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Review Article

Hermeneutic Approaches to Medicine: From Objective Evidence to Patient as Sacred Text

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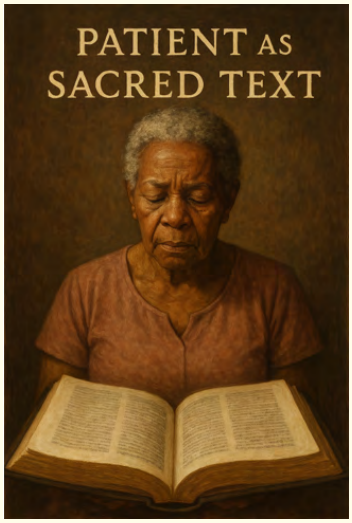
Abstract

This paper examines various hermeneutic frameworks applied to the medical context, comparing approaches that focus on the interpretation of medical literature with those that view the patient as a text requiring interpretation. Beginning with Matthew Links' analysis of evidence-based medicine as analogous to religious textual interpretation, we expand the comparison to include narrative medicine, anthropological perspectives on illness narratives, the Buddhist concept of upaya (skillful means), and the emerging concept of the "patient as sacred text." Through this analysis, we identify common threads and distinctive contributions of each approach, arguing that the metaphor of patient-as-text offers unique insights into the ethical dimensions of clinical practice. We conclude that an integrated hermeneutic approach to both medical evidence and patient encounters may enhance clinical practice by combining scientific rigor with interpretive wisdom.

Keywords: *Medical Hermeneutics; Fourfold Interpretation; Evidence-Based Medicine; Narrative Medicine; Upaya; Patient-Centered Care; Sacred Text; Clinical Decision-Making*



Figure

Introduction

The practice of medicine has always involved interpretation-of symptoms, diagnostic data, research evidence, and patients' stories. In recent decades, scholars from diverse fields have applied hermeneutic frameworks, traditionally used for textual interpretation, to various aspects of medical practice. These approaches range from analyzing how clinicians interpret medical literature to examining how they "read" patients themselves.

This paper explores these interpretive frameworks, beginning with Links' analysis of how physicians' approach medical literature with different interpretive stances [1]. We then expand this comparison to include additional frameworks: Charon's narrative medicine [2], Kleinman's anthropological approach to illness narratives [3], Cassell's examination of suffering [4], Foucault's analysis of the medical gaze [5], Frank's work on illness narratives [6] von Unwerth's application of the Buddhist concept of upaya [7], and the emerging concept of "patient as sacred text" [8]. Through this comparison, we aim to identify common threads and distinctive contributions of each approach, with particular attention to the ethical implications for clinical practice.

Daniel's influential work "The Patient as Text: A Model of Clinical Hermeneutics" (1986) provides another crucial framework for understanding medical interpretation. Drawing directly from medieval biblical exegesis, Daniel proposes a comprehensive fourfold interpretive model specifically designed for clinical decision-making. His approach offers a structured method for organizing the interpretive process in medicine that complements and in some ways anticipates many of the frameworks discussed in this paper.

How we read medical texts

In his 2006 BMJ article, "Analogies between reading of medical and religious texts," Links explores how physicians interpret medical literature through frameworks analogous to religious hermeneutics [1]. He identifies three interpretive approaches-fundamentalist, conservative, and liberal-each representing different ways of relating to evidence-based medicine.

Links describes medical fundamentalism as treating the literature as "law, a series of 'sacred texts' that are treated with great respect and are to be applied literally" [1]. This approach gives "little allowance for individualization, show[s] little scepticism about the limitations of the literature, and tend[s] to undervalue non-randomized evidence" [1]. In contrast, a liberal approach "sees the literature as a guide, establishing principles that need to be applied to specific situations" [1].

Through examples from oncology practice, Links demonstrates how these different interpretive stances affect clinical decisions. For instance, when considering whether evidence from one drug can be extrapolated to another, or how to apply clinical trial data to patients who would not have met trial inclusion criteria, physicians' underlying hermeneutic approaches significantly influence their decisions.

Links concludes that "variations between these world views reflect different ways of reading evidence, not a disparity in the value placed on the evidence" [1]. He advocates for awareness of these differing assumptions and calls for tolerance in medical discourse, acknowledging that sometimes "equally valid but different views" exist regarding the interpretation of medical evidence.

