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"I Can Do For Me": Race, Health, and the Rhetoric of Self-Love and Suffering

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This essay explores the relationship between the discourses of religious belonging and health care among African-American women in Memphis, Tennessee who participated in a diabetes intervention program at a faith-based community health provider. It focuses especially on their descriptions of how they discovered the importance of self-care, often expressed with the phrase "I can do for me." I argue that the language and practices of biomedical contexts can work at cross purposes with the goal of encouraging good self-care, but that the insights of narrative medicine and womanist theology represent helpful correctives. This essay draws from womanist theology the concepts of surrogacy and self-love and from narrative medicine a method for cultivating in medical practitioners a capacity to appreciate the perspective of others. The central thesis of this essay, then, is that when we analyze the language of self-care using insights from womanist theology and narrative medicine, we discover the basis for a new way of construing the relationship between health seeker and health care provider that has the potential to disrupt the unconscious bias among health care providers that leads to disparities in treatment for racial and ethnic minorities.

Keywords: Health Disparities, Narrative Medicine, Self-Care, Surrogacy, Womanist Theology

In 1999, among growing public awareness about differences in the quality of health care received by racial and ethnic minorities, the United States Congress requested that the Institute of Medicine conduct a study to determine whether and to what extent such disparities exist. When the institute issued the report in 2003, it hit the health care world like a bombshell. In 764 extensively documented pages the authors of *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* spelled out clear evidence that disparities do exist and that they cannot be explained simply by differences in access or socio-economic status.[1] The bombshell in the report was that the disparities resulted substantially from bias, stereotyping, and uncertainty[2] on the part of health care providers.

The report showed that in conditions ranging from cardiovascular disease and cancer to diabetes and pregnancy, minority patients do not receive the same diagnostic tests, analgesics prescriptions, or treatments. The report also showed that minority patients were more likely to re-

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[1] Brian Smedley, Adrienne Stith, and Alan Nelson, eds. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (Washington DC: Institute of Medicine, The National Academies Press, 2003). Full text PDF available at http://www.nap.edu/catalog/10260.html.

[2] Uncertainty increases when white physicians interact with minority patients partly because the physicians do not know how to read the cues minority patients give them about their condition. Physicians regularly make inferences about a condition based on what they can observe, what they expect based on their knowledge of a patient or assumptions about that patient's background, and what the patient communicates about symptoms. If physicians make biased assumptions about a patient's background or are sufficiently unfamiliar with the communication patterns of a particular ethnic or racial group, then uncertainty grows and misdiagnosis becomes more likely.

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ceive procedures such as amputation of limbs or castration as treatment for conditions that are often controlled with less extreme measures in white patients.[3] As a regular feature of the health care experience, minorities find that health care providers simply do not order for them the same tests and procedures or prescribe appropriate medications that they do for white patients. Moreover, their failure to do so is not rooted in a professional judgment about differences in how such patients respond to treatments or as a concession to a patient's inability to afford treatment. The difference comes down quite simply to racism—perhaps not the explicit, self-avowed racism of an earlier generation, but the implicit, even subconscious racism our history and society has bequeathed us and that has become endemic in contemporary social structures, discourse, and everyday interactions.

Unequal Treatment called into question a generation of medical training that had taught practitioners, in effect, to be colorblind, to ignore social and cultural differences, to treat only the condition. The idea sounds good: Treat every patient the same regardless of their sex, gender, race, ethnicity, social class, sexual orientation, or nation of origin. Develop a "medical gaze" that assures you sweep aside all attention to social context as irrelevant and narrow the scope of your attention to the clinical issue at hand.[4] Fix a broken bone in a male, black leg just as you would in a female, white leg.

