



# Pain, Silence, And The Limits Of Language In Paul Kalanithi's *When Breath Becomes Air*

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**Abstract:** This paper explores the intersection of medical humanities and literature in expressing illness. It introduces narrative medicine, which merges scientific expertise with narrative skills to validate patient experiences, particularly in articulating pain. Paul Kalanithi's memoir exemplifies how pain can inhibit communication, supporting Elaine Scarry's assertion that pain can render language ineffective. Silence, whether stemming from suffering or a conscious choice, is discussed as having multiple meanings, with Kalanithi highlighting the need for physicians to actively listen to patients' values. Various narrative techniques are analysed, such as fragmentation, repetition, and metaphor, to convey the chaotic experience of illness. The study emphasizes the ethical duty of clinicians to develop narrative competence and engage with patients' voices, a sentiment echoed by scholars Prabhu and Goldie, who argue that listening is crucial for accurate diagnosis and understanding patient identity. Literature not only expresses suffering but also offers the vocabulary and moral insights necessary for healing, positioning storytelling as essential in making sense of pain.

**Keywords:** Medical humanities; Pain; Silence; Narrative strategies; Empathetic listening.

## I. Introduction

Medical Humanities is an interdisciplinary area that draws together the insights of literature, philosophy, history and the arts in the study and practice of medicine. At its heart is narrative competency, the ability to “recognize, absorb, interpret, and act on the stories and predicaments of others.” Rita Charon observes that technological advances in modern medicine have not abolished the need for clinicians to accompany patients through their illness. She maintains that “a scientifically competent medicine alone cannot help a patient grapple with the loss of health or find meaning in suffering” and physicians must develop the capacity to listen to and honour patients’ stories. This combination of scientific knowledge and narrative competence offers a humanistic style of care that enables clinicians to comprehend the personal and ethical aspects of sickness. Medical Humanities is concerned with the continuing challenge of how pain is represented. Physical pain is an inescapable fact of human life, yet it is also a private matter, frequently beyond articulation. “physical pain...ensures [its] unsharability through its resistance to language,” notes Elaine Scarry in her groundbreaking study *The Body in Pain*. She contends that suffering not only lacks words, but destroys them, pushing sufferers into a pre-verbal state of cries and groans. Pain, with no outward object, “is not of or for anything,” defies objectification in language. This, Scarry argues, means that the sufferer knows the agony is real, while those outside can only wonder that there is any pain. Medical Humanities looks for ways to adapt this inward, sometimes wordless experience into stories that can be shared and recognised.

The problem of the language of suffering has been a long-standing concern for literary writers. In her essay *On Being Ill* (1926), Virginia Woolf complains that English, which can express “the thoughts of Hamlet and the tragedy of Lear,” has “no words for the shiver and the headache”; a lovesick schoolgirl may turn to Shakespeare or Keats for the words to describe her feelings, but “let a sufferer try to describe a pain in his head to a doctor and language at once runs dry”. Woolf writes that sufferers are forced to

"coin words" for their agony. Her sorrow points to the cultural divide between the eloquently expressed world of feeling and the inarticulate world of physical misery, supporting Scarry's argument that pain can annihilate language. The Medical Humanities seeks to fill this gap by considering the story of sickness as a viable source of knowledge. Charon's paradigm of narrative medicine asks clinicians to listen carefully to patients' stories, and to attend to the embodied, emotional aspects of sickness. In thus way it offers a framework for understanding suffering not as an ineffable private occurrence, but as a lived experience which can be shared, interpreted and ethically reacted to. So, to get an understanding of the resistance of pain to words becomes a beginning point for an exploration of how literature and narrative can give a voice to suffering and re-instate meaning and dignity to the ill.

