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Ways of Knowing in Family Medicine: Contributions From a Feminist Perspective

Lucy M. Candib, MD

Feminist psychologists have recently drawn a distinction between separate and connected knowing, two different ways of finding out about the world. Family medicine practice uses connected knowing to discover, through empathy, what another person may be experiencing; in contrast, family medicine research, in order to gain academic credibility, relies on separate knowing, typical of scientific thinking. These two ways of knowing have been variously described by Bruner as paradigmatic versus narrative, by Kuzel as rationalistic versus naturalistic, and by Stephens as seeing versus hearing. The two ways of knowing vary in their use of context, time span, believability, and empathy. Family medicine, in a parallel with women who are finding their voice in a world that has not respected them, must come to blend the two ways of knowing. We can begin reframing our research questions by drawing on knowledge of our intimate, long-term connections with patients, thus underscoring the importance of the knower and the relationship with the known.

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The goal of this article is to clarify some ways of looking at the world and to point out the implication of those ways for family medicine. I will use distinctions made by both men and women writers, but I will draw most heavily on a recent study about how women come to know about the world, called *Women's Ways of Knowing*.¹ This book offers an understanding central for family medicine in thinking about the problem of research: that those who have less power in the world have more difficulty finding their voice and that their way of listening, learning, and speaking about what they know is essentially different from the way that those in power hold forth.

In recent years, a number of authors have begun to draw distinctions between two different ways of finding out about the world. The names of the two different ways vary by the authors: Bruner writes about the paradigmatic versus narrative ways;² Kuzel describes rationalistic versus naturalistic knowing³ (see page 665 in this issue); Stephens talks about seeing versus hear-

ing;⁴ and, most recently, Belenky et al describe separate versus connected knowing.¹

Bruner describes the two modes of thought as:

. . . irreducible to one another . . . (I)n their full development, the one seeks explications that are context free and universal, the other seeks explications that are context sensitive and particular.²

Bruner's paradigmatic mode (also known as the logico-scientific mode) is based on categorization and the methods by which categories are linked to each other to form systems; based on consistency and non-contradiction, this mode tests hypotheses to arrive at empirical truth. Bruner describes the narrative mode as working in two "landscapes" simultaneously: the landscape of action (ie, the plot, the agent, the goal) and the landscape of consciousness (what the actors know, think, or feel). While believability is the touchstone of narrative, falsifiability is the standard of the scientific method.⁵ We shall return to this distinction in a later section.

What the family physician does when she or he sees a patient in the office is closer to constructing a believable account in Bruner's narrative mode than it

is to proving an empiric hypothesis in the paradigmatic mode. What I wish to argue in this paper is that our research should therefore begin as an amplification of this familiar narrative mode instead of insisting that research to be valid must fall within the logico-scientific frame.

In our own literature, Kuzel has drawn a similar distinction between rationalistic inquiry (what is usually taken to be the traditional scientific method) and naturalistic inquiry.³ Kuzel distinguishes between the different forms of trustworthiness recognized by the two forms of inquiry: for instance, the rationalistic mode uses the criteria on internal and external validity; the naturalistic mode depends on credibility. He also points out the differences in the investigator's stance: objectivity, with all its implications of distance and separateness, is central to the rationalistic mode. What Kuzel calls *reflexivity* is the stance of the naturalistic observer who consistently examines the contribution of his or her own perspective and interpretation to the investigation at hand. We will return again to the concepts of credibility and reflexivity in the next section. Kuzel goes on to articulate in detail the implication of these alternative models for research.

Stephens has recently drawn the distinction between seeing and hearing as two different avenues that lead to two different understandings of patients.⁴ Twentieth century medicine respects the primacy of what can be seen; our capacities to generate visual images of our patients' bodies have expanded far more rapidly than we could have imagined only 20 years ago. At the same time, our abilities to hear patients have probably not grown and may indeed have atrophied further. It is this listening/hearing that allows our imaginations to become open to the imaginations, the hopes and fears, of our patients. In hearing and listening we take the other into ourselves. This is the sensory correlate of the kind of knowing I have been describing.