The fourfold hermeneutic model

Stephen Daniel offers a structured approach to medical interpretation that draws explicitly from medieval biblical exegesis. Daniel adapts the medieval fourfold sense of scripture-literal, allegorical, moral, and anagogical-to create a comprehensive model for clinical decision-making.

Daniel argues that "the art of interpretation has traditionally been an integral part of medical practice, but little attention has been devoted to its theory." His model organizes interpretive activity both logically and comprehensively, proposing that a patient is analogous to a literary text which may be interpreted on four levels:

- The literal level: This includes both "the literal facts of the patient's body and the literal story told by the patient." At this level, the physician collects objective data through physical examination, laboratory tests, and the patient's narrative.
- The diagnostic level (corresponding to the allegorical): This involves determining "the diagnostic meaning of the literal data." Here, the physician interprets the patterns and signs to develop a diagnosis or understanding of what ails the patient.
- The praxis level (corresponding to the moral): This encompasses "the prognosis and therapeutic decisions" that emerge from the diagnosis. This is where interpretation leads to action in the form of treatment plans.
- The holistic level (corresponding to the anagogical): This final level involves "the change effected by the clinical encounter in both the patient's and clinician's life-worlds," recognizing how the medical encounter transforms both parties.

Daniel's model provides a valuable framework for understanding how clinicians move from collecting objective data to making meaningful diagnoses and treatment decisions that ultimately transform both the patient's experience and the physician's understanding. His approach highlights that interpretation in medicine is not merely technical but involves a progression from scientific observation to human meaning-making and ethical action.

Reading the patient's story

While Links focuses on interpreting medical literature, Rita Charon's concept of narrative medicine shifts attention to interpreting the patient's story. Charon defines narrative medicine as "medicine practiced with the narrative competence to recognize, absorb, interpret, and be moved by the stories of illness" [2]. This approach positions the patient's narrative as a text requiring skillful interpretation.

Charon argues that physicians must develop skills in "close reading" similar to those used in literary analysis. She writes, "As literary scholars examine a text for its multiple meanings and its value systems, physicians can use these same methods to examine the patient's narrative for its multiple meanings and value systems" [2]. This approach recognizes that patients' stories, like literary texts, contain layers of meaning that may not be immediately apparent.

The narrative medicine approach extends beyond Links' framework by positioning the patient, rather than medical literature, as the primary text requiring interpretation. Charon's work emphasizes that physicians must interpret not only what patients say but how they say it-attending to metaphor, frame, time, plot, and desire in patients' narratives [2]. This attention to narrative structure complements but differs from Links' focus on interpreting medical evidence.

Von Unwerth relates an illustrative case from Charon's practice that demonstrates the power of narrative attunement. A patient presented annually with unexplained chest pain that required hospitalization but showed no cardiac abnormalities on testing. Only in the fourth year did Charon ask whether anything significant had happened during that season, discovering that the symptoms coincided with the anniversary of the patient's father's death [7]. This case exemplifies how attentive listening to a patient's full narrative can reveal connections between physical symptoms and life experiences that might otherwise remain hidden.

Anthropological perspectives

Arthur Kleinman's anthropological approach to illness provides another framework for interpreting patients' experiences. Kleinman distinguishes between "disease" (biological pathology) and "illness" (the lived experience of suffering), arguing that physicians must interpret both dimensions [3].

Kleinman writes, "The physician... listens to the sick person's narrative with the distance and abstraction of someone who [has] the technical knowledge to decode the symptom of disease in the body" [3]. However, he argues that this technical "reading" must be complemented by interpretive understanding of the personal and cultural meaning of illness in the patient's life.

Kleinman's approach parallels religious hermeneutics in recognizing that illness narratives contain both literal and symbolic dimensions. Just as religious texts are interpreted both literally and allegorically, Kleinman suggests that illness must be interpreted both biomedically and symbolically, with attention to cultural context.

Unlike Links' focus on medical literature, Kleinman's framework addresses how clinicians interpret the cultural and personal dimensions of patients' experiences. This approach shares with narrative medicine an emphasis on patients' stories but adds particular attention to cultural frameworks of meaning.

Interpreting suffering

Eric Cassell's work on the nature of suffering adds another dimension to medical hermeneutics. Cassell argues that suffering occurs "when an impending destruction of the person is perceived," requiring physicians to interpret more than physical symptoms-they must understand the threat to the patient's personhood [4].

Cassell writes, "The relief of suffering and the cure of disease must be seen as twin obligations of a medical profession that is truly dedicated to the care of the sick" [4]. This requires developing interpretive skills to understand the meaning of illness in the context of a patient's life, values, and goals.

