Landscape of Altered Being: Autopathography and Embodiment in *When Breath Becomes Air*[1]

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Introduction

This article is primarily concerned with the ways in which we make sense of a life altered by the bodily crisis of severe illness. Susan Sontag identified the illness-infused space of life as "the kingdom of the sick" in *Illness as Metaphor* (Sontag 3). Virginia Woolf has called it the "undiscovered country" in her essay *On Being Ill* (Woolf 32). In case of life-shattering severe illness, Paul Kalanithi calls this landscape a "featureless wasteland of his own mortality" in his 'autopathography' on lung cancer titled *When Breath Becomes Air* (Kalanithi 148). Published in 2016, Kalanithi's narrative traces his journey as a neurosurgery resident and his life after being diagnosed with stage 4 lung cancer towards the end of his training. Kalanithi remains preoccupied with understanding suffering and death before and after his terminal diagnosis in two distinct ways. The lived experience of illness compels him to chart his journey from seeking the truth of death to expecting and experiencing death as a patient. As a cancer patient, his physical condition ebbs and flows, resulting in a display of mental fortitude and vulnerability concurrently. Hence, the narrative style and strength it displays simultaneously resonate with illness, suffering, loss, and grief. The narrative is divided into four parts – the prologue, a section titled "In perfect health I begin," another titled "Cease not till death," and an epilogue by Paul's wife, Lucy. Strikingly this division of the two main sections establishes the transformations and rifts related to the onset of an illness. This article acknowledges this rift between the pre-diagnosis and post-diagnosis worlds, between the diagnostic identity and narrative identity, and between the doubly altered realities for the narrator, who navigates a space where he is transformed from a healer and healthy individual to an ill individual with the signature armband declaring his status as a patient. It aims to establish the centrality of the body in this transition to an altered existence and the role of autopathographies in discovering the middle ground for expressing oneself and navigating the myriad ways to live with and beyond an illness. The aim to contribute to the discourse of the bodily experience requires categorising the medical body and the lived body as two distinct yet not entirely separate explanations concerning bodily existence. To completely disrupt the deterministic categorisations inherent to explanations in medicine, it suggests that Kalanithi's narrative acts as a 'thirdspace' or middle ground, affirming his open-ended position as experiencing witness of his own suffering.

To conceptualise pathography before autopathography, it must be noted that the word pathography was first used by Dunglison in his *Medical Lexicon* (1856), where it meant "a description of disease" understood in broad strokes and adhering to bio-scientific methods of communicating a medical narrative (Dunglison 648). Aronson later interpreted it as "the study of the effects of any illness on the writer's (or other artist's) life or art, or the effects of an artist's life and personality development on his creative work" (Aronson 1599). Etymologically, *autopathography* breaks down into *auto* (self), *patho* (suffering/experience), and *graphe* (writing), meaning the story of one's suffering. Yet some of the earliest accounts of the word can clarify the difference in orientation and objective of illness narratives in the medical and non-medical worlds. A 1930 snippet from *The Lancet* describes autopathography in relation to neurotic disorders and suggests that the physician author's experience of the disease "probably added to his understanding of the suffering of other victims of the same disease and the episode prompts enquiry how far subjective experience of pain or illness is *helpful or necessary to the physician*" (651) [emphasis added]. This indicates the medical intention of including it as evidence in medical intervention, valid only if it occurs in the experiences of a doctor. To delineate contrast, author

Anne Hunsaker Hawkins suggests that it is a term to describe the biographical or autobiographical writings that describe "the personal experiences of illness, treatment and sometimes death" (Hawkins 1). For Hawkins, these narratives offer us "a disquieting glimpse of what it is like to live in the absence of order and coherence…by an illness that often seems arbitrary, cruel and senseless…Pathographies concern the attempts of individuals to orient themselves in the world of sickness" (Hawkins 2). As opposed to the medical approach from the outside, Hawkins' view positions the reader in the interior of these experiences. A significant implication of categorising autobiographical narratives under the term *Autopathography* is the distinction between illness and subsequent suffering as an impasse in the embodied meaning-making process fundamental to life. When Thomas G. Couser describes autopathographical narrative as a first-person narrative of illness and disability, he theorises it as an acknowledgement and an exploration of our condition as *embodied* selves (Couser 65). Through Kalanithi's narrative, this article argues that the autopathographical narrative provides a thirdspace to accommodate and reformulate the altered embodied existence of the ill and the drastic alteration in one's lived experience.

