Medical Aid in Living for a Scientific Age

Re-framing Medicine by Re-thinking Psychiatry

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Dedicated
to
putting the patient - as - person
back in the centre

- A prism –

Passing white light through a solid glass prism
unveils all the colours of the spectrum.
What was concealed is now revealed.
This is called enlightenment.

Passing medicine through a prism
reveals the parts of the whole.
One comes to know the rightful place
where each part belongs.

For the patient-as-person that rightful place
is at the centre of life.
This is called living with enlightenment.

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Preface

Medical Aid in Dying is a watershed event in the history of a people. Legislated as a legal right by the Parliament of Canada, Medical Aid in Dying is now part of our culture. However, unlike nature, culture is not a given. Rather it is cultivated for culture is what man as *anthrōpos*, the Greek term for the non-gendered person, does with nature. And so, culture is not permanent as in fixed and static but dynamic. However, since legal rights cannot belong to some and not to others, Medical Aid in Dying is now embedded in the social landscape. This right places a duty on others to end the life of another. This alters that landscape for it informs how we see ourselves, how we see others, and how we are seen by others. The lessons of history teach us that some citizens follow the laws of the nation irrespective of what that law may state. Thus, some publicly endorse a law because 'it is the law'.

Of further note is that while Medical Aid in Dying is now part of a culture, as a legal right it cannot be limited to a defined population. And so, the initial limitation to a progressive physical illness not amenable to curative intervention has been challenged. Legislation has been passed by Parliament to expand Medical Aid in Dying to the mentally ill. This expansion was initially scheduled for 2023 but was paused until March 2024. It has been paused further until 2027. However, the legislation for this expansion still stands.

This expansion is significant for while deductive reasoning is central to the role of science in medicine, its role in mental illness is peripheral. Deductive reasoning is the cornerstone of science whereas inductive reasoning is the cornerstone of treating mental illness. A further issue in its early stages at this time is the expansion to Advance Directives for patients who subsequently develop dementia. These developments require a re-look at Medical Aid in Dying.

A microscope is an instrument designed to explore the world of microbes and molecules beneath the surface. A

telescope is designed to explore the stars and galaxies above. White light passed through a solid glass prism reveals the full spectrum of colors. And so, what is concealed is now revealed. A prism, then, is also an instrument of exploration. However, its field of exploration is not vertical in search of explanation of the universe great and small but rather horizontal in search of understanding of a lived reality. A prism, then, in revealing what was concealed brings to the surface what makes up that reality.

Passing Medical Aid in Dying through a prism unveils the many parts which contributed to its inscription into our culture. In the context of Medical Aid in Dying these parts can be seen as 'organs of the body politic'. While medicine is on the cultural spectrum, Medical Aid in Dying to a large extent came <u>to</u> and <u>not from</u> medicine The public discourse was largely from outside of medicine. And yet, medicine as a practice bears the burden of Medical Aid in Dying.

A re-look at Medical Aid in Dying requires a consideration of all the parts of the cultural spectrum. This is motivated not by moral judgment of 'what is' but rather by understanding of how 'what is' came to be. The parts considered here are medicine, law, Parliament, the academy. and the media. Added to this is 'religion' understood as *re ligare* (to be bound to) in the objective sense of the term for it is the nature of humanity to be bound to something. However, while Medical Aid in Dying may have been the stimulus for what follows, it is not the *raison d'être*. Since medicine bears the burden of Medical Aid in Dying, it is important to look at medicine through a prism in order for medicine to find its rightful place in the cultural spectrum. And so, while what is presented here begins with a re-look at Medical Aid in Dying in search of understanding, it concludes with an understanding of Medical Aid in Living. This understanding is in the context of science and technology which is the dominant force in the culture of our time.

What is presented here speaks <u>*to*</u> all of the parts of the cultural spectrum. It is this way for two reasons. First medicine is part of that spectrum. Second all members of society have a voice in their culture. While the voice speaking comes <u>*from*</u> within medicine, albeit from a time past, it does not speak <u>*for*</u>

medicine but rather *to* medicine as a profession and as a practice of our time. Most importantly is what this voice says to medicine: "*Listen to the patient*." There are two reasons for this. First no one can speak for another. Second it is from the patient that one learns the art of medicine. It is here that re-thinking psychiatry can contribute to re-framing medicine 'patient-as-person'.

Society faces many challenges in the 21st century. These challenges touch medicine, both practitioners and patients, in a context of vulnerability in a special way. Medical Aid in Dying is a challenge for medicine. However, its discourse was to a large extent from outside of medicine. Medical Aid in Living for a Scientific Age is a discourse that occurs within medicine, i.e. the patient encounter. 'Re-framing Medicine by Re-thinking Psychiatry' gives voice to this. It is through this that Medical Aid in Living may come to occupy its rightful place at the centre medicine as a practice in the 21st century.

Francis B. Kelly
Ottawa, Canada
March, 2024

Introduction

Medical Aid in Living for a Scientific Age

Medical Aid in Dying, commonly referred to as MAiD, is a significant moment in our history. But it is particularly so for medicine since it is medicine which is burdened with its practice. The opening Chapter does not argue against Medical Aid in Dying but rather explores its genesis. It is this way since the first step in addressing any reality is to understand how it came to be. Passing Medical Aid in Dying through a prism unveils the many aspects that led to its presence onto the social landscape. While these aspects may have been known, they were seen more as separate parts and, hence, perhaps not seen as a whole. But a prism identifies the parts as a whole for each part contributed to the genesis of Medical Aid in Dying.

'The Genesis of Medical Aid in Dying' (Chapter 1) explores the contribution of several parts that make a whole. While medicine was a central element of this genesis, other aspects unveiled by the prism were also significant. These, too, were considered but in less detail than the contribution from medicine. However, these contributions were not less relevant. This resulted is Medical Aid in Dying being not just a paradigm of medicine but 'A Paradigm for the 20th Century', the sub-title of Chapter 1, which has been bequeathed to the 21st century.

A paradigm is defined as a 'pattern'. (Funk & Wagnalls) And so, the opening Chapter serves as an introduction to a section of three chapters which explore how a pattern was established. While the focus is on medicine, the content presented in this section is, to a large extent, theoretical. 'Philosophy in Medicine' (Chapter 2) looks at philosophy through a prism where five different fields of philosophy, each in their own way relevant to medicine, were identified. Of these ethics (moral), metaphysics, and existentialism were

given closer attention. While this fell far short of an academic standard, the issues raised were relevant to medicine as a practice. It was noted that many consider medicine as a moral encounter. However, what was presented here gave space not only to ethics but also to other parts of the philosophical spectrum.

A further, but not unrelated, aspect is presented in 'Re-thinking Human Nature' (Chapter 3). Since medicine is an encounter *interhomines*, i.e. between people, how the nature of the person is understood is central to medicine. But this, too, is largely philosophical. However, it is philosophy with an impact on culture for how one the understands the person influences the culture that flows from human activity. This directly impacts on medicine as a practice.

The third element of this section 'How We Know What We Know and Why We Know It' (Chapter 4) also relates to the two preceding Chapters but in a way that prepares for the practical. The subject of knowledge is introduced as a theoretical concept. But the '*How*', the '*What*' and the '*Why*' are oriented to the practical. An important practical aspect of this knowledge is the introduction of three principles: i.) identifying the problem as the first step to a solution, ii.) the theory of opposites, and iii.) the patient as teacher. In a sense Chapter 4 closes this section while, at the same time, serving as a preparation for what follows.

The centerpiece of the entire work is presented in the four Chapters which follow where theory transitions to practice. This section opens with 'The Distressed Body' (Chapter 5). Several models of medicine reflecting how we 'think' about medicine in the 21st century were presented. Added to this was a perspective of medicine from an earlier time, i.e. ancient Greece, via the Greek tragedy *Philoctetes* seen through the lens of a modern observer schooled in medicine. In addition, cultural aspects from earlier times, e.g. Greek and Latin, were also presented. This Chapter was a 're-thinking' of medicine from 'disease' to 'illness'. Science frames medicine as [DISEASE]. (Figure 5.1) Illness frames medicine [PERSON as PATIENT]. (Figure 5.9)

But 're-thinking' also pertains to psychiatry. This re-thinking is presented in two chapters: 'The Distressed Psyche

- Parts I and II (Chapters 6 and 7). In part I how psychiatry thinks is presented and critiqued. This 're-thinking' is largely informed by Kleinman and McHugh two voices from within the psychiatric community. This frames mental health [PATIENT as PERSON]. (Figure 6.4) This places psychiatry in its rightful place, i.e. its proper place, understood as 'appropriate' meaning 'belonging to'. But this place is not only within mental health but is also within medicine not as an add on but as integral to medicine as a practice. Part II presents an understanding of the person and, hence, relates to a distressed psyche.

