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Narrative Constitution in the Medical Consultation

A Contribution to the Dynamics of Narrated Feelings in Factual Texts

This paper aims, ultimately, to make a contribution to the study of the narrative constitution of factual narratives, and, with that aim, it focuses on a particular subclass of an oral and interactional character: the illness narrative. To this end, on the basis of the analysis of a corpus produced in a public hospital in the southern Buenos Aires metropolitan area (Argentina), it proposes: 1. A brief historical-critical review of the main contributions to the reflection on the *story* / *discourse* dichotomy and the failed attempt to deconstruct it; 2. The hypothetical postulation of a different functioning of these two structural levels in factual and fictional autodiegetic narratives, and the pointing out of the central role of emotions in this respect, in a theoretical-methodological sense. 3. A partial model, devised for the analysis of medical consultations, which justifies the differentiation of two levels on the represented side (the *what*) and which seeks to account for the function of narrated feelings in the logic of co-narration that takes place in the doctor's surgery.

The *story* / *discourse* distinction is not only "the mother's milk of narratology" (Phelan 2011, 58) but it is also inherent, as its necessary consequence, to Gérard Genette's definition of narrative: "la représentation d'un événement ou d'une suite d'événements, réels ou fictifs, par le moyen du langage" (1966, 152). These two fundamental tiers of narrative constitution, story (= *un événement ou une suite d'événements*) and discourse (= *la représentation, par le moyen du langage*), have historically been conceived without paying too much attention to their link with the real world, no matter how much Genette uses the term "réels" (reals). The reason for this disdain is obvious: almost none of the models created from the Russian formalists onwards have been designed to analyze factual texts, in which fidelity to the real world is, as a matter of principle, a determining factor.

Among the *desiderata* of narrative theory lies the study of the applicability of such models in non-fictional settings. Despite the progress that has been made in this respect[1], the task of investigating the structure of narratives in the diversity of factual fields (journalism, science, medicine, law, everyday life, etc.) and narrative genres has not yet been undertaken in a comprehensive and holistic sense. Our paper, written under the conviction that "[w]e still do not appreciate as we ought the importance of narrative schemes and models *in all aspects of our lives"* (Culler 2007 [1981], 130; our underlining), aims at fulfilling that ambitious goal, but it is based solely on the illness narrative as it emerges in the context of medical consultation.[2]

In our contribution, concretely, we offer: 1. A presentation of the main approaches to narrative constitution and, in particular, the *story* / *discourse* distinction, and a refutation of the possibility of "deconstructing" it in the specific case of the factual text. 2. An indication that the illness narrative produced in the medical consultation has a differential quality with respect to the autodiegetic fictional narrative, namely: the determinability *in principle* of the boundary between the structural levels, in which the representation of emotions acquires great theoretical-methodological importance for therapeutic purposes. 3. A justification that the story tier should be divided into two sublevels because of its heterogeneous nature and, in relation to this, an inquiry into the functioning of emotions within the dynamics of the conarration that is established in the medical office.

The almost incomprehensible set of narrative types is not, of course, homogeneous, but neither is the much more restricted subset of factual narratives. In our pragmatically determined conception of narrative structure, it is urgent to take into account the enormous variety of discursive genres and regimes of truth. What we assert throughout this article (which, in some cases, is of a tentative or exploratory nature) is based on the assumption that it is a mistake to apply indiscriminately and aprioristically the same structural model to the analysis of all existing narratives. At least, we believe that, in doing so, the possibility of capturing the distinctive features of each particular narrative and each particular genre is lost, thus rendering invisible an aspect of its very constitutional nature.

1. The *story* / *discourse* distinction: some classical narratological approaches and their failed "deconstruction"

The first modern approach to the narrative constitution was the distinction between *fabula* and *sujet* made by the Russian formalists in the early decades of the 20th century. Although there were several Russian authors who dealt with this opposition (among them, V. Shklovsky. L. Vygotsky and M. Petrovsky), the most prominent later on was Boris Tomashevsky's contribution in the chapter "Thematics", included in his *Theory of Literature* (1925; rev. 1928), at least to the extent that it was widely disseminated in literary studies in Western countries in general –and in Argentina in particular. Based on the notion of "motif", which we can assimilate to that of event or happening, Tomashevsky distinguished the two tiers (*fabula* and *sujet*) as follows:

> Mutually related motifs form the thematic bonds of the work. From this point of view, the *fabula* is the aggregate of motifs in their logical, causal-chronological order; the *sujet* is the aggregate of those same motifs but having the relevance and the order which they had in the original work. The place in the work in which the reader learns of an event, whether the information is given by the author, or by a character, or by a series of indirect hints—all this is irrelevant to the *fabula*. But the aesthetic function of the *sujet* is precisely this bringing of an arrangement of motifs to the attention of the reader. Real incidents, not fictionalized by an author,

> may make a *fabula*. A *sujet* is wholly an artistic creation. (Tomashevsky 1965 [1925], 68)
>
> In short, the *fabula* is 'that which really was'; the *sujet* that how the reader learns about it. (137)

Among the statements made by Tomashevsky, we are particularly interested in two, which we can explain in this way:

1. The *fabula* is already something (aesthetically) configured, since its events are ordered not only temporally but also in a causal sense. We add: it supposes a first degree of elaboration with respect to the mere succession of events in time, because for something to be considered the effect of a previous thing, a *hierarchization* is necessary. Further, many times, in matters that concern the intentions and motivations of the human being (that is, leaving aside the determinisms that obey natural laws), an *interpretation* becomes necessary, as well, of what, in the end, is nothing more than a succession of facts which, taken on their own, are not qualitatively differentiable in the incessant flow of becoming.

The latter becomes quite clear when we make a simple mental exercise based on a famous reflection by E.-M. Forster. Let us recall first his distinction between *plot* (which has a logical-causal structure and can be assimilated to Tomashevsky's fabula) and *story* (a mere chronological succession of events, like the chronicle[3]). Regarding this, Forster says: "'The King died and then the Queen died'. That is a story. 'The King died and then the Queen died of grief'. That is a plot." (1972 [1927], 35). Now, suppose that "The King died and then the Queen died of grief" is a statement within a journalistic (factual) text. What journalist, no matter how well versed he or she may be in the affairs of the royal family, would be in such a privileged epistemological position as to be able to affirm, *with absolute certainty*, that "the queen died *of grief*" (and of a grief caused by the death of her husband) and not for any other reason?