This approach complements Links' framework by suggesting that different interpretive stances apply not only to evidence but to patients' experiences of suffering. A "fundamentalist" approach might focus solely on biological disease, while a more holistic interpretation would consider the broader dimensions of suffering.

Foucault's "medical gaze"

Michel Foucault's analysis of the "medical gaze" offers a critical perspective on how medicine "reads" bodies. In "The Birth of the Clinic," Foucault explores how modern medicine constructed a particular way of seeing that transformed patients' bodies into objects of knowledge [5].

Foucault describes how the clinical gaze "was no longer the gaze of any observer, but that of a doctor supported and justified by an institution" [5]. This institutionalized gaze involves specific ways of interpreting bodies that are shaped by power relations and medical discourse.

Foucault's analysis provides a critical counterpoint to other hermeneutic approaches by highlighting how power shapes interpretation in the clinical encounter. While Links focuses on how physicians interpret evidence, Foucault examines how medicine itself constructs its objects of knowledge through specific interpretive frameworks.

"Wounded storyteller"

Arthur Frank's work on illness narratives adds another dimension to medical hermeneutics. Frank identifies different types of illness narratives-restitution, chaos, and quest narratives-each requiring different interpretive approaches [6].

Frank argues that the dominant medical approach tends to privilege restitution narratives (focused on cure) while struggling to hear chaos narratives (which lack coherent structure) and quest narratives (which seek meaning in illness). He writes, "The physician's healing begins with listening. The healing begins with the patient's story of the illness, but it is enhanced in the physician's retelling of that story to the ill person" [6].

Frank's work focuses on how patients themselves interpret their experiences through narrative and how physicians might better "read" these narratives without imposing medical interpretations that silence patients' voices. This approach shares with narrative medicine an emphasis on patients' stories but adds particular attention to the ethics of witnessing suffering.

Von Unwerth notes how Frank identifies the potential conflict between two ways of experiencing the body during illness: "a duality of sensibility, a conflictual experience of the body as, simultaneously, an object to be known, and the subjectively felt collection of sensations which we alone experience as ourselves" [7]. This tension between the body as scientific object and the body as lived experience highlights the need for interpretive approaches that can bridge this gap.

The Buddhist concept of skillful means

Matthew von Unwerth's article "Listening to the patient: A perspective from narrative medicine" introduces the Buddhist concept of upaya (skillful means) as a framework for understanding the patient-clinician relationship [7]. Upaya refers to the tailoring of communication to the specific needs and understanding of the recipient. As von Unwerth explains: "Upaya means speaking in the language of the other, intuiting what is meaningful to them and motivating to them, and presenting the message in those terms" [7].

The concept originated in the Lotus Sutra, a foundational Buddhist text, which illustrates upaya through parables. One such parable describes the Buddha encountering a gardener and, instead of using esoteric language to convey enlightenment, simply handing him a flower-communicating through the medium the gardener knew best [7]. This approach recognizes that "every person sees, feels and experiences the world differently, through his or her own lens, determined by his or her own cultural, historical, family and individual experience" [7].

Von Unwerth draws parallels between upaya and psychoanalytic practice, particularly the concept of "analytic listening" or "free-floating attention." This practice involves hearing beyond a patient's explicit words to discern recurring themes, idiosyncrasies, and omissions that reveal deeper preoccupations. He notes that in analytic listening, "everything becomes significant" [7]-from breaks in thought to repetitions of certain themes or unusual emotional responses to particular topics.

The concept of upaya provides a framework for understanding how clinicians might adapt their approach to each individual patient. Von Unwerth argues that "this meeting of the patient on their own terms, to behave and communicate with them in the ways that their own behavior presses us toward-is the beginning of the creation of what the British analyst Donald Winnicott called a 'holding environment'" [7]. This parallels the mother-infant relationship, where the mother serves as the infant's "first translator of the world" [7], helping the child interpret both external stimuli and internal sensations.

In practical terms, von Unwerth suggests beginning the clinical encounter with an open question-"what brings you to treatment now?"-allowing patients to frame their problems in ways that make sense to them. This approach "allows the patient to set the terms of her own treatment" [7] and invites the clinician to enter the patient's world rather than imposing a predetermined framework.

The patient as sacred text

The metaphor of "patient as sacred text" represents an emerging framework that explicitly draws on religious hermeneutics. In this approach I suggest that patients should be approached with the same reverence, care, and interpretive rigor traditionally given to sacred texts [8].