The concepts of separate and connected knowing are helpful in gaining legitimacy for a crucial theme in family medicine, the importance of knowing the patient. Four women psychologists have written a pathmaking book called *Women's Ways of Knowing*.¹ They felt that how women come to learn about the world differs from how men come to do it; to examine this possibility, they interviewed hundreds of women, some several times over a period of years, asking how they describe themselves, how they see themselves in relationships, how they see themselves in the world, how they come to learn and to know, and how they see, identify, and solve moral problems. The authors describe a sequence of ways that women come to learn about the world and themselves in that world. In particular, they demonstrate the relevance of this sequence to the process of gaining an education.

One of the later steps in learning Belenky et al call "procedural knowing." This is the kind of learning that goes on primarily in academic settings, where students learn the methods of argument and analysis of each discipline. Form is more important than content; how you set about it is more important than the position you take. While many different interpretations of a piece of work are possible, not all are equally valid. In contrast to the previous stage of subjective knowing, at this time, an excess of personal involvement in interpretation is suspect. Much of family medicine education goes on at this stage: residents learn the essentials of our methods but have difficulty seeing the importance of their own or the patient's unique personal contributions to solving common problems in our work.

Family medicine research goes on more actively at the subsequent step of separate knowing. Based on critical thinking, objectivity, and reason, separate knowing actively excludes the self. Separate knowers willingly confront authorities, using rhetorical skills and highly polished arguments. But, the women Belenky et al interviewed at this stage felt a particular emptiness and pointlessness in their success.

Separate knowing stands in sharp contrast to connected knowing, which is built on the belief that "trustworthy knowledge comes from personal experience rather than the pronouncements of authorities."¹(pp.112-3) Connected knowers seek to find out about the other person's experience; in family medicine, we usually set about this by actively trying to find out what the other person is experiencing—to know how he or she is perceiving the world.

Separate knowers learn through explicit formal instruction how to adopt a different lens—how, for example, to think like a sociologist. Connected knowers learn through empathy. Both learn to get out from behind their own eyes and use a different lens, in one case the lens of a discipline, in the other the lens of another person.¹(p.115)

In these terms, I would argue that the long-term practice of family medicine goes on at the level of connected knowing, while our research stays confined to separate knowing. The resultant disjunction produces practitioners who do not write and researchers who do not practice.

Belenky's group found that through connected knowing a woman would come to learn about another person or about a written work or an art form by taking it into herself, finding the ways in which she can see the world from the point of view of the other. The other is no longer "out there" but also within. Such connected knowing is not strictly defined along gender lines, but the separate way of knowing is clearly

more compatible with male sex role socialization, which emphasizes and depends on male separateness,⁶ while connected knowing is more compatible with the way women are socialized to see relationships as the central activity in their lives.^{7,8} Although the term *connected knowing* has been put forward by feminists, I am not making the claim that only women think this way; on the contrary, I suspect that many, if not most, men in family medicine think this way as well but may feel guilty about it! After all, men are even more strongly socialized to think that only rational, emotion-free objectivity is the proper way to look at the world.

What all these descriptions—Bruner, Kuzel, Stephens, and the Belenky group—have in common is the recognition that a certain way of finding out about and knowing the world has held the dominant position in academia—not only in the natural sciences and the social sciences but also in the arts and humanities. Despite the popularity of the idea of scientific revolutions, in science and medicine the reigning viewpoint remains the positivist conception of science. The other way of knowing and finding out is now starting to make itself heard. Unfortunately, in family medicine, in the pursuit of academic credibility, we have up to the present failed to acknowledge the legitimacy of our customary way of knowing and instead have attempted in our research and our writings to employ what is more accepted as the scientific way of knowing. Since this is not actually our primary way of working and learning, it is no surprise that up until the present, our research and our practice remain so disconnected.

What I would like to do now is to take four distinct features of these different ways of knowing and point out family medicine's legitimacy as a discipline of connected knowing, to use the Belenky term. The four features I will discuss are only some of many—but the comparisons will begin to shape the outlines of a world view familiar to family medicine but not considered as a legitimate way of thinking.

1. Context

In naturalistic or connected knowing, the context is central to understanding the person or situation with which we are faced. We feel we do not have a good fix on something until we have a feel for the surroundings in which it is embedded. The goal of this standpoint is a comprehension of the uniqueness of this person's situation, illness, or recovery. Individual, family, or n of 1 studies followed over long periods of time can exemplify research in this framework. In contrast, rationalistic or separate knowing relies on removing the phenomenon from its context and isolating the elements with the goal of establishing a useful generalization, law, or rule about such instances. This approach seeks to strip away differences look-

ing for common elements that bind examples together. Controlled trials are a paramount example of this way of thinking.