2. The second quotation – a footnote that was deleted from subsequent editions – and the last sentence of the first one raise some doubts about the nature of the *fabula*: if the *sujet* is "entirely" artistic, is the *fabula* not artistic because it contains something of what really happened, whether in the real world (factual story) or in the fictive world (of a novel, for example)? Although the facts it contains are not preliterary, the fable seems, nevertheless, to be more "natural" than the *sujet*, since it has a more immediate relation to "reality" (factual or fictive), from which it can even take its materials. It does not matter so much that we dispel this doubt raised by the relative ambiguity of Tomashevsky's text as the fact that it makes explicit the problem unresolved or not adequately taken into account by the model: the reference to reality.

The reception of the Russian formalists by French structuralism was important for the understanding of the narrative constitution. Roland Barthes (*récit* / *narration*) and Tzvetan Todorov (*histoire* / *discours*) testify to it, especially when considering their contributions to the 8th issue of the journal *Communications* (1966). Classical narratology reached, on this basis, two canonical formulations: on the one hand, Gérard Genette's (1972 and 1983) three-tiers model – *histoire* / *récit* / *narration* – and, on the other, Seymour Chatman's (1978) binary

distinction between *story* (the *what*) and *discourse* (the *how*). In turn, if Chatman inspired Gerald Prince's (1982) and Matías Martínez' / Michael Scheffel's (1999) models, Genette's proposal was taken up without major alterations by authors such as Shlomith Rimmon-Kenan (1983), H. Porter Abbott (2002), Mieke Bal (1977 and 1985) and, in the Spanish-speaking world, José Ángel García Landa (1998).[4]

Karl Köhle and Armin Koerfer (2012), to give an example from the medical field[5], do return to the dichotomic model. At the same time, their contribution involves an immediate application to the factual domain of a model initially devised for fictional literary texts. They speak of "Chronik" (chronicle) and "Narrativ" (which seems to translate the English term "plot") and base their distinction on Forster's example (1927), to which we have just referred: "The King died and then the Queen died" is a Chronik; "The King died and then the Queen died of grief" is a Narrativ. The authors add that the reorganization of the facts of the Chronik by the Narrativ facilitates the "self-understanding of the [speaker]" and the "involvement of the listener". The sense of vulnerability produced by illness is conjured by ordering the events into an intelligible whole – events which are now presented as regulated by "plausible relations" (2012, 369) rather than by anarchic ones.

The distinction between *story* and *discourse* as conceived by classical narratology (and, above all, by Chatman) has become the target of attack of some deconstructivist proposals, among which a much commented and criticized article by Jonathan Culler (1981) stands out. In short, Culler believes he has found "a certain self-deconstructive force" that leads him to postulate the existence of "two logics" that coexist conflictingly and, moreover, would call into question any possibility of a non-contradictory and coherent science of narrative. These two logics can be understood on the basis of the answer one chooses to give to the question of which comes first: the events (the story) or the discursive organization (2007 [1981], 130).

In the first case, events cause (motivate) their representation in discourse, with respect to which they are independent, and, in the second, they are conceived as a product of the needs of discourse. Culler explains: "the distinction between story and discourse can function only if there is a determination of one by the other", so that "the analyst must always choose which will be treated as the given and which as the product". For the author, the problem is that "either choice leads to a narratology that misses some of the curious complexity of narratives and fails to account for much of their impact" (130), insofar as "the power of the narrative depends precisely on the alternative use of extremes, [on] the rigorous deployment of two logics, each of which works by excluding the other" (123).

If the facts are conceived as a mere product of discourse, Culler continues, the texts lose "their intriguing and dislocatory power", for in that case it cannot be seen that discourse "makes a selection and even a suppression of possible information" from the level of the story (130), which generates an interest in knowing what has really happened. If, on the other hand, events are considered

to pre-exist and to be independent of the discourse, which only represents them textually, it is overlooked that there are instances of the story that subvert the functioning of narratives and present events as determined "by structures of signification" (125), that is, "not as givens but as the products of discursive forces or requirements" (119).

Whereas one of the logics, that of the pre-existence of events, is supported by classical models (and also by us), Culler endeavors to provide examples that would account for the other. Culler's position has been long discussed and (we may say) refuted (cf. Chatman 1988; Adams 1989; Ryan 1991; Fludernik 2002 [1996], and Kafalenos 1997). Thus, here we merely reinforce, with specific reference to the factual narrative – Culler says that the "double logic is by no means confined to fictional narrative" (124) – that it is completely absurd to hold that facts may not pre-exist discourse or that they can only be explained as a product of the latter's requirements. Moreover: in factual texts, of course, this pre-existence of events is logical *and* ontological.

We can use Culler's mosquito simile: one can first have an itching sensation in order to find (or imagine), later, its cause in the mosquito, but this does not mean that the itching causes the mosquito to bite me. It is only in the context of discovery (to use Karl Poppers term) that the unpleasant physical sensation precedes the bite. The natural-logical order of things is, thus, that first the mosquito bites me and then, because of it, I scratch myself (context of causation). In factual texts, the causal relations at the level of the story must necessarily correspond to the "ordinary laws of nature" (Chatman 1988, 15). This implies, among other things, a temporal succession in causality: cause A (the mosquito bites me) temporally precedes effect B (I need to scratch myself). In factual settings (although the same happens when the fictional world is mimetic or realistic), otherwise, the story refers to the real world, in which one of two things happened: either the mosquito bit me or it did not bite me.

While it is true that the relationship between the "event [in the story] and its significant reworking [at the level of discourse] is [always] one of suspicion and conjecture" (Brooks 1979, 77), for the proper reception of factual texts, it must be assumed that the truth (what really happened) can be recovered *in principle*, insofar as the referent of the factual text is the real world, in which, as in the structural level of the story that ideally signifies it, facts take place in some way and not in another. What may happen in the specific case in question is that for some conjunctural reason human means are not sufficient to recover the truth (for example, due to failures in the investigation, the physical disappearance of all the participants or oblivion, etc.). This is why we say *in principle*: if God exists, we could appeal to his omniscience.

In the fictional realm, facts are performatively produced by the communicative act in which a real author creates, out of nothing, a second, imaginary communicative situation. From the point of view of that real communicative situation, indeed, one cannot speak at all of a pre-occurrence of events; but when we assume an internal position in the imaginary communication between a fictitious narrator and a fictitious reader, we may talk of a logical pre-ocurrence of events.