This section closes with 'Living Our Humanness' (Chapter 8) It is here that existentialism as a practice is developed largely due to the contributions of Yalom and Boss. While the two agree on many aspects and while Yalom's 'existential concerns' are well informed, he presents these concerns in language more in keeping with philosophy. Nevertheless, there is merit in the views expressed for they are not irrelevant to the clinic. Living our humanness pertains not just to a distressed body but also to a distressed psyche. And so, it speaks to all of medicine.

But medicine in our time can be seen in the light of an earlier time. Ancient Greece is that earlier time. This opens the third and final section. It was there that an 'Apologia for the Art of Healing' was written some 25 centuries past. The German philosopher Hans-Georg Gadamer wrote The Art of Healing in a Scientific Age which was grounded in the original 'Apologia' but adapted for our time. 'Wholeness as Healing' ' (Chapter 9) is founded on these two sources. It is in this wholeness that the 'person-as-patient' migrates to the 'patient-as-person'. This migration is directly aligned with re-thinking psychiatry.

It is in 'living our humanness' (Chapter 8) by re-thinking psychiatry that medicine is re-framed [PATIENT as PERSON]. (Figure 8.2) It is through the art of healing that 'wholeness as healing' (Chapter 9) informs this re-framing. How this may look is presented in 'Putting the Person Back in the Centre' (Chapter 10). This is 'How Might Psychiatry Save Medicine', the sub-title of this Chapter, and brings to conclusion what began in Chapter 1. But 'how psychiatry

might save medicine' is a possibility and opportunity and, as such, is an invitation to a pathway to Medical Aid in Living. But it is a pathway less travelled.

An Afterword - 'A Paradigm for the 21st Century' follows the closing Chapter and, except for the century, mirrors the sub-title of the opening Chapter. However, here it is presented as a possibility for this century and not as a fact of the past century. This is both the challenge and the opportunity in which both Medical Aid in Dying and Medical Aid in Living are implicated. While medicine is a culture and is situated in a wider culture, these cultures change over time. However, the patient-as-person remains a constant but must live in changing times. In our time science and technology occupy a central place. However, they operate in a closed space whereas nature occupies an open space. This accounts for the 'Nature and Culture', the sub-title of the Afterword. This brings an increased imperative to the challenge and opportunity.

A seminal event in the genesis of Medical Aid in Dying was the alliance of academia and private sector interests in cost savings through Advance Directives. Also noteworthy is the present interest in further expansion of Medical Aid in Dying from mental illness to Advance Directives. And so, this journey begun in Chapter 1 includes an Addendum - 'Advance Directives Re-visited'.

While this work is heavily accented with 'physician' as the practitioner, it includes all health care providers for all professions that provide care to patients share the same traditional ethos of fiduciary responsibility and patients' interests. The 'medical profession', then, is better understood as the 'medical professions'. And so, for 'physician' one can read 'health care provider' / 'care giver'. Of further note is the reference to 'man' throughout the text is in the sense of '*anthrōpos*', the Greek term for the non-gendered person.

A word about the cover:

Passing light through a solid glass prism unveils the full spectrum of colours where each colour has its rightful place but where none goes beyond its proper boundary. This is

enlightenment. Passing culture through a prism unveils the parts that make up that culture. But whereas light is a natural phenomenon, culture is not for it is cultivated by the human mind guiding human hands. And so, each part of the cultural 'rainbow' seeks its rightful place - the place where it belongs.

Passing Medical Aid in Dying through a prism unveils its parts. Among the many parts are medicine and science and technology each also with its own culture. This, too, brings enlightenment for it leads to understanding of each part. Science and technology is both necessary and beneficial to medicine; however, it is also a challenge. But a prism not only unveils the parts. Placing the parts back in the prism in their rightful place allows the parts to become whole again.

Medical Aid in Living is medicine's rightful place. Medicine can be framed in three ways: [DISEASE] which is what science does, [PERSON as PATIENT] which is what illness does and [PATIENT as PERSON] which is what psychiatry is invited to do. But there is only one patient. Looked at from above the image on the cover is a solid three-sided pyramid. This reveals the re-framing of medicine Each side represents a framing of medicine. Each framing, then, belongs in the pyramid and thereby forms the whole of medicine. The three frames meet in a line from the apex to the centre of the base. This puts the patient-as-person back in the centre where the person belongs. Medical Aid in Living for a Scientific Age explores how medicine in the 21st century might come to fill this pyramid.

Chapter 1

The Genesis of Medical Aid in Dying

A Paradigm of the 20th Century

> Euthanasia . . . signifies an opportunity to deal more humanely and rationally with prolonged meaningless suffering.[1] M. Angell

I. Introduction:

In 2016 the Parliament of Canada, at the behest of the Supreme Court, enacted legislation whereby 'Medical Aid in Dying' (MAiD) became part of the Canadian social landscape. This was the culmination of a process within medicine that began in the closing decades of the 20th century. This resulted in vacated space which provided an opportunity for other elements to come forth and occupy that space. In brief, the dynamic was twofold - a 'movement out' and a 'movement in'. 'Dynamic' aptly describes this movement for the Greek term *dunamis* carries the sense of power and power cannot lie dormant.

Medicine is but one door among many which opens onto society. And so, while Medical Aid in Dying in its immediate context is a medical procedure, its genesis is more complex. While it is essential to look at Medical Aid in Dying through the lens of medicine, this lens is, by itself, insufficient. Passing light through a prism reveals all the colours of light. So, too, looking at Medical Aid in Dying through the many cultures that make up a the larger culture of a society provides a truer understanding of its genesis. To look at Medical Aid in Dying through the lens of the medical culture says something about that culture. To consider Medical Aid in Dying through the many cultures of a society says something about that society.

What follows is a consideration of Medical Aid in Dying through the various sub-cultures within the larger culture. Since medicine is where Medical Aid in Dying becomes a reality, medicine is the first and foremost culture to consider.

II. The traditional ethos of medicine:

Although never expressed in those terms, Medical Aid in Living (MAiL) dates back 25 centuries to the origin of medicine in Ancient Greece. From the outset medicine has been considered not just a craft but a particular kind of craft. Notably, there is and always has been an inherent asymmetry in the patient - physician encounter. Vulnerability is part of human existence. However, unlike other vulnerabilities, e.g. socio-economic, political, etc., disease carries a very particular vulnerability for it unmasks our mortality. Disease confronts a patient with the boundary of existence. [2] This confrontation is inherent in the reality of being a patient and makes the 'bedside', a term used herein to describe all physician - patient encounters, an existential matter. It is this existential condition which defines medicine.

The physician, as are all healthcare providers, duly informed with state of the art knowledge, is committed to serving the patient's needs. The fiduciary responsibility - a responsibility that is grounded in patient vulnerability - is the *sine qua non* of medicine. This fiduciary responsibility requires a stance of 'disinterest' *vis-à-vis* the patient. Thus, health care providers do not serve their own interests or interests of third parties but rather the interests of the patient exclusively. Patient vulnerability and its corollary fiduciary responsibility are the twin pillars of medicine's traditional ethos - the former being the source of the latter. From its beginning the *raison d'être* of medicine as a profession was a commitment to 'medical assistance in living'.

This was the vision and the practice of Dame Cecily Saunders (1918-2005) the 'mid-wife' of the modern hospice movement and a pioneer of palliative care as it was practiced in the later decades of the 20th century. Central to palliative care had been '*end - of - life* care' by which is meant that patients receive 'life care' into and including the end of their

natural life. Just as Medical Aid in Living embraced '*end - of - life* care', so, too, did it define Medical Aid in Living.

And so, with only rare localized exceptions, e.g. medicine under the Nazis in the 1930s and 1940s, MAiL has been part of medicine since its beginning. But Medical Aid in Living was non-existent in the discourse on Medical Aid in Dying in Canada's Parliament, in the Court, in the academy, and in the media. Something happened in the 25 century interval between Ancient Greece and our time today. Unlike Medical Aid in Living, which is inherent to medicine, Medical Aid in Dying as a practice intending the death of a patient is not. For this reason to explore how Medical Aid in Dying came about is both necessary and informative.

