



## RESEARCH ARTICLE

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# “And so, it goes with God” The Patient's Two Accounts, the Mashal as Clinical Instrument, and What Life of Pi Teaches Hermeneutic Medicine

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## ABSTRACT

Yann Martel's *Life of Pi* ends with a survivor offering two irreconcilable accounts of the same 227 days and asking his investigators not which is true but which they prefer [1]. This paper takes that scene as the best available model of a situation clinicians meet constantly and are poorly trained to recognise: the patient who has more than one account, both their own, mutually untranslatable, and who is watching to see which one the room will accept. Two decades of criticism on the novel have divided sharply over whether its refusal to adjudicate is a philosophical achievement or a sleight of hand, and I survey that division because its terms are exactly the terms of the clinical problem. I then argue that the interpretive tradition best equipped to handle a text that is undecidable in reference while remaining determinate in use is the midrashic one, and that the rabbinic mashal — as analysed by Stern, Boyarin, Fishbane, and Kermode — supplies the structural category that the narrative-medicine vocabulary of “the patient's story” lacks. The mashal supplies an application and then withholds its sufficiency, leaving a residue the application fails to collect. Martel performs precisely this: he hands the reader the key, through the investigators' own decoding, and the first story does not collapse. Four consequences for practice follow — that the addressee participates in producing the version, that accounts are maintained at cost, that anomalous detail signals the account's limit rather than its falsity, and that institutional documents systematically require the version that helps patients least. Two symmetrical clinical errors are named, four criteria of discernment proposed, and the limit case examined, where no account can be constructed at all. Throughout, I distinguish three questions clinical training conflates — the etiological, the theodicy, and the endurance question — and argue that the patient's account answers the third while clinicians grade it as an answer to the first.

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## The Room in Tokyo

The scene is brief and it is the hinge of the book. Two officials from the Japanese Ministry of Transport come to a hospital room in Mexico to interview the only survivor of a sunken freighter. They have a bureaucratic mandate: establish why the ship went down. What they get instead is a boy who tells them about 227 days in a lifeboat with a zebra, an orangutan, a hyena, and an adult Bengal tiger.

They do not believe him. They say so. They ask for what really happened, for the straight facts, for an account without invention. Pi observes that the telling of anything is already an invention, and then, obligingly, gives them a second version. In this one the lifeboat holds four humans: a sailor with a shattered leg, Pi's mother, the ship's cook, and Pi. The cook amputates and then eats the sailor. He kills Pi's mother. Pi kills him and eats him too. The correspondences are exact, and the officials work them out on the spot — zebra to sailor, orangutan to mother, hyena to cook, tiger to Pi.

Then Pi asks his question. Neither story explains the sinking. In both, the ship goes down and his family dies and he suffers. Nothing turns on which one is factual. So: which do they prefer?



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Which is the better story, the one with animals or the one without? Mr. Chiba answers first — the one with animals. Mr. Okamoto agrees. Pi thanks them and adds that so it goes with God [1].

The novel's architecture reinforces the asymmetry. The animal story occupies the bulk of the book; the human version runs to some fifteen pages. More tellingly, Pi never tells the second story to the writer who frames the novel. It surfaces only because that writer obtains, a year later, the tape and report from the Japanese Ministry of Transport. The version without animals reaches us as a document, retrieved from an archive, produced under interrogation — and the novel makes us aware of its provenance in a way it never does for the first.

The final page completes the pattern. Okamoto's official report, filed with the shipping company, commends the survivor's endurance and notes that no other castaway has managed so long at sea in the company of an adult Bengal tiger [1]. The bureaucracy adopted the tiger. The chart, in the end, carried the parable.

That last detail is the one clinician should sit with longest. A note on scope. Martel named the doomed freighter, and the lifeboat with it, *Tsimtsum* — the Hebrew term for the divine self-contraction in Lurianic kabbalah, the subject of Martel's own undergraduate thesis, as the novel's opening pages disclose. The theological architecture behind that choice has been treated at length by Reiser, who reads the two stories as an enactment of the dispute over whether the contraction is to be understood literally or figuratively [2]. That reading is not required for anything argued here, and I do not pursue it. This paper treats *Life of Pi* as a literary structure with clinical consequences and leaves its theology to a companion study.

I have read other literary texts against clinical experience before — Baum's Oz as an American midrash of divine concealment [3], Harper Lee's novel as a study in the concealment of innocence [4]. *Life of Pi* is the first I have found that theorises the procedure while performing it.



### Two Accounts at the Bedside

Before turning to the critics, let me say plainly what is at stake clinically, so that the literary discussion that follows is not mistaken for an ornament.