In the factual realm, we are faced with another situation: the real author only reports the events, he cannot produce them, since they are given beforehand and independently of any textual elaboration.[6] Here, the pre-occurrence of events is literal: the sequence of events in the story – although located in a structural level that can only be accessed by abstraction from the level of discourse – refers, however, to reality, of which it is postulated to be a reliable reproduction.[7]

2. Homodiegetic narration in fiction and illness narratives: the question of the boundary between story and discourse

Dan Shen (2020) is also in line with those who convincingly refute attempts to deconstruct the story / discourse binary opposition. After throwing Culler's arguments overboard, Shen proposes, however, "a non-deconstructive challenge", i.e., to explore "certain areas where these distinction is not tenable" (228). For Shen, "[t]he distinction between story and discourse will be blurred", for example, "when one element belongs at the same time both to the level of story and to that of discourse" (230). This would occur, above all, in homodiegetic narration, which is of particular interest to us, since this is the form that patient narratives assume, by definition:

> In homodiegetic narration […] the borderline between story and discourse may dissolve when the I's narrator function (which belongs to the level of discourse) and character function (which belongs to the level of story) converge or cannot be distinguished. As the narrator is narrating her own story, sometimes it is, for instance, difficult to distinguish the narrator I's view (belonging to the level of discourse) from the character I's view (belonging to the level of the story) in narratives where there is little gap between the two […], especially when the story relations extend to the time of the narration. (238-239)

The example Shen proposes is taken from the ending of Ernest Hemingway's *My Old Man* (1923), a short story in which Joe, a naive first-person narrator, seems to question (only momentarily) the image he has always had of his own father, Butler, a horse jockey by profession, after hearing two resentful gamblers speak badly of him following his death in a racing accident. A colleague of the dead father's, present at the scene, tries to convince Joe that old Butler was a fine person, and then there is a suggestive shift from the verb tense to the present: "But I don't know. Seems like when they get started they don't leave a guy nothing" (qtd. in Shen 2002, 239). These two final sentences would communicate, at the same time, Joe's immediate reaction to what he is told (story level) and the narrator's view in the present (discourse level), which makes it impossible to really decide which of the two thinks so.

At this point we should note a divergence from the (homodiegetic) patient accounts in our corpus, where we didn't find such undecidability. In the factual realm the textual world evoked is postulated as an accurate reproduction of our real world. At least, that is the intention with which the discourse is produced. And real events (whether mental or external) occur at a precise point in time

which, logically, can always be identified, if not in fact, then *in principle* (as we said). In any case, as our collected narratives have been produced in conversational contexts, in cases where the practitioner is in doubt, he or she can always ask to find out whether a certain thought or feeling belongs to the I narrator and / or to the I character of his patient's narrative.

The following excerpt is taken from the consultation of Mirta, a 65-year-old polyglobulic patient who, at the time of the recording, is recovering from a stroke and is only a few days away from being discharged from the hospital. What is striking about this case is that Mirta suffered the stroke in the hospital itself, where she had gone two weeks earlier for a routine bloodletting, according to her own explanation. Moreover, the events evoked took place in the same room where she is now visited by the doctor, who, to start the conversation, asks her why she is hospitalized:[8]

5	D	WHAT happened to you? tell me about it. why are you hospitalized?
6	P	well I came to have a bloodLEtting done in uh uh in the day hospital. I had the
7	P	bloodletting. I finished it at about four o'clock in the afternoon. my HUSband
8	P	brought me in. dropped me off and then came to pick me up.. then I call him and
9	P	tell him (?). look they have already given me the serum. so come here to get me.
10	P	wEll. he was coming here to pick me up and I had to leave the day hospital. so
11	P	they took me out. / the doctor./ the nurse gives me the tea with cooki::es in case
12	P	my blood sugar got low or something like that. um:: I sit on the bed and she tells
13	P	me to be careful not to fall (?) well (?). no no. it's ok. I sat on the bed and she tells
14	P	me look. it's very hot. don't (?get burned). and:: I started to::/ she left. she left it
15	P	THEre. I sit up. to drink the tea and I TAKE the cookies and try to open them and
16	P	I CAN'T. I can´t.. this hand wouldn't move. it wouldn't move.

In Mirta's story, which presents an autodiegetic narrator like Joe in Hemingway's, there are elements that are located both in the tier of story and in that of discourse, by the mere fact that the I narrator and the I character have the same identity and, furthermore, because the consultation takes place in the same location where the onset of the stroke took place. The use of place adverbs *here* (line 9) and *there* (15), and of the demonstrative in the phrase "this hand" (16), are key to understanding such identification. The adverbs locate the facts in the communicative situation (discourse level), but, at the same time, they serve to organize the sequence of events narrated in the story. The same happens with Mirta's pointing out her hand, which is the one that, at the level of the story, stopped moving, but also the one that is looked at, in the present, by the doctor.

The "here" and the "there" point, at the level of story, to the hospital and the little table on which the nurse has left Mirta's tea, respectively, and, at the level of discourse, to the same objects, but as given in the communicative situation. Further, the hand that the doctor looks at is, evidently, the same hand that Mirta could not move when the events took place. But this does not blur the boundary: we understand that the hospital, the little table and the hand are the same, but also different, since a certain amount of time (two weeks) has passed in between. This accounts for the logical-temporal primacy of the facts and the elements of the story (things and characters) over their presentation in the discourse level.

The story / discourse distinction is preserved, even if the same element belongs, at the same time, to both levels.

It may be said that our example is misleading in that the act of enunciation takes place in the location of the evoked events. But there are other parts of the same interview that also show the extent to which the constitutive ambiguity of Hemingway's homodiegetic narrative analyzed by Shen, which poses a challenge to the story / discourse distinction, does not apply in factual contexts. What we will see now is how the doctor, through her questions, manages to re-establish the differentiation between the levels of story and discourse when the boundary is rendered opaque by the way the patient presents the facts. The fact that the doctor is able to resolve the ambiguities with her interventions reveals an important differential characteristic of the (factual) illness story with respect to the (fictional) tale of the American writer.

In lines 23-33, Mirta refers to the moment when she wants to say something to the nurse but cannot, which establishes in those attending her the certainty that she is suffering a stroke. The doctor's question (31-32) aims to highlight the extent to which the I narrator and the I character in the story do or do not share certain knowledge. The fact that the patient answers affirmatively (she clarifies that already at the time of the story she was aware that she was not speaking but babbling) does not imply a blurring of the boundary between story and discourse, but it only suggests that there are no asymmetries regarding the information that both agent and narrator handle in this respect. However, there is an asymmetry between the two, for example, with respect to the awareness of the stroke: "I didn't associate the stroke with it [i.e. the series of behaviours she was experimenting]", says the patient in line 73.

In lines 44-49 laughter appears, which seems to detract from the seriousness of the enunciation of an event that, by definition, has been unpleasant for Mirta (we assume); the same happens in lines 57-69, where she refers to the husband's arrival and his surprise when he is given "the things and not the wife" (61). By the way: the distance between laughter and the uncomfortable event also serves to re-establish the distinction between I character and I narrator. In line 71 we find another key question of the doctor, which has, for us, the same function as that of lines 31-32: to re-establish the precise boundary between story and discourse, thanks to the possibilities afforded by face-to-face conversation.