The Medical Body and the Lived Body

The conjecture, articulation, reception, and limitations of one's altered reality in a landscape of existential duality are closely associated with concerns about the categorical status of the narrator of an autopathography. This persona can be an object containing the disease or a dis-eased subject experiencing the suffering, hinting towards a conflict at the center of the supposed exclusivity of these categories in relation to each other. But this narrative also confronts the question of occupying a position of power within the clinic and systematically losing the control that power embodies in case of being the object of medical intervention. This lies at the core of Kalanithi's reality of being a doctor and a patient who *contains*, *possesses,* and *is* the lived body that experiences illness. Kalanithi represents the medical profession with respect to its usage of cadavers, "we objectify the dead, literally reducing them to organs, tissues, nerves, muscles…Seeing the body as matter and mechanism is the flip side to easing the most profound human suffering" (Kalanithi 49). By objectifying the dead and the alive body, biomedicine focuses on the inside activities of the body, and often the suffering person becomes a transparent vessel containing the disease, while non- medical enquiries focus on the experiential realities and larger contexts affecting health. Evoking Foucault, Anirban Das, in his book *Towards a Politics of the (Im)Possible*, outlines the modern medical fascination with the interiority of the body, where an ontology of the disease was replaced by the ontology of the body. He theorises that with the advent of modern science, the spatiality of the body became the space of alterity, and the location of diseases shifted from their classifications to bodily spaces. This bodily space features the medical knowledge of the body - consisting of anatomical, physiological, and biochemical details. As opposed to that, the lived body corresponds closely with the phenomenal self that presupposes embodiment based on experience, among other things. Das describes the phenomenal self as having "a sense of the everyday and a bodiliness" (Das 76). This statement recognises that together with embodied experiences, the lived body (embodying its phenomenal self) has a spatial location and context as well. Kalanithi's struggle with effectively comprehending the truth of life and death emphasises symbols and interpretations within medicine as manifestations of human relationality and its stories.

Thus, autopathographies are by definition concerned with the person and contexts often shrouded behind the disease. Before arriving at narrative nuances, the important distinction between disease and illness must be understood as directly related to the biomedical and non-biomedical explanations of the natural world. Therefore illness, in contrast to disease, is "not merely a dysfunction of a body subsystem but a systematic transformation of the way the body

experiences, reacts, and performs tasks as a whole" (Carel, Phenomenology and its application in medicine 41).

To elaborate on the observations above, the ways in which the bodies experience these crises must be critically observed. This can be understood via the differentiation between the medical conception of the suffering body and a more wholesome understanding of the lived body in suffering. The former is the body-object, whereas the latter is the body-subject. In the philosophy of illness, the former is identified as the objective body or *le corps objectif*, and the latter is called *le corps proper*, or the lived body. In her work, philosopher S. Kay Toombs reiterates that the medical understanding of the suffering body and the experiential understanding of the lived body exhibit great differences. She reflects on the boundaries of generalised medicine and the personalised experiences of individuals (Toombs 31). Kalanithi realises this difference when medicine identifies him solely as a medical body, "it occurred to me that my relationship with statistics changed as soon as I became one" (Kalanithi 134). He becomes the object of inquiry when his status changes from healthy to sick. The sick body is not only a statistic but also a problem and a target of control. Philosopher Martyn Evans also suggests that the medical body is an object of inquiry, a site exposed and anatomised, and a manifestation of problems to be understood and fixed. It is a source of data, a passive, uncharacteristically inert, and yielding body (Evans 18). Hence biomedicine often observes the objective body, whereas autopathographies are essentially concerned with the subjective experience of the lived body.