## II. Pain and the Failure of Language

Pain, particularly when it is severe or chronic, is notoriously difficult to describe. Medical Humanities scholars observe that physical pain has no external referent; it "is not of or for anything". Elaine Scarry explains how pain destroys language. The sufferer knows with absolute certainty that they are in pain, but pain resists objectification and so it is invisible to others. But the problem is not just theoretical; writers of illness narratives must translate a highly private experience into a public text. Paul Kalanithi's memoir *When Breath Becomes Air* is a vivid example of this challenge. Kalanithi's cancer experience shows how pain can stretch language to its breaking point. On a train journey, he describes a sudden attack of back spasms that renders him unable to speak: "Over the last few months I'd had spasms in my back of varying ferocity, from simple ignorable pain, to pain that made me forsake speech to grind my teeth, to pain so severe I curled up on the floor, screaming ... naming each muscle as it spasmed to stave off tears" (p. 110). He describes the gradations of pain and the height of it overwhelming his ability to speak. To cope he falls back on the technical vocabulary of anatomy: "erector spinae, rhomboid, latissimus, piriformis," as if naming the muscles can contain the experience. Yet the passage's halting syntax and ellipses convey language breaking down under the weight of suffering. He is silenced by pain, and all that remains are groans and scientific terminology.

Elsewhere Kalanithi ponders the insufficiency of words in the face of questions of life-and-death. In medical school he realises that "words began to feel as weightless as the breath that carried them ... "I wanted that direct experience" (p.43). Moral action, he argues, is "puny compared to moral speculation". This insistence on direct embodied experience points to a fundamental aspect of pain: it is felt in the body before it can be conceptualised. Even when precise, language seems inadequate to bear its weight; it can feel "weightless" and detached, leading the sufferer to look for bodily knowledge rather than abstract discussion. Kalanithi also knows that when surgery isn't possible, language is the clinician's primary tool. When facing patients with severe brain damage, he writes, "When there's no place for the scalpel, words are the surgeon's only tool" (p. 87). Here language is not an instrument of exact description but a way of accompanying patients and families through suffering and decisions about life and death. The quotation highlights the paradox: words are inadequate to convey the subjective intensity of pain and yet necessary for ethical care. He has to use language to explain prognosis, to empathise, and to co-create meaning with those he serves as a physician.

Literary theorists can help explain why language strains under pain. Scarry says that pain "makes sure of its unsharability by its resistance to language". Pain is not easily represented because it has no external object; it destroys the contents of consciousness, and reduces the sufferer to inarticulate cries. Similarly, Virginia Woolf notes that English can convey "the thoughts of Hamlet and the tragedy of Lear," but has "no words for the shiver and the headache"; when a sufferer tries to describe a pain "language at once runs dry" and one must "coin words". Woolf's complaint, echoed in Kalanithi's memoir, underscores a cultural poverty of vocabulary for bodily pain. Writers thus fall back on metaphor, analogy, clinical terminology or silence to signal what cannot be directly said. Kalanithi's story demonstrates various methods of representing pain: shifting from scientific accuracy to sensory description, counterposing silence and speech, and recognising the impossibility of complete

expression. In this sense, it resonates with the wider project of giving voice to suffering that is common to Medical Humanities. Illness narratives, by illustrating the failure of language and the difficulty of communicating pain, draw readers to recognise the embodied realities behind clinical diagnoses and to ethically position themselves with respect to the suffering body. They show that, even if pain is beyond language, literature can still point to its presence and humanise those who feel it.

### III. Silence as Suffering and Resistance

Silence is a recurring theme in illness narratives where it can signify physical pain, emotional trauma, social isolation or a form of resistance. In Paul Kalanithi's memoir *When Breath Becomes Air*, he writes about how patients facing a devastating diagnosis often fall silent: 'Patients, when hearing the [bad] news, mostly remain mute... "Silence usually prevails, whether out of dignity or shock, and so holding a patient's hand becomes the mode of communication" (96). Here silence denotes the deep chasm between the medical facts and the emotional reality of the patient. Words fail in the face of the shock of mortality, and the non-verbal support of the doctor becomes paramount. Kalanithi continues to remind readers that the word patient itself comes from the Latin *patiens*, which means "one who endures hardship without complaint" (96). In other words, silence is built into the social role expected of the sick, who are praised for stoicism and endurance even when silence can deepen their isolation. These passages demonstrate how illness can silence through the overwhelming of the capacity to speak and through cultural expectations that valorise quiet endurance.