It is important to note that the doctor's questions, which demonstrate the determinability of the boundary between story and discourse in the illness narratives, at the same time account for the ontological completeness of the factual agents in stories about reality. It is because Mirta is a real person that the doctor can ask questions in order to gain access to her story from another perspective, something completely impossible in a fictional text. The narrative constitution of the illness narrative has thus a nature and a functionality that must be carefully differentiated from the structure of the fictional narrative. Moreover, we can infer from the doctor's strategy that it seems to be of therapeutic or at least communicative importance that the boundary between story and discourse is not blurred.

23 P right. and I had no strength in my left hand. so I say. no. what I do?. many
24 P times I had caught that… but not so. not so like that./THAT time. then I took the
25 P nurse call bell and I pressed it with this hand. then the nurse came and said to me.
26 P did you get burnt?. No I said to her. no.. it came out.. as a gurgling sound like a

27 P bahbahbahbahda::d
28 D Uh-huh

29 P and she keeps telling me what's wrong and I don't ans/ I answered her, but I don't

30 P ANnswered her with words. as BAbbling. she says. then she calls
31 D did you realise that you were talking nonsense?/

32 D that you didn't get what you wanted to say?
33 P yes. exactly

34 P and that I was telling her what was happening to me.. a:::nd I cou:::ldn't:. the other
35 P nurses came and said to me. what's wrong with you? what's the matter? what do
36 P you feel? and I was telling them and there was no way they could understand what I
37 P was feeling. then she didn't know what to do and the other one says to her.. let's
38 P take her to: thera/ to the emergency ward. she says her.. well. let's go. one of them
39 P went to get something from the../ so that they would take me to the ward to tell
40 P them (?) and when I got there../ I tell her there are my things. I had a little bag in
41 P which I had put my nightdress to be there. there are my clothes. my shoes are in the
42 P bathroom. they

43 P are not there.. I tell her put them there in the
D did all that come out of you?

44 P NO. <laughs> I was signing+
45 D <laughs> so ALL THAT was in your head but it didn't come out+

46 P right. NO IT DIDN'T COME OUT NO. and I was telling her right trststssste and I,
47 P then she says your shoes, do you want to put on your shoes, tststs <laughs> no+. I
48 P tell her to put them there and give them to my husband, that's what I was saying
49 P her, but I couldn't get that out
[…]
57 P we::ll um: they took me away… she grabbed/says that my husband was outside that
58 P a nurse appeared and said to him these are your wife's things and my husband says
59 P HOW?.. IF I CAME TO GET MY WIFE <laughing loudly> where is my wife?..+
60 P well
61 D they brought him the things and not the wife
62 P no <laughing loudly> he said WHOM SHOULD I ASK?. well <lower> um:+
63 P and I was left there with my wife's things
64 D they left him standing there
65 P yes. they took me to the ward.. in the ward they ASked me questions and I answered
66 P what they asked me. but there were no no no words. it was babbling and I looked at
67 P them as saying HOW CAN'T YOU UNDERSTAND ME <laughing> how can't
68 P you understand me+. at no time did I lose CONSCIOUSNESS

69 D you are aware of everything in great detail. of everything
70 P yes. right

71 D at that time. were you worried?

72 P YES:: NOT worried. about me. but um what was happening to me? I didn't
73 P underSTAND what was happening to me::: I didn't associate the stroke with it

We must now draw our attention to the role played by the "affect / emotion / feeling complex" (or, simply, AEF complex, cf. Shanahan 2007, 29 ff.) in Mirta's narrative, which we will take as a representative case of what occurs in most of the illness narratives in our corpus. Lines 6-16, as we have said, constitute Mirta's narrative response to the doctor's question, "WHAT happened to you?" (5). In this regard, up to and including "I sit up" (15), we can say that no emotion is depicted. The patient reconstructs the events almost in the manner of a report of discrete, objective facts. But then, in line 16, the repetition of phrases ("I CAN'T. I can't"; "this hand / it wouldn't move") and the emphasis ("I CAN'T") indicate (at least) surprise or incredulity.

Emotions are recognisable here from such marks at the level of enunciation / speech. Moreover, at first glance, there seems to be a complementary relationship between these marks – an index of emotionality – and the way in which the patient produces a narrative tension. This can be seen, on the one hand, in the decision to postpone the direct response (that she had a stroke) and, instead, to recover previous events by narrating them, starting from lines 7-8 ("my HUSband brought me in") almost without anachronisms. On the other hand, such relationship can be observed in the recovery of the nurse's two warnings, which allude to an imminent danger – "be careful not to fall", "look. it's very hot. don't (?get burned)" –, as if following the popular dictum *third's time the charm*. The climax is reinforced, then, by being charged, through (apparently unconscious) decisions at the level of discourse, with an emotional weight hitherto absent in the patient's account.

Regarding the distinction between story and discourse, we can affirm that emotions seem to play a key theoretical-methodological role in interactional contexts such as the medical consultation. Guided by common sense, we assume so insofar as it would be strange for someone to feel the same way at the dramatic moment of suffering a stroke (even if he or she is not fully aware of it), as at a later moment – when that person has recovered and can reflect on it with the peace of mind that comes with her health finally recovered. In our case: the shock or strangeness was experienced by Mirta in the storyworld; in front of the doctor, Mirta no longer feels exactly the same not only because, among other things, as we have said, she is now out of danger, but also because she has already been told what happened.

It seems wise to bring up here the distinction between "affect" and "feeling", i.e. between "preverbal bodily states" and "(meta)representations of emotional states" (Struth 2015, 126), respectively. The "uncontrolled" affect, which activates in the human animal an "evolutionary programmed set of reactions", on the one hand, and feeling, mediated by reason and language, on the other (126). Mirta's narrative illustrates very clearly the extent to which affect – we should not be misled by the fact that she uses the verb "to feel" – cannot be expressed linguistically, when she says that "there was no way [the nurses] could understand

what I was feeling" (36-37). This differentiation would be particularly appropriate for a socio-discursive genre such as the medical consultation, insofar as the doctor's office is constituted precisely as an institutionalized space in which, by means of the patient's narrative, the lived experience is reflected on from a certain distance.

