

## Subjectivity, Voice and Narratives in Clinical Medicine

“What does considering the patient as an embodied subjectivity have to tell us about contemporary clinical encounters?” One way of pursuing this question is: “What is the relation between subjectivity and the patient’s narrative?” But there are others: “What is the patient’s narrative of a clinical encounter?” Or, “What ways does the clinic tolerate the narrative of the patient and in what ways is it marginalised?” These are recognisable bioethical questions and have been explored by some prominent names in contemporary bioethics.<sup>1</sup> I will link the idea of subjectivity as it appears in the patient’s narrative to a philosophical analysis of medicine derived from the continental rather than the analytic tradition.

When we think of narrative, we think, *inter alia*, of the voice telling the story. We should also think of the silences and the contexts that constrain and surround that voice, distorting, at some points, our ability to appreciate or conceive of the subject speaking to us. These related ideas: stories, voices, silences, and narratives have wide currency in contemporary bioethics and are closely linked to what is called patient-centred medicine, but the idea of subjectivity takes us deeper towards a conception of the human soul or the subjective body<sup>2</sup> that needs further theoretical articulation.

### NARRATIVES

Narratives, in the context of patient-centred approaches to medicine, remind us that health care is a journey in which the professional should be a trusted guide or partner bringing a certain kind of expertise and authorisation needed at key junctures in that journey.<sup>3</sup> This perspective allows us to understand many aspects of a patient’s experience in a health care relationship, but it should also lead us to ask about the voice of the subject who is the patient and relate it to the production of an inscribed body that has been subjected to various rituals and discourses peculiar to the clinic (we could call them the culture of the land of *Clinicum*<sup>4</sup>).

The biopsychosocial model does something slightly different. It draws on the reality of the patient’s lived experience or narrative to understand aetiology and the phenomenology of disease but, in and of itself, it may not carry an ethical imperative. It can be used merely as

a way to come to a more comprehensive surview of the patient's presenting condition (the guise in which a person crosses the border into *Clinicum*). Consider, for instance, the young woman who walks stooped and presents with neck pain which is causing headaches and making her normal daily living problematic for her. The clinician may notice that she has very big breasts and that her attitude is one of self-effacement. An enquiry reveals that she is on the waiting list for breast reduction surgery, and the question of separate surgery for a neck condition with a somewhat less than clear relationship to her pain and headaches begins to be seen in a fuller light. Allowing her to talk about her story may indicate more than the fact that she has a difficult and stressful life as a relatively unsupported mother and may convey something of the way she lives her everyday experience in the presence of others. The ethical imperative becomes inescapable when the patient is seen as subject and author/narrator with lived subjectivity at the centre of her own story, which ought to be understood as she lives it rather than in terms of categories supplied by others. We see that she needs, inter alia, to shake off certain highly distorting images of herself that she has developed and that drag her down.

The patient with large breasts is some-body – a lived inscribed body with an image of itself that has effects on the subject living it. The subjectivity of the patient is always already mediated in ways that should inform our understanding of the patient-centred narrative and its narrative voice, because what finds its way into the text (which is a life-as-understood-by-the-person-living-it revealed in a medical context) is moderated by the discursive environment of the clinic. The patient's voice is immensely valuable and already has broadened our vision of what is happening in the clinical context, but that should be seen as the beginning of our transformation of the clinical encounter.<sup>5</sup> The narrative voice reveals the subject as the being-who-speaks and is constrained by the discourses in which s/he participates, so that the patient may find it difficult to articulate what is happening to him or her as a subject not at home in the clinic.