Every physician who has taken a history knows that patients bring more than one version. This is not a claim about deception. It is a claim about structure. The woman with intractable pelvic pain has a story about a surgery and a story about a marriage. The man with poorly controlled diabetes has a story about his

pancreas and a story about the years he was not eating because there was nothing to eat. The veteran with headaches has a story about a blast wave and a story about what he did after the blast wave. In each case, one account is offered readily, and the other is available only under conditions — of time, of trust, of the right question, or of a demand backed by institutional force.

The narrative-medicine tradition taught us to attend to this and taught it well. Kleinman gave us the explanatory model and the distinction between disease and illness [5]. Frank gave us the typology — restitution, chaos, quest — that still organises most clinical thinking about how the ill narrate themselves [6]. Charon gave us the discipline of close reading at the bedside [7]; Hunter showed that medicine's own knowledge is narratively structured before it is propositionally structured [8]; Good demonstrated how thoroughly clinical training reconstructs what a trainee can perceive [9]. I have drawn on all of them in arguing that the patient history is not a data-gathering exercise but an act of interpretation with a text at its centre [10,11].

But the vocabulary has a limitation. It speaks of *the* patient's story, singular, to be elicited, honoured, and integrated. It has much less to say about the situation in which there are two stories, both the patient's own, both true to their own logic, mutually untranslatable, and where the patient is watching to see which one you want. That situation is not exceptional. In my experience it is the ordinary condition of any encounter that lasts more than one visit.

That is the first of two limitations, and the more familiar one.



### Three Questions Medicine Conflates

The second is less familiar and more consequential. It concerns not how many accounts a patient has but what any of them is an account of. Three different questions are in play in most serious illness, and clinical training runs them together.

The etiological question asks what mechanism produced this. Medicine answers it, sometimes well, and owes the patient its best answer.

The theodicy question asks why this happened to *me*, and whether it can be reconciled with any account of a world worth living in. Medicine cannot answer it and should not pretend to. Tilley's argument is the one clinician most need: theodicies characteristically function to silence the sufferer rather than to console [12]. A justification offered at the bedside is nearly always a way of ending a conversation.

The endurance question asks how one goes on. It is answered

not by explanation but by construction.

Return to the Tokyo scene with that distinction in hand and its structure becomes visible. Pi is explicit that neither account explains the sinking. Both cover the 227 days. The officials came for the first question, are given answers to the third, and the second sits unasked in the room between them.

The same holds at the bedside, and it is why correction so often lands as injury. The account a patient construct almost never explains the catastrophe; it explains the survival. The woman who has organised her account around a surgeon's error is not explaining why she developed the disease. She is explaining how she has continued since. The man whose account centres on a single lift in 2019 is not explaining the degeneration in his spine. He is explaining why he is still here and still trying. Clinicians routinely receive these as causal claims, evaluate them as causal claims, find them wanting as causal claims, and correct them — and are then puzzled that the correction wounds.

What follows is an argument that the interpretive resources for that situation already exist, in two literatures medicine does not read: the critical debate over Martel's ending, and the theory of midrash.

### Indeterminacy and Its Discontents

*Life of Pi* has now generated two decades of criticism, and the division within it is instructive, because the critics divide along precisely the fault line that clinicians divide along.

The hostile readings came first and came from serious quarters. James Wood, reviewing the novel for the *London Review of Books* shortly after the Booker, treated it as a work evangelical in its defence of the implausible, and complained that what it has to say about the reader's credulity is ordinary [13]. His deeper objection was that Martel had displaced the interesting question. It is easy, Wood argued, to tell contemporary readers that their god is or ought to be Story, since most of them already assume as much; the harder and unasked question is what Pi himself believes, and by leaving it unexamined the novel seduces the reader's credulity without ever engaging it. Wood's charge, in short, is that the indeterminacy is unearned — a rhetorical effect rather than a philosophical result.

Stewart Cole developed the objection into an argument about category error. Martel, on Cole's reading, conflates two kinds of belief that ought to be kept apart: believing in a story and believing in God [14]. The move from "the story with animals is the better story" to "and so it goes with God" smuggles an aesthetic preference into the position of an ontological claim. One may prefer a narrative on grounds of richness, vividness, or consolation without thereby having any reason to think it corresponds to anything. Cole's essay is the sharpest statement of the case that the ending is a conjuring trick.

Florence Stratton, in the same issue, arrived at a related conclusion by deconstructive means, arguing that the novel is hollow at the core — that its own textual operations undermine the religious claim it advertises [15]. Her most useful contribution for present purposes is the term "tiger aesthetic":

the observation that readers choose the animal story not because it is more beautiful in the abstract but because it performs a function, offering a means of coping with trauma and a defence against what the second story contains. Stratton means this as a critique. I will be taking it as a description, and as the most clinically accurate sentence in the secondary literature.