In any case, there may be, in Mirta's story, "a fleeting breakthrough into performance" (Bauman & Briggs 1990, 74; cf. Carranza 2020, 48-75), i.e., a staging of those feelings of disbelief at the time of the events. As a result of it, the patient shows herself as apparently feeling the same as in the past, perhaps unwittingly seeking to move her interlocutor or appeal in some way to her. Sometimes, however, it happens that "in the act of retelling (and reliving) past events", "the same bodily symptoms" are evoked, which testifies to the emotional intensity or affectivity with which the traumatic event has been experienced and the extent to which the individual is still affected in the present (Struth 2015, 129). Finally, we may be dealing with what Culler calls an "evaluative device designed to prevent us from saying 'So what?'" (2007, 129).

But what matters to us here is that the distance between the experience and its performance or staging, or between the original emotional symptoms (affective response) and their "repetition" in the present, is, in short, a way of understanding the categorical boundary between the level of story and that of discourse. As we have been arguing, such boundary is always (beyond appearances and at least in principle) determinable in vast areas (if not in all) of the factual narrative. This also applies if we consider that the dramatic passage in Mirta's narrative could be due to requirements of signification (at the level of discourse). As it is a factual text, the doubt as to which comes first – the event or the discourse – is resolved by a simple question, as Culler himself is obliged to admit: "Is this incident true?" (2002, 129). Or, in our case: Is it true that Mirta felt surprised or incredulous when she had the stroke?[9]

3. "Substratum" and story, or how narrated feelings play a role in logical-causal sequences

In what we have said so far, there is something confusing: we have claimed (at the end of section 1) that, in factual settings, the story tier refers "to reality, of which it is postulated to be a reliable reproduction". However, in commenting on Tomashevsky's notion of fabula (our story), we affirmed that the relations of causality it contains (at least when they do not obey a natural determinism) presuppose a hierarchisation and even an interpretation of events that, as such, cannot be found in our "reality". This terminological ambiguity leads us to defend, following the line of Karlheinz Stierle (1973 [1971]) and Wolf Schmid (2010), the need to subdivide the tier of what is represented by discourse (the *what*) into two levels: *Geschichte* and *Geschehen*. The latter would be precisely the level prior to any process of hierarchisation and interpretation.

For Schmid, *Geschehen* (Eng. happenings) is "the amorphous entirety of situations, characters and actions explicitly or implicitly represented, or logically implied, in the narrative work" (2010, 190). He conceives it as "a continuum that is spatially fundamentally unlimited, can be endlessly temporally extended into the past, can be infinitely divided internally, and can be concretized into infinite properties" (190). The *Geschichte* (Eng. story) is the result of two complementary operations of selection from the *Geschehen*, which transform the latter's infinitude "into a limited, meaningful form"; it implies a double selection of factors of the *Geschehen* (situations, characters and actions) and of certain properties from the "infinite mass of characteristics that can be ascribed to the selected elements" (191).

Following Schmid, the story covers "the elements explicitly represented and furnished with certain characteristics in the text, the denoted and qualified situations, characters and actions" (191). Besides, it contains the selected events *in ordo naturalis*, in contrast to the next level, that of *Erzählung* (narrative), which brings them into an *ordo artificialis* by means of a process of linearization (those events which in the story, for example, occurred simultaneously now appear one after the other) and permutation (analepsis, prolepsis, etc.). Finally, the *Präsentation der Erzählung* (presentation of the narrative) is the phenotypic tier, the only one accessible to direct observation: it supposes the manifestation of the story in a concrete medium: verbal, filmic, mimic, musical, figural and so on (192).

Our main interest here is to emphasize the following: it is somewhere between the tier of the *Geschehen* and that of the story that a good deal of the "signification", i.e., the attribution of meaning, takes place. These are two tiers separated, in fact, by a "threshold of meaning" or *Sinnschwelle* (Stierle 1973, 532). Donald Spence's claim about narrative, namely that its anthropological function has been – since immemorial times – and continues to be that of "turning happenings into meanings" (Spence 1987), can be appreciated to a large extent in the way in which story selects certain events from the *Geschehen*-substratum and hierarchises them insofar as it places them in the position of cause or effect. The result of all this is the "imposition" of an interpretation (human, subjective, etc.) on facts or chains of facts.

From here on, we will speak of *substratum* to refer to a level on the *what*-side that resembles Schmid's *Geschehen* but differs from it because we conceive it on the basis of the study of our corpus and – therefore – it is only useful for medical consultations and (perhaps) other interactional genres. The existence of the substratum, as a tier that underlies the story level, is deduced from the analysis of the interaction between doctor and patient, and taking it into consideration is also key to medical therapeutic work in a broader sense.

For illness narratives, it is valid to affirm that the substratum is a structural level in which, potentially, there exist those possible causal connections between facts that were left aside by the patient as superfluous or as a result of some other more unconscious reason as, for example, shame or embarrassment. In other words, the substratum is constituted, among other things, by the set of all the logical-causal possibilities that are not actualized at the level of the patient's story

but remain "latent". The substratum thus functions as a reservoir from which new causal connections can be generated, different from those made explicit in the story. It is for this reason that the substratum – as we understand it here – is a highly relevant level of analysis for the doctor and that, moreover, it is justified to make a subdivision within the level of the "what" of the story.

Although the story is what the patient makes available to the doctor through his or her narrative, initially as a faithful representation of what has happened, the very interrelation of the story with the substratum, which is set in motion in the dialogical space of the consultation, unleashes an intersubjective dynamic, a true phenomenon of co-narration[10], which often leads the patient to make changes in his or her story in the course of the consultation (or from one consultation to the next). This generally occurs as a consequence of specific interventions by the doctor, which lead to making explicit another logical-causal framework, alternative to the one initially presented. Such alternative framework supposedly captures more authentically the reality that has been experienced, which the patient, mistakenly, believes to be reproducing accurately at the beginning of the narrative.

Some of this can be seen, in our opinion, in Pedro's story, from which we reproduce, in parts, an excerpt (lines 126-154). Pedro is a 72-year-old man from Alberti, a rural town in the province of Buenos Aires, who a few weeks before the consultation underwent a cholecystectomy for gallstones in the gallbladder and common bile duct, but is now going to be re-operated because an infection has caused cholangitis and portal vein thrombosis. He has just finished the antibiotics prescribed to combat the bacterial infection and is preparing for the surgery in the days following the consultation. The doctor, who already knows the patient, asks him about the large amount of body weight he has lost in the last time, which puts the spotlight on Pedro's body and the changes brought about by the disease:

126 D how much weight do you think you've lost.. pedro? how much did you weigh/what
127 D would be your normal weight?
128 P if I tell you, you won't BELIEVE me.. I must have weighed ONE HUNDRED and
129 P thirty.
130 D and the other day we got weighed. do you remember? how much did you weigh?
131 P seventy-two and a half something like that. right?
132 D yes. so you lost weight

133 P YES::::... that is to say, MIne would have to be seventy-eight... eighty at most.
134 D you are very tall

Pedro then proposes two causal explanations for his abrupt weight loss that are not linked in principle to any emotional issue: i) the organic process of the illness itself, and ii) the fact that he has not eaten well in the last few weeks of his hospitalisation in different health centres until he arrived at the hospital El Cruce (line 136). This double logical-causal nexus is situated at the level of the story, in which we can then recover the following events: *he became ill – he was hospitalised*

– *he did not eat well* – *he abruptly lost weight*. But then the doctor suggests the possibility of interpreting the event (the loss of body mass) in another alternative way and surprisingly alludes to the sadness she has noticed in the patient (line 137) “the other day” (line 130).

