intima a journal of narrative medicine

FIELD NOTES | SPRING 2016

Pedagogy By the Oppressed:

My Journey to Narrative Medicine

By Apurva Khedagi

In my freshman year of college, I was granted an opportunity to pursue any project that I proposed, anywhere in the world. I knew exactly where I wanted to go.

When I was young, my family and I traveled to Mumbai every summer to visit my grandparents. As we drove from the Chatrapavti Shivaji airport to my grandmother's home, we always drove past the largest slum in India—one of the largest slums in the world. The shacks slapped together with corrugated metal and trash propelled like waves across my car window, moving only transversely and never ending. The waves of illegal homes abruptly crashed as they hit the land where some of the tallest, wealthiest housing in India resided. The disparity was overwhelming; it cried out for action. In freshman year, the slums of Kandivali, Mumbai was where I chose to begin.

Knowing that preventable diseases caused the majority of deaths in Kandivali, I naively entered with this proposal: spread sanitation and basic health awareness and provide vaccinations. On my first day, however, I met Shushma and her a two-year-old daughter, Sona. I followed Madhura, a health worker, as she made her way around the incredibly dark, narrow and intricate alleys to reach Shushma for a home visit. When I tried to leave after our visit was completed, Sona *clung* on to the end of my shalwar kameez—she would not let go of me. So, I spent the rest of the day just playing with Sona. I sat on the lone grey mattress in Shushma's home, one she used both as a couch and a bed. I played with Sona while Shushma cooked, cleaned, and washed dishes. Slowly, our barriers of background, class, and clothing started to break down. I listened as Shushma shared her life with me.

During the next three weeks, I spent most of my time just sitting with women, helping them make hair clips, playing with their babies, listening to their stories, and building friendships. Astonishingly, I even learned to navigate my way through the maze-like alleys filled with rats, gutters, and my worst fear—stray dogs. Through the relationships we formed, we crafted solutions to use their current health resources to the utmost advantage. We derived ideas such as placing metal tops on their large blue water drums, the source of their drinking water and the source of mosquito breeding, of malarial infection. As I spent time listening to the women's illness narratives, they told me how malnutrition was the central cause of the morbidity and mortality that resulted from preventable diseases. The more I listened, the more secrets were revealed.

Two years later, during my junior year in college, the relationships I had built with the women in Kandivali pulled me back. I missed them. I returned to continue tackling the unfair situation through a research-intervention project on nutrition. I created animated videos on nutrition and led a ten-week intervention with participating Kandivali women. At the end of the intervention, the women implemented the knowledge of nutrition to develop original nutritious recipes, which we then combined to form a cookbook. Together we developed recipes; together we developed solutions to address malnutrition.

During my very first week in Kandivali, I met Vanita. The first day I walked into the Janupada region, I saw Vanita's smile shining from the other end of the alley. I could feel the warmth that her smile was radiating. I knew I had to approach her.

Vanita's Story

Vanita always wears a colorful sari, never black, grey or white. The end of her sari is always wrapped around her waist to prevent it from getting in her way when she works; and Vanita is always working. She wakes up every morning to begin her household chores before she leaves for work at 7:30 a.m. She returns home to her second shift, to finish her endless chores including cooking, washing dishes, washing clothes, and filling the water drum. Although Vanita works all day and rarely has any time for herself, she always greets everyone with her warm smile, one even brighter than the colorful saris she wears. I am in awe of her ability to never get tired or frustrated.

Amidst all her work, Vanita participated in the intervention every week, always sitting in the front row. To understand what drove Vanita to attend the session every week, I asked for her reflections in a final interview I conducted. She said to me:

> "Acha laga. Kuch to apna koi kuch poocha apne se. Unke paas se, tumare paas se apne paas aya, apne paas se tumara paas aya. Esa acha laga."
> *I liked it. Someone asked something from me. From you I got something and from me you got something. That I liked.*

Vanita told me the fact that her voice, her knowledge was valued in our efforts to address malnutrition is what she liked most about the intervention.