III. Medicine and the genesis of Medical Aid in Dying:

Three developments in the practice of medicine stand out in the genesis of Medical Aid in Dying: science and technology, bioethics, and managed medical care (MMC) However, these developments do not stand alone for they bring synergy to this dynamic.

A. Science and technology:

Technological advances in diagnostic and therapeutic capabilities were the hallmark features of medicine in the closing decades of the 20th century. McGregor (1989) noted that in the 1960s medicine had limited therapeutic options for many patients, e.g. nitrates and little else was available to patients with coronary artery disease. However, by the end of the 1980s as therapeutic options expanded so, too, did improved outcomes. Moreover, therapeutic options in the 1960s came at little financial cost in comparison to options two decades later. [3]

This therapeutic success resulted in patients living longer with illnesses that were previously beyond medicine's therapeutic reach. Accompanying this development was the aging of the post-WWII cohort resulting in a demographic bulge in the 1980s which made further demands on health care. Increased costs was based on these two factors. While these

costs pertained to any health care system irrespective of funding, it is not without relevance that Canada's publicly - funded health care system was inaugurated at a time before many of technological advances had reached the bedside and, hence, costs were relatively low. [4]

The role of technological advances is of fundamental importance in understanding modern medicine. But it is more fundamental to understand how these advances came about. The mechanism which the scientific method employs is quantification. It is through its exploration that the natural world is measured and verified. The scientific method explores the biology of our existence, i.e. the 'natural world' of the human body. It is this way for it is *bios* which lends itself to such exploration. What is explored is how disease comes about and what therapies are efficacious. The twin features of measurability and verifiability bestowed upon science an 'explanatory power' grounded in what can be called 'numeracy' in the sense of calculation. The Latin term '*ratio*', in its narrow interpretation, is a mathematical term and, thus, is a measurement. Technology augmented a physician's capability, thereby increasing the asymmetry between the patient and the physician.

B. Bioethics:

Ethics is a branch of philosophy which deals with matters of moral concern. Bioethics is moral philosophy focused on life issues and, therefore, finds a home in medicine. Discourse in bioethics saw this enhanced asymmetry brought about by advances in technology in moral terms of a power paradigm whereby the patient was seen not as more advantaged due to more therapeutic options but more vulnerable *vis-à-vis* the increased power placed in the physician's hands. In this climate patient autonomy became a central issue of bioethics. This brought some changes in language. As an effort to empower the patient and mitigate the enhanced power imbalance the 'patient' in some settings was replaced with 'client'. In other settings the patient as 'consumer' was promoted. [5]

Other developments also occurred. One was the emergence of 'Do not resuscitate orders' (DNRs) which when written on a hospitalized patient's chart relaxed any urgency in treating emergencies which may arise. DNRs were best suited for hospitalized patients. 'Living Wills' - also known as 'Advance Directives' - became the mechanism for addressing the issue in the pre-hospital setting. Both gave a patient a say in their care. But both also served the institution and bureaucracy, especially if the patient opted for 'supportive care only' in certain envisioned future circumstances.

However, technology does not have a solution for everything that may befall a patient. Neither does technology come without risk. Nor did technology come with a guarantee. The combination of no guarantee in the presence of risk gave added weight to uncertainty. And so, while one may survive technology being used 'successfully, ' life could be further encumbered. Thus, a disconnect between what technology promised and what it may actual deliver - a possibility in theory - was borne out in reality. 'Permanent Vegetative State' (PVS) is one such, albeit extreme, reality. This led to considering the risk in terms of benefit in the clinical context.

It was in the era of advances in technology and science that the concept of QALYs (quality of life years) entered the medical vocabulary. QALY is a multiple of 'quality of life' and 'years one is expected to live'. The 'formula' can be written as follows: quality-of-life x years expected to live = QALY. A high QALY score is associated a life of higher quality than a low QALY score. Inherent in this equation is that older patients as a population cohort necessarily have lower QALY scores. This speaks to the aging demographic noted above. As a calculation QALYs assumed the explanatory power that accompanies science. But 'numeracy' applied to QALYs is so far below that standard of explanatory power that it is quality posing as quantity. In spite of this flaw, QALYs spawned other changes in the medical lexicon. Thus, concepts such as 'life not worth living', 'pointlessly living' and 'delaying death' became common parlance in palliative care. This new vocabulary changed the conversation at the bedside. But this vocabulary was not limited to palliative care. Beginning in the 1990s

physicians - in - training were schooled in how to have this conversation at the bedside. [6]

As this way of thinking and speaking was adopted by palliative care and beyond, a transition from *end-of-life* care' consistent with and integral to 'medical aid in living' to '*end of* life - care' consistent with and integral to 'medical aid in dying' occurred. A subject of further interest to bioethics consistent with the above was the removal of the distinction between passive and active euthanasia. (See Note 16 below.) A further aspect of bioethics that gained ascendancy and came to have a central place was utilitarian ethical theory by which benefit was evaluated in the context of costs. The change in the medical vocabulary noted above relates to this utilitarian ethic. Cost-benefit analysis was the application of numeracy at the bedside.

C. Managed medical care (MMC):

The demographic changes that emerged in the 1980s came with increased financial burden to health care funding. This spawned an interest in cost savings and rationing of health care. Thus, the business model was imported to medicine in the 1990s under the name of 'managed medical care' (MMC). One example shows the significance of this change.

In the pre - MMC era a Head Nurse, being responsible for seeing that patients on a hospital ward received the care required, was fully aware of the clinical situation of every patient on the ward. Under MMC this position was re-named Nurse Unit Manager (NUM). [NUM can also be considered short form of 'numbers', i.e. 'numeracy'.] However, this carried clinical sequelae. The NUM, now a manager, had the priority of system management, thereby replacing the clinical priority of patient care with institutional care. Thus, Nurse Unit Manager was not just a change in title but a change in function. This was a change in culture. System management was linked to resource allocation. MMC can be seen as the application of utilitarian ethical theory. It is difficult to know whether bioethics fostered MMC or whether MMC fostered bioethics. What is clear is that the two converged as bioethics

moved away from patient autonomy as its priority to utilitarian ethical theory where cost benefit analysis became the focus.

The year following McGregor's comments noted above the Canadian Life and Health Insurance Association provided financial support to a physician to pursue studies in bioethical issues . . .

> specifically those (issues) related to 'living wills', the wide use of which he (Singer) believes would improve the quality of health care and could *save* the North American health care system *billions of dollars annually*. [7] (*Italics* added)

Note that 'quality' and savings in 'dollars' are brought together. And so, benefit and costs, having been joined in MMC, would now be expanded to include 'living wills'. The three converge. Relevant to this merger is the QALY score and the ensuing bedside conversation. To the extent that the QALY influences the conversation, it influences the 'Advance Directive / Living Will. Influencing the choice patients make in the Advance Directive / Living Will translates to the care provided and, therefore, impacts on the costs.

A member of the Canadian Life and Health Insurance Association funded the Sun Life Financial Chair of Bioethics at the recipient's academic home. Singer, having completed studies in bioethics, became the Director of the Joint Centre for Bioethics (JCB) in 1996. Resource allocation is a core component of the Master of Health Sciences in Bioethics program offered at the Centre. Thus, bioethics, academia, and the insurance industry converged. Pellegrino (1999), a noted clinician with widespread experience in teaching and publishing on bioethics, has critiqued the introduction of a business ethos into medicine that is promoted by managed medical care. [8]

The rationing of health care and resource allocation became topical as the 20th century closed. Ubel, a physician-behavioural scientist, became a prominent advocate of MMC both at the bedside and at the policy level of rationing health care. The bedside and policy belong together for policy always has application in mind. Of note is that one of the determinants

of health care rationing is 'behavioural economics' by which reasoning and 'self-interest', e.g. institutional, corporate, or bureaucratic, are part of the evaluation. [9] This 'self-interest' is a departure from the traditional ethos of medicine.

The seed of convergence of bioethics, MMC, and academia planted in the 1990s bore fruit at the bedside in 2015 - one year before Medical Aid in Dying became part of the Canadian cultural landscape. The Ottawa community newspaper VISTAS reported on a study led by a hospital - based ethicist showing financial savings associated with consultation with palliative care services. [10]

D. Summary - Medicine and Medical Aid in Dying:

Three elements came together in the closing decades of the 20th century contributed to, if not form, medicine's legacy for the next century. These can be considered under the Latin terms *ratio* and *rationis* which can carry multiple meanings. In the realm of technology and science the person is considered objectively. This is a requirement of investigating the pathway of disease and developing strategies for therapeutic intervention. The cornerstone of this process is *ratio* understood as calculation for it is this calculation that knowledge gained can be reproduced and verified through experimentation. While the person is considered objectively and the process is objective, the process is to serve the patient as subject. This has been successful in that medicine can offer more to patients today than yesterday and has promise to offer more tomorrow. Science and technology, then, through the clinician belong at the bedside.