Against these, a recuperative line developed. Gregory Stephens argued that the novel does not oppose science to religion at all but models their integration, and that the better story incorporates rather than displaces empirical seeing [16]. Hamza Karam Ally, in the most philosophically ambitious treatment, reads the book as an updating of *Moby-Dick*, in which each novel tempts its protagonist to glimpse the divine within the indifference of animal nature, and in which the choice Pi offers is between a world that opens onto mind and a world that refuses that desire [17]. Ally's category is the limit of the symbolic, and his argument is that the novel is precisely about the point at which symbolisation fails to secure what it reaches for.

Now the analytic point, which is where this bears on the clinic.

What unites Wood, Cole, and Stratton — critics of very different temperaments — is a shared assumption that the indeterminacy must resolve, and that a novel which declines to resolve it has cheated. Wood wants the unanswered question answered. Cole wants the two kinds of belief separated. Stratton wants the hollowness exposed. Each treat undecidability as a defect in the artefact rather than as its subject matter.



That assumption has a long history in narrative theory, and the theory has moved past it. Booth's account of unreliable narration presupposes that the reader can measure the narrator against the norms of an implied author and thereby locate the discrepancy [18]. Phelan's more differentiated taxonomy — misreporting, misreading, misregarding, and their underreporting counterparts — likewise assumes an authorial vantage the reader can occupy [19]. *Life of Pi* systematically withholds that vantage. There is no position in the text from which the two stories can be adjudicated, because the frame narrator is himself a character, the second story arrives as a ministry transcript rather than as authorial disclosure, and Pi's own commentary insists that any telling is already an invention. Pi is not an unreliable narrator in Booth's sense. He is a narrator whose reliability has been made structurally undecidable, which is a different and less familiar thing.

Reception theory named this long ago and named it as a

feature. Ingarden identified the places of indeterminacy in a literary work — spots the text leaves unfilled and the reader must concretise [20]. Iser built a theory of reading on the gap: the unwritten portions are not deficiencies but the mechanism by which a reader is drawn into constituting the work [21]. Empson had already catalogued ambiguity as a resource rather than a fault, culminating in the type where a text means two incompatible things at once [22].

The clinical translation is immediate. Wood, Cole, and Stratton are the Japanese investigators. They are intelligent, they are not acting in bad faith, they have a legitimate professional mandate, and they are demanding the story without animals. And the objection they raise — that a preference is not a warrant, that the patient's chosen account is unearned, that its function is defensive — is exactly the objection a good clinician raises internally about a patient's account several times a week. The question this paper asks are what to do next, given that the objection is often correct.



### Reading in the Gaps: What Midrash Knows

The interpretive tradition best equipped for a text that is undecidable in reference while remaining fully determinate in use is the one that grew up around the Hebrew Bible. It is worth setting out for a clinical readership, because it is not part of the standard humanities toolkit medicine has borrowed.

The classical statement of the problem is Auerbach's. Comparing the Homeric epic with the binding of Isaac, he observed that Homer externalises everything — nothing is left unexpressed, no motive unstated — whereas the biblical narrative is spare to the point of obscurity, weighted with an unexpressed background, and therefore demands interpretation rather than merely permitting it [23]. Indeterminacy, on this account, is not a flaw in the Hebrew text but its constitutive mode. Alter developed the same insight into a poetics of reticence [24]. Sternberg went further, distinguishing the gap that a text invites the reader to fill from the blank it declines to acknowledge, and describing the resulting drama of reading as a governed system rather than a free-for-all [25].

Midrash is what happens when a reading community treats those gaps as an obligation. Kugel's account remains the clearest introduction: midrash is verse-centred, provoked by small surface irregularities in the text, and it proceeds by generating

narrative to account for them [26]. Fishbane's contribution was to demonstrate that the process begins inside Scripture itself — that the biblical corpus contains its own exegetical activity, a *traditum* continuously reworked by a *traditio*, so that interpretation is not something applied to a finished text from outside but the mechanism by which the text came to exist [27]. His later work extended the argument to the mythopoetic imagination of the rabbis, showing that the tradition does not merely explain inherited myth but continues to make it [28,29].

Boyarin then supplied the theoretical frame that has proved most durable. Midrash, on his account, is intertextual reading: the biblical text is gapped, ideologically driven, and heterogeneous, and midrash reads those fissures by bringing other portions of the canon to bear on them [30]. This is neither the recovery of an original intention nor the free invention of meaning. It is a constrained practice with real interpretive discipline.

That last point needs emphasis, because in the 1980s the field flirted with a much looser claim. Handelman's *The Slayers of Moses* argued for a deep affinity between rabbinic hermeneutics and modern literary theory, positioning midrash as a precursor of deconstruction [31]; the Hartman and Budick volume opened the conversation to a wide literary readership [32]. The equation was quickly and rightly contested. Stern argued that midrash is not indeterminate in the deconstructive sense — that its polysemy is bounded, purposive, and answerable to a community's needs, and that assimilating it to a poetics of infinite deferral misdescribes it [33,34]. Boyarin made a parallel objection from within the field.