In phenomenological tradition, philosopher Havi Carel also describes, "disease is to illness what our physical body is to our body as it is lived and experienced by us" (Carel, The Phenomenology of Illness 17). As a philosophical approach, phenomenology focuses on phenomena, i.e., what we perceive, rather than on the reality of things, i.e., what really is, thus centralising the body as the initially perceiving entity. This entity, the lived body, is theorised as the site and vehicle of experience and action, along with being fundamental for life. While illustrating the epistemological difference between the two bodies, Evans claims that the medical body deems illness as secondary to disease; individual experiences are factually explained and accounted for; whereas for the lived body, illness is the existential obstruction and intrusion upon itself (Evans 28). Hawkins also asserts that compared to the medical expectations of disease, people and their families are "suddenly plunged into 'essential' experience- the deeper realities of life" in illness (Hawkins 1). Kalanithi, who trained as a doctor for more than a decade, writes, "I knew a lot about back pain, its anatomy, its physiology, the different words patients used to describe different kind of pain – but I didn't know what it *felt* like" hinting at this fundamental difference between the biomedical and the non-medical approach to the suffering body-subject (Kalanithi 12) [original emphasis]. As a doctor, he recognises the significance of the science of medicine, but it is as a patient that he really understands the diseased body in the configurations of limitations, bodily doubts, and uncertainties about the concrete corporeal future. He describes a metamorphosised personal world where previously effortless bodily activities become difficult and automatic processes appear to be done with broken bodily tools, resulting in a constantly overwhelmed body. The body feels unlike itself, shaping a converted sense of his identity. Thus, Kalanithi's narrative clearly implies that bodily reality affects our worldview. This conflict of experiencing illness first hand and having that experience pre-defined and *pre*scribed by the larger mechanisms leads to the question of illness as embodied and embodiment as a context for everything. The embodied experience of illness prompts most ill people to experience the world differently. Illness becomes the overwhelming context for everything.

The Phenomenology of Illness and the Embodied illness

Biomedical sciences aim to explain a phenomenon, whereas experiencing, understanding and interpreting are the qualitative objectives in illness. This is based on the difference between the Cartesian assumption about the human body and the diverse experiential realities of bodies in illness. The former assumes that the body is like any other body in the world: a functioning machine that requires mechanical assistance when in need of repair. The latter suggests that all bodies are different since our lived experiences differ contextually. Conrad and Barker have evaluated the cultural embeddedness of certain illnesses and the social construction of illness experiences. They formulate that the 'patient experience' is very different from the 'illness experience' since the medical intervention and the patient experience prescribed by biomedicine are largely based on the Cartesian divide (Conrad and Barker S71). Similarly, in *The Body in the Medical Thought and Practice*, Drew Leder contradicts the Cartesian dualism, "when the body falls sick, we are left not simply with a broken machine, but with a world transformed" (Leder 5). Kalanithi weaves the story of his life, which is disrupted and thus, supposedly demarcated by illness. Yet he never abandons the humane sensibility of undergoing suffering. He verbalises the ineffable in illness by living through it, narrating the truth as experienced. Against the over-theorised, over-philosophised ideas about life before impending death, his narrative communicates this mortal encounter in the form of loss of bodily familiarity and inviolability. What is available to the people as common knowledge and expected facts of suffering and death are different in experience. In the first section of the book, his instances of medical matters are infused with non-medical language, framed in conversations of ethics, morality, social, and emotional issues. Alternatively, the latter section abounds in medical jargon, where his distance from his professional identity increases and the previously muted kinship with his body resurfaces. The medical body that predominates the medical imagination concedes to the lived body. As he claims, the man who expressed himself through his body realises that bodily change, an expected outcome of medical treatment, affects bodily image. Furthermore, this implies that basic realities of life appear in contrast to blind determinisms in illness. Additionally, Kalanithi's fascination with neuro-surgery is supported by the fact that the brain – a bodily organ that mediates our experience of the world – questions the dissociation of metaphysical meanings of life when there are problems with the body. He observes that our brain, a part of our bodily being, "gives rise to our ability to form relationships and make life meaningful," it can be deduced that a bodily disruption launches questions about subjectivity and identity beyond immediate physical threat (Kalanithi 38). Merleau-Ponty's phenomenology can navigate this disruption through his concept of perception as central to experiencing phenomena. Carel describes that for Merleau-Ponty, the body is involved in the very possibility of experience since perception is an embodied activity. The bodily senses initiate perceptions and lead to experience and the consciousness of the world. This experience is fundamental to subjectivity – changes in one's body have far reaching effects on one's sense of self since embodiment, perception, and subjectivity are all connected. Therefore, to phenomenologists of illness, Merleau-Ponty's 'body subject' arises from perception (Carel, Phenomenology and its application in medicine 36). Merleau-Ponty philosophises that our experience is first and foremost an embodied experience of fleshly physical existence. Thus, when our perception and experience of the world change in illness, the separate yet harmonious co-existence of the objective body and the lived body is disrupted, which is otherwise sustained in the everyday experience of health (Carel, Phenomenology and its application in medicine 39). It is then that we perceive and become aware of the body's presence. Kalanithi's poetic description of his life before cancer diagnosis has a sense of physicality and bodily exuberance in it, a harmony with his environment and his objective body – a quiet co-existence of both his objective body definable through science and his lived body experienced and understood through reflection. Contrastingly, when the severity of his cancer increases, his fatigue and exhaustion deliver him literally and metaphorically breathless. He becomes aware of the body's failure to continue to work like its past version. This change positions the "body in crisis" as the central figure in his transformation. With the pivotal figure of this "body in crisis" looming large, his position