The second element is bioethics. Since medicine is a moral encounter, bioethics also pertains to medicine. However, its proper place at the bedside is uncertain. The promotion of patient autonomy is a positive. However, to the degree that bioethics aligns itself with other interests noted above rather than patient's interests raises questions as to its place at the bedside. The presence of QALYs and subsequent changes in the medical vocabulary at the bedside conversation add credence to these questions. A place at the bedside evaluated by traditional ethos of medicine of patient interest

makes it unclear as to where bioethics belongs or whether this ethos is still central to medicine as a practice as the 20th century closed. The report in VISTAS indicating the merger of bioethics and resource management speaks to this lack of clarity.

The third element managed medical care (MMC) is directly involved with rationing health care. As a calculation this is *ratio* in its mathematical sense. But it is also *rationis* as reasoning since 'rationing' of health care requires a 'rationalization'. Behavioural economics in considering the self-interest of third parties, e.g. corporate or bureaucratic, in allocating resources provides this rationalization. It is for this reason that MMC lies outside of the traditional ethos of medicine.

Of the three elements noted science and technology clearly is in the service of the patient. Although its process is grounded in objectivity, its goal is the patient as subject. MMC in a privately-funded system serves corporate interests. In a publicly-funded system it can also serve third party interests, e.g. institutional. And so, it is unclear where interests - patients' and others' - begin and end. However, it is clear that at the end of the 20th century and into this century the bedside is not reserved for patients' interests only. Indeed, developments suggest that patients' interests have become marginalized. In MMC the patient is treated, at least in part if not principally, as an object to be acted upon by third party interests. Bioethics is a hybrid in that patients' interests are claimed to be served; however, the merger of bioethics and managed medical care indicates that patients' interests may not always be the only consideration at the bedside and even when present may not be primary.

Any deviation from medicine's commitment to the vulnerable puts the traditional ethos of medicine as a profession in jeopardy and, therefore, also the vulnerable whom medicine as a practice serves. What has been presented here indicates that this ethos has not always been upheld. This gives an opening for the emergence of practices inimical to the *raison d'être* of medicine. Medical Aid in Dying is one such practice. This is the genesis of MAiD from within medicine. But the genesis of MAiD is more complex and, therefore,

merits further consideration.

IV. Medical Aid in Dying and Culture *au sens large*:

What has been presented above is within the context of medicine. But Medical Aid in Dying is more than a medical procedure. It is a culture for it cultivates a stance toward the patient as a person. While medicine itself is a culture, it subsists within a larger culture for it is but one door of many which opens out onto a larger society. Thus, the genesis of Medical Aid in Dying is relevant to this wider culture. This relevance is twofold. The wider culture is implicated in the genesis of Medical Aid in Dying which itself is a culture and, therefore, speaks to this wider culture in that it says something about what it means to be human and who we are as a people. For these reasons it is worthwhile to pass Medical Aid in Dying through a prism in order to identify and consider some of the major parts of the larger culture that were not only implicated in its genesis but are also affected by its presence.

Of the many parts that make up a culture that have brought Medical Aid in Dying to the social landscape several are noteworthy: medicine, law, the academy, Parliament, the media, and religion. This list is not exhaustive but each in its own way is relevant to Medical Aid in Dying. Of these parts medicine has already been considered and will only be referred to here peripherally and only rarely. While each part can be considered as independent, in reality they are interdependent for each speaks not only for itself but also to the whole.

A. The law:

It was through the Supreme Court of Canada that the Parliament of Canada was charged with the task of providing legislative guidance on euthanasia. With respect to this task the relevant law is the Canadian Charter of Rights and Freedoms. In its interpretation the Court is charged with considering the intent of the signatories of the Charter. The Court provided one interpretation in the closing decade of the 20th century and a different interpretation in the second decade of the 21st century. Thus, it is unclear if the intent of

the Charter's signatories was given equal consideration in both settings. In its second ruling the Court required Parliament to enact legislation affirming the 'right to die'. Two crucial points follow from this.

The role of the Court is to interpret the laws of a nation not dictate those laws. In the legal framework rights come with duties such that one's right is another's duty. And so, a 'right to die' carries a duty of others to fulfill that right. Parliament was charged to enshrine the right to die in the nation's jurisprudence. However, while the discourse was about rights, the imperative, ever-present but never openly expressed, was about duties that rights demand.

The United Nations' Universal Declaration of Human Rights (1948) is a seminal document on human rights. This Declaration mentions 'rights' 51 times, 'duty' once, and 'dignity' four times. The Declaration, thus, is skewed toward rights. However, given the context of the Nuremberg Trials this is understandable. While the authors of the Declaration agreed on the importance of human rights, they could not find agreement as to the foundation of those rights. Nevertheless, the Declaration stands as a major contribution to the discourse on human rights today.

However, rights do not stand alone for duties and dignity are relevant to rights. In fact, the Declaration's opening statement acknowledges 'the inherent dignity and equal and inalienable rights' of humanity. Duties align with rights for one's rights impose duties on others. But duties align with rights in another way as well. While my right places a duty on another, my right also places a duty on me to honor the rights of others. And so, each of us has a duty to assist others in living. Rights and duties, then, are not two separate 'one-way streets' but one street with traffic going in both directions. As for dignity it, too, belongs in the traffic to both the passenger and the chauffer.

The legal context does not capture the broader sense of duty presented here. Nor does it engage an understanding of dignity. In its narrow application the legal aspect is deemed wanting for dignity as inherent to our existence and duties to assist others in living were never addressed. What is addressed through the Court is when rights are not upheld. This

presupposes that a duty was not exercised. In the context of a 'right to die' this presupposition requires that a duty be imposed on others to honour that right. This was the dynamic of the discourse on euthanasia that ensued in Parliament. But while the legal component of our culture is essential, it is but one element of the larger culture contributing to the genesis Medical Aid in Dying.

B. The academy:

The proper role of the teaching profession is not simply to impart knowledge but to foster an appetite for learning in pursuit of understanding. Truth, then, seen as understanding is the currency of the academy. Since understanding is never complete, one is always learning. This involves following where inquiry takes one. This knowledge exists to be put in the service of the person and the community. The teacher, therefore, is accountable both to the student and to the commonweal.

Among the animals of the world humans are unique in that in pursuit of knowledge and understanding we have tools of language and reason. However, if used improperly we are at risk of ending up not in understanding and truth but in its constant companions – misunderstanding and error. Osterle (1963) has noted that errors come from two sources: language and reasoning. [11] Thus, the sources of yesterday's errors are the same sources as today's errors. While change is a feature of history including the history of thought, the *sine qua non* of reasoning remains unchanged for it is today what it was in antiquity. While language can be used to express reasoning, it can be, and has been, used for purposes other than reasoning while appearing to be reason. This is rhetoric. This pertains to the public and professional discourse of Medical Aid in Dying.

'Compassion' is an example of an error of language. As a compound word its etymological root is twofold: '*cum* [with] and *passio* [movement]. The proper understanding of 'compassion', then, is 'movement with'. However, many understand and, thus, promote 'compassion' differently. Leder notes that the root word of patient is *patio* which carries the sense of 'to suffer'. Aligning this with *com*

[together, with] he concludes that 'compassion' is 'to suffer with'. [12] 'Compassion', in the context of medicine, is often considered as 'suffering with' [*cum patio*] such that the suffering is actually shared. The patient *qua* patient is defined by a threat to personal well-being whereby one moves to a new uncertainty. Thus, *cum passio* [movement with] better expresses this reality.

Rosenberg's understanding of 'empathy' illustrates this difference. He sees empathy as 'presence'. And so, in his practice when finding himself feeling what the patient is feeling he, in words to himself, notes: "I'm not with the other person. I'm home again. So I say to myself 'Go back to them'." [13] By 'home again' Rosenberg means his own 'home' and, thus, no longer present as in 'journeying with' for he had been 'suffering with' the patient. By present he means being present to what is alive in the moment. Returning to the patient to be present with them in their journey is *cum passio* [movement with]. Feeling what the other is feeling - even if that were possible which it is not - would be '*com patio*' and not *cum passio*. The proper sense of 'compassion' has been usurped in the discourse on Medical Aid in Dying.