The example of a broken bone is especially instructive in demonstrating how completely the "colorblind" model of health care delivery fails. Augustus White, an orthopedic surgeon and the first African-American department chief at Harvard, points out "a bone break is about as simple and straightforward as an injury can get. There is no relation to culture, language, unhealthy lifestyle, or whether African Americans might be [averse] to some kinds of treatments. It simply must be fixed, and the considerable pain of it has to be addressed."[5] However, *Unequal Treatment* showed a horrifying consistency across medical providers: African American patients are simply not prescribed the analgesics they need to control the pain from long bone fractures. A generation of health care providers, trained to treat everyone the same, failed, simply failed, this simplest test of equality. White speculates that racial prejudice might make it more difficult for a white physician to identify with the pain of a black patient. He also notes that pain produces hostility and that, especially in the case of a black male patient with the intense pain of a long bone fracture, health care providers may be reflexively fearful of expressions of anger from black men. To some degree everyone who has grown up in a racist context will absorb its assumptions, and this means that physicians of all racial and ethnic backgrounds—including African Americans themselves—are likely to have internalized such associations and, therefore, to respond reflexively to black anger in the same way.

Theory and Method

A decade after *Unequal Treatment* was issued, the clinical community is still coming to grips with the reality that racial disparities are caused not only by social circumstances external to the clinic, but also by bias internal to health care providers. Clearly, we need a new model of medical training and a new vision for the patient-provider relationship, one that dispenses with the supposed colorblindness and neutrality of the old model and that instead emphasizes empathy

[3] Smedley, Stith, and Nelson, *Unequal Treatment*, 5-6.
[4] Smedley, Stith, and Nelson, *Unequal Treatment*, 595-603.
[5] Augustus A. White III, *Seeing Patients: Unconscious Bias in Health Care* (Cambridge, MA: Harvard University Press, 2011), 215.

and self-awareness. One proposal about how to develop a new model emerges from the literature of narrative medicine. Rita Charon, a chief architect of the narrative medicine movement, argues that a core problem with the way the profession trains medical practitioners correlates to their inability to recognize, let alone to value, the perspectives of others. Medical students are trained to filter out the social context of a patient narrative in order to distill only the biological facts relevant to making a diagnosis. The impulse of medicine, she notes, is to reduce, while the impulse of narrative is to multiply meaning.[6] Narrative medicine notices that the basic structure of our language for the body is narrative, story. In our assertions about what we feel and sense and in our questions about what is going on, we are trying to tell a story that makes sense of our lives. Charon contends that training biomedical practitioners in the literary skills of narrative analysis will ultimately result in a better patient experience and in better outcomes.

I take as a case study in listening to the stories of the body the language of self-care deployed by African-American women in a diabetes intervention program in Memphis and demonstrate how womanist theology helps us to make sense of their particular stories. A deep engagement with womanist theology, however, reveals that it helps in not only understanding and naming the content of the women's language, but also suggests a method for listening to them. With its focus on the fluid, dynamic, and improvisational nature of interpersonal, spoken communication, womanist theology offers a method that is compatible with and complementary to narrative medicine. Womanists sometimes use the term *audiation* from jazz music to communicate the nature and primacy of oral communication. This approach suggests that attention to the language and rhetorical strategies peculiar to clinical contexts and to how they intersect the primary language of underserved populations, racial and ethnic minorities in particular, highlights the challenges and opportunities facing both health care providers and seekers.[7]

Ultimately, I address this essay to biomedical practitioners who wish to become better listeners to and conversation partners with those who come to them seeking health. When clinical practitioners learn to identify the values and assumptions embedded within their own language, they are better equipped to engage appreciatively with the values and preferred language of those who come seeking their services. This approach is not a comprehensive solution to overcoming race-based disparities – we will need other approaches too – but a step in the right direction that begins simply by noticing how people narrate the meanings of their bodies.

We will listen carefully to 21 African-American women who managed to make significant progress in managing their diabetes when they participated in the Healthy Living Program, an 18-month program administered by the Church Health Center, a faith-based, non-profit community health provider in Memphis, Tennessee. Primary care providers at the Church Health Center, a place that provides health care for the working uninsured of Memphis, referred the participants. Over the course of the first twelve months of the program, participants received regular screenings, the opportunity to meet with nutrition counselors and health coaches, and a free membership to the wellness facility, which offers weight machines, a walking track, aerobics classes, an

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[6] Rita Charon, *Narrative Medicine: Honoring the Stories of Illness* (New York: Oxford University Press, 2006), 27.