Silence is not always a voluntary act; it can also be forced upon by family or medical authority. In *The Cancer Journals* Audre Lorde reflects on her experience of having a mastectomy and notes that she once thought silence would protect her, but she eventually realised that "my silences had not protected me. "Your silence will not save you" (37). Lorde rejects the social pressure on women with breast cancer to hide their scars and emotions; breaking silence is an act of survival and solidarity. In her warning silence is presented as a tool of social control, rendering the sufferer invisible and obedient, while speaking out is a way to resist. Likewise, in Atul Gawande's *Being Mortal*, he tells the story of an older woman who wanted to die, telling her son, "I'm ready," before vomiting blood in the night and "not pressing the call button or saying anything... She stayed in bed, silent" (77-78). She refuses to ask for help; her silence is her way of taking control of her dying process rather than being subjected to institutional routines. The family's ultimate decision to honour her DNR order shows how silence can be a self-protective form of agency in the face of medical systems that might otherwise prolong suffering.

Kalanithi's reflections on silence therefore resonate with these other writers. Silence in medical encounters can be caused by shock or dignity, for instance when patients cannot express words for their diagnosis. Yet, as Lorde argues, silence can also be socially imposed by expectations that patients should endure quietly. To speak can be an act of resistance, one that allows individuals to repossess their voices and redefine their identities outside of the sick role. Gawande's story shows how silent treatment can be an act of agency on the part of patients to determine the moment and manner of death. Taken together these stories show that silence in illness is not a unitary phenomenon; it may refer to suffering, express what cannot be said, or be used as a weapon against medical and social power.

### IV. Narrative Strategies of Illness: Fragmentation, Metaphor, and Beyond

Illness frequently renders the body and mind alien, and language often fail to express this disturbance. In this way, writers respond to the lived experience of sickness with fragmentation, repetition, metaphor, imagery, diary-like forms and fractured narrative. These tactics reflect the disorganised chronology of disease and the incapacity of regular writing to describe pain and uncertainty. This essay discusses these

strategies in relation to Paul Kalanithi's book *When Breath Becomes Air*, bringing them into dialogue with theorists of pain and storytelling.

### Fragmentation and Enumeration

A dramatic example of fragmentation is shown in Paul Kalanithi's account of a corpse dissection in medical school. He labels it a "medical rite of passage and a trespass on the sacrosanct," and cites the ambivalent sentiments it evokes—"revulsion, exhilaration, nausea, frustration, and awe"—before observing that "everything teeters between pathos and bathos" (p. 44). The listing of experiences echoes the way sickness breaks down a person into discrete sensations. The list progresses from visceral responses ("revulsion," "nausea") to abstract emotional states ("awe"), implying both physiological and existential responses. The move from "trespass" to "rite of passage" is an oscillation between taboo and need. This fragmented form allows Kalanithi to document several, sometimes conflicting, answers without subjecting them to one narrative arc. Fragmentation can also be in the form of diary-like entries. Kalanithi's book is chronological but also has contemplative vignettes, as if he was writing a series of diary entries. This structure produces pauses in the story, and asks readers to live times of uncertainty. His death cuts short his life story, so his wife's epilogue completes the book in another voice. The narrative actually breaks off, foregrounding the unfinishedness of disease. Rita Charon says that physicians require "narrative competence" — the ability to "acknowledge, absorb, interpret, and act on the stories and plights of others". Fragmentary, diary-like writing fosters this competency in that it preserves the patient's voice in its discontinuities rather than pushing it into a neat storyline.

### Metaphor and the boundaries of language

Throughout, Kalanithi faces the insufficiency of words to convey mortality. In writing on his choice to be a neurosurgeon instead of a philosopher, he writes, "Words began to feel as weightless as the breath that carried them" (p. 43). The metaphor of words as "weightless breath" implies both the frailty of language and the manner in which discourse evaporates in the face of corporeal experience. Kalanithi compares this insubstantive language with the craving for "direct experience". The recurring breath metaphor reveals a chasm between the abstractions of philosophy and the pragmatic reality of working with live brains. Metaphor thus becomes a tool for indicating that which cannot be articulated explicitly. The theory of pain helps to explain the need for metaphor and imagery in disease narratives. Elaine Scarry writes that bodily pain "does not simply resist language, but actively destroys it, bringing about an immediate reversion to a state anterior to language" (p.4). Pain destroys the very medium of communication, so narrators resort to indirection: lists, analogies, visual images, and pauses that mark the breaks where language fails. Kalanithi's weightless words and his litany of emotions throughout the cadaver dissection perform this method; they bring sensations and sentiments to life without trying to explain them.