Language can also be used in ways that may not be in error but can be ambiguous or can obfuscate in order to promote a discourse to a predetermined conclusion. This is a strategy to argue 'from' conclusion disguised as an argument 'to' conclusion. However, in reality it is not an argument at all but only an appearance of an argument. Adding the appendage 'dignity' to the 'right to die' is an example. Aligning 'death' with 'dignity' suggests a *raison d'être* for death as a right. However, since death is inevitable, death as a 'right' is somewhat dubious. But 'Death with Dignity' merits critique not just conceptually but on grounds of language and reasoning.

An alliteration is a linguistic device in which words are tightly bound together such that a word is seen and heard in the light of the other. The initial letter of each key term is identical, thereby providing the glue that binds the words together. This gives the phrase a strength that it would not otherwise have when either word is used alone. Thus, the combination carries an authority of a truth which appears to

be self-evident and, therefore, likely to go unchallenged. In brief, the words standing alone cannot carry the weight that they carry together. '**D**eath with **D**ignity' is an alliteration and, as such, tends to preclude rather than invite debate. '**S**top the **S**teal' is an example of another alliteration in another context. A further example is '**P**ublic **P**rivate **P**artnership' spoken as P3 and written as PPP. An alliteration is not an error of language. Rather it is a linguistic device that belongs in the domain of rhetoric.

The irony is that in 'Death with Dignity' the two key words journey together and present an ambiance of 'compassion'. Noteworthy is how 'Death with Dignity' was enabled by the medical profession. An example from the palliative care academic literature illustrates this. Writing on Advance Directives and the incompetent patient Singer notes:

> When the treatment decision is made, however, the patient is no longer competent and thus in most cases *lacks* interest in privacy, *dignity* and other values that presuppose some appreciation of those concerns.[14] (*Italics* added)

While Singer is citing a source, he is giving tacit approval to the statement. And so, dignity as a concept is introduced in Advance Directives in anticipation of possible palliative care in some future time. As noted, language from medical academy adopted in the late 20th century implied dignity as a calculation, e.g. QALYs (quality life years), which generated language such as 'life not worth living', 'pointlessly living', and ' delaying death'. (See Note 6 above.)

But 'dignity' also merits consideration on grounds of reasoning. The advocates of Medical Aid in Dying understand 'dignity' as external attributes or bodily functions of my person. However, historically dignity has been understood as inherent to our humanity irrespective of our functional capacities or external circumstances. Dignity is not acquired but rather is a given. The U.N. Declaration understood this. Thus, dignity remains present even when attributes may be absent and when others do not respect one's dignity. In one view compromised function diminishes our humanity; in the other view we remain fully human with full dignity in spite of compromised function. In Solovyov's philosophy human

dignity is inherent and inalienable. [15] Dignity, then, is not based on attributes but rather is grounded in the essence of human life. Dignity is independent of bodily function and, therefore, immune from erosion by bodily dysfunction. The disabled community knows this. Thus, a person's QALYs score has nothing to do with one's dignity.

But this view of dignity was never presented in the public discourse on Medical Aid in Dying or if presented was not given equal weight. It is this way because an alliteration tends to foreclose debate for, much like a proverb, it carries not only the weight of a truth but is identified as the whole truth. However, unlike a proverb, an alliteration carries only the appearance of a truth. This foreclosure on debate that arises from alliterations such as 'Death with Dignity', is not an error of reasoning for it is not reasoning at all. 'Death with Dignity' is not an argument in favour of Medical Aid in Dying. Rather it is a conclusion without having the burden and accountability that reasoning requires.

But error of reasoning can be found in the genesis of Medical Aid in Dying when philosophers argued that passive euthanasia and active euthanasia were equivalent. Previously, it was widely held that the two were considered distinct such that 'passive', i.e. allowing to die, was permissible and 'active', i.e. intentionally ending life, was not. However, Rachels (1986) argued that this distinction was untenable since both passive and active euthanasia shared a common outcome, i.e. death of the patient. [16] But in passive euthanasia death is neither inevitable nor intended. This makes passive distinct from active where death is both intended and certain as a direct result of actions taken. The elimination of this distinction was embraced by some, i.e. the euthanasia movement, and uncritically accepted by others. Matters of moral import are especially in need of rationality. Medical Aid in Dying is such a matter and, therefore, merits correct reasoning.

The removal of the distinction between active and passive euthanasia is philosophical adventurism for it takes philosophy in a direction other than reason - a direction that many in the academy were willing to follow. [17] Ends and means are two pillars of philosophical discourse. Identifying passive euthanasia with active euthanasia misconstrues these

pillars. This is an error of reasoning and impacts negatively on the 'rational', understood as reasoned, basis on which to make a case for Medical Aid in Dying.

C. Parliament:

Parliament differs from other cultures in society in important ways. Unlike law and medicine, there is no body of knowledge common to all Parliamentarians. But this is not a criticism or a shortcoming. The very fact that membership in Parliament is diverse brings a new and essential dimension to public discourse and helps Parliament perform its proper function which is to enact legislation on behalf of all citizens of the State. While medicine, law, and the academy each have an immediate focus, albeit different, on the individual, the primary focus of Parliament is the well-being of the community. The State also differs in that while it may be collegial in theory in that it exists to serve the commonweal, in reality it tends to be less than collegial in its discourse. In this environment reason as a tool of persuasion, a tool championed by Socrates, is not infrequently usurped by rhetoric.

While the State does not have the hallmarks of a profession *per se*, Parliament is an institution with its own authority, responsibility, organization, and accountability. In fact, as an institution none has higher standing. The proper function of Parliament is the social well-being. This carries the sense of 'social health' in the non-medical sense of the term 'health'. This is captured by the term 'common good' also described as the commonweal. The guiding principle of the State in fulfilling its proper function is *Salus populi suprema lex* (health of the people is the supreme law). *Salus populi suprema lex* is for the benefit of the commonweal. It is to this end that Parliament enacts legislation. This separates the State from the Court. The 'right to die' illustrates this division.

The Court charged Parliament with task of enacting legislation to support the 'right to die'. This would carry a duty of one to end the life of another. But the State has a duty to protect its citizens. And so, it has a duty to protect the rights to life of its citizens. A case in point is the COVID-19 pandemic where public health measures were mandated to protect the

citizens of the State, especially the most vulnerable. And so, duties to assist others in living fall on all citizens of the State. Noteworthy is that no elected Head of State - Federal, Provincial, or Territorial - voiced the 'common good' as a rationale for such public health measures. Such thinking, absent from Parliamentarians in 2020, was also absent in the 2015-16 debate on the 'right to die'.

To the Court belongs the function to adjudicate a case in the light of relevant legislation. It is here that the particular meets the whole - where the benefit of the individual meets the benefit of the commonweal. The Court is where *Salus populi suprema lex* is put to the test. The Court, bounded by the demands of and in the service of a profession, meets Parliament which, while lacking a similar basis of standards, has no less legitimacy or responsibility to assist all of its citizens in living. This provides background from which Medical Aid in Dying emerged.

The discourse on Medical Aid in Dying was grounded in the Canadian Charter of Rights and Freedoms, specifically the Section which protects 'life, liberty, and security of the person'. To exercise one's liberty to end one's liberty is not simply legal matter but is fundamentally an existential issue and, as such, is not a matter for the Court other than declaring that something is, or is not, a crime. Thus, suicide, once considered a crime, is no longer considered as such. But Medical Aid in Dying is different. The matter facing the Supreme Court of Canada based on case law was the 'right to die'. If one were to have a right to die, then, in the legal framework an other has a duty to fulfill that right. The Court did not defer the matter to Parliament but rather referred it to Parliament with a recommendation that a 'right to die' be legislated.

A Joint Parliamentary Committee was struck to explore euthanasia. This Committee heard witnesses from the public. However, it has been claimed that the Committee gave preferential access to those in favour of euthanasia. [18] Thus, the testimony sought and heard was skewed toward euthanasia. The standard of debate requires that both views of a subject be given equal space in order to arrive at a reasoned conclusion. It is this way so that one can evaluate

different positions. In not meeting this standard the integrity of the Committee and its Report is devalued.

It is also a matter of public record that the governing Party initially announced that its MPs would be required to vote along Party lines, i.e. support any proposed legislation regarding euthanasia, only to later withdraw this demand as 'being premature'. However, having at first demanding the vote be according to the Government's dictate, the point would not have been lost on its MPs. With Bill C-14 'the right to die' became enshrined in Canadian law. But the process which gave birth to Medical Aid in Dying was flawed. However, the matter could not end with Bill C-14.

