This is the

profound significance of narrative as a foundational element not only in medicine but in the broader humanistic fabric of society.

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