2. Time Span

Narrative or naturalistic knowing relies on observations, if you will, made over a prolonged span of time. When we have not been present in the pasts of our patients, we use tools like the genogram or life story to explore their pasts. Our present work is predicated on maintaining our connections over a long enough time span to participate in the unfolding of the individual and family narrative. Stephens has highlighted the importance of this historical perspective for individual patients in his work on clinical biographies⁹ and careers of illness.¹⁰ The prime example of work focused on families within a community was conducted by F.J.A. Huygen¹¹ in his monumental work tracing the family medical histories of hundreds of Dutch families for up to four generations. In contrast, the attention span of most North American research is very short; for example, a recent retrospective study on the "natural history" of palpitations¹² studied patients with a mean age of 43 for a mean period of 41 months. While all clinical work must pay some attention to the role of time, as in the "history of the present illness," the customary dominant view in clinical research is far more cross-sectional than longitudinal in constructing an understanding of what is going on.

3. Believability

Narrative is about "the working out of human intentions in a real or possible world."^{2(p.106)} One of the assessments of a narrative lies in its believability. In family medicine, we must initially listen to and accept the story the person tells us about himself or herself. In clinical care, this stance is exemplified by our approach to the child who tells us that he or she has been sexually abused. We must act based on our belief that the narrative is true. Our job is not to disprove the statement but rather to begin our work based on the likelihood that it is true.

Using disprovability in contrast to believability, the paradigmatic, or rational world, is evaluated through "the operations of causes, structural requiredness, reasoned correlation."^{2(p.106)} To test hypotheses in this framework, we attempt to disprove them. Both the judicial system and the scientific hypothetico-deductive systems function to attempt to disprove hypotheses. Belenky et al said,

Presented with a proposition, separate knowers immediately look for something wrong—a loophole, a factual error, a logical contradiction, the omission of contrary evidence.^{2(p.104)}

Belenky et al found that women were uncomfortable with doubting—that they either saw it as a game or as something threatening to their relationships with others where someone might get hurt. Doubting requires a particular suspiciousness of the person’s involvement in his/her story and in that person’s own personal responses to it: doubting relies on the removal of self or objectivity. Believing, in contrast, felt real to the women Belenky’s group interviewed,

Perhaps because it is founded on genuine care and because it promises to reveal the kind of truth they value—truth that is personal, particular, and grounded in firsthand experience.^{1(p.113)}

Believing means that you accept as valid another person’s experience in shaping his or her way of looking at the world, even if you do not share the experience or viewpoint. The person’s subjectivity is important in your understanding of the other.

Research in our discipline based on believability rests on the assumptions that the narratives that people tell about themselves make sense, that our job is to understand the story they tell, to put together the person’s picture of what is happening. McWhinney has described this patient-centered activity as “the transformed clinical method.”¹³ An example of empiric research carried on in this tradition is Schooley’s inquiry into the emotions patients experienced prior to an office visit for episodic care.¹⁴ Her work demonstrates yet again that if we allow ourselves to hear what patients are telling us, their expectations and requests will make far more sense.

4. Empathy

The last set of distinctions I would like to make between the two ways of looking at the world involve empathy. The connected knower cares deeply about the person she or he is learning about; she or he takes into herself or himself the other’s experience. As in the narrative, the naturalist, and the hearing modes, we attempt to let the other in, to allow the other to speak to us, to listen actively to the one speaking. This contrasts with the separate stance of the rationalistic knower for whom feeling is suspect, who would argue that if you care too much you cannot exercise rational judgment. Dissection and other visual modes of finding out about the world are examples of the practice of separate knowing, from which caring is best removed. As White pointed out at the 1986 Society of Teachers of Family Medicine (STFM) Annual Spring Conference, for rational knowers, science and caring are two separate activities—often separated by gender as well.¹⁵

These four characteristics—contextuality, life-history perspective, believability, and empathy—are strong strands woven into the fabric of connected knowing. And, it is connected knowing that I have shown to be integral to our daily practice. Yet, separate knowing appears to be an inevitable aspect of the world of science in which we live and work. Does the dichotomy between separate and connected represent an ultimate schism, or can we envision the possibility of some future synthesis?