changes from doctor to patient while everyone around him remains the same. Here he acknowledges that the illness irreversibly impacted his identity and personhood and that "nothing about it seemed recognizable" (Kalanithi 121). While describing his physical changes since the diagnosis, he continues, "my body, the identity tied to it, had radically changed" (Kalanithi 125).

Kalanithi gives the example of a woman who has a brain tumour and highlights the doctor's knowledge of her test results before herself due to having access to discipline-specific technical knowledge that is usually inaccessible for laypeople. As per Kalanithi, the doctor "could see the vastness of the chasm between the life she'd had last week and the one she was about to enter" (Kalanithi 93). Thus, the medical professional is privileged about the awareness of the difference between the lives before and after the onset of illness. Phenomenologically there is an otherness of our own body in illness, a loss of identification, a loss of future, of the ability to take action, of exercising one's will through the bodily autonomy, "a rupture of the familiarity, flow, rhythm and time" in illness (Ahlzen 6). This rupture also creates newer fissures in the worlds within and without illness, indicating the distance between the practitioner and the patient, while the latter's singular narrative as told through the body does not conform to the grand narrative of medicine.

Ahlzen brings up philosopher Fredrik Svenaeus' stance on the phenomenology of health that theorises that health functions as the homelike being-in–the–world (this corresponds to Heidegger's *Dasein*[2]), whereas illness becomes the unhomelike being-in-the world. The bodily being-in-the-world is the site for the production of meaning structures that govern our existence in the world (Ahlzen 7). This unhomelike being "arises from the changed conditions of embodiment and the loss of attunement of one's body with the environment" (Carel, The Phenomenology of Illness 37). The embodied enworldedness in illness entails new epistemologies that cannot be formulated without considering bodily crisis. Reiterating this embodied quality of illness, Kalanithi writes

> As a doctor, you have a sense of what it's like to be sick, but until you've gone through it yourself, you don't really know. It's like falling in love or having a kid. You don't appreciate the mounds of paperwork that come along with it, or the little things. When you get an IV placed, for example, *you can actually taste the salt when they start infusing it*. They tell me that this happens to everybody, but even after eleven years in medicine, I had never *known*" (140) [Emphasis added].