I rehearse this dispute because its resolution is exactly what the clinical problem requires. The mature position in midrash studies is that a text can be genuinely undecidable at the level of reference — one cannot establish what happened — while remaining fully determinate at the level of use, because the reading community has purposes, constraints, and stakes that discipline which readings are admissible. Meaning is not thereby arbitrary. It is answerable to something other than correspondence.

That is precisely the position a clinician occupies with a patient's two accounts. One cannot establish which is factual. One is nonetheless obliged to act, and the action is answerable — not to correspondence, but to whether the reading serves the person's capacity to go on. Wood's demand that the indeterminacy resolve, and Cole's demand that the categories be separated, are demands that the reference be settled. Midrash is the tradition that learned to work well without settling it and did not thereby collapse into relativism.

Within that tradition, the instrument built specifically for this is the *mashal*, the parable.



### What a Parable/Mashal Is

Two classical formulations establish the range.

The midrash on the Song of Songs offers the parable of the king who lost a gold coin, or a pearl, in his house, and who found it by the light of a wick worth a penny. Let the parable not be small in your eyes, the midrash concludes, for by its light one comes to grasp the words of Torah [35]. Note the asymmetry: the parable is cheap, the thing it recovers is priceless, and there is no route to the priceless thing except through the cheap one. The parable is not a lesser version of the truth. It is the only available access to it.

Maimonides, reading Proverbs 25:11, describes the parable as apples of gold in settings of silver filigree: seen from a distance the silver, seen closely the gold within [36]. The external meaning has its own worth — it is silver, not dross — but it is perforated, and the perforation is deliberate.

Stern's analysis of the rabbinic mashal supplies the structural point on which everything below depends. The *nimshal* — the application, the referent, the "this refers to" that follows the parable — typically does not exhaust the mashal. The parable leaves a residue that the application fails to collect, and this residue is not a defect of composition but the engine of continued reading [33,34]. Kermode, working the same seam in Mark 4, notices that the parables are said to be given precisely so that those outside may look and not perceive: concealment is the declared function, not an accident of obscurity [37]. Boyarin's account of the gapped and generative text makes the point from the other direction [30].

I have argued across several papers that this structure describes the clinical encounter better than the narrative model does, and that the patient's account functions as parable rather than as report [38-40]. What that argument has lacked is a case in which the structure is demonstrated rather than asserted.

### Symbol, Allegory, Mashal: Why Richard Parker Is Not a Symbol

Here is where the standard psychological reading of *Life of Pi* goes wrong, and where the correction has clinical consequences.

The standard reading says: obviously the second story is the real one, the animals are symbols, Richard Parker is the dissociated survival-self, and the animal story is a trauma narrative in

disguise. Everything in that sentence is defensible except the word *obviously*, and the word *obviously* ruins it.

Allegory has a key. Once you have the key, the vehicle is discardable — nobody rereads *Pilgrim's Progress* for the terrain. Symbol, in the Romantic and later Jungian sense, points toward a meaning in which it participates, but the pointing is the whole relationship, and the symbol remains an object of contemplation rather than an act performed on a hearer.

The mashal does something neither of these does. It supplies a *nimshal* and then withholds its sufficiency.

Martel gives us the *nimshal*. He gives it in full, with every correspondence spelled out by the officials themselves. And the story does not collapse. That is the structural signature of a mashal rather than an allegory: the key is handed over, and the door still does not open all the way.

This is why the psychological interpretation, arrived at too fast, repeats the officials' error. It performs the substitution, feels the click of resolution, and stops reading. But something remains uncollected. The 227 days are not accounted for by the second story any more than by the first. Whatever Pi lived through has a duration and a texture that only the animal account preserves. Strip the animals and you do not get the truth. You get a shorter document.



Ally's category of the limit of the symbolic names the same phenomenon from a psychoanalytic direction [17]. Where I differ is in the evaluation. For Ally the failure of symbolisation to secure its object is the novel's tragic burden. For the midrashic tradition it is the ordinary condition of reading anything that matters, and the parable is the instrument built to work under that condition rather than to escape it.

### The Addressee Makes the Version

Pi does not tell the two stories to the same audience. He tells the animal story to the writer, at leisure, over years, in his home in Toronto, with his children in the house. He tells the human story once, in a hospital bed, to two officials from a ministry, under an implied threat that his account will otherwise be rejected. The second story is not the truth emerging. It is a version produced under interrogation, for interrogators, in the register interrogators accept.

This is not an incidental observation about the plot. It is the central clinical fact, and it is the one the critical literature has almost entirely missed, because criticism attends to what the text says rather than to the conditions under which each version was elicited.