### Form of Diary, Pauses and Broken Narrative

Kalanithi's biography is intimate, like a diary: small passages, chronicling personal patient interactions, scans, family events. The diaristic format divides the story into discrete parts, with pauses that echo the stop-and-start rhythms of therapy and remission. The memoir is composed of letters and reflections written at various eras, resulting in a layered timeline rather than a linear narrative. Such disruptions reveal the temporal dislocation of disease, when life is about hospital appointments and test results, rather than milestones. Broken narration is a literal occurrence of the conclusion of *When Breath Becomes Air*. Kalanithi's final notes halt mid-story and his wife, Lucy Kalanithi, pens the epilogue. The jarring change in speech highlights the rupture of not only existence, but the story one attempts to tell about life when faced with terminal sickness. In medical humanities this awareness of fragmentation has ethical consequences. Charon argues that "a 'scientifically competent medicine alone cannot help a patient grapple with the loss of health or find meaning in suffering'" (p. 1898). Narrative medicine recognises the imperfection, interruption, and fragmentation of the narrative patients tell, and educates physicians to listen for the gaps and silences, not to fill them in.

## Repetition and Imagery

Repetition is a common device in illness tales, indicating the repetitive nature of therapy and the all-pervasiveness of agony. Kalanithi does not repeat words for emphasis, but some imagery recur in his biography, such as scalpels, MRI scans and sunsets over the Stanford hills. They are refrains that signify periods of his condition and career. Every recurrence has a new meaning, An MRI machine that once promised diagnosis, Now signals progression, And the surgical room, a place of mastery, Is now one of fragility. By repeating pictures, rather than sentences, the narration is able to depict how experiences are revisited and modified over time. Another important tactic is the use of imagery. For example, the corpse scene is full of visceral details: “the flesh of the forearm peeled back,” “diseased lungs”—pictures that are equally clinical and emotional. The contrast between holy and profane (‘sacrosanct’ against ‘tedium’) encapsulates the conflict between the mystery of the flesh and the routinisation of medicine. Such pictures anchor abstract thought in sensuous experience, allowing the reader to envision what would otherwise be unreachable.

Writers employ techniques such fragmentation, repetition, metaphor, imagery, diary form, pauses, and broken narration in order to convey the unspeakable experience of disease into consumable narratives. These tactics are on full display in Paul Kalanithi’s memoir: his enumerations disaggregate the ego into a spectrum of feelings, his metaphors struggle with the inadequacy of words, his diaristic structure inserts pauses and breaks that echo the disruptions of sickness. Elaine Scarry and Rita Charon provide theoretical explanations of the need for such strategies: suffering destroys language, and ethical medical treatment needs sensitivity to the experiences of patients. Together, they show that sickness narratives do not just tell a tale but also create new forms for articulating experiences that cannot be told in a chronological way. Knowing these narrative tactics enhances our knowledge of how people make sense of suffering and how physicians may better react to patients’ needs.

## V. The Ethic of Listening in Narratives of Illness

Illness narratives are not only clinical stories but stories of a person’s life that need to be heard with respect. When a body is falling apart, the patient’s voice is frequently not heard. To listen to that voice and its context is an ethical obligation for physicians and carers because it recognises the suffering subject as a person and not as a case. Through stylistic choices and thematic emphases, disease tales reveal that listening is part of healing, requiring attention, empathy and awareness.