***

Similarly, Sarita, another woman I met in Kandivali, offered a complementary understanding. Sarita only speaks Bhojpuri and participated in the intervention, despite it being led in Hindi. As we sat together in Sarita's home during the final interview, I worked to understand what drew her to participate in the intervention every week. Sarita revealed that she most enjoyed

our group community and taking part in developing the cookbook.

Through Vanita and Sarita, I come to understand the significance of unobstructed listening and narrative humility[1]. Through Vanita's story, I understand how this form of co-learning, co-creation, allows for the development of effective solutions. Through Sarita's story, I understand how such intersubjectivity can be experienced even without a common language. I understand the significance of the relationships that were built within our group. The friendships and the sense of empowerment drove them and other women to attend despite their exceptionally busy schedules. The friendships and the sense of empowerment drove Sarita to attend despite a lack of common language.

In the *Pedagogy of the Oppressed,* Brazilian educator and theorist Paolo Freire identifies two ways of education: the banking model and the problem-posing model. Within the banking model, the teacher deposits information into the local individual's minds, perceiving oneself as the sole carrier of knowledge. On the other hand, the problem posing method of education calls for a bidirectional knowledge transfer, for dialogue in order to develop solutions. Both the teacher and student learn and teach together to address issues such as that of malnourishment (Freire, 79).

As I entered Kandivali, I recognized that my background as student with over fourteen years of education from the West traveling to the under-resourced area of Kandivali posited an inherent, fixed difference between the women and I. However, as a single woman who does not know how to cook, the women's skill in cooking dismantled the power-dichotomy that rested within this inherent difference. I stood by their side in their small but warm kitchens, listening and learning how to cook. Slowly, our barriers of background, class, clothing and knowledge started to break down. The recipes, the solutions we developed were derived through a bidirectional knowledge transfer.

I come to understand how the cookbook we developed became a form of Pedagogy *by* the Oppressed. The cookbook not only acts as a forum to dissemble the teacher-learner dichotomy, but also as a set of solutions developed by the women themselves, highlighting the embodied knowledge of the women. *We were a team*, not teacher and students or health worker and patients, but all united toward the same goal. Basic health is a basic human right and the death and sickness caused by preventable diseases was an infringement on their human rights, on their dignity.

I shifted away from the proposal I had entered Kandivali with to: listen, learn, and then work to develop solutions together. This understanding, their stories, led me to narrative medicine—

[1] Dr. Sayantani DasGupta coins the term narrative humility to express how "the patient's story, at least initially, belongs entirely to him" (DasGupta 980). Narrative humility refers to the recognition that we can never fully understand another's story. In turn, this recognition calls for humility, for respect, and for the need to wholly listen to the Other.

to recognizing the *power* that narratives have in the offering and receiving of effective, and more importantly, dignified care.

As a Narrative Medicine masters student I continue on this learning journey, working to understand and bridge the differences between disease and illness, between curing and healing, and between pain and suffering. I work to practice narrative humility and unobstructed listening. As a physician, I hope to let the *art* of medicine, this mindset and these skills, guide my actions. Therefore as I continue upon this journey, I let the stories of individuals, stories like those of Vanita and Sarita, continue to mold my efforts.

***

Works Cited

Dasgupta, Sayantani. "Narrative Humility." *The Lancet* 371.9617 (2008): 980-81. Web.
Freire, Paulo. *Pedagogy of the Oppressed*. New York: Continuum, 2000. Print.

Apurva Khedagi is student within the M.S. Program in Narrative Medicine at Columbia University. She recently graduated from Stanford University, where she studied Human Biology. An aspiring physician, Apurva is very interested in patient-physician relationships and their impact on how care is offered and received. She reflects on experiences that founded this interest and led her to narrative medicine.