## THE SUBJECT

The logical/noumenal subject is, for many philosophers, transcendent of any articulated experience.<sup>6</sup> Kant, for instance, talks of *the noumenal subject* – that being-in-itself not encompassed by our descriptions; Wittgenstein of the subject who is not a psychological subject and not even part of the world; and Levinas of a subject who escapes all attempts to totalise or describe him or her and whose subjective-being-in-the-world cannot be categorised or “fitted” into the world of another (a world configured or totalised by certain discourses).<sup>7</sup> For Levinas, the subject is in-definable because there is an ongoing and developing interaction that ontologically constitutes the human subject as a being-in-the-process-of-becoming. The soul (or psyche) of the subject is, to some extent (as Heidegger remarks), correlative with those things the subject relates to, but they do not delimit or circumscribe it because the subject experiences and makes sense of the world in his or her own way inseparably linked to his or her life story (a story not evident or totally accessible from the outside – a story, for instance, in which others stare at me because of my “boobs”). The subject is inscribed or bears the traces (physical wounds and traces in brain microprocessing) of his or her entanglement with the world in a way that makes each (potentially storied) moment lived by that subject

irreplaceable by a moment lived by anybody else. This is intensely so in the world of the clinic, where the patient's role is a reality that may disrupt certain therapeutic relationships (and where transference in both directions is going on between the bright young things that have become doctors and the patients who are constantly tempted to project parentalism on them).

We can, however, usefully add a touch more phenomenology at this point, in order to understand the relation between subjectivity and medicine.

## THE TRANSCENDENCE OF THE SUBJECT

Imagine a human subject having an experience of something – perhaps of a doctor's surgery. Notice that the subject transcends and “contains” the experience as her/his experience. S/he transcends and contains it in many ways. *First*, any given experience is part of a totality of experiences participated in by that subject (who is temporally extended and narratively constructed beyond his or her participation in a particular event or encounter). *Second*, the way s/he stories and lives the moment draws on an embeddedness in discourse and relationships connecting him/her to a family, a society, a microculture, and a moment in history, all of which bring into that experience far more than can ever appear in a telling of it. *Third*, something specific to the dyad, triad (or polyad) and the moment that is the clinical encounter (with the transcendent backgrounds each of them brings to it) arises or emerges within it. *Fourth*, aspects of that encounter may not be able adequately to be expressed in any conversation that can be had by the patient (or the doctor) and so the encounter-as-experienced may be contained and (assimilated/accommodated) by each of them in ways that they have or have not anticipated. For instance, you may meet me in my clinical persona as a neurosurgeon and discuss a neck problem or a headache, but you and I are aware that there is more to me than is encapsulated by what happens in that clinical moment. We each have a past and a future, a learning history, competencies, and so on, all of which go beyond this moment, and yet they colour the moment and what follows from it (sometimes radically when there is harm or a life-altering outcome). If, for instance, I am the kind of clinician who inspires trust and openness in my patients and you have suffered many betrayals but give your trust, and then I let you down, your bitterness may be consuming. You may even pursue me with complaints in a way that seems far out of proportion to anything I have done.

A further aspect of the subjectivity of the patient is the touch of something alien and yet perhaps intimate in that the objects (speaking as broadly as possible to include the clinical episode, the disease discovered or suspected, the regimen or drugs applied to the disease, and so on) constituting the experience are all realities not confined to (but meeting in) that moment. Each clinical encounter (and its objects or aspects) has a documented and inscribed being that touches me but which also locates me at a certain point in *Clinicum* that constrains my and your discourse about it.

A human subject not only transcends the particular place and time of an experience, but also of all their experiences in that their thinking about the world embraces things they have not experienced (for instance, things learnt about from others, from books, from television and so on). Notice that these things themselves transcend their representations. I may hear that

I have cancer, but I am aware that the reality of cancer is only indicated or hinted at within the message or even my lived experience of it (this follows from the general point about the transcendence of the object). It is something beyond my apprehension of it – an unknown which threatens me in ways that I can try to understand but which has its own energies and laws of existence. All our shared significations of cancer are partial, both inadequate to the reality they attempt to capture and seductive because they seem to help us to encompass or contain the thing. But part of us knows that a cancer is *actual*, beyond its life in “the mirror world” (with multiple “regimens of truth”) where we locate ourselves so as to understand what has touched us.<sup>8</sup> The threat of cancer is that it shares ontology with us and affects us as beings in ways that outstrip our names for it, even though they help us come to grips with it.