This framework builds on earlier approaches but adds a distinctive dimension of reverence. It suggests that the patient's body and story contain wisdom that transcends the clinician's expertise, requiring an approach of humility rather than mere technical proficiency.

The patient-as-sacred-text metaphor draws particularly on Jewish hermeneutical traditions. Handelman has demonstrated how rabbinic interpretive methods involve careful attention to textual details, recognition of multiple layers of meaning, and the understanding that texts speak across time and contexts [24]. She writes, "The rabbis develop extraordinarily sophisticated techniques of reading to uncover the multiple meanings and interconnections of the biblical text" [24]. Similarly, Fishbane's work on Biblical interpretation shows how sacred texts have historically been approached with the understanding that they contain "manifold levels of meaning requiring different interpretive strategies" [25].

These religious hermeneutic traditions offer rich models for clinical practice. Fishbane describes the interpretive stance toward sacred texts as one of "sacred attunement"-a practice of deep receptivity and responsiveness to the text [26]. This parallels the clinical attentiveness advocated by narrative medicine but adds an explicit dimension of reverence.

The patient-as-sacred-text metaphor implies several interpretive principles derived from religious hermeneutics [8,24,25] which attests to multiple layers of meaning (literal, allegorical, moral, anagogical):

- Careful attention to context
- Interpretive humility
- Community of interpretation (multiple perspectives)
- Reverent attention to detail.

Boyarin's work on intertextuality in rabbinic interpretation offers another relevant model, showing how meaning emerges through connections between seemingly disparate elements [27]. Applied to medical practice, this suggests the importance of recognizing connections between various aspects of a patient's history, symptoms, and experiences that might not initially appear related.

This approach extends Links' religious analogy from medical literature to the patient. While Links describes how physicians approach evidence like religious texts, the patient-as-sacred-text metaphor suggests that patients themselves should be approached with the interpretive care given to scripture.

The concept of the patient as sacred text resonates with von Unwerth's discussion of upaya. Both frameworks emphasize the need to approach each patient with attentiveness to their unique "language" and context. The sacred text metaphor adds an explicit dimension of reverence, suggesting that the patient contains wisdom that transcends the clinician's expertise, while upaya emphasizes the skillful adaptation of the clinician's approach to the patient's particular needs and understanding.

Bruns notes that hermeneutics has historically been concerned not just with understanding texts but with "the ethical problem of how to relate to what is other than oneself" [28]. This ethical dimension is central to the patient-as-sacred-text metaphor, which frames clinical interpretation as an ethical responsibility rather than merely a technical skill.

Comparative analysis

These varied hermeneutic approaches offer complementary perspectives on interpretation in medicine. Table 1 summarizes key aspects of each framework.

Despite their differences, these approaches share several common threads: All acknowledge that medical practice involves interpretation shaped by underlying assumptions. Each emphasizes that good interpretation requires attention to context, whether

Approach	Primary "Text"	Key Interpretive Concepts	Distinctive Contribution
Links	Medical literature	Fundamentalist, conservative, liberal interpretations	Analysis of how physicians approach evidence
Charon	Patient narratives	Close reading, narrative competence	Emphasis on literary techniques for interpretation
Kleinman	Illness experience	Disease vs. illness, cultural interpretation	Anthropological perspective on cultural meaning
Cassell	Suffering	Person-centered interpretation	Focus on suffering beyond biological disease
Foucault	Bodies	Medical gaze, power in interpretation	Critical analysis of how medicine constructs knowledge

Table 1: *Comparison of hermeneutic approaches to medicine.*

the context of evidence, narrative, culture, or personhood. Particularly emphasized in Handelman's and Fishbane's work on religious hermeneutics [24,25], this principle recognizes that both medical literature and patients contain multiple layers of meaning requiring careful interpretation. All critique purely reductionist or technical approaches to medicine, advocating for broader interpretive frameworks. Each approach acknowledges that how we interpret both evidence and patients have profound ethical implications. As Bruns notes, hermeneutics is fundamentally concerned with "the ethical problem of relating to the other" [28].

Daniel's fourfold model aligns with these common threads while offering a distinctive structure for organizing the interpretive process. His emphasis on the "change in life-world" effected by interpretation parallels the ethical dimensions highlighted by Bruns and embraced in the patient-as-sacred-text metaphor. Daniel's recognition that "seldom are the answers in medicine more than tentative" likewise resonates with the interpretive humility advocated across frameworks.