Clearly, there are always two epistemologies for the physician, i.e., of the human subject and that of nature and science (Ahlzen 325). The former is acquired experientially and is complicated through the embodied experience of lived realities, as shown above. Whereas the latter consists of the medical knowledge received through practice and pedagogy. As a practical and therapeutic endeavor, medicine positions physicians in the conflict zone of a gaze that Evans believes is "committed to nature" and another to the personal and the historical significations related to the patient (Evans 23). Kalanithi's position as a former physician transformed into a terminal patient situates him in both these categories and he transitions from the familiar world of observing anatomy and detecting anomalies to embodying them in an unfamiliar world.

These concepts are not placed together to highlight medicine's incompetency in detecting and treating cancer. Instead, they amplify what the introduction asserts – that illness is an innately embodied event in the bodily history that has contingencies in realities other than that of medicine. Illness becomes a disruption in the self, one where bodily existence loses attunement, balance, and familiarity in relation to itself and the world. Kalanithi's narrative integrates this disruption with a fractured temporal sense of reality inherent to a crisis, calling it "the chaos of the past months" and "contracted sense of the future," differentiating his former self from his ill self (Kalanithi 146). Therefore, due to the centrality of all our experiences being mediated by bodily crises, as Carel

elaborates, well-being and illness become a context for a changing landscape of reality (Carel, The Phenomenology of Illness 78). Kalanithi's words echo this early in the book

> I *received* the plastic arm bracelet all patients wear, put on the *familiar* light blue hospital gown, walked past the nurses I knew by name, and was checked in to a room — the *same room* where I had seen hundreds of patients over the years. In this room, I had sat with patients and explained terminal diagnoses and complex operations; in this room, I had congratulated patients on being cured of a disease and seen their happiness at being returned to their lives; in this room, I had pronounced patients dead. I had sat in the chairs, washed my hands in the sink, scrawled instructions on the marker board, changed the calendar. I had even, in moments of utter exhaustion, longed to lie down in this bed and sleep. Now I lay there, wide awake.
> A young nurse, one I hadn't met, poked her head in.
> '*The doctor will be in soon*.' (16) [Emphasis added]

With the progression of his embodied ill-experience and subsequent medical intervention, he is relegated to the role of the patient, becoming the *other*. Das has also deconstructed the body as seen in medicine, asserting that the medical register itself confers a symptoms-ness on the spatiality of the body, signifying some reality outside of itself (Das 82). As evident in the above extract, both the space of the ill body that has been undone for interpretation and the medical space that confines the ill signifies the alterity of the bodily reality for Kalanithi. Thus, he experiences and gradually internalises what it means to be sick in the contemporary medical world. This systematically prescribed idea of the sick person determines the rights and responsibilities of the patient as a functioning part of the social system. However, since it is prescriptive in nature and is normalised through a complex social network oriented towards control, conformity, social productivity, and quantifiable outcomes, patient-hood is double-edged, for it overwhelms the patient by restructuring social and embodied realities, demanding a reorientation of all aspects of being. Kalanithi writes, "doctors in highly charged fields met patients at inflected moments, where life and identity were under threat" (Kalanithi 113). Hence in the moments where biomedicine mediates human experience along with our embodiment, the sufferer needs a thirdspace and middle ground to find meaning and express oneself. The critically decisive temporal juncture also compels the patient to seek coherence, control, and calm in the narrative spatiality of self-narration. To accommodate this experience of alterity requires the understanding of what researcher Katharine Cheston adapts from Carel's phenomenological geography of illness, calling it the 'metaphorical topographies' in her use of phenomenology in the context of bodily space in illness. She states that illness alters "how the ill person inhabits their world and perceives the environment around them" (Cheston 7). These metaphorical topographies embody the uncharted landscape of illness that Kalanithi and others identify in their personal experiences of illness. Woolf even identifies this landscape in its plurality, hinting at the singular individual experiences of illness against the generalisations of medicine. On the other hand, Sontag hints at the inevitability of individuals arriving in the 'kingdom of the sick' (Woolf 32, Sontag 3). It can be derived from all three of them that illness experience is a distinct metamorphosis that requires stories to decipher the transition.