### Ethical Practice and Listening in Kalanithi’s Memoir

In *When Breath Becomes Air*, neurosurgeon Paul Kalanithi considers the experience of being a patient. That experience shows him that technical proficiency alone is not enough. He says of his neurosurgery residency: “technical excellence was not enough. As a resident, my highest ideal was not saving lives—everyone dies eventually—but guiding a patient or family to an understanding of death or illness”. This text reframes the physician’s obligation: the doctor should speak truthfully and assist families in understanding pain, rather than just preserving life. To that end, Kalanithi leaves the dispassionate language of medical charts behind, and gathers families together to speak calmly about possibilities, engaging them “in a space where [patients] were a person, instead of a problem to be solved.” His story underscores that listening to patients and their families is a precondition for ethical actions. Kalanithi also understands that neurosurgery is about accessing another’s psyche and identity. Before operating on a patient’s brain, he says he must “first understand [the patient’s] mind: his identity, his values, what makes his life worth living, and what devastation makes it reasonable to let that life end.” This comment highlights the importance of listening to the patient’s story and of paying attention to what is not being expressed. Kalanithi’s book models, then, an ethic of listening: by respecting the patient’s experience and context, he learns to lead decisions in keeping with the patient’s values and sense of self. The biography is a challenge to see his own sickness journey, to demonstrate

how narrative may transcend personal pain into a collective, compassionate experience.

### Insights in Medical Humanities Research

The medical humanities scholars contend that listening is not optional, but crucial to ethical conduct. Gayathri Prabhu's remark on narrative ethics notes that health practitioners are in a continual state of "receiving, processing and responding to life narratives," and "listening is an integral part of the diagnostic, therapeutic and curative processes". She stresses that listening becomes an ethical act when the listener is overwhelmed by the full emotive weight of another's suffering. Listening must be reflexive and responsible, with an acknowledgement of the obligations that come with the hearing of a particular tale. Drawing on narrative ethics theorists Rita Charon and Martha Montello, Prabhu argues that the single instance only comes into being via storytelling and that obligations derive from the act of listening. Prabhu's research bolsters Kalanithi's assertion that comprehending a patient's values is part of medical care, by pointing out that listening itself has ethical bounds .

Likewise, John Goldie, writing in the *British Journal of General Practice*, emphasises the role of power relations in medical interactions. He describes a home visit and how the "importance of listening and responding to patients' narratives" became obvious when he abandoned the interrogative medical approach and let a patient to tell her tale in her own terms. Goldie advises that when the concerns are reduced to medical terminology clinicians run the risk of ignoring the patient's perception of reality. Moving into the patient's frame of reference helps reinforce identity and allow sharing of meaning. In conclusion, therapists need to be conscious of discursive power and develop what others have termed a 'loving gaze', which prioritises mutuality and respect rather than the 'arrogant eye' that dismisses patients' opinions. This research supports Kalanithi's understanding that it is the physician's responsibility to work with patients and families to co-create meaning, rather than to prescribe therapy.

### Identifying the Voice of the Patient

To listen ethically is to be attentive not just to the substance of patients' words, but also their tone, their silences and their larger settings. Prabhu refers to Arthur Kleinman's biography, *The Soul of Care*, in which Kleinman writes of caring for his wife and being a "intense listener" who hears not just words but also "human tone". This attention to tone reflects Kalanithi's own awareness of the unsaid concerns, values, that underlie his patients' actions. In all situations the storytelling method asks the listener to be there completely, to receive the telling without cliches and to bear witness with compassion. The ethical listener, therefore, is one who realises that each sickness story is unique and that the job is to honour its singularity.

Illness narratives involve more than clinical data; they require careful, empathic listening that identifies the patient as a story teller with a past, a voice and a set of beliefs. In Paul Kalanithi's memoir, a doctor learns how to help patients and families cope with the dreadful diagnosis they get by listening to their stories and learning about who they are. Prabhu and Goldie et al. have argued that listening is an ethical act, essential to diagnosis and therapy, and that joining the patient's frame of reference is an affirmation of identity and co-creation of meaning. These speakers together make the case that in ethical medicine we have to listen for the human narrative underlying the sickness and respond with humility, presence and respect.

## Conclusion: Literature as a Mode of Suffering

Literature is not only the decoration of experience; it is the shaping of suffering when anguish cannot be directly translated into language. Neurosurgeon and researcher of literature Paul Kalanithi testifies to this in *When Breath Becomes Air*. Looking back at his college days, he adds, books were his “closest confidants, finely ground lenses providing new views of the world”. He continues, literature “not only illuminated another’s experience; it provided ... the richest material for moral reflection”. These words indicate that long before his disease Kalanithi viewed literature as a means to apprehend human significance. After his diagnosis he returned to books and memoirs of sickness to find a vocabulary for his own death. He found phrases and pictures in Tolstoy’s *The Death of Ivan Ilyich*, Solzhenitsyn’s *Cancer Ward* and Beckett’s famous line “I can’t go on, I’ll go on” that helped him tell a life that was coming to an end. That is, literature provided analogies and narrative constructions when his own words failed.

