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The clashing voices of medicine and the lifeworld: institutionalized knowledge vs. patient narratives in the clinical hierarchy of relevance

In his monograph *The Discourse of Medicine* Elliot Mishler mentions a conflict between 'the voice of medicine' and 'the voice of the patient's lifeworld': the former is regarded by physicians to be a formal and reliable manner of expressing knowledge about the body, while the latter is perceived as an irrelevant and even disruptive influence because of its biographical, contextual nature. Clinical judgement is characterized by a strict hierarchy of relevance which prioritizes the 'voice of medicine' as a source of 'proper' evidence, while the 'voice of lifeworld' resides at the level of mere testimony. The two 'voices' sometimes appear to be addressing separate issues in two distinct languages. The patient relies on first-person utterances and describes unique, existentially meaningful subjective experiences (symptoms) of which she tries to 'make sense'. She often employs an 'involved' language of concern about the way her life will change in relation to the diagnosis. Practitioners, on the other hand, use a professional language and adopt the detached, objective third person point of view, which enables their pursuit of reliable, tangible evidence (clinical signs). Preoccupied with detecting and correcting pathological deviations, medical professionals are in particular subject to quantification tendencies, even framing prognosis in terms of calculation-based estimates (e.g., 'survival chance', 'expected quality of life'). Since they hardly ever borrow terms from the patient's language of pain, discomfort or (dis)ability, one cannot reasonably expect a significant overlap between the way physicians and their patients construe and problematize illness. Thus the epistemic rift and power imbalance inherent to the majority of physician-patient interactions results in the absence of a shared conceptual apparatus. Physician-philosophers such as Eric Cassell or Anna Luise Kirkengen have often pointed to this lack of shared meaning when attempting to explain medicine's failure to integrate patient experiences of illness as an important part of clinical practice and the discourse of medicine. The question is, how much is at stake here? What are the epistemic risks of prioritizing institutionalized knowledge over patient narratives? Drawing on Alvan Feinstein's notion of 'intellectual infirmity', presented in his classic book *Clinical Judgement*, this paper explains why the 'voice of medicine' will always be just as prone to bias and logical fallacies as lay reasoning.