This leads to the contention that experiential narratives such as autopathographies mediate the representation of illness by becoming the middle ground where norms of biomedicine, of the medical body can be addressed, challenged, or negotiated with. It must be observed how autopathographies materialise these necessary significations in order for the lived experience of embodied illness and bodily vulnerability to be expressed, shared, and derived meaning from.

Autopathography as Thirdspace

The distinction of autopathography as a sub-genre of autobiographical narratives acknowledges the variety and validity of lived experiences as legitimate evidence in understanding human suffering. From ethnographic, psychoanalytic, and literary perspectives, lived experience has preoccupied the cultural imagination for recent decades, indicating the relevance of personal and subjective accounts of experience in scientific knowledge. This statement does not undervalue other narrative forms charting the illness experience, such as poetry by patients, films, pandemic narratives, fictional writing, and carer-memoirs. Instead, it suggests that autopathographies focalise individual illness and its impact on the individual's private and social worlds. For Kalanithi, the book is not merely a physician-author's meditation on illness. Instead, it is a transcription of a life devoted to comprehending suffering and death through medicine and narratives, beginning from perfect health and leading to the death of the narrator. Autopathographies such as this regard disease not as something that happens to people but assemble the fragments of a life *recreated* by illness. Yet, they obligate themselves neither with an authentic nor the whole version of the truth. Their claim to provide an all-inclusive narrative of illness as experienced subjectively by the sufferer herself relies on the objective of making sense of the cataclysm in bodily existence, of interpreting it when paradigms of interpretation through bodily integrity are disrupted. All life-writing is self-referential. However, autopathographies describe a self in acute phenomenological crisis, ill at ease and out of depth. They represent and reconfigure the illness experience of alterity or *other*ness by manifesting the landscape of one's altered being.

Pioneer in the practice of Narrative Medicine[3], Rita Charon in *Narrative Medicine: Honoring the Stories of Illness* (2006), has asserted that the personal narrative functions as a significant tool in the clinical encounter, a middle ground between "one's inner reality and the outer reality of the world" (Charon 172). She propounds that narratives become the site of attention, representation, and affiliation between the physician and the patient, indicating a larger purpose of narrative construction in case of illness beyond mere representation and aesthetic value. The objectives of narrative medicine might be pragmatic in nature. Nevertheless, the primacy of patient-narratives it champions contributes to locating the central theme of seeking human knowledge in telling the stories of illness, impairment, and/or medical differences in corporeality. Kalanithi's meditations on death are rooted in the bodily processes of living with a terminal illness. Death might be an event, but "living with terminal illness is a process," signifying the difficulty of grasping human knowledge in its entirety or externality (Kalanithi 161). Human knowledge, be it of the world, of oneself, or of death, comes from a form of human relationality that occurs in intersubjective exchange. Medicine, much like narrative, embodies this intersubjective exchange. Arguably, Kalanithi's autopathography becomes a safe space where this exchange happens – where boundaries of active-passive participation and doctor-patient are diluted. His quest to redefine himself as a neurosurgeon after one round of treatment originates in this urge for the dissolution of boundaries.

Narratives have also been theorised to provide the space where changed realities for ill individuals are articulated. In the case of Kalanithi, he is transformed from physician to patient – from the "actor to being acted upon" (Kalanithi 180). In this existential quandary of facing the universal truth of human mortality, Kalanithi contemplates, "torn between being a doctor and being a patient, delving into medical science and turning back to literature for answers, I struggled, while facing my own death, to rebuild my old life — or perhaps find a new one" (Kalanithi 139). He ponders the words from Beckett, saying, "*I needed words to go forward*…I can't go on. I'll go on" in order to make sense of the disorientation, bodily vulnerability, and the ambiguity between uncertainty and certainty often synonymous with severe illness (Kalanithi 149) [emphasis added].