In the legal setting 'rights' are universal in that they are not and can not be applied to some and not to others. And so, while C-14 circumscribed Medical Aid in Dying to a predefined situation, such circumscription could not go unchallenged in the Court. Thus, subsequent developments via jurisprudence have widened the scope of Bill C-14 (2016) to Bill C-7 (2021) to include mental illness as an 'indication' for Medical Aid in Dying. The seed for further expansion to Advance Directives in patients with dementia has been planted in the public's consciousness. Once again Advance Directives surfaces.

With the introduction of Medical Aid in Dying to jurisprudence the 'right to die' has *de facto* become part of the Canadian Charter of Rights and Freedoms. In addition, *Salus populi suprema lex*, the fundamental principle that guides legislators, was put in abeyance - intentionally or otherwise. Sébastien Grammond, a future Federal judge, in commenting on Bill C-14 has noted that the Government appears to have simply 'cut and paste' the essence of the Supreme Court's ruling. [19] But this is tantamount to being governed by the Court. The evidence suggests that Parliament intentionally did not seek balanced knowledge regarding euthanasia but rather unreservedly obeyed the Court's dictate. Parliament, thus, has failed to exercise its proper function.

However, there is another aspect of importance where Parliament acted not by Court degree but independently. Bill C-14 mentions conscience *en passant*. On May 30, 2016, a

motion to amend Bill C-14 which would have explicitly respected conscious rights of health care providers not to participate in Medical Aid in Dying was rejected by Parliament (Yes - 97 / No- 222). [20] Thus, the legacy of Bill C-14 is that in the one piece of legislation the 'right to die' was enshrined in Canadian law and, at the same time, 'the right to conscience' was rejected. A dubious legal and Parliamentary legacy.

D. The media:

The role of the media is to inform the community. Its responsibility is to bring forth balanced analyses of issues facing a community. For this reason freedom of the press is essential to the well-being of society. This role and responsibility is unique and, thus, separates the media from other sectors of society noted above. While the media are an essential instrument for social good, it is difficult to classify the media as an institution or as a profession. William May comments on this in the following:

> Intellectually, journalists have emphasized the formal standard of accuracy. . . . However, the journalist's intellectual mark differs strikingly from that of the classical professional. (Other). . . professions. . . have each produced a body of literature, which practitioners master and apply to human needs. Whatever intellectual disputes emerge in the professions, their bodies of knowledge remain relatively objective. . . . Journalism, however, lacks a body of organized knowledge from which it derives authority. [21]

This lack of a basis of authority is significant.

But May's critique of journalism goes further. He continues: "The journalist of the 1890s depended upon a *double confidence*: that a reporter could get at the facts and that the facts would carry their own moral significance." (p.201, *Italics* added) This double confidence is now ill-founded. May explains:

> In this century. . . journalists have . . . realized that they cannot attain the ideal of *disinterested*

> *objectivity* . . . not simply because of personal bias, incompetence, or malicious intent, but also because of the constraints of the organization, its deadlines and customs. [22] (*Italics* added)

Two related points are noteworthy. First journalism lacks an organized knowledge base on which to ground authority. Second journalists cannot attain disinterested objectivity. However, in spite of these shortcomings the media have become the leading 'teachers in modern culture'. This influence is so widespread that . . . "(j)ournalists and other media specialists . . . *exercise more power* as teachers and transmitters of . . . cultural ideals than does any other . . . group." (p.204, *Italics* added) How this power is exercised impacts on how a society understands an issue and how it functions.

This power operates in a milieu whereby those with power have no intellectual authority and thereby no objective accountability and having no standards are not obliged to act with disinterested objectivity. The following is worthy of note for it speaks of this power. In years past when newspapers were placed in metal boxes on high traffic street corners, a newspaper identifying itself as 'the national newspaper' - not by name but by reputation - had the caption on the box which read '*Not just reporting the news but making the news*' next to an image of its leading columnist. This columnist penned support for euthanasia.

In a column entitled 'Assisted suicide - the issue we can't ignore' reference was made to Justice Sopinka's comments speaking for the 5-4 majority ruling against PAS (Physician - Assisted Suicide), i.e. active euthanasia (1993). Justice Sopinka noted that there was 'no public consensus' implying that, at least in part, this was a justification for the decision. [23] This suggests that the Court's rulings can be changed by altering public opinion. Polls in 2014 favoured PAS / active euthanasia suggesting that Justice Sopinka's earlier reservations had been addressed. In February 2015 the Supreme Court of Canada ruled (9-0) in favour of PAS / active euthanasia. It seems, then, that the 'court of public opinion' influences the Supreme Court of Canada. But polls are largely

influenced by how an issue is framed. The media play a role, at least indirectly, in framing the debate in a certain manner. The media, then, have immense influence on framing a debate and subsequently directing public opinion which played a role in the Court. Of note in this regard is the report in the community newspaper VISTAS reporting of financial savings generated by palliative care. (Note 10)

Regarding the 1993 case noted above the same illness afflicted Justice Sam Filer. However, his narrative differed in several ways: his illness was more advanced, he had support, and he petitioned for life not death. Yet, his narrative was not etched in the public's consciousness due in no small part to the media in spite of the fact that his case was in the public record. This illustrates how journalists imprint their views on society by reporting on a narrative uncritically and without 'disinterested objectivity'. Of further note is that Justice Filer's narrative entered the academic literature a few years later (1996) but was largely ignored by the bioethics community even though it was in their domain. [24] However, by this time utilitarian theory and its relevance to and convergence with managed medical care had been well established within bioethics.

A medium that is truly committed to informing society and forming the public's consciousness would put forth different opinions from different sources on the same issue and, as much as possible, at the same time. However, rarely is more than one view put forth in any single media outlet or platform. In this situation errors of language and reasoning noted above are more likely to accompany the information conveyed to the public. While the media serve society as a conduit of information, they are also a conduit of opinion. This opinion is some times overt but more often is covert in the choice of information conveyed. In this way the media not only inform but also form the public's consciousness.

Fundamental to a democratic society is freedom of expression. However, when a medium offers only one opinion on an issue society is not fully informed and, therefore, the public's consciousness is skewed in a direction which that medium wishes to go. Thus, the real battle for social policy is played out not only <u>in</u> the media but also <u>by</u> the media. In brief,

it is the public's consciousness which is in play for the media know that whoever controls the public's consciousness controls the world. [25] But May, via Schudson, notes that . . . "(n)othing in [journalist] training gives them license to shape the other's views of the world." (p.201, [Brackets] original)

This takes on added importance and urgency in the Information Age where social media can and do propagate information and misinformation. In such circumstances reason as a tool of persuasion, already weakened by traditional media, atrophies further through displacement by rhetoric or by manipulation. [26] And so, increasingly in the 21st century it is the medium of social platforms that serve this purpose with greater breadth but with lesser depth.

In conclusion, while the media may not meet May's qualification of a profession and may not even be an institution, they are instrumental in the proper functioning of society. The key function that the media perform in today's world is to influence or create consciousness on any subject that enters the public domain. Manipulation of consciousness, then, becomes a possibility if not a reality. However, unlike other parts of the cultural spectrum noted here each with its professional standard of personal disinterest and a body of knowledge, the media are not held accountable to any such standard. In the realm of subjectivity, adversarial messaging, and sensation there are no standards. In addition, journalists ask questions but questions are not asked of them. Media focus on problems and carry no responsibility or accountability for providing answers. Furthermore, media have the last word. And so, coupled with this power to influence comes a limited public accountability. This sets the media not only *apart from* but also *above* the medical, legal, and teaching professions, the judiciary, and Parliament none of which have such an imbalance of authority and accountability. But this comes with two costs: a cost of credibility that is charged to the media and a cost of poor service that is paid by society.

E. Religion as '*re ligare*':

Religion, as considered here, is not limited to its common use which is in a 'faith' context. The etymological

root of religion is *re ligare* which carries the sense of 'being bound to'. The term 'ligature' as in surgery is derived from *ligare*. Since one can be bound to anything, anything can be a religion. Indeed, since man desires to be bound to something, one can say that man is a religious being. Every religion has a dogma and promotes a doctrine based on this dogma. The term 'dogma' carries a sense of 'the minimum'. However, when the minimum becomes the maximum, orthodoxy becomes the norm. While orthodoxy is not itself prescriptive, in practice it frequently becomes such. This promotes a sense of legal or forensic culture which is frequently encountered in religions, i.e. 'what man is bound to'. The binary A vs B dynamic of the media is an example of a forensic culture whereby 'one' is right at the expense of the 'other' who is wrong. Thus, orthodoxy is a feature of all religion. Two examples illustrate this.