The sense in which the person is transcendent of their body and brain is brought to our attention when we notice that the best representation of the body and brain of a human subject leaves out the perspective of the person whose body and brain it is. Subjective presence (equipped with a unique learning history or narrative viewpoint on the world), as I have noted, is not captured by any representation and is always unique. It unifies the life of the individual and their resources in such a way as it makes sense to say of a brain-damaged person, to use Luria’s words, that he “fought with the tenacity of the damned to recover the use of his shattered brain.”<sup>9</sup> If he uses his brain and we have dismissed the idea of a physically extensionless *res cogitans*, then he transcends his brain but not in a way that removes him from the physical world altogether. The transcendence concerned is that of the subjectivity that binds together one’s physical and cognitive attributes and lives in fear and trembling because it is mortal and vulnerable. Mortality and vulnerability are to the fore in all medical encounters (a skeleton not shut away in the closet, but in the body where it holds things together, can be revealed, and where it may be seen to hold the seeds of its own destruction). When I ask for the results of my tests, I agree that the inner me, that which holds me together and is my life, can be laid bare in a way that may hold direct implications for my mortal self. But is there a further sense in which a person is transcendent of the history and physical reality of their entire life as an organism?

The fact that there is more to a person than their history as a biological organism is evident in his or her knowledge about things that are not part of that history (the Land Wars, or the Highland Clearances, for instance). This is particularly true in the clinical encounter when people bring to those encounters inscribed bodies with traces of history, culture, discourse and personal interests that inform and sometimes limit their ways of understanding what is happening to them. These traces form the “grooves” invisibly configuring the “magic slate” (or mystic writing pad) of conscious life as it records or represents a person’s experience of being-in-the-world-with-others.<sup>10</sup> The magic slate only appears blank but in fact is, as Freud so clearly saw, always already inscribed with grooves into which the stylus tends to slip. The appearance of a fresh start, or “having put all that behind me” therefore should not be read naïvely, but with attention to what gives rise to those words and due care for the solicitude that is apt given that reality.<sup>11</sup> This is evident when a patient “sticks” or cannot contemplate some intervention – such as syringing of the ears, or complying with medication – because of some long-forgotten associations.

## THE IMMANENCES OF SUBJECTIVITY

The way in which anything is apprehended is immanent to experience in that there is a sense in which a thing understood in a certain way is internal to or realises its unique nature within the experience that so reveals it. Think for instance of bronchitis, pneumonia and pleurisy. All are chest infections and the last is popularly regarded as being the most serious. But, medically speaking, almost all episodes of bronchitis cause some pneumonia, and almost all pneumonias involve a touch of pleurisy and they all often respond to antibiotics (if caused by bacteria). But a human subject, suffering an illness, takes part in constructing an immanent reality: the illness as experienced by this individual. The illness inscribes the suffering individual and that inscription has a value or affect attached. The patient, if subsequently asked, "Have you ever had a serious chest infection?" might say "Yes" if told that he had "a touch of pleurisy," but not if told (in a certain tone of voice), "It's just a bit of bronchitis." The tone of voice conveys to the patient a degree of "fear and trembling" apt for the mortal and therefore ontological significance of this "knowledge".

Such immanent realities become part of the cumulative formation of the subject as a being-in-the-world. The soul or psyche is, in a very real way, a sum of all those encounters in which the subject has participated and the disciplines which s/he has undergone to learn how to signify them.<sup>12</sup> These disciplines, or ways of shaping a human soul, allow situations to be understood and stories to be told but also, like the traces on the magic slate, they make grooves into which subjectivity is wont to slip. Some of them are governed by alien agendas and others are part of one's being in a much more comfortable or "owned" way. Because of their potentially mortal significance and their roots in the language of another culture (the other-culture of *Clinicum*), most of the immanent aspects of the clinical encounter for most people are not comfortable. Some, for whom transference and the "Name of the Father"<sup>13</sup>, incarnate in the medical persona, is an important part of their being, only find peace in *Clinicum* and its fascinating language. Most people visiting *Clinicum* have an assigned place but s/he can also irrupt into the lives of those they encounter, especially when their narratives disrupt tellings and questionings legitimated within the culture. For this reason it is important for us to look beyond the voice of the patient as s/he tells a clinical story (that meets the cultural constraints) to the subjectivity of the person<sup>14</sup> who is the focus of "patient-centred medicine".