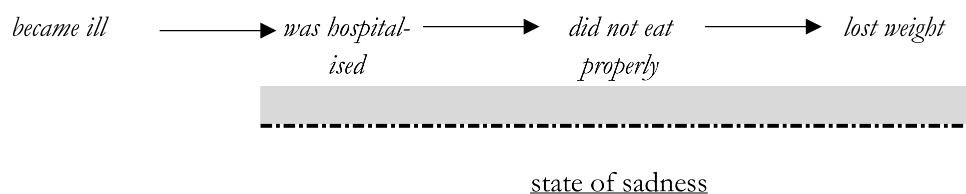
Pedro’s reaction to this suggestion is one of full acceptance (“yeah. you know”, line 138), as if the doctor has finally found the real cause of the abrupt weight loss, one that until now has remained “hidden”. This positive reception of the doctor’s suggestion is revealed most forcefully in the physical response: beyond the suggestive pauses when answering, for the first time in the whole interview, Pedro trembles when speaking (line 138). This is indicative of a state of strong emotional affectation, produced – as was possibly also the case in Mirta’s narrative, as we have seen – by the act of remembrance, constitutive of the medical consultation. As Struth says, “memories can trigger emotional states” (2015, 129).

135 P I was really overweight <throat cleaning>+ but I lost all that... because of the

136 P disea::se or because you don’t eat well <lower> or because+
137 D you were a bit sad too

138 P yeah. you know::... it’s not easy for so long... I wasn’t <with a certain trembling in
139 P his voice> used to being+ locked up for so long either.. I used to be out and about
140 P all the time../ I’m bah and I used to walk around a lot

What is certain is that the doctor’s intervention complicates the logical-causal framework of this segment of the story, insofar as it incorporates a state of sadness which, from a certain moment during the hospitalisation, is superimposed on the events. We illustrate this graphically in the following diagram, which shows the causal links between the events and the “superimposed” emotional state. The grey band represents an area in which there is a series of diffuse causal links between the state of sadness and the different events that make up the story level. These logical relationships are difficult to fathom, but, in any case, they have a bidirectional character in the sense that, very presumably, they feed back on each other.



What we believe is that this accounts for the dynamics that takes place, in the framework of the doctor-patient conversation, between the level of the story and its substratum. The relationship between the state of sadness and the weight loss is, so to speak, “available” in the substratum but has not been actualised by the discourse and therefore does not appear as recoverable in the story. The modification of Pedro’s story by virtue of the doctor’s acute appreciation of it

thus attests to the theoretical-methodological importance of the structural level which we call "substratum", both for the doctor and for the narrative scholar. Moreover, in this case, the inclusion of the "sadness" factor is key in the subsequent course of the consultation, since it allows the patient to verbalise new elements that until then have not appeared or have remained implicit.

The fact that sadness moves to the level of the story (explicit level) provokes in the patient an urge for explanation: it thus acts as a trigger for a new section of the narrative. Lines 138-140 should be read as the beginning of a narrative explanation of the cause of the state of sadness: more precisely, it is a matter of going deeper into the subject. Pedro seems to notice that the mere relation between his hospitalisation and his sadness is not enough, and alludes to the fact that he "used to be out and about all the time" (*era muy andariego*) and "used to walk around a lot" (*andaba caminando*), which contrasts sharply with his confinement; at the same time, he waits for an approval to continue. The doctor notices this immediately and, consequently, asks about his daily routine in Alberti (141 and 143). Pedro answers her with an iterative account in the historical present (lines 144-150):

141 D what do you do there in Alberti?
142 P I'm retired now. but I just can't stop at home... that is./ I can't stop at home
143 D what is your day like in Alberti?
144 P and well I get up at five thirty in the morning now for example... I go for a walk to
145 P the docks... ten blocks there and back... then I go to a small workshop that I have
146 P that I work on handicrafts in ro./ in LEAther and rope for the horses and….that's
147 P until noon or maybe I get bored and I go to the villa or I go to do something else
148 P over there... but that is GENERALLY until noon... I sit down to eat and then I
149 P rarely sit for long... I just sit down for a while because nowadays the days are long
150 P and I get up and then I go back to the workshop
151 D great
152 P yes. it was a NIce life <dull laughter>+
153 D <laughter> inDEED+.. your life is very nice and that's why it's so hard for you to
154 D be locked up here

Pedro's iterative narrative, with its explanatory function (aimed at making the doctor really understand why he is sad), foregrounds his sense of a break in the continuity of life, which is characteristic of illness narratives. In this narrative genre, the irruption of illness establishes a "before" and "after", an intermission or cessation, in the manner of a transformation, a *Verwandlung* (in a real Kafkaesque sense), which leads self-perception and one's own identity construction to a crisis (cf. Rimmon-Kenan 2002, 12; Frank 2013 [1995], 56). The oscillation between self-characterisation in the past and present tense in Pedro's account (*I used to be* / *I am*; lines 139-140) makes it clear, in any case, that "being locked up for so long" as a result of the disease has highlighted, among his very central concerns, the uncertainty as to whether or not his life will be able to continue in the same way as before.

At the end, the doctor seems to want to show Pedro that his life as an "out-and-about person" (an *andariego*) in the village is not lost forever. When Pedro

concludes, he makes an assessment in the Spanish imperfect past tense, insisting that this period of his life is lost forever: "yes. it was a NIce life" (*sí. era una vida LINda*; line 152). The doctor, then, corrects him, uses the present tense – "is" (*es*; 153) – and points out that it is because his life not only *was* but *is* "very nice" that now, in the hospital, he is sad and, as a consequence, has lost weight abruptly. In other words: *Peter's life was and is very nice – it was interrupted temporarily by illness and confinement – he has been and is sad – he has lost weight.* The correlate of this modification is an opening towards the future as a space of possibility: *Pedro will possibly return to his former life.*

If the event representing the complication (the confinement) is linked to sadness because it has forced Pedro to abandon his simple and happy life in the countryside, it is now a matter of it all acquiring a sense of transitory nature. The struggle between rival interpretations (*is* vs. *was*) should be read as a wager, on the part of the doctor, that, in the end, a certain air of hope will prevail. It is an effort to ensure that sadness is understood as a passing state to be overcome: this is seen, moreover, in the contrast between Pedro's subdued, melancholic laughter (153) and the doctor's almost jovial laughter (154) – and the emphasis by the adverb "inDEED" – which seems to indicate to the patient that there is an alternative (happier) way of interpreting the events and which predisposes him better for the surgical intervention.