[7] I borrow the term "health seeker" from Gunderson and Cochrane and choose it rather than "patient" to communicate the active role that clients of health care organizations play. They are not simply the passive recipients of others' agency; they are also the agents of their own health. I also avoid the term "consumer" with its suggestion that health is a commodity and the way that this term constructs the relationship between providers and seekers in market-based terms. Throughout the essay I will choose the term "patient" or "seeker" depending on what is implied by the context under consideration. See Gary R. Gunderson and James R. Cochrane, *Religion and the Health of the Public: Shifting the Paradigm* (New York: Palgrave MacMillan, 2012), 81-98.

exercise pool, and more. After the first year, participants were given an additional six-month, free membership to the wellness facility.

Participants nearing completion of the program were invited to participate in a conversation about how well it had worked for them. The one-on-one conversations were facilitated by students from Rhodes College who were participating in the Health Equity Internship program.[8] The students were provided with a template to guide the conversation, but were also taught to allow the conversation to flow naturally and to follow the lead of their conversation partner. This was not an interview where subjects were being studied; rather it was a conversation where program participants could educate us about their experiences.

Many important themes emerged from our conversations with the women of the Healthy Living Program, but this essay will focus on just one: Their understanding of the importance of self-care.[9] When we attend to the language of self-care using the insights of womanist theology, we discover the basis for a new way of construing the relationship between health care providers and seekers that is liberating and empowering for both. I will begin by considering the constraints on good self-care and womanist resources for encouraging it. In the second section of the paper, we will consider in more detail why the traditional model of health care delivery and of the relationship between health care provider and patient is inadequate for this task and how narrative medicine proposes reconfigure it. Finally, we will conclude with an analysis of a womanist perspective on communication and what it suggests for how we might best develop a model for health care delivery.

"Who Gonna Take Care of Me?": Surrogacy and Self-Love

When Georgia explains what she has learned about managing her diabetes, she reports simply "I was everybody's caregiver…. I had to take care of myself now."[10] Growing up, she had been taught that "loving yourself was *vain*," the idea of vanity so distasteful that she pronounces the word as though it leaves a foul taste in her mouth. Her family, her church, her society provided a framework about what it meant to be a woman, to be a black woman, to be a mother, a spouse, a faithful Christian and a caregiver. Her body had a story and that story did not include loving and caring for her, except as a means to better care for others. However, she had learned that if she wanted to live, to avoid insulin and "the needle," to use her limbs without fear of amputation, to see through eyes and know she will not lose her sight, then the story of total self-giving for the sake of others was inadequate. Her body had a story, but now she needed a new twist to the plot. "I had to learn," Georgia explains, that "a loving heart doesn't mean a doormat."

In, "You Have to Show Strength," an article exploring how the intersection of social constructions of race and gender for black women may place them at increased risk for depression, Tamara Beauboeuf-Lafontant argues that the "discourse of being strong may normalize a distress

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[8] Many thanks to Rhodes College student interns Alex Galloway, Jasmine Tate, and Chiamaka Ugorji who facilitated these conversations during the 2012-13 academic year. Dr. Elizabeth Thomas, director of the Urban Studies program at Rhodes College, and Jenny Bartlett-Prescott, Clinical Services Director at the Church Health Center, collaborated with me in designing the template.

[9] In an earlier essay, I examined three other themes emerging from these conversations in order to understand the roots of medical fatalism. See Kendra G. Hotz, "'Big Momma Had Sugar, Imma Have It Too': Medical Fatalism and the Language of Faith among African-American Women in Memphis," *Journal of Religion and Health*, 54, no. 6 (2014): 2212-2224.

[10] All names and identifying information have been changed to protect confidentiality.

inducing level of selflessness and powerlessness."[11] She attends carefully to the language of strength that women in her study used, noting how often they appealed to the need to "be strong" or "show strength" for the sake of others. Beauboeuf-Lafontant argues that women often invoked the language of strength in ways that corresponded to what Charisse Jones and Kumea Shorter-Good have identified as the "sisterella complex," a sense of self that demands "extreme other-directedness" and has the effect of silencing women from voicing their needs and suffering.[12] Ultimately Beauboeuf-Lafontant argues that "the construct of strength is rooted in a set of problematic assumptions: that strong black women are the stark and deviant opposites of weak and appropriately feminine white women, that strength is a natural quality of black women and a litmus test of their womanhood, and that being strong accurately characterizes black women's motivations and behaviors."[13] She effectively demonstrates that the discourse of strength may exacerbate existing conditions that already place black women at an increased risk for depression while also masking the symptoms of depression and inhibiting black women from seeking help.