## THE OTHER AS INFINITE OR UNCAPTURABLE

The need to ground our ethics in an ontological recognition of human beings as subjects has led, paradoxically, to a problematisation of the subject in a way that reinforces but also casts away certain strands in clinical thinking.<sup>15</sup> The fact that each and every human being is, him or herself, the centre of a lived world with its own stories and paths of meaning, which may not coincide with those of any other person, implies that in the clinic one is in touch with something both fragile and irreplaceable. So resistant is the lived embodied subjectivity (some body who is somebody) to becoming a story told by anyone other than the subject living it, that attempts to capture the subjectivity of a subject in a clinical story is bound to fail. For that reason we can justifiably think of a subject as a *Ding-an-sich* (thing in itself), or

*noumenon*<sup>16</sup> which cannot be reduced to any representation or characterisation whatsoever. That truth is also indicated by Heidegger's term *Dasein* that draws our attention to the fact that the human being is entangled and vulnerable in a reality that variously buffets, comforts, seduces, misleads, shapes, and persuades him or her that things (the world, the self, self-in-the-world) are thus and so. This is particularly true in medicine where a clinical version of my story, as delivered to a legitimating authority in the health care setting may result in my being represented as, for instance, a patient with mental disorder, or a "somatising" patient. This representation or image can then obscure me as a subject and post a façade in my place (albeit rich in detail about my story).

What is more, the self-conception of a subject, after Lacan, can only be thought of as an *imago*. An *imago* is a unified (self-)conception distilled from and reflecting my dealings with others. One reads others and their responses or reactions to find out who one really is and then, just as a mirror seems to present a single "image," one comes to believe in a self that embodies the somebody one seems to be.

At this point we have drawn on both Emmanuel Levinas' ethical/ontological subject and the thought of Jacques Lacan. Both problematise the subject by distinguishing between the subject in itself and any conception of it (even a self-conception), where the former is immersed in and inscribed by the world, and elusive. But the storied subject can replace the subjectivity of a human being with something ideal, notional, or epi-phenomenal in relation to subjectivity as it is lived.

## SUBJECTIVITY IN THE CLINIC AFTER LEVINAS AND LACAN: THE LIVED CLINICAL IMAGO

Lacan combines Freudianism with the insights of structuralism and post-structuralism. He sets out to investigate the structure of the unconscious and argues that the Unconscious is structured like a network of signifiers (not a network of significations as one might assume from the normal structuralist model of language):

Signifier  
signified

The structuralist claim is that linguistic meaning is a product of the contrasts or differences between signifiers. By focusing on the relations between signifiers as the key to linguistic meaning, the structuralists divert our attention from the simplistic tendency to divide the world on the model of traditional semantics:

Sign  
Object

This latter (overly simplistic) tendency leads to two theses which do not serve us well in understanding human subjectivity:

- (i) There is a one-to-one correspondence between words and objects.
- (ii) There is some one thing for which each word stands.

These theses make us look for an object-like thing that is the human subject and results in us identifying the subject either with an other-worldly or non-physical object (a *res cogitans*) or, alternatively, identifying the subject with the body (as a biological phenomenon), neither of which do justice to human subjectivity. In medicine this supports the tendency to see the subject as a biological organism and illness as a malfunction in a working (biological) system. Subjectivity relegates that reductive view (even when it takes into itself psycho-social parameters) and confronts us with the living being who engages us and is not a totality to be measured.