Angela Woods has described these narratives as essentially expressive, transformative, therapeutic, embodied, interpersonal, and temporal (Woods 73). The act of writing about a life-altering event functions as a means to many ends, including reclaiming authority over oneself. Woods evokes author Arthur Frank's contemplations on the fractured self in illness that the creation and performance of narrative becomes a form of testimony that reclaims and re-orients the self (Woods 75). Kalanithi as the patient, has access to both the facts of the objective body and the experiences of the lived body. This dual knowledge cannot be authentically accessible to him as a mere physician because the changed self has a more intimate experience of illness and a subjective reflection on it. The notion of the 'thirdspace'[4] that Susan Squier alludes to can be extended to the liminal space of this dual knowledge that autopathographical narratives traverse. This space allows for the in-betweenness of illness to be documented, narrated, and interpreted. Squier quotes Edward W. Soja while describing the thirdspace as "a meeting point, a hybrid place, where one can move beyond existing borders" that allows for a sense of permeability between disciplines and interests (Squier 64). In the case of illness experience, this thirdspace can be understood as existing beyond the categories of the lived body and the medical body challenging the normative constraints that aim to universally define the subjective experience of a disease.

Medicine mirrors the dyad of the self and the other in the identities of doctor and patient, respectively. The medical profession derives its supremacy by juxtaposing itself with the ill, thus appropriating the two in this dyad and creating the machinery of healthcare that aims to sustain these dyadic hierarchies. For Kalanithi, the self and the other are formed in one, and the dyadic relation is internalised and dissolved. Here, the self cannot simply be derived, identified, and defined through the other because both of them occupy the same (bodily) space creating a zone of contradictions, both spatially and phenomenally. Allowing the contradictions and pluralities, this thirdspace is where the narrator negotiates between his diagnostic and narrative identities. The writer embodies dual positions such as "the observing subject and the object of investigation, remembrance, and contemplation" (Smith and Watson 1). Autopathographies take up this task by providing and *becoming* this thirdspace where the objective/universal encounters the subjective/particular and a critically aware subversion of hierarchies occurs. Life-threatening illnesses have been a pivotal point of narratives of suffering where the consciousness of mortality manifests in contemplations on life itself. These narratives contextualise the suffering individual in the world beyond that of biomedicine, focusing rather on the impact of diagnosis, treatment, and resultant debility on their experience and interpretation of the world. Kalanithi also agrees that in redefining meaning in one's life, illness demands reconsideration of values and priorities (Kalanithi 160).

Soja's concept of the thirdspace operates within the trialectics of space, where the thirdspace is understood through a critical thirding-as-Othering in the context of the first and the second space. As simultaneously real and imagined, actual and virtual, individual and collective space, the thirdspace encompasses the lived experience. Laden with cultural symbols and experiences of living, it can be related to the lived realities of illness. When Squier adapts this space for a discussion of Graphic medicine, the objective is not to deem graphic medicine a lawless land but to propose it as a space where orders of both worlds ease, to allow pluralities of resistance and redirections of the categorical binaries. In the context of autopathographies, the concept of a 'thirdspace' allows breaking down dualisms in an intervening space where essentialist categories of patient-healer, objectivity-subjectivity, unknowable-the unimaginable, and subjecthood-objecthood are re-thought about, negotiated, and reconstituted against reductionisms (Soja 55). Kalanithi's narrative embodies this thirdspace as it transcends different binaries – his doctor-self and patient-self travel the landscape of illness together, and his writing bridges the rift between objective-scientific and subjective, non-scientific knowledge in a quest of seeking the inexpressible through language.