In conversations with the women of the Healthy Living Program, we heard repeatedly narratives of strength that map cleanly onto Beauboeuf-Lafontant's findings. The women told us of their struggles to make ends meet on low wage work. Ida, a hair stylist, complained, "I'm getting paid child wages." Many of the women served in poorly compensated caregiving positions or served in roles modeled on traditional domestic labor. They worked in private homes and in nursing homes caring for the elderly, in day care facilities, in school cafeterias, and as housekeepers. They often pulled together two or even three part-time positions and put in long hours, yet never seemed to qualify for employer-sponsored health insurance. Many of the women reported that even the free membership to the Church Health Wellness center came at the high cost of transportation – the cost of gasoline for a twelve mile round trip in an older automobile with poor fuel efficiency or the time to arrange a visit around the city bus schedules adds up.

In addition to the hardship of living on "child wages," the Health Living women also frequently found themselves caring for siblings, parents, and grown children whose health had begun to fail. They were the ones others called on when they were feeling ill or needed to go to the emergency department. They were also the ones who cared for those sick friends and relatives when they came home from the hospital. In both their wage-earning work and in their church and family lives, they found themselves cast into the role of the selfless caregiver whose sense of identity and meaning were derived from their capacity to serve others – to comfort the aged, to feed and entertain the young, and to set aside any concern for self in the interests of others. In addition, family members expected them to do all of this without complaint, as though it were an essential expression of their very nature as black women.

Although they were often tempted to set aside their own welfare for the sake of others, the women in our conversations learned to resist this temptation by reexamining their religious beliefs and affirming that their own bodies are worthy of care, rest, and respect. They found resources within their own language and traditions about the meaning of the body to resists the scripts that bound them in destructive roles of servitude.

When the women were asked what they had learned from participating in the Healthy Living Program, they reported many outcomes one might expect from a health care-based program on

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[11] Tamara Beauboeuf-Lafontant, "'You Have to Show Strength': Race, Gender, and Depression," *Gender and Society*, 21, no. 1 (2007): 28.
[12] Beauboeuf-Lafontant, "'You Have to Show Strength,'" 32.
[13] Beauboeuf-Lafontant, "'You Have to Show Strength,'" 31.

diabetes: to avoid fried foods, to consume water rather than "drinks,"[14] to move more, and to monitor their blood sugar carefully. However, one theme emerged consistently that seemed to form the foundation for other healthy behaviors: The conviction that their faith did not demand that they exhaust themselves for others and that they could, as faithful Christian women, "do for me." They reported, in other words, that they had found the motivation for self-care did not have to come from a desire to be well enough to serve others, but that they could seek their own good for their own sakes.

"I was putting everybody in my family before me," explains Patricia. "I said then I had to take control over myself and my health. So I, you know, decided I said 'Hey, this is for me, and I got to do it for me." The notion that she might do something, anything just for herself came as an epiphany. That idea had simply not been a part of the way she told her own story. Another participant, Jasmine, explained "I had to focus on myself a little bit," hedging her self-care with the assurance that only "a little bit" of her focus would shift to herself. "This is something for me," Vivienne reported almost apologetically. "I'm always running for everybody else and never had time for myself. So this is for me." To get her diabetes under control, says Ida, "all I had to do was want to help myself." Wanting to help herself however, was something she had to learn, and it ran contrary to what others had taught her to want—to help others. "While I run around taking care of everybody else," Dorris asks sharply, "who gonna take care of me?" To answer the question what she had learned from the program, Hattie explains simply "Um, I can do for me."