Patients do not have a story that they then decide whether to disclose. They have a repertoire of tellings, each indexed to a listener, and the listener's posture participates in producing the version. Spence's distinction between narrative truth and historical truth in psychoanalysis made this point about the consulting room decades ago [41]: what emerges in an interpretive relationship is jointly constructed, and its warrant is coherence and usability rather than correspondence. Schafer described the same process as the retelling of a life rather than the recovery of one [42]. Bruner generalised it to the construction of reality as such [43]. Mattingly showed it operating in real time in therapy sessions, where clinician and patient improvise a plot together [44].

What the clinical literature has been reluctant to say plainly is the corollary: the demand for the story without animals is itself an intervention, and often a destructive one. When we press for the bare account — the mechanism, the timeline, the actual sequence, no invention — we are not neutrally extracting data from a container. We are specifying which of the patient's versions is admissible in this room, and we are usually specifying the one that costs them most and helps them least.

This reframes what I have called sacred listening [11,45]. It is not passivity, and it is not the warm reception of whatever comes. It is the deliberate construction of an addressee to whom the better story can be told without being punished for it. The clinician is not the audience of the story. The clinician is a condition of its existence.



### The Labour of the Tiger

A detail clinicians will recognise immediately: Pi must feed the tiger. Every day. The animal story is not a comfort; it is work. He fishes, he rations, he trains, he asserts dominance, he risks his hands. The parable has upkeep costs.

The narrative-medicine literature tends to treat the patient's account as something they have. It is better understood as something they maintain, at expense. The man who has organised his life around the story that his back was destroyed by a specific lift on a specific day in 2019 is not merely holding an opinion; he is performing continuous maintenance on a structure, and that maintenance consumes energy which is then unavailable elsewhere. The woman who has held for thirty years that her mother did the best she could be doing the same.

Two consequences follow. First, the maintenance is observable, and its cost is a legitimate clinical datum — often more informative than the content of the account. Second, and this is where clinicians go wrong: you cannot remove the tiger without providing for the interval. Pi's account survives because the animal is fed. Take the animal away in a fifteen-minute visit and you have not liberated the patient from a distortion. You have removed the thing that was holding them upright, and you have not replaced it.

Stratton's tiger aesthetic, stripped of its polemical charge, states the mechanism exactly (15). The animal story is chosen because it does something. The critical question is not whether that is a defence — it is — but whether the patient can currently do without it.

The parable's limits are what make it inhabitable. An account stripped of its protective structure is not clearer; it is unlivable, and the patient will either rebuild it out of sight or stop talking. Clarification without provision is not clarification. It is exposure.



### The Carnivorous Island

Chapter 92 is the passage most readers find gratuitous and that I take to be the novel's most sophisticated move. Pi lands on a floating island of algae, populated by meerkats. It sustains him by day. At night the island turns acidic and kills whatever remains on its surface, and Pi discovers, inside a piece of its fruit, a human tooth.

Even the officials in Tokyo, who have swallowed a good deal, balk here. The island is where the first story fails its own plausibility test from the inside.

I read the island as the parable's self-indictment: the point at which it produces a detail it cannot metabolise and thereby confesses its status as parable. The tooth in the fruit is not a symbol of anything. It is a foreign object — the residue Stern describes, made unmistakably visible [33]. In Sternberg's terms it is a gap the text refuses to let the reader close [25].

Clinically, these moments are frequent and under-recognised. A patient delivering a well-maintained account produces, in passing, one detail that does not belong: a date that cannot be right, an effect that does not match, a person who appears once and is never mentioned again, a fact volunteered and immediately minimised. Every experienced clinician knows the small internal jolt of it.

The temptation is to seize it — to say, *there, that is the real story, tell me about that*. This is exactly the wrong response, and it is the response the officials give: they call the island impossible and demand a different account. The tooth is not a lever for prying open the true version. It is the patient's own signal that the account has a limit and that they know it has a limit. The correct response is to register it, to let the patient see that you registered it, and to leave it in the room unclaimed. What you are establishing is that this is a place where the residue can exist without being confiscated. That is a precondition for the second story ever being told voluntarily — which is the only way it is worth telling.

### **Institutions That Require the Story without Animals**

The insurance investigators Okamoto and Chiba are not villains. They are functionaries with a mandate. Their employer needs to know why a ship sank. They are, structurally, the insurer.

Modern medicine is organised around a set of documents that demand the story without animals and will not accept the story with them. The history and physical, with its chief complaint reduced to a phrase. The problem list. The diagnostic code, which requires that suffering be assigned to a tax on before it can be reimbursed. The prior authorisation. The disability determination. And, most nakedly, the independent medical evaluation and the deposition, where a life is reorganised around a single causal question and where the presence of a tiger in the account is treated as evidence of malingering.

