The Three Linguistic Layers of Medical Epistemology

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Language plays a crucial and complex role in medical epistemology: from the conceptualization and communication of medical knowledge, through the linguistic codification of cross-cultural notions of illness, health and wellbeing; and to very capacity of individuals to articulate and express the (inter)subjective experience of illness itself. Investigating the complex role of language in the formation, development and contestation of medical epistemology(ies) as a field of inquiry is therefore paramount for a more complete understanding of the intricate connections between knowledge, experience, health and language.

The paper explores these intricate connections by identifying and examining three distinct linguistic "layers" in the language of medical epistemology, and their relative strengths and limitations: **(I) *medical language***, namely the conceptual and argumentative scientific system of knowledge. This includes, for example, the professional language of diagnostic tools such as the McGill Pain Questionnaire (Sussex 2009). **(II) *the cross-linguistic dimension of health and illness***, in the form of culture-specific articulations of physical and mental health. These include, for example, particular taboo words for illness (e.g. "a terrible disease" in Hebrew), or cross-cultural conceptions of depression (e.g. a chemical unbalance in the mind of an individual; an interpersonal phenomenon; a punishment from God) (Peled forthcoming). And **(III) *the articulability of the experience of illness*** in phenomenological terms, namely the capacity to put into words the very intersubjective experience of suffering itself, regardless of the specific language in which it is articulated. This includes, for example, the experience of *indescribability* associated with the phenomenology of depression (Ratcliffe 2014).

A more comprehensive understanding of the role of language in medical epistemology, the paper argues, is pivotal for any debates over agency, autonomy and authority in medical ethics. These include, for example, issues of epistemic injustice (Fricker 2007); alterity (Kirmayer 2015) and epistemic humility (Wardrope 2015) in physical and mental health care; and the role of dialogue in the moral re-synchronization of sufferers from depression (Peled unpublished). A more language-aware medical epistemology, the paper concludes, is likewise pivotal for a better-informed and more effective healthcare training, delivery and practice.

References

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