Womanist theology, an academic expression of black women's faith traditions, which derives its norms, sources, vocabulary, and communicative patterns from black women's experiences, best expresses the theological resources embedded within the women's narratives of the body. Womanist theologians address both the temptation to self-denial as well as the hope of self-love. They offer careful explorations of how society constructed black as surrogate mothers and lovers in ways that funnel them into caregiving roles that discourage self-care and often leave them drained. However, the womanist emphasis on self-love also mirrors the very hope that "I can do for me" expressed by many of the Healthy Living women.

Womanist theology identifies the social script that binds black women in roles of self-denying service as a form of surrogacy. *Surrogacy* names the ways in which unjust social systems create conditions that force women into filling a role for another, either literally or by systematically closing off all other options. In her groundbreaking work, *Sisters in the Wilderness*, Delores Williams argued that the biblical figure of Hagar—a slave woman, a concubine who bore a child for Abraham as a surrogate for Sarah, his barren wife—provided a model for both the coerced and voluntary forms of surrogacy that black women regularly find themselves in.[15] Hagar had been forced into surrogacy, but later internalized the role and took it on voluntarily for the sake of her son. Black women have often been coerced into surrogate roles as lovers, mothers, wives, and daughters. They have been forced into sexual surrogacy as slave women who were raped by their masters or as desperately poor mothers who prostitute themselves to support their children. They have stood in for white women as mothers, wives, and daughters, filling roles as nannies, house maids, and elder care providers. They take on these burdens for others,

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[14] Nearly every woman noted the importance of learning to consume water and avoid "drinks," meaning sodas. I found it intriguing and troubling that the default "drink" for quenching thirst was a highly-processed, high-sugar soda. This preference was so pervasive that "water" had to be asked for by name, but sodas could be indicated with the generic term "drink."

[15] Delores Williams, *Sisters in the Wilderness: The Challenge of Womanist God-Talk* (Maryknoll, NY: Orbis Books, 1993).

sometimes forced into it by economic and social conditions that leave them almost no other space to develop an identity, at other times internalizing the script and taking on the role voluntarily.[16] We can see in the history of slavery and beyond how black women are constructed and constrained by these definitions that leave little room for affirmation of the self. Womanism lifts up from black women's experiences and names through the religious discourse of surrogacy the destructive capacity of our social expectation that black women will be strong for others and are naturally other-oriented in a self-denying way. These are the very dynamics we see at play in the women of the Healthy Living Program.

However, womanism also highlights resources within black women's experience for cultivating self-care. In her now famous definition of womanism, Alice Walker affirms that a womanist "loves herself. Regardless."[17] Being a womanist means practicing self-love in a world that communicates that you are unlovely and unloveable. It means affirming one's beauty and value in a world that says black women are ugly and worthless. Being a womanist means carving out space to be somebody in a world that encourages black women to recede into the background, a nobody. It means taking time to pamper yourself in a world that defines real womanhood in ways that constrained white women to emotional, physical, and intellectual fragility while regarding black women as beasts of burden and, therefore, beyond the pale of the truly feminine. A womanist learns to love herself "regardless."

"This is God's Temple:" Agents and Patients in Clinical Discourse

Many of the women had absorbed a theology that cast the role of faith in the passive, as a patient, waiting attitude that accepts whatever life brings one's way.[18] As a result, they reported an almost universal difficulty connecting their faith to the need for changes in diet and lifestyle that accompany managing a chronic condition like diabetes. Some, like Vivienne, had been explicitly taught that going to the doctor indicated a lack of faith. Others wondered whether the presence of disease indicated the same. Brenda reported that it simply never occurred to her to "apply my faith to healthy living." Only when prompted did the women search their memories for stories of faith that might connect to healthy living. "Well, Jesus didn't walk around fat and out of shape," Sonia puzzles out. When pressed, Dorothy remembered that Jesus taught, "don't put nothing that don't supposed to be in your body in there." Others recalled, "Jesus walked everywhere" and that "everything natural with him."

Although they had absorbed a theology of passivity with respect to care for their own bodies, many of the women also drew on their traditions to forge new links between faith and health:

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[16] James Cone has noted that churches and juke joints provided the exceptions to this rule in the Jim Crow south. They were the places where black women and men could assert their own sense of self and could cultivate the inner resources to resist the "othering" and invisibilizing forces of the dominant culture. See, James H. Cone, *God of the Oppressed* (Maryknoll, NY: Orbis Books, 1997).