Science understood as 'scientism' can be considered a 'religion' in that it is what we are bound to today. Science in medicine is a tool to explore disease. Scientism and technology as a 'religion' is way of being. It is how we understand and engage our world. 'Secularism' seeks to displace all religions that are grounded in a Deity from the public domain. But in doing so it also is a religion with its own' 'deity' for its advocates are bound to secularism and secularism is what binds them together. Both 'scientism' and 'secularism' have an orthodoxy manifested as a way of being. An ideology, be it political, social, or economic, operates in the same way. But each 'religion' carries an imperative of commitment, compliance, and loyalty. It is this orthodoxy which must be upheld. Any breach of the veil of orthodoxy is a threat to the 'religion' and puts one's place in the 'community' at risk.

Religions understood as *re ligare* each with its orthodoxy can, and often do, act as an impediment to discourse, dialogue, and debate in search of understanding. To the degree that this occurs each tends to become prescriptive.

F. Summary:

Several sectors of society implicated in the genesis of Medical Aid in Dying have been considered. While each has

an autonomy and creates its own culture, each also is situated in and contributes to the wider culture in which a society expresses its values. In brief, culture is cultivated and, as such, is dynamic. Each sector has principles which underlie its culture. Since culture is dynamic, these principles are not prescriptive but rather provide guidance and framework for engaging circumstances which arise. However, these principles must be upheld and honoured if a sector is to honour its tradition to serve society otherwise not just the part but the whole is placed in jeopardy. However sometimes they can come in conflict.

The traditional ethos of medicine as a profession - patient vulnerability and fiduciary responsibility - has been noted. Three developments have challenged the 'profession': science and technology, bioethics, and managed medical care (MMC) - each with its own principles and promoting a culture. Added to this was a demographic bulge of an aging cohort born in the early years post -WWII. And so, some physicians felt that they were practising the administration of medicare rather than medicine. Danielle Ofri has noted: "I can't tell you exactly when it happened, but sometime in the past two decades, the practice of medicine was insidiously morphed into the delivery of health care." [27] That 'sometime' was the emergence of MMC in the 1990s. This reflects the erosion of the medical profession's traditional ethos as the practice of medicine increasingly came under the influence of the factors noted above. But of additional importance is that in the 1990s physicians-in-training received a different formation than the preceding generation. The difference being the influence most notably of bioethics aligned with MMC. Not only had the medical culture changed but future physicians were formed in this new culture where conversation about death was taught. (See Note 6 above.)

On the matter of medical education a further development relevant to Medical Aid in Dying is noteworthy. In 2016 the in-coming first year class in the medical faculty of the University of Ottawa had a lecture on euthanasia on day 1 of their medical education. [28] Thus, within months of being established as a legal right Medical Aid in Dying entered the

medical curriculum on the first day in the formation of future physicians! And so, just as physicians whose education began in the 1990s were formed in a culture of managed medical care, physicians whose education began in 2016 will be formed in a culture which ends patients' lives.

Of note regarding the traditional ethos of medicine as a profession is a comment from Paul Kalanithi (1978 - 2015). In his memoir of illness he speaks of a discussion among peers in medical school concerning their 'commencement oath':

> As graduation neared . . . we sat down, in a Yale tradition, to *rewrite* our commencement oath - a melding of words of Hippocrates, Maimonides, Osler along with a few other great medical forefathers - several students argued for *removal* of the language *insisting* that we place our patient's interests above our own.[29] (*Italics* added)

The initiative was rejected.

There are two ways to interpret this. One is to understand '*removal*' as referring to '*patient's interests above our own*'. Alternatively, '*insisting*' can be understood '*that we place our patient's interests above our own*' be inserted in place of language which would have been removed. The message common to both interpretations is that 'patient's interest' is not universally held within medical education for either 'several students' endorse this view and the medical faculty does not or the faculty does and 'several students' do not. This reveals that 'disinterestedness' is vulnerable in the current medical environment and indicates that vigilance is constantly required to maintain its central place in medicine as a profession so that it will have a central role in medicine as a practice.

The law is where the State and the citizen meet. The role of the legal profession is not to write the laws of the nation but rather to interpret these laws in the context of the case being presented. Of paramount importance is that the rights of the participants be upheld, i.e. the plaintiff and the defendant. The genesis of Medical Aid in Dying carries important points that pertain to the legal profession. The first is the Court mandated Parliament to enshrine the right to die in Canadian

Law. However, the Court's role is to interpret not amend the Charter. But also noteworthy is that in Court a lawyer argues not to conclusion but rather from a conclusion that favours the client.

The realm of rights is accompanied by the realm of duties. But duties considered merely as a reciprocal of rights forecloses any consideration of duties on their own merit. As a reciprocal of the 'right to die' there is a 'duty to bring about that death'. This 'duty' was assumed but was never articulated as such. With Bill C-14 the State not only enshrined into Canadian Law the right to die it also enshrined into the Canadian social landscape the duty to end another's life. The latter being aligned with the rejection of conscience rights of the dutybound. The public discourse from both the legal profession and from the Parliament never did highlight this aspect of the right to die.

Moreover, the notion of duties that we owe each other in a society was never front and centre in the discussion. This void continued with the public health measures instituted in the COVID-19 pandemic as the good of the commonweal was never articulated as a rationale for such measures. And so, the void of the 2015-2016 Medical Aid in Dying debate continued into the discussion surrounding the pandemic of 2020. The result is that duties understood as such are absent from the consciousness of Parliamentarians and Canadians at large and, therefore, are not articulated in the culture of our time. And what is left unsaid atrophies over time. This is highlighted in the debate on Medical Aid in Dying when a motion to protect the right to one's conscience was defeated by Parliament. And so, the duty to follow one's conscience on a matter of life or death was denied for those whose conscience says not to take another's life. These points lead to the conclusion that *Salus populi suprema lex*, the fundamental principle of the State, was held in abeyance by Parliament in the discourse that gave birth to Medical Aid in Dying.

The role of the academy is to stimulate inquiry. It is in this role that one follows inquiry to where it goes. But since inquiry never ends, understanding is never complete but always *en route*. But this journey requires the proper use of language and reason. However, in the genesis of Medical Aid

in Dying it was shown that this proper use was missing. The mis-use of 'compassion' and the use of the alliteration Death with Dignity are examples of language. Equating passive euthanasia with active euthanasia (Rachels) is an example of the mis-use reasoning. In addition, evidence that language was used with intention to confuse and obfuscate discussion in favour of the desired result, e.g. alliteration, reveals the weakness of alliterations as a tool for reasoned debate These errors either went unnoticed or if noticed were ignored. The academy exists to pursue the truth and understanding. The academic discourse that produced Medical Aid in Dying fell short of this standard.

The role of the media is to inform the public. The issue for the media is the content of that information. But this is also an issue for the public as there are no standards other than what the media outlet wants the public to know. And so, it is the public's consciousness, i.e. how the public may view a particular subject, that is in play. This consciousness becomes a commodity for manipulation since there is power in being able to influence that consciousness. Polling data has become part of the media's toolkit. But polling data is, to a significant extent, influenced by the framing of the questions asked. The importance of polling was noted with respect to euthanasia. In addition, rarely do the media present more than one view of an issue. This, too, was noted with respect to the 'right to die'. But the media cannot be faulted for not upholding standards for they have no standards. But that, itself, is a cultural problem.

Given that *re ligare* ('to be bound to') is the etymological root of 'religion' one can be bound to anything. The importance of this observation is that within a culture there are many and varied candidates vying for that position. Each carries a core set of values which one is expected to uphold. The more tightly those values are held, the more prescriptive they become and the more allegiance they command. In addition, this gives added import to those views such that no other views are tolerated. This creates a climate of conflict between 'religions'. Rather than having a discourse on the founding principles of a 'religion' the discourse tends to be about the different conclusions. Science and secularism

were noted to be religions in the objective sense of term. It is in this same sense of the term, the media can be seen to operate as an instrument, i.e. voice, of a particular world view held by those who have authority over the media. It is these views which form the public's consciousness.

Considering Medical Aid in Dying through a cultural prism one notes that there are many 'parts' of the cultural spectrum which have been involved in its genesis. Each 'part' has its own culture and each culture contributed to the genesis of Medical Aid in Dying.