But what is the source from which Pedro undertakes the task of reconstructing what really happened? Confined to the doctor's office, the patient's only access to facts is through his blurred memories. Memory is to the patient what historical sources are to the historian. Unlike the novelist, "the historian is not free to invent his / her own story", since he can only aspire to construct "the most convincing and consistent account of events possible from [his/her] sources" (Fludernik, 2009 [2006], 3); we might think that the same applies to the patient, who seeks to be respectful of the events, or at least of the way in which he remembers them. Ideally, no patient would deliberately misrepresent the facts, because his or her healing is at stake.

The patient's source – memory – is, in any case, extremely precarious and changeable. Memory, as we know, is far from being a reliable resource for accessing the lived or historical past. As a process that is not only "reproductive" but fundamentally constructive, it cannot be understood as a diaphanous mirror in which the past is rigorously reflected. In the process of remembering, among other things, "[d]etails may be distorted to increase coherence; rationalizations not present in the original may be introduced; details that are consistent with the synthesized coherent story may be added; and details that are inconsistent may be dropped" (McClelland 1995, 69).

The question we could ask ourselves in relation to this is whether in the latest version of Pedro's story (*he lost weight because, in addition to the fact that he had to spend a long time locked up and did not eat well, he was/is very sad*) the extratextual reality has been better captured than in the beginning (*he lost weight because he had to spend a long time locked up and did not eat well*), and we must immediately answer that it is impossible to know. This is the same situation of our imaginary hypothetical

journalist reporting on the supposed cause of the Queen's death: from the epistemological position of the doctor (and also of the patient himself), beyond the clues provided by the bodily and emotional reactions described, one cannot be absolutely certain that one interpretation of the logical-causal nexus is better than the other.[11]

In any case, what we believe is that in medical consultation the above question is – to a certain extent – superfluous, precisely because the past referred to cannot be fully recovered with the means available (memory). In historical discourse, the possible world constructed by the historian offers a "model of the past of the actual world" (Doležel 1998, 792), which he or other historians will have to refine in subsequent work, for example, when a new document is found, in order to obtain ever more accurate models. But the doctor's criterion in the interactional context of the medical practice does not seem to be the same as the historian's at all (i.e., accuracy). What the doctor is interested in is, at least, that the story told acquires a *vitally useful meaning* for the patient himself (Köhle / Koerfer 2012, 369).

In other words, the participants (patient and doctor) seek to recover reality but with the ultimate aim of discovering the extent to which what has happened can take on a (new) meaning for the patient's current and future life. In their interaction, the identification of the affects and feelings (their passage to an explicit level) linked to the events seems to play an important role.

The past reality is the starting point and its reconstruction is the goal of any honest factual narrative, but with the means available in the interactional framework of a medical consultation, the correspondence of the illness story to the reality as it has actually happened cannot be established with complete certainty and it would therefore be unwise for such correspondence to be the intended purpose of the interaction. What does emerge from the co-narration in the consulting office is something more beneficial for the patient's everyday life: *a meaningful (i.e., healing) explanation*, which may be more or less accurate in terms of reference to reality.

The – if not "total", then at least highly plausible – accuracy of a story in relation to reality can only be verified, ideally, with the help of additional techniques and evidence. For example, in the field of law, through the review of security cameras, examination of fingerprints, DNA samples, clinical studies, etc. It may be that the decision to include sadness as a causal factor in explaining Pedro's weight loss is due solely to "the requirements of significance", as Culler (2007 [1981], 129) would defiantly put it. Whether this is the case or not, however, it is something that *could be determined by suitable means*: for example, if there were a machine to measure human emotions and their influence on material reality – it is not unlikely that such a thing would be invented in the future. This is, moreover, a notable difference between the factual text and the fictional world-creating literature.

4. Conclusions

The starting point of this paper was the classical distinction between story and discourse and the proposition that the analysis of narrative constitution must both take into account the factual or fictional condition of the story in question and include a pragmatic consideration of contexts and socio-discursive genres. We have tried to justify this on the basis of the particular case of a corpus made up of illness narratives produced in medical consultations, collected at the hospital El Cruce "Néstor Kirchner" in Florencio Varela (Buenos Aires, Argentina) during the year 2022. This means that the conclusions apply only to this subclass of factual accounts that have the particularity of being produced in a face-to-face conversation between a patient and a doctor who holds institutionally backed up knowledge.

As we intend to show, two characteristics can be distinguished in this type of narrative that should constitute a wake-up call about the immediate, automatized and indiscriminate use of models initially devised for the approach to fictional and literary texts. Thus, 1. In the illness story (as in all factual narratives) the pre-occurrence of events in relation to their presentation in discourse is logical and ontological, since what is stated or referred to has actually occurred, as opposed to the fictional story, which produces events performatively. 2. It is difficult – if not impossible – to think of situations in which the distinction between the level of the story and that of discourse becomes irretrievable, as it occurs in certain cases of homodiegetic fictional narrative. It seems to be of communicative (and perhaps therapeutic) importance that this boundary is not blurred.

In the light of the above, we have proposed a partial model of narrative constitution that does not claim to be universally valid, as it has been designed only for the illness narrative as it occurs in the face-to-face medical consultation. Again, the reflection on the narratives in our corpus is the basis on which we have elaborated our conceptual approach. This means that our model, which, following Stierle and Schmid, proposes a distinction between substratum and story and also includes the notion of "source", not only supports the premise of a necessary differentiation between the factual account and the fictional narrative but it is pragmatically determined, insofar as it is attentive to the particular context of discourse production.

In our approach, the question of affect and emotions becomes particularly relevant, for a number of reasons:

1. As illness narratives deal with the narrative reconstruction of unpleasant (and, sometimes, traumatic) events linked to one's own body or mind, we are led to think about the discursive strategies that are activated in the (re)construction of what was felt, which can be deployed consciously (performance, with a more or less persuasive purpose) or not (emotional reactions triggered by the task of remembrance that sets the story in motion).