[17] Alice Walker, *In Search of our Mother's Gardens: Womanist Prose by Alice Walker* (New York: Harcourt Brace Jovanovich, 1983), xi.

[18] This sense of faith's passivity in the face of personal health crises is curious because, of course, black church traditions have been anything but passive in the face of social injustice. The call of faith in those instances has always been a clear, prophetic call to protest, to march, to preach liberation, and to sing hope and change. The idea that suffering is to be endured passively seems to be restricted primarily to the realm of personal, bodily suffering. Suffering caused by injustice, on the contrary, is to be actively and vocally denounced. And what we might call "provocative suffering" that results from such engagement with the powers that be is to be embraced for the sake of proclaiming the reign of God. James Cone explores the identification of black suffering with Christ, whose suffering on the cross came at the hands of an unjust empire, in *The Cross and the Lynching Tree* (Maryknoll, NY: Orbis Books, 2011).

Faith without works, they knew with certainty, is dead. Nevertheless, the most common theme that encouraged an active view of faith was the image of the body as a temple of the Spirit. Without prompting, most of the women reported that their bodies were worthy of love and respect, deserved rest and care, because they were the dwelling place of the Holy Spirit. Patricia expressed the idea in this way: "Knowing that this old body is not mine; it does not belong to me. This is a temple of the Lord. And I've got to treat it as a temple of his. And I don't want to defile what he has loaned me…. But if I keep putting on all that fried chicken and all that spaghetti and all that stuff, it's not good…. So you have to look at it in a different way. Health-wise this is God's temple…. I've got to protect it. I've got to shield it." If God's own Spirit saw fit to reside within their black and weary flesh, then the women felt confident that it was, in fact, not vain to love their bodies and to "do for me." In Patricia's case and in many others, the Healthy Living women were only able to give themselves permission to love their bodies and to be active agents of their own health by appealing to the rhetoric of surrogacy. They were stewards of bodies that do not belong to them; they shield and protect these bodies on behalf of another. They had found a way to turn the destructive force of surrogacy on its head.

The resources to engage in new and healthy life choices did not need to come from an external, white, biomedical provider. Those resources for self-care and self-love were already present, ready for deployment in powerful ways when these women were valued as agents of their own wellbeing and authoritative interpreters of their own bodies and traditions. When we asked them to educate *us* about faith and health, they found the language they needed to make the changes they wanted.

From their own resources, and in cooperation with a clinical care provider, these women claimed their agency and, in doing so, found remarkably effective ways of managing their disease. Yet the women also reported that the model employed by the Church Health Center is rare in clinical care. In other contexts, they had not felt equally respected, nor had they been encouraged to take the initiative for their own health. Why? In what follows, I argue that the design in many clinical settings discourages agency and that consequently works at cross-purposes with the goal of empowering health seekers to follow a plan of care.

There exists a vast and growing literature linking social circumstances to health outcomes.[19] One of the clearest lessons to emerge from these studies of the *social determinants of health* is that the sense of being out of control triggers certain stress hormones that regulate functions such as blood pressure and blood glucose levels. Those who face a lifetime of stressors related to racism or poverty experience in their own bodies the health effects of never being in control and of prolonged exposure to elevated stress hormones. In short, poor and ethnic minorities (regardless of socio-economic status) are more likely to experience diseases such as hypertension, stroke, and diabetes. Although social determinants vastly overpower clinical interventions in their effect on health outcomes, clinical contexts either can exacerbate the sense of being out of control or can contribute to a growing sense of agency in a health seeker.