I have written about the systematic exclusion of context from clinical decision-making by these forms, and about the errors that follow — errors invisible to quality metrics because the metrics are built from the same forms [46]. Weiner and colleagues demonstrated empirically that physicians frequently fail to individualise care because they miss contextual information patients have in fact supplied [47]. The finding is usually read as an attention problem. I think it is a genre problem. The forms have no field for the animals — and the same forms perform an anonymisation, converting a named person into a case, a bed, a code, which I have argued is itself an epistemic injury and not merely an administrative convenience [48].

There is a further consequence, and here I want to be careful, because it concerns my own medico-legal work. In the personal-injury setting the claimant is required to produce a causal narrative of a specific kind: a mechanism, a proximate cause, a

permanency, a prognosis. The claimant who tells the story with animals loses. So, they learn, over months of preparation, to tell the story without. What is then produced in deposition is a document of considerable accuracy and almost no truth — accurate in every particular and false in its silence about the 227 days. The examiner who mistakes that document for the patient has been deceived by his own instrument.

Note what Martel does with this. Okamoto files the report, and the tiger is in it. The institution, having demanded the bare version and received it, records the other one anyway, because the officials are human beings and the better story is the one they can carry away. I take this as a genuine, non-sentimental observation: the parable leaks into the chart because clinicians are people, and the leakage is where the practice of medicine lives.



### **The Departure Without a Backward Glance**

The lifeboat reaches Mexico. Richard Parker climbs out, walks toward the jungle, and does not look back. Pi weeps — not for his family, not yet, but his heart is broken by the tiger, and specifically for the absence of a farewell.

If the tiger is the survival-self — the part that killed, that did not hesitate, that was not gentle and not the boy his mother raised — then the grief is for a part of himself that departed without acknowledgment, and that cannot be thanked because thanking it would mean naming what it did.

This is the most clinically productive image in the novel, and it is under-used.

Consider the patient in sustained recovery from addiction who becomes unaccountably bereft at eighteen months. The substance was the tiger: it did work, it kept something at bay, it was ferocious and competent, and now it is gone, and there is no one to whom the loss can be spoken, because every available listener will hear the mourning as relapse risk. I have argued elsewhere that the appetitive self is not to be exterminated but transformed, and that recovery frameworks demanding its annihilation set an impossible term [49]. The tiger walks into the jungle. It does not turn around. But it was not a demon.

Consider moral injury. Shay's veterans and Litz's model both describe the aftermath of having done, or failed to prevent, what violates one's own moral order [50,51]. What the animal story permits is a grammar in which the act belongs to the tiger. This is not evasion; it is the only grammar in which the act can be

brought into speech at all, before it can be owned. I have argued that the resources for moral repair lie in frameworks that can hold a divided self without either exonerating or destroying it [52,53]. Insisting on the human story too early does not produce accountability. It produces silence.

Consider, too, the survivor of prolonged coercion who reports the period in the third person, or in the passive voice, or as something that happened to a girl she used to know. Herman named the necessity of establishing safety before reconstruction [54]. Felman and Laub demonstrated that testimony requires a witness capable of receiving it, and that in the absence of such a witness the event has, in a real sense, not yet been told [55]. The animal story is what testimony looks like when the witness has not yet been established.

### The Two Errors

The framework generates a symmetrical pair of failures, and honest practice requires naming both.

The first error is interpretive violence: preferring the second story, demanding it, treating the parable as a defence to be dismantled and the animals as resistance. This is the error the officials commit at the beginning of the interview, and it is the error the hostile criticism commits at the level of the text. It has a long clinical pedigree — every school that treats the manifest account as a code and the interpreter as its holder, every intake form that reduces a life to a tax on, every consultant who says *let's just get to what happened*. Ricoeur's hermeneutics of suspicion is a legitimate and necessary discipline [56], but Gadamer's insistence that understanding proceeds through the fusion of horizons rather than the conquest of one by the other is the corrective [57]. Suspicion applied unilaterally to a suffering person is not rigour. It is an assertion of jurisdiction.

The second error is interpretive collusion: preferring the first story unconditionally, on the grounds that it is the better one and that meaning making is intrinsically healing. This error is now the more common one in the humanistic wing of medicine, and I have argued against it directly [58]. Cole's objection applies here with full force: the fact that an account is preferable is not by itself a reason to credit it [14]. Not every consoling narrative deserves to be honoured. A story that transfers full agency to a virus, a diagnosis, a chemical imbalance, or a family curse may relieve the patient of unbearable weight and may simultaneously relieve them of the responsibility on which any change depends. Sontag's polemic against the moralising metaphors of illness remains necessary [59]; so, does the opposite caution, that flight into pure biological mechanism is itself a metaphor with consequences. Hillman is honest about this: therapy traffics in fictions, and the question is never whether a fiction is present but which one, and what it does [60].