The tendency to objectify the subject is reinforced by the fact that we can and do think about a person (even the first person) as we do about any other thing, a tendency reinforced by seeing oneself in the mirror. This results in an image of the self as unified, with a certain physiognomy, an object being related to by others as a distinct individual, whereas subjectivity may not be any of these things (totally or as it is in itself). The image of the self or *imago* is, in fact, an attempt by a human subject to achieve an adequate self-conception which mirrors what they read about themselves in the reactions and responses of others to them. Therefore subjectivity is correlative, as suggested, with the many things (including people and institutions) to which a subject relates and in relation to which his or her being takes on shape.

The human subject is touched or affected by many things, and Lacan uses the term *tuche* to indicate *the touch of the real* that impinges on us and that we attempt to capture by signification. We are, on Lacan's account, creatures jointly formed by language and causality so that the memories, images, inspir(it)ations, that animate us make us hybrid things. The dynamic hybrid that is a person is cumulatively formed by the effects of myriad touches of the real and the meanings we give to them. A human subject is therefore a being-in-the-process-of-becoming who cannot be caught by any essential or definitive description (even by him or herself). The character and identity which appears to the world, we could say (to echo Heidegger), is a manifestation for sensible intelligent beings such as ourselves of a *hypokeimenon* (something lying beneath) that we can detect but not delimit. Imagine, for example, a person suffering an auto-immune disease such as rheumatoid arthritis. Such a person is a dynamic psycho-physical complex living a trajectory in which part of herself is attacking her; her pains form the signals of that attack conveying messages whose meaning cannot be known until the destructive process has finished its work. She knows this because she feels it, and that is the dominating narrative that thematically constructs her lived subjectivity. To treat such a person effectively is to sense one's way into that experience and frame any clinical moment against it.

The idea of a something lying beneath the phenomena or appearances which we encounter when we meet somebody suggests some body (or substance) and thus the two tendencies in finding the source of the patient's story. Medical knowledge is biological (and therefore natural and physical) so (just as Freud did) doctors tend to identify the *hypokeimenon* with a biological organism and its inner workings. But we (and Freud) also notice the affinity of the human being with *geist* and may think of the *hypokeimenon* as to do with meaning or spirit<sup>17</sup>. Neither view, nor the opposition between them, serves us well. The biological view does not look awry at a world of human subjectivities and the media in which they live and move and

have their being. The overly spiritual or romantic view does not see that each of us is also some-body (an embodied, identifiable subject with a meaningful life) prone to the ills that flesh is heir to and, in the fibre of their being, aware of that fact. We need therefore to look even more awry to unsettle this impasse.

### LOOKING AWRY AT WHAT IS REVEALED: THE *HYPOKEIMENON*

What lies beneath or is expressed in a clinical narrative is, I have argued, not only a voice, but also a complex of some body and all the discursive entanglements which have inscribed it to make it somebody. A subjectivity is therefore more than the biological organism who is the topic of a narrative (or the soul who floats behind the narrative awaiting release from fleshly bondage). And a narrative itself is more than a text or a set of statements that reveal a person from a particularly intimate or accurate point of view; it is indwelt and animated by a subjectivity (as *hypokeimenon*) that presents him/herself through the encounters which will be partially captured in self-tellings (according to the discourse available in the context concerned). What lies beneath is not a biological reality (à la Freud or the materialists), but an ontological and ethical reality (as outlined by Levinas or Heidegger) meeting us in ethical space where we recognise and are recognised, where we witness and our deeds are witnessed, and where we touch and are touched. Each moment of our contact with another human being is ethical, and the multiplication of such moments defines a relationship in which a human being is entangled. For that reason, “the function of speech is not to inform but to evoke”.<sup>18</sup>

The statements making up a person’s story are, in one sense, everything there is to say (and they have a great deal to say), but yet they are not the thing at all – they are merely the surface or the mode of appearing of the embodied subject – and at an ethical level an encounter (even if it is a brief encounter) with that subject can be much more engaging than any story. We have seen this traced out in the story of the cancer patient and the examples (mentioned only) of the somatiser, the rheumatoid sufferer, and the mental health survivor; in each case the subject can become eclipsed by their story as received.