This means that the particular issue of how social constructions of black women's bodies constrain black women from practicing good self-care has broader implications for health care delivery, especially with underserved populations. Specifically, it points us to how problematic it is that traditional healthcare delivery coaches individuals into a passive role that discourages expressions of agency most likely to motivate a health seeker to value and care for herself. Traditional medicine operates on a paternalistic model that presupposes the patient is the passive re-

[19] For a good introduction to the social determinants of health see William C. Cockerham, *Social Causes of Health and Disease* (Malden, MA: Polity Press, 2007).

cipient of the actions of others (the term *patient*, after all, means "the one acted upon") rather than the agent of her own well-being. It assumes that the relationship between the healthcare provider and the patient is hierarchical rather than a partnership and that the patient owes deference to the provider. The provider is understood as the objective, neutral authority who deals in facts, not values. The provider, therefore, has no need to try to understand the situation from the health seeker's perspective or to align a fact-based plan of care with the seeker's values and life goals. A traditional model, if it is attentive at all to the narrative structure of embodiment at all, construes the provider as the (s)hero or shero of the story. Put another way, "the doctor" is in control and issues orders, while the "patient" is responsible only for compliance. If there is a story, it is the story of the heroic doctor whose choices and actions ultimately control the narrative. The patient becomes a secondary character in the story of her own body, a damsel in distress awaiting her (s)hero's actions. In clinical contexts as they are currently constructed, the provider is the agent and hero.

Imagine this narrative: You walk into a room designed for waiting. Your time is not the time that governs this space. Before anyone will see you for "care," you must provide evidence of your ability to pay for it. After waiting for a time, someone escorts you into a cold, sterile place where you are measured: your weight and height are noted, a blood pressure cuff squeezes your arm, a pulse oximeter pinches your index finger or ear lobe, someone then inserts a thermometer into your mouth. You sit still in deference to the delicate temperaments of these measuring devices. Someone then moves you into a small room where you exchange your clothing for a confusing garment that resembles nothing so much as a large paper towel. You sit on the edge of an exam table with no back support. You then wait – measured and prodded, effectively naked. You wait – shorn of all the makers of your distinctive identity – for the fully clothed expert to enter the room after a perfunctory knock to poke and prod your body and to make a judgment about its soundness. The expert then asks you questions, and when you begin to answer, you are interrupted within 18 seconds.[20] Perhaps bodily fluids are needed to confirm the expert's judgment. If so, you are escorted down another maze-like hallway to a lab where blood is drawn or you urinate into a little plastic cup. Orders will be given, and, unless you are a "difficult" or "non-compliant" patient, you follow them. You are not in control. Everything about the situation communicates that simple message: you are not in control.

However, the social determinants of health tell us that not being in control is at the heart of the problem. The clinical context, as currently constructed then, only reinforces an underlying distortion and represents one more obstacle in exercising agency. Recent developments in person-centered care and narrative medicine, as well as attention to the social determinants of health, have begun to challenge this paternalistic model of healthcare delivery. Combined, these models suggest that we had better promote good outcomes with individuals coming into clinical contexts. Providers need to regard them as active agents in their own stories, health seekers whose choices, values, and actions control the narrative. Healthcare providers are better conceived of as partners and facilitators. Biomedical practitioners who wish to serve as effective partners in health with underserved populations in particular must achieve a reorientation of perspective. This perspective will help them appreciate the barriers to good self-care that underserved seekers confront and to enter empathetically into their stories not as (s)heroes and protagonists, but as supporting characters who encourage, enable, and celebrate their agency.

[20] Charon, *Narrative Medicine*, 66.

Literary and Rhetorical Skills

What stands in the way of this reorientation is often the assumption, reinforced in biomedical discourse, that medicine is the neutral arbiter of facts. Medical students trained in this assumption gradually lose their empathy for patients as they lose their ability to grasp the perspective of another.[21] Narrative medicine suggests that achieving a reorientation of perspective that allows biomedical practitioners to recognize their own situatedness and to value the perspectives of their health seekers will require healthcare providers to develop a set of literary skills. Charon argues that when physicians are trained to listen for and be moved by stories of illness they can begin to overcome the lack of empathy and failure to recognize and value the perspectives of others that too often characterizes medical practice. She argues that learning to read for plot, genre, metaphor and so forth can help practitioners to recognize similar features in how their patients narrate the onset of disease. As practitioners become skilled in losing themselves in a good story, in learning to value the perspective of the characters in literature, they can learn to recognize and value the perspectives of their patients.