The empirical literature supports both halves of this caution and is more equivocal than either camp allows. Cassell's foundational distinction is that suffering is not pain but a threat to the integrity of the person, and that restoring intactness is as often a narrative operation as a physiological one [61]. Janoff-Bulman described trauma as the shattering of assumptions about benevolence and meaning, and recovery as their reconstruction into something habitable rather than original

[62]. Taylor's cognitive-adaptation studies found that patients facing life-threatening illness who built causal accounts and maintained beliefs about control adjusted better than those who did not — and that the accuracy of those beliefs was not what predicted the adjustment [63]. Park's review confirms the broad association across a large and heterogeneous literature [64]. That is a real case for the story with animals. But Wortman and Silver's findings are the necessary corrective, and the one clinicians have most often not encountered: a substantial proportion of the bereaved and traumatised never find meaning, do not show the distress the model predicts, and are harmed by the expectation that they should, because it tells people who are coping that they are coping wrongly [65]. Frankl's testimony remains extraordinary, but in much clinical usage it has been converted from a witness into a prescription [66]. Prescribed meaning is a demand disguised as a comfort.

The clinician's position is therefore not "honour the patient's story." It is closer to Martel's own: know that it is a story and evaluate it as one. This is the discipline White and Epston built entire therapeutics on — treating the account as revisable rather than as either fact or symptom [67].

### Four Criteria of Discernment

If both stories are stories, and the clinician must nonetheless act, on what basis? The midrashic answer developed above — determinate in use though undecidable in reference — requires criteria that test use rather than reference. I propose four. They are not tests of truth. They are tests of whether a given account is doing work or preventing it.

One: does it leave a remainder? A parable with no residue is an allegory, and an allegory in a patient is usually a defence. If the account explains everything, accounts for every symptom, and answers every question without friction, it has ceased to be a way of approaching experience and become a substitute for it. The presence of a tooth in the fruit is a good prognostic sign.

Two: can it be re-entered? A living account admits new detail on subsequent tellings without collapsing. A sealed one is recited identically each time, in the same words, with the same emphases. Verbatim repetition across visits is not consistency; it is fossilisation, and it usually indicates the account has become load bearing in a way that makes revision structurally impossible.

Three: does it preserve agency somewhere? Not necessarily in the patient — Pi's agency is displaced into the tiger, which is exactly the point, and that displacement is a legitimate temporary structure. But agency must exist somewhere in the account. A story in which no one, human or animal, could have done otherwise is a story that has closed the future. This is the criterion I would defend most strenuously [58]: the problem with explanations that relieve us of responsibility is not that they are false but that they are terminal.

Four: can the patient tolerate your knowing there is another version? This is the sharpest of the four and the easiest to apply. You do not have to ask for the second story. You have only to let the patient see that you understand there is one and observe what happens. Relief is a good sign. Panic is diagnostic

of something else. Indifference usually means the second story is not yet formed.

None of these requires the physician to adjudicate what happened. All are available in an ordinary visit. And all presuppose the epistemic virtue proper to clinical work, which is the capacity to proceed well without knowing [68].

### Where the Account Cannot Be Built

I would be misrepresenting the argument if I ended with a serviceable technique, because it has a limit, and the limit is not rare.

Everything above assumes that the patient has two accounts. Some have none.

Frank's own typology contains the exception to his framework. The chaos narrative, in his account, is the anti-narrative told from inside the suffering rather than from any vantage upon it, without sequence, without the retrospective coherence that makes narration possible at all. Frank is explicit that chaos cannot properly be told while it is being lived, and that listeners resist it, because it offers nothing to hold and threatens the listener's own sense that illness has a shape [6]. What presents in clinic is not two stories but a stalled one — repetition, fragments, the account that begins again each time from the same place.

Scarry's analysis explains why. Physical pain, she argues, actively destroys language: it resists objectification, reduces speech to the sounds that precede speech, and unmakes the world the sufferer had inhabited [69]. A parable requires a world in which to set its terms. Where the world has been unmade, the materials are not there.



And Felman and Laub describe the third form of this failure. Where there has been no addressable other, the event has not been narrated even to the person who lived it — not because they conceal it but because testimony is a relation, and the relation was never formed [55]. Laub's point is the one clinician most need: the listener is not the recipient of an already-existing account but a participant in whether it comes to exist at all.

There are patients in this territory. Every clinician who works with the catastrophically ill, the bereaved parent, the survivor

of atrocity, knows the room in which no story with animals can be constructed, because there is nothing to construct one from.

This is not a failure of the framework. It is a region within it, and it has its own discipline. The clinician's task there is not to supply the missing account, offer a provisional one, or reach for the consolations a parable would ordinarily provide. It is to be the addressee in advance of the address — to remain in a room where nothing said will be adequate, long enough that the relation exists before the account does. I have argued elsewhere that recognising the insubstantiality of clinical language is a precondition for using it honestly [70]; this is the situation in which that recognition costs something.

That is not a technique. It is a posture, and it is the hardest thing in clinical medicine.