What lies beneath the patient’s story (or identity, character, role-in-the-world, medical history) is nothing simple, contained within the skin of that person (their body, a substance), but something that is composed of the many encounters that have formed that person as an embedded and embodied subjectivity in a historico-cultural context. But the enormity of the truth of the clinic is that the being-in-the-process-of-becoming somebody is not only transcendent but immanent, and affected by the traces left by the clinic on their body (“an inscribed surface of events”<sup>19</sup>). That reality is affected by the conversations in the clinic and the subtle gestures and paralinguistic communications that give presence or tone to those conversations; so that if I am seen as a somatiser, I might find that messages about bodily pain are not treated according to their content but according to their context, and I might become more and more desperate for someone to appreciate the real suffering that I am going through. This, as should be evident, has ramifying implications for clinical life.



## BEING-WITH IN THE CLINIC

In clinical life we have an almost instant entrée into the sharing of worlds with another person, but it is a very asymmetrical sharing. The other irrupts<sup>20</sup> into the life of the clinical professional only rarely, but always demands a response to the illness that has disrupted his or her life and necessitated the attendance at the clinic. As one sees what is at stake in the life of the patient (the one who suffers the disease), the life of the clinician is engaged and the ethical nature of the encounter enters a different arena where it carries special obligations. Those duties of care configure themselves in the face of the immanence of a “fear and trembling” at one’s own mortality before something unconditional but only partly apprehended.

The opportunity in the clinic, where the patient presents with their broken story<sup>21</sup> and reveals that his/her life has strayed from the path s/he thought him/herself to be on, is for a movement towards healing – or making whole again – through growth in the company of another. That opportunity is reciprocal; it challenges both the professional and the patient. It is an open-ended opportunity, because in any human encounter two worlds meet each other with their stories of courage, pain, trust, joy, disappointment, and so on. The structure and operations of power in the clinic minimise this actuality and reduce it to a matter of the “fore-grounding” of a legitimated clinical story; which may be fine for many of the encounters involved and the relatively straightforward health care needs involved. But sometimes the subject who is living the story needs more recognition than their story allows for or than they can say. The narrative voice, construed as the voice of the subject, coming from another world, may need to be heard at this point, with an appreciation that the subject is a multiply inscribed body through which events in life have become articulated and who is currently being touched by what happens. Instinctively one might recognise this, provided one’s instincts are alert. The reflective practitioner does notice what is happening and the ethical practitioner responds in a way that is fitting, that tends to healing, or opens the way for the human subject to work towards his or her needs being met rather than for him/her to perpetuate a broken story. That is particularly the case where the delineated-problem-solving mode of medical engagement is patently not what is apt to the subject whose story one is hearing.

## BEING INSPIR(IT)ED

As human subjects, we are inspired (inspired – given spirit and a sense that life is, after all, worthwhile) as others respond to us and show that they care what happens to us. Much of that inspiration does come from stories; some arises just from being-with-another. Being with the other is more poignant when it is attended by an awareness of mortality (as is universally the case in the clinic). The wonder of a human life is given especial value when we realise that each of us is living unto Death – the loss of being-in-the-world-with-others (we could call *Clinicum* a land where one is always walking through “the valley of the shadow of death,” so that The Name of the Father is profoundly important). That is why hospice and palliative care always provoke the deepest questions about our humanity and the value of human life. When death has been introduced to a situation, we are drawn to attend to that which we value in ourselves and others – our links, as bodies who are subjects, to the realm of mortality and biology. Medicine faces us with this ontological truth on a daily basis, and therefore the topic

of subjectivity in medicine is of vital interest to both medicine and philosophy and is a point where not only science finds a useful method<sup>22</sup>, but also where ethics finds its subject matter both engaging and unavoidable.