Integration: Toward a comprehensive medical hermeneutics

These diverse hermeneutic approaches need not be viewed as competing frameworks but as complementary perspectives illuminating different aspects of medical practice. An integrated approach would recognize that clinicians must interpret both medical evidence and patients, with different interpretive skills required for each.

The metaphor of patient-as-sacred-text and the concept of upaya both offer particular value in emphasizing the ethical dimensions of clinical interpretation. By suggesting that patients should be approached with reverence and that communication should be tailored to each individual's unique understanding, these frameworks highlight the moral responsibility inherent in the clinical encounter.

Daniel's fourfold model offers a systematic approach that could help integrate these diverse perspectives. His progression from literal data to diagnostic meaning to therapeutic action and finally to transformation of life-worlds provides a structure within which various interpretive methods could be situated. For example, Links' analysis of interpretive stances toward evidence would primarily operate at Daniel's diagnostic level, while Charon's narrative medicine approaches would span all four levels, with particular strength at the literal level (gathering the patient's story) and the holistic level (transforming understanding).

Von Unwerth's discussion of the mother-infant relationship as the prototype for all caregiving relationships provides a developmental foundation for understanding the clinical encounter: "Mother (or whoever serves as an infant's first and primary caregiver) is the infant's first translator of the world, as well as translator of himself, his own body-his internal sensations, stimuli, his wants and needs-to his own emerging understanding" [7]. This original relationship involves a delicate balance-the mother must be attuned enough to translate the infant's needs accurately but not so overactive as to inhibit the child's growing independence.

Integration of these approaches suggests several principles for clinical practice. Clinicians should develop awareness of their own interpretive stance toward both evidence and patients. Personal conscious and unconscious bias needs to be made aware of. Different interpretive methods (scientific, narrative, cultural, ethical) are appropriate for different aspects of medical practice. Then a recognition of the limitations of any single interpretive framework and openness to multiple perspectives require a level of humility despite the extensive local specialized medical knowledge claimed.

Other takeaways include a notion of ethical interpretation whereby interpretation is not merely a technical skill but ethically laden that respects the complexity of the patient history and the story behind the history. Each patient requires a unique approach, speaking in their "language" and adapting to their particular needs and understanding. A holding environment becomes a critical ingredient whereby the creation of a safe space where patients feel seen, heard, and responded to in ways that facilitate healing.

Conclusion

The application of hermeneutic frameworks to medicine-whether focused on interpreting evidence or patients-offers valuable insights into the interpretive nature of clinical practice. Links' analysis of how physicians' approach medical literature provides a starting point for understanding the different interpretive stances that shape clinical decisions.

Expanding beyond Links' framework, approaches such as narrative medicine, anthropological perspectives on illness, the Buddhist concept of upaya, and the patient-as-sacred-text metaphor offer complementary insights into how clinicians might better "read" patients themselves. These approaches share common ground in recognizing the multiple layers of meaning present in clinical encounters and the ethical responsibility inherent in interpretation.

Daniel's observation that "the quality of care and efficacy of therapy are directly related to the care taken in interpretation" underscores the practical significance of these hermeneutic approaches. His fourfold model, while developed decades before many of the frameworks discussed here, anticipated the need for a structured approach to interpretation that honors both scientific rigor and human meaning.

Von Unwerth's application of upaya to the clinical encounter emphasizes the need for clinicians to adapt their approach to each individual patient, "speaking in the language of the other" [7]. This concept resonates with the sacred text metaphor's emphasis on reverence and careful attention to the patient's unique context and meaning.

In an era of increasing technological sophistication and specialization, these hermeneutic approaches remind us that medicine remains fundamentally an interpretive practice. By developing interpretive skills traditionally associated with humanities and religious studies, clinicians may enhance their ability to provide care that addresses both the biological and existential dimensions of illness.

As von Unwerth concludes: "This altering of the conventional balance of the communication, where one listens and responds and is devoted to the other, is the essence of psychoanalysis and psychotherapy. But it is also an essential feature of all relationships of care and healing-the priest who takes confession, the social worker who manages a case of domestic abuse, at times the police officer or fireman who consoles the afflicted. And of course the doctor with his patient" [7].

This devotion to listening and responding to the other represents the common thread that unites all hermeneutic approaches to medicine, whether focused on evidence-based physicians and healthcare givers, or on patients themselves.

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