### Practice After the Two Stories

Let me draw the argument into what it changes on a Tuesday afternoon.

Ask which story. This is Pi's move, not Martel's, and it is the one clinician almost never make. Pi does not wait to see which account the officials will adopt, nor let them adopt one silently. He names both options, states plainly that nothing factual turns on the choice, and requires an answer. We adjudicate constantly and silently — every note, every test ordered, every thread not followed selects a version, and because the selection is unstated the patient experiences it as reality rather than as a choice made by someone with institutional authority. Asking makes the adjudication visible, returns interpretive standing to a patient who is otherwise being assessed for credibility, and — the part that matters most — makes the second story sayable without demanding it, because a person who has been asked which account they prefer has been told, without confrontation, that you already know there is more than one. In practice the question is rarely as bald as Pi's. Serviceable forms: *There seem to be two ways you've told me about this — which one feels truer to you right now?* Or: *When you explain this to yourself, is it the same explanation you just gave me?* Or, simplest and often most productive: *Is there a version of this you don't usually tell doctors?* Three cautions. Do not ask instead of doing the causal work medicine owes; asking which story someone prefers, when what they need is a diagnosis you have not pursued, is an abdication dressed as humility. Do not ask early, since the question presupposes a relationship in which a second version could safely be acknowledged, and in a first encounter it reads as an accusation of inconsistency. And do not ask where there is no second story: in the territory of Section 15 the question is cruel, because it presumes materials the patient does not have.

Stop asking which is true. In almost every clinical situation the question is unanswerable and the effort to answer it costs more than the answer would be worth. The exception is the narrow band where a factual determination is required for a specific action — a safety assessment, a legal finding, a differential that turns on mechanism. Those are real, and should be conducted explicitly, with the patient told what is being done and why, rather than smuggled into the texture of a therapeutic conversation.

Ask instead who the story is for. Which version is this, addressed to whom, produced under what pressure? The answer reorganises the encounter faster than any other single question.

Treat the account as maintained, not possessed. Ask what it costs to keep. Patients are almost never asked this, and it frequently produces material a decade of history-taking has not.

Register the residue without confiscating it. The tooth in the fruit is a communication about the account's limits. Note it. Let them see you note it. Do not pry.

Refuse both errors. Do not demand the second story. Do not ratify the first as sacred simply because it is theirs. Apply the four criteria.

Know the room where none of this works, and do not leave it.



I have argued for some years that the patient is a text and the encounter an act of interpretation [11,71] and that the parabolic structure of that text is not a metaphor for the clinical relationship but its actual mechanism [38,39]. *Life of Pi* is the best available demonstration of the claim, and it demonstrates it at the point where my earlier papers were weakest: the moment when the parable's key is handed over and the parable does not die. That moment is not a literary curiosity. It happens in clinic constantly, and clinicians who have not been taught to recognise it interpret it as evasion, or as poor historianship, or as a personality disorder.

One further point, and it is the reason the argument is reflexive rather than merely observational. Physicians carry their own version of the theodicy problem. We need our cases to mean something. The death that resists interpretation, the deterioration our best account does not cover, the patient who does not improve and whose failure to improve we cannot locate — these produce in us the same demand for a story that we observe in patients, and we satisfy it with the materials at hand: the non-adherent patient, the difficult family, the somatic overlay, the personality disorder. Those are our animal stories. They are chosen because they work, they are maintained at cost, and they too have a tooth in the fruit. A clinician who has learned to notice which story a patient has chosen, and why, and what it costs to keep, can notice the same about the account in his own note. That is the practical content of proceeding well without knowing [68] and what distinguishes it from evasion. It is not a stance toward uncertainty in the abstract. It is the ability to say, of one's own account of a case: this is the story I prefer; I know that I prefer it, and I know what it is doing for me.

Two officials in a hotel room in Tokyo were asked which story they preferred. They preferred the one with the animals. Then they filed a report that contained the tiger and went home. That is a reasonably exact description of what a good clinician does all day, and we should stop apologising for it.

### And So, It Goes with God

*She gives me the version with the surgeon in it.*

*Dates. The name of the anaesthetist.*

*A corridor. A door that did not open.*

*Then, near the end of the twenty minutes,  
the other one. A house. A winter.*

*A man who is in none of the notes.*

*I have a box for the first.*

*The second has no box.*

*It has a tooth in it, small, unaccounted for,  
which I write in a margin  
where the billing cannot reach.*

*Somewhere a boy is feeding a tiger  
because the tiger is what got him this far,  
and when the trees take it back  
it does not turn around,  
and he weeps for the animal  
before he can weep for his mother.*

*Ask me which one happened.*

*Ask the water. Ask the freighter  
that went down under its borrowed name.*

*Neither account explains the sea.*

*Account for the man in the boat.*

*I file the report they asked for.*

*I put the tiger in it.*

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