Kalanithi's wife, Lucy, writes in the epilogue that his narrative is a salient protest against the contemporary death-avoidant culture, voicing the need to tell one's story that holds primacy in illness. It is an avenue of exercising discursive agency and discovering unanticipated identities in the face of catastrophe, a tool of resistance to oblivion and of comprehension of death. Kalanithi's autopathography becomes a means to derive and consequently shape a 'narrative identity' out of the losses, discontinuities, and transformations related to his physical being. This 'narrative identity' is distinct from his 'diagnostic identity' imposed by medicine. The narrative identity can be extended to what he imagines as his legacy for his daughter in a narrative that embraces mortality and accommodates his subjective reality. The crises in identity as tied to the bodily vulnerability appall him, and he contemplates

> *Who could, or should, I be?* As a doctor, I had had some sense of what patients with life-changing illnesses faced—and it was exactly these moments I had wanted to explore with them... But I'd had no idea how hard it would be, *how much terrain I would have to explore, map, settle*. I'd always imagined the doctor's work as something like connecting two pieces of railroad track, allowing a smooth journey for the patient. I hadn't expected the prospect of facing my own mortality to be so disorienting, so *dislocating* (147) [emphasis added].

Here, the narrative becomes what Rimmon-Kenan has described as a mode of experiencing, perceiving, and interpreting the world and negotiating identities (Rimmon-Kenan 22). The sufferer carves his way through the wasteland of mortality by using narrativisation. Weaving the experience of illness, like that of a revelation, requires narrative structures. They are necessary in order to derive meaning from them and exercise control over a life with an unruly and uncontrollable body. Kalanithi's narrative serves as the form of resistance to the reductionisms of biomedicine, allowing him to rearrange boundaries of being patient and healer and deliberate the modalities of experiencing suffering in illness and awaiting death. The answers Kalanithi sought from biomedicine are provided by the narrative that enables him to critically negotiate between the binaries of experiential-biological and personal-impersonal manifestations of death. Bodily meaning permeates the categorical differences in what he calls 'the kinship of having the body' existing in the medical establishment between doctors, patients, and even cadavers (Kalanithi 50).

Conclusion

Narrativising disease-related experiences opens pathways to address and make sense of the unknown, accommodating the chaos to bring a sense of order to find meaning within the meaninglessness of human mortality – meaning which is constantly a flux and an inevitability. Kalanithi himself suggests that writing an autobiographical narrative becomes his way of surviving this gruesome process and facing his mortality. He ends his narrative with the hope that through his words, he leaves behind the person that his loved ones can still recognise, despite having his physical being altered and associated identity questioned. He hopes to recognise himself in that recognition and in his narrative. It is through this thirdspace, the middle ground of autopathographical narrative, that he voices himself and defines meaning again. In his iconic sentence, Kalanithi asks, "where did biology, morality, literature and philosophy intersect?" This paper contends that the answer can be sought *through* an autopathographical narrative (Kalanithi 41). Autopathography emerges as this thirdspace where reductionism and politico-cultural fixations of identity are negotiated with. Multiplicities of othering beyond the dualisms allow for resistance to emerge. The thirdspace is visualised as necessarily open-ended, with prospects of fluid identities and negotiations of meanings. Thus, the open-endedness and distinctness of illness experience carved through the bodily being are inscribed upon the autopathography and allow it to not be compelled by the demand of definitives but by an often-unfinished individual quest for meaning.

Notes

1. An initial version of this article was presented at the international conference on *Alternate, Virtual and Augmented Realities* organised online by the Institute of Medical Humanities, Durham University, Durham, 20-21 September 2021.
2. *Dasein* translated as 'being there' or 'being-in-the-world', is a concept propounded by Martin Heidegger in his *Being and Time*, reflecting on the singular human experience of being.
3. Narrative Medicine is a narrative-based interpretive practice in clinical medicine that Professor Rita Charon has founded. It aims to improve verbal and non-verbal communication between the healthcare professional and the patients by focusing on their intersubjective encounters in the clinical space.
4. In order to elucidate her point, Susan M. Squier theorises that graphic medicine occupies an in-between space or third space (notice the two separate words) and refers to Edward W. Soja's concept of thirdspace that complements historicality and sociality of social space. Soja's idea is related to the three types of social spaces – Firstspace (the physical and perceived space), Secondspace (that which exists as an abstract or conceptual space, the conceived space), and the Thirdspace where the above two meet (i.e., the lived space). These have been adapted in the article to elucidate narrative as a spatial configuration for illness experience.

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