2. We have found that affects and emotions (or, more generally, the AEF complex) are elements of particular interest in order to explore the differentiation between the structural levels of story and discourse in certain factual texts of an interactional nature such as the medical consultation. This is due to the fact that the doctor's office is an institutional location where, in general, consultants reflect on what they felt (in the past) and where – sometimes – emotional processes experienced spontaneously by the I character become conscious for the I narrator.

3. A doctor trained in narrative medicine has a particular interest in "dismantling" causal links as they are presented at the level of the story in order to propose other possible connections which he recovers from the level of the substratum (Schmid's *Geschehen*). In this search for new meanings and interpretations, the awareness of the emotions triggered by the events experienced before and during the consultation seems to be a goal sought by the doctor, as it serves the patient to continue narrating and to put the narrated events in a new light. This mechanism, at the same time, demonstrates the very existence of the substratum level.

Now, why should we study the narrative constitution of narratives? At the beginning we echoed Culler's reflection that understanding the schemes of narrative is important *in all aspects of our lives* (Culler 2007 [1981], 130). Unfortunately, Culler has not explained what exactly he means by this, but the assertion has worked for us as an incitement to think about the relationship between narrative constitution, emotions and the factual socio-discursive spheres in which human activity takes place. In the opposite direction, Schmid thinks that the recognition of narrative levels only serves as an "aid [within the field of narratology] to the analysis of the fundamental narrative devices" at play in the production of a narrative (2010, 175).

It seems to us, in any case, that both propositions complement each other: the identification of the narrative procedures (e.g. causation) that lead to the final product (the text with which the doctor is confronted in the consultation, for example) serves to understand how human beings reconstruct and make sense of the past in a contextual and generically determined way. Hence, the interest in the study of narrative constitution goes far beyond narratology. It is on the series of transformations that each level operates that one can glimpse at the complex cognitive-communicative process by which a fragment of reality is transformed into a "tellable" text. This is of great interest for the narratologist but also for the understanding of our social life and the way we interact with others in the different spheres through which our existence unfolds.

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[1] Cf., among others, for the case of historiography, Stierle, 1973 [1971] and White, 1979 [1973].
[2] Our corpus is composed of eight patient accounts recorded at the hospital El Cruce "Néstor Kirchner", located in the Florencio Varela district. Attended by a low-income public, this hospital has a "Cuidados Humanizados" (Humanized Care) area, directed by Dr. Beatriz Carballeira, in which patients with serious and/or complex illnesses are given the opportunity to be heard (https://www.hospitalelcruce.org/). The consultations, each lasting between 40 and 50 minutes, were recorded during the first semester of 2022 by Lucas Meddis, a medical student at the Universidad Nacional Arturo Jauretche (UNAJ, Argentina), as part of a research work under our direction. Both the protocol for the recordings and the use of the collected data were approved by the Hospital Ethics Committee and received the informed consent of the patients. The names and some data were altered in order to protect the anonymity of the persons involved.
[3] In Tomashevsky's model, the notion of "chronicle" (xronika) must be added to those of fable and sujet. This concept refers to "a simple statement of the sequence of events" (1965, 68). That is to say, the chronicle would be that chain of events that are ordered by means of causal relations at the level of the fable.
[4] For this panoramic synthesis, we rely on Scheffel 2010, rev. 2013. The works in question are as follows: "Introduction to the Structural Analysis of Narratives" (Barthes, 1966); "The Categories of Literary Narrative" (Todorov, 1966); *Narrative Discourse: An Essay in Method* (Genette, 1972); *Narrative Discourse Revisited* (Genette, 1983); *Story and Discourse. Narrative Structure in Fiction and Film* (Chatman, 1978); *Narratology. The Form and Functioning of Narrative* (Prince, 1982); *Einführung in die Erzähltheorie* (Martínez / Scheffel, 1999); *Narrative Fiction* (Rimmon-Kenan, 1983); *The Cambridge Introduction to Narrative* (Abbott, 2002); *Narratologie. Les instances du récit: Essais sur la signification narrative dans quatre romans modernes* (Bal, 1977); *Narratology. Introduction to the Theory of Narrative* (Bal, 1985), and *Acción, relato, discurso. Estructura de la ficción narrativa* (García Landa, 1998).
[5] The handbook produced by the father of German psychosomatics Thure von Uexküll, *Psychosomatische Medizin* (1st ed. 1979), which includes the chapter "Das Narrativ" by Köhle and Koerfer, has, in successive editions, given more and more space to narration.
[6] We take this distinction from Doležel, who differentiates fictional texts, composed of performative statements, from "cognitive texts", which have the function of offering a representation of the world (1998, 790). Doležel's assertion about the different nature of the gaps in the two types of texts is particularly illustrative. If in fictional texts the gaps have an ontological nature, since they are created in the act of world building, in factual worlds the "incompleteness" derived from the gaps is epistemological: "it is given by the limitations of human cognition" (1998, 795).
[7] It is a truism to say that first the facts have to happen (*reality* and, as its abstract representation, *story*) so that, in a later step, they can be narrated in a certain way (*discourse*).
[8] For the transcription conventions of the cited passages, we have broadly based ourselves on Ciapuscio (2022), who in turn is guided by the Bielefeld Conversation Analysis group. Insofar as our interest is placed at the level of the story, we have simplified as much as possible the marking

of elements proper to narrative enunciation. In addition, we have translated the passages (produced in Spanish) into English, so that many linguistic and prosodic aspects are unrecoverable for the reader of this article. Finally, we would like to thank Professor Guiomar Ciapuscio for her generosity in familiarizing us with her work, which was also carried out, by chance, in an earlier period, at the same Hospital. The markings we have used are the following:
CAPITAL LETTERS = emphasis.
: = lengthening of a sound or syllable.
. .. … = pause: very short, short, longer.
(?word) = insecure transcription
<Comment> + = comment is valid for the segment up to the + sign.
/ = noticeable interruption, correction.

[9] While Culler initially claims that the "double logic" also applies to the factual narrative (2002, 124), later in his article he assumes a position closer to ours by conceding that "in so-called 'natural narrative'", the decision as to whether an event has actually happened or has been placed there for the needs of discourse "usually emerges as a question about fictionality (Is this incident true?)". What we find problematic is the following: "but as soon as we approach [the natural narrative] as a short story rather than a narrative of personal experience, then the question of the relation of story and discourse finds no such simple outlet" (129). We wonder why we should approach a factual interactional account as a short story.

[10] Co-narration could be defined as "the joint construction of the narrative development by its interacting actors" (Carranza 2020, 16 [our translation]).

[11] At most, we can deduce a certain vision of the human being and, more generally, of the world, made evident by the process of signification that takes place in the passage from substratum to story. In our example, both doctor and patient share the idea that feelings are an important factor in a person's material life.