Philosophers and physicians agree that the significance of life is its story-shape. In a review of Atul Gawande’s *Being Mortal*, palliative-care physician Jenni Linebarger writes that Gawande “tells us that life is meaningful because it is a story” (p.238). Human existence is not a mosaic of unconnected feelings but an arc whose shape is defined by the moments that count. A moment of pleasure or anguish is disconnected without a story. A tale may make a cohesive whole out of suffering. Narrative, then, is the setting within which suffering is contextualised and made sense of. Arthur W. Frank makes a similar point in *The Wounded Storyteller*: ‘Becoming seriously ill is a call for stories ... stories have to repair the damage that illness has done to the ill person’s sense of where she is in life’ (pp. 53–54). That disease requires storytelling, as Frank insists, emphasises that narrative is not an optional extra: it is how individuals reassemble themselves after physiological upheaval. When disease threatens the continuity of the person, sharing a narrative helps restore a feeling of self and place pain in a purposeful trajectory.

These thoughts enlighten Kalanithi’s own story. As his sickness advanced and the precise vocabulary of science failed to bear the existential weight of dying, he turned to metaphors, allusions, and lines drawn from literature and poetry. This intertextuality is not a literary flourish but ethical praxis: by linking his pain with the tales of others, Kalanithi recognises the shared human situation, inviting readers into solidarity. Literature doesn’t take away pain, but it lets pain be observed and formed. When he states that “Literature not only illuminated another’s experience; it provided ... the richest material for moral reflection”, he confirms that tales and metaphors provide form to misery and make it comprehensible.

Thus, literature plays an important role in the medical humanities. It provides languages and narratives that allow patients and carers to communicate experiences that otherwise might remain mute. Gawande’s argument that life has value as a tale, and Frank’s claim that serious sickness needs stories, add up to the idea that human beings earn dignity not just by surviving but by narrating their experiences. In Kalanithi’s narrative, when language fails to contain physical agony, literature may lend form and moral weight to suffering. Through tales, suffering is no longer a raw, incommunicable truth, but a common narrative that can be understood, remembered and respected.

## Works Cited

1. Charon, Rita. "Narrative Medicine: A Model for Empathy, Reflection, Profession, and Trust." *The Journal of the American Medical Association*, vol. 286, no. 15, 2001, pp. 1897–1902.
2. Frank, Arthur W. *The Wounded Storyteller: Body, Illness, and Ethics*. 2nd ed., University of Chicago Press, 2013, pp. 53–54.
3. Gawande, Atul. *Being Mortal: Medicine and What Matters in the End*. Penguin Books, 2014, pp. 77–78.
4. ——. *Being Mortal: Medicine and What Matters in the End*. 2014. Quoted in Jenni Linebarger, "A Physician Review of Atul Gawande's 'Being Mortal,'" *Pallimed*, 24 Oct. 2014, p. 238.
5. Goldie, John G. S. "The Ethics of Listening and Responding to Patients' Narratives: Implications for Practice." *British Journal of General Practice*, vol. 61, no. 585, 2011, pp. 306–307.
6. Kalanithi, Paul. *When Breath Becomes Air*. New York: Random House, 2016, pp. 27, 30-110.
7. Lorde, Audre. *The Cancer Journals*. Aunt Lute Books, 1980, p. 37.
8. Prabhu, Gayathri. "Narratives of Endurance and the Ethics of Listening." *Indian Journal of Medical Ethics*, vol. 6, no. 4, 2021, pp. 332–333.
9. Scarry, Elaine. *The Body in Pain: The Making and Unmaking of the World*. Oxford UP, 1985, pp. 4–5.
10. Woolf, Virginia. "On Being Ill." *The New Criterion*, 1926, pp. 34–35.