The patient's voice, captured only inadequately in the patient's narrative, speaks to us of a living subject who is somebody and, in medicine, the bodily aspect of some-body is itself a source of ontological insecurity so that human subjectivity betrays itself "by every careless word it utters". Thus we need to be alert to the subject whose story we are catching a glimpse of when we meet someone in the clinic. Most of the time the somebody concerned is straightforwardly presented, but sometimes the subjectivity who is some-body is not easily discerned behind the story that has been erected to obscure them, and one has to look awry to see them. Either way, the subject whose voice speaks to us in the story is the being-in-the-world-with-others who is asking for help in the clinic.

- 1 Howard Brody has coined the term "narrative ethics" for this way of looking at the clinical encounter (e.g., in *Principles of Health Care Ethics*, R Gillon and A Lloyd, eds (Chichester: Wiley, 1994)).
- 2 The human soul – for an Aristotelian at least – is the psyche, that form which animates and integrates a human being as a living being of a distinctive type so that it is more or less equivalent to the subjective body, as distinct from the platonic soul which is thought to be an inner substance of an immaterial or spiritual type.
- 3 See in this regard Art Frank, "The Wounded Storyteller," Howard Brody, "Stories of Sickness," or Katherine Montgomery Hunter, "Doctors' Stories". I have discussed that perspective in *Bioethics in the Clinic: Hippocratic Reflections* (Baltimore, MD: Johns Hopkins University Press, 2004).
- 4 I use this figure to explore some of these issues in *Bioethics in the Clinic*.
- 5 Thus the growth of narrative bioethics.
- 6 Sartre, for instance, critiques the idea in *The Transcendence of the Ego*, but then seems to only with difficulty heed his own critique in *Being and Nothingness*.
- 7 Kant discusses the problem in the first critique (B 406-432).
- 8 "The mirror world" is the world in which life is mirrored by signification and symbolism and, because we are subjective beings, it is in a metastable and transformative interaction with the world of actual encounters, of flesh.
- 9 See A R Luria et al, *The Man with a Shattered World: The History of a Brain Wound* (Cambridge Mass.: Harvard University Press, 2004).
- 10 The figure is that of the old wax-based magic slates covered with a membrane on which one could write and, with a lifting of the membrane, erase what is written and use the blank slate again. Freud observed that the slate remained inscribed even though what could be read on the surface apparently renewed itself without a trace of former messages showing through. They did show through, of course, but only in the bumps and irregularities of what was written anew.
- 11 We could here notice the Māori word *utu*, with the idea of not forgetting (even if forgiving) that which has gone before and which ought to inform our current dealings with one another. A certain amount of history may need to be acknowledged, for instance, for the current conversation to be "real."
- 12 Heidegger makes this point (*Being and Time*, 1972, H14).
- 13 The term is from Lacan and represents the domain and reach of authority, solidity, legitimation, and life. We find our place in a domain implicitly ruled "In the Name of the Father" who gives us life and the word, the context in which we have belonging, a place, and our lives have meanings which can be limned.

- 14 Person as *per-sona* or that which is spoken through in the context of a stylised representation of events as on a Greek stage is particularly apt in this context.
- 15 “Casts awry” is derived from *Looking Awry*, the work in which Slavoj Žižek applies the post-structuralism of Jacques Lacan to popular culture.
- 16 The terms are Kant’s and indicate the reality that is only selectively and partially rendered into representational form as phenomenon by human thinking.
- 17 Freud was alert to the ontological implications of this fact, but in an age of biological psychiatry we are tending to overlook it as he himself ultimately seems to have done.
- 18 Jacques Lacan, *Écrits*, trans. A. Sheridan (London: Norton, 1977), 86.
- 19 Michel Foucault uses this formulation (e.g., in *The Foucault Reader*, P Rabinow, ed. (London: Penguin, 1986), 83.
- 20 The term “irrupt” is from Levinas.
- 21 Howard Brody uses the formula, “My story is broken; can you help me fix it” to evoke the plight of the patient (one who suffers).
- 22 The Hippocratics noticed that the possibility of demonstrably getting it right or wrong made medicine a prime candidate as a science.

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