Stephens has argued that the narrative form¹⁶ and McWhinney has argued that the naturalist form¹⁷ are in essence forms of observation and are therefore preliminary steps in science making. This posture, however, implies that they are a more primitive version of scientific observation as it is classically understood and therefore are reducible to steps in scientific method. I disagree; to me, the narrative/naturalist form is not reducible to observation, particularly because of the crucial role of the connected self in coming to understand about the world through this mode. It is because of connected knowing that family medicine is a distinct and different entity from other medical disciplines.

Belenky et al describe the way that women move beyond the dichotomy between separate and connected: they integrate the voices to create constructed knowledge. These learners were able to integrate what they came to understand intuitively and through their own experience with what they were able to learn from others. “All knowledge is constructed, and the knower is an intimate part of the known.”^{1(p.137)} Using self-knowledge, constructed knowers use themselves as “an instrument of understanding”^{1(p.122)} In constructed knowledge, I seek to unify the pieces of the whole self—for me, doctor, mother, daughter, lover, thinker, activist—in my work, avoiding the compartmentalization of thinking and feeling, professional and personal, that tears up my colleagues. It is in this constructed knowledge of family medicine that we can learn to recognize, attend to, and respect the contribution of ourselves as persons to our work with patients, to accept and value ourselves as an active instrument of knowing and of healing.

Constructed knowing requires questioning the assumptions and the frames of knowledge; we begin to pay attention to the asking, “What is the question?” And that is what I believe family medicine must do now—start the process of asking what are the right questions. Family medicine can listen to the voices of women coming to find their way of knowing in a world that has not respected them and can use these understandings to construct our own knowledge based on our intimate, personal, long-term connectedness with our patients. Family medicine, committed to both

the personal and the scientific, can choose in our research to blend the visions, highlighting the importance of the knower and the relationship with the known. Using this standard, we can sift through all of the voices we hear and words we read and find those to which we must listen.

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REFERENCES

1. Belenky MF, Clinchy BM, Goldberger NR, Tarule JM. Women's ways of knowing: the development of self, voice, and mind. New York: Basic Books, 1986.
2. Bruner JS. Narrative and paradigmatic modes of thought. 84th yearbook of the National Society for the Study of Education. Chicago: University of Chicago Press, 1985.
3. Kuzel AJ. Naturalistic inquiry: an appropriate model for family medicine. *Fam Med* 1986;18(6):369-74.
4. Stephens GG. On seeing and hearing in medicine. *Continuing Education for the Family Physician* 1985;20:754-6.
5. Popper KR. The logic of scientific discovery. New York: Harper and Row, 1968.
6. Chodorow N. The reproduction of mothering: psychoanalysis and the sociology of gender. Berkeley, Calif: University of California Press, 1978.
7. Miller JB. Toward a new psychology of women. Boston: Beacon Press, 1976.
8. Gilligan C. In a different voice: psychological theory and women's development. Cambridge, Mass: Harvard University Press, 1982.
9. Stephens GG. Clinical biographies: issues in longitudinal care. *Continuing Education for the Family Physician* 1985;20:260-75.
10. Stephens GG. Careers of illness: problems in the diagnosis of chronic illness. *Perspect Biol Med* 1986;29:464-74.
11. Huygen FJA. Family medicine: the medical life history of families. New York: Brunner/Mazel, 1982.
12. Knudsen MP. The natural history of palpitations in a family practice. *J Fam Pract* 1987;24:357-60.
13. McWhinney IR. Are we on the brink of a major transformation of clinical method? *Can Med Assoc J* 1986;135:873-8.
14. Schooley S. Taking a patient-centered history—a new clinical tool. Presented at the Society of Teachers of Family Medicine 1986 Annual Spring Conference, San Diego.
15. White KL. Ciencia y caridad. *Fam Med* 1986;18(6):379-83.
16. Stephens GG. What kind of research in family practice? *Family Medicine Teacher* 1980;12(2):8-9, 21-6.
17. McWhinney IR. The naturalist tradition in family practice. *J Fam Pract* 1977;5:375-8.