The central insight of narrative medicine is simple: Every *body* has a story. The language of our bodies is natural to us. The tropes, diction, and syntax we use to tell the stories of our bodies emerge from the rich social entanglements that surround, support, constrain, and define us. Those contexts provide an imaginative set of images and ideas that tells us what to expect and hope for our bodies, whom to entrust with their care, and what to make of new and unexpected sensations. We carry within our imaginations narratives of our bodies, stories of our flesh woven together from half-remembered episodes of delight and trauma, of mysterious aches and unexpected pleasures, of family members with bodies like our own and of unique perceptions that only we have known. We draw together the bits and pieces of enfleshed experience, sorting through the flotsam of conscious memory, in an effort to give a coherent account of who we have been and who we are becoming. The story-telling framework of our social context helps us to make sense of our experiences by providing pathways for weaving disruptive, even traumatic bodily experiences into coherent accounts of the self.

The natural language of the body grows up organically in the soil of family stories and then picked up in the conversations overheard as women at church clean up after a potluck. This natural language of the body is very different from the biomedical discourse of clinical medicine, but skilled clinical practitioners can discover clues that connect the natural narrative to the biomedical one in diagnostically useful ways if they can learn to listen, and cultivating skills in literary and narrative analysis is an effective way to learn to listen.

Everybody has a story, but it is important to remember that our primary way of telling stories is not in the long form of novels nor even in the written form of short stories, where plot lines are carefully developed and dialogue meticulously planned. The first human stories were face-to-face encounters; they were oral stories told to audiences whose faces the storyteller could see and read whose responses called out innovations and adaptations in the telling. Storyteller and hearer belonged to a common community and shared values and hopes.

Womanist theology takes as a theme the primacy of oral communication. This is a form of theology that values the norms of oral discourse—norms of community and equality, of free play and adaptability—over those of the written word. Speakers expect interaction. However, if readers wish to respond to writers, they must squeeze their comments into the margins. Womanists prefer the improvisational, conversational pattern of oral communication, with its egalitarian

[21] Charon, *Narrative Medicine*, 8.

norms and expectation of multiple voices, over the patterns of written communication with its implicit assumptions about hierarchical modes of authority and power.

Womanists often appeal to the "dialogical intent" [22] of theology and to its similarity to audiation,[23] the skill that allows jazz musicians to "play off" on one another and to improvise on an old classic. The emphasis on theology's dialogical nature respects the fluidity of our identities and the ways in which who we are and how well tell our stories is wrapped up with the relationships we form with those who receive and are entrusted with our stories. [24]

Could this suggest a new way of engaging the health seeker? Perhaps one could complement the skills of literary analysis by the playful, improvisational skills of jazz musicians and of the authority-less back-and-forth of good conversation. Perhaps the womanist preference for oral communication and its "dialogical intent" suggests that health care providers step away from the role of the literary critic, who "reads" the patient's story, and into the role of conversation partner. The health care provider, then, becomes a participant in the story, not the hero to be sure, but perhaps a crucial supporting character.

When we attend carefully to the rhetorical choices that vulnerable health seekers deploy, when we value their language and learn to listen respectfully, we find that they often already have many of the resources they need to become active agents in their own health and healing. When the Healthy Living women reported that they had learned that "I can do for me," they were reporting truths that they had uncovered from their own religious traditions, and were doing so in their own voices and with their own language. Clinical health care providers, therefore, can best become aware of their own bias and develop true solidarity with their health seekers, when they encourage health seekers to become the hero of their own stories.

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[22] Delores Williams, "Womanist Theology: Black Women's Voices," in *Weaving the Visions: new Patterns in Feminist Spirituality*, ed. Judith Plaskow and Carol P. Christ (San Francisco: Harper Collins, 1989), 183.

[23] Stephanie Y. Mitchem, *Introducing Womanist Theology* (Maryknoll, NY: Orbis Books, 2005), 79.

[24] Arthur Frank also highlights the dialogical nature of storytelling and hearing. See *Letting Stories Breathe: A Socio-Narratology* (Chicago: University of Chicago Press, 2010) and "Narrative Ethics as Dialogical Storytelling," in *Narrative Ethics: The Role of Stories in Bioethics*, special report, *Hastings Center Report* 44: 1 (2014), 16-20.