V. Conclusion: A Paradigm of the 20th Century:

Culture is not a given. Rather it is cultivated by human activity. Within the wider culture which make up the social fabric of a nation are found several smaller parts each with its own culture. This makes each of us a cultivator. In its immediate context Medical Aid in Dying has become part of the medical culture of the 21st century. But Medical Aid in Dying also has a presence in the broader social context of the culture at large. A paradigm is defined as a pattern. Thus, Medical Aid in Dying can be considered a paradigm in two ways: one within the medical culture and the other with respect to the wider culture.

Within the medical context Medical Aid in Dying can best be understood as 'therapeutic nihilism' as nothing of therapeutic value is sought. However, with respect to therapeutic initiatives while Medical Aid in Dying stands out, it does not stand alone. Prostate cancer illustrates this point. In years past when post mortems were performed at teaching hospitals on a regular basis it was noted that some elderly men had prostate cancer. However, this pathology was unrelated to the cause of death. This 'incidental' finding eventually led to a view that asymptomatic prostate cancer need not be treated. And so, '**W**atchful **W**aiting' - another alliteration - came to be a common approach to patients with prostate cancer. The rationale being that to treat such patients when asymptomatic would expose them to harm of adverse events of therapy and unnecessary anxiety for a disease that may have no serious consequences. It was deemed better to

wait for symptoms, e.g. bone metastases or spinal cord compression etc., and then offer them palliative care since the disease would then be incurable. The same rationale led to notion of 'over diagnosis' for cancers of breast and bowel detected by screening.

The rationale of Watchful Waiting and its partners was considered to be consistent with the Hippocratic principle of *primum non nocere* - 'first do no harm'. This principle is also the rationale for 'harm reduction' with respect to 'treating' alcohol and drug addiction. However, while grammatically *primum non nocere* is not a double negative, it does carry the appearance of a positive, i.e. 'no harm' at that moment. But both 'acts' of omission and commission carry moral import. While *primum non nocere* as an act of omission may on the surface appear to be morally sound, it comes at the cost of not risking to do good. In these situations the issue is not only a failure to do good but a decision not to attempt to do good. Harm reduction sets a low therapeutic standard.

The moral import on the clinician's role in this can be mitigated by having the 'informed' patient make the decision. But the information may be skewed toward a pre-formed decision which is what alliterations do in arguing '*from*' conclusion. In addition, interests other than patient's interests are also implicated in this 'information'. As in any patient decision, the specter of Advance Directives and the accompanying medical vocabulary are not far away. These developments represent therapeutic nihilism. This establishes Medical Aid in Dying as the paradigm of the practice of medicine in our time.

But Medical Aid in Dying is also relevant to other 'parts' of the cultural spectrum for here, too, one found elements of its genesis. Thus, Medical Aid in Dying is not the exclusive domain of medicine but rather a part of our social fabric for it expresses the culture of a nation. In brief, it is stance toward an other. But this 'other' is a very particular 'other' - the most vulnerable among us. And so, Medical Aid in Dying is the paradigm of the 20th century - a paradigm bequeathed to us as part of the Canadian social landscape of the 21st century. This is the second paradigm.

The contribution of the many parts noted above suggests that Medical Aid in Dying was developed in a vacuum whereby several 'organs of the body politic' malfunctioned. Examples include medicine's traditional ethos, the blind acceptance of 'duties' as a reflex of 'rights,' the abandonment of Parliament's foundational principle *Salus populi suprema lex* which includes Parliament's rejection of conscience rights, and the academy's uncritical acceptance of errors of the language and reasoning in the discourse that gave birth to Bill C-14. This describes a vacuum. The media served as a conduit transporting these 'parts' to the public's consciousness.

And so, while it is tempting to say that Medical Aid in Dying was created in a vacuum, to describe its genesis in this context is misleading for this description in and of itself is incomplete. It is this way because power cannot lie dormant for it cannot but be exercised. And so, a vacuum cannot be left vacant for power demands that that which is vacant must be occupied. This vacancy was filled by the convergence of corporate and bureaucratic interests whereby utilitarian ethical theory embraced by bioethics aligned with private sector interests which permeated the medial academy and spawned managed medical care. It is in noting the vacuum and what filled the vacuum that one comes to fully understand the pathway to Medical Aid in Dying. It is this which is the genesis of the paradigm not only of medicine but of the 20th century as it came to a close. This sets the stage for the 21st century - the first century of the 3rd millennium. But to explore this further one turns to the beginning of the century just passed.

Schweitzer, in the Preface to The Philosophy of Civilization (1923) , notes that the subject of 'the decay and the restoration of civilization' has occupied him since 1900. [30] Fundamental to his thought is the term *Weltanschuang* which can carry several meanings. Of the four interpretations in translation of the term - 'theory of the universe', 'world theory', 'world-conception' and 'world-view' - the translator of Schweitzer's text comments:

> The first is misleading as suggesting, wrongly, a scientific *explanation* of the universe, the second and third . . . suggest an *explanation* of

> *how and why* our human world is what it is. The last carries a sufficiently wide knowledge of our corner of the universe to allow *all factors* to be taken into consideration. [31] (*Italics* added)

This speaks to the matter at hand, i.e. the vacuum and what filled the vacuum.

Of note is the term 'explanation' which resonates with 'explanatory power' and numeracy - features of the scientific method applied to the human body. Also of note is the mention of 'how' and 'why' of what is. The 'explanation' of 'how' and 'why' pertains to disease which is what a patient has. However, the 'why' can also be understood as purpose or meaning which pertains to illness which is what a patient lives with. To understand 'how' and 'why' as synonymous, i.e. two terms to express a singular reality of what is, is to dismiss purpose or meaning or to see purpose / meaning in functional terms only. This dismissal is captured by Angell's opening citation. (Note 1) But *Weltanschuang* as 'world-view' is not circumscribed in terms of explanation of how what is but goes beyond explanation to encompass 'all factors'. *This* pertains to euthanasia for it impacts on how the discourse on Medical Aid in Dying was framed.

There is a further aspect of the genesis of Medical Aid in Dying which has never been unveiled but belongs to all that has been revealed. The work of Canadian-born psychologist Albert Bandura (1925-2021), particularly Moral Disengagement (2016), is relevant. He writes of social cognition which can be viewed as how we understand and thereby participate in our culture. This is illustrated in the following:

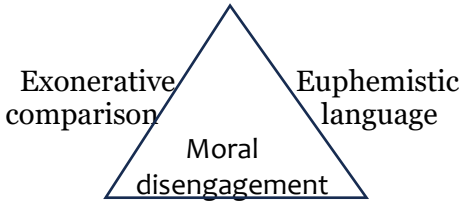

Figure 1.1 Bandura's moral disengagement

Bandura identifies three elements of this social cognition

which contribute to moral disengagement: moral justification, exonerative comparison, and euphemistic language. [32]

The genesis of Medical Aid Dying exhibited all three features of social cognition that make up moral disengagement. 'Moral justification' can be understood as 'moral rationalization' for it is difficult to justify the taking of an innocent life. 'Meaningless suffering' is the comparator which exonerates Medical Aid in Dying. 'Quality of life' (QALY's) and 'Death with Dignity' become the euphemistic language of the 'justification' process. In fact, Medical Aid in Dying itself is a euphemism for it is a re-phrasing of Physician - Assisted Suicide (PAS). Thus, MAiD replaced PAS in our public consciousness and public discourse. The invocation of *primum non nocere* noted above fits the framework of moral disengagement

- Culture –
Farmers cultivate;
And that we call agriculture.
We cultivate each other;
And that we call culture.
And so, we are all farmers.
But the 'other' is not a cash crop!
And if we think otherwise;
Then our culture is in demise.

This verse is grounded in experience as a volunteer in Hospice Care in a non-professional capacity post-retirement. It was there that one witnessed 'medical aid in living'. It is this way for living one's' humanness is the cornerstone of hospice care where 'one' is everyone - patient, family, staff, and volunteers. In brief, people cultivate each other. But Medical Aid in Dying has arrived at Hospice Care through a mobile MAiD team - the reasoning being 'it is the law'.

But Bandura's writing also speaks to this reasoning for 'social cognition' exists in all facets of our collective lives. [33] And so, 'it is the law' is a position that can endorse the social cognition of the time. Whether that endorsement is active or passive is immaterial for it gives that social cognition a greater foothold in the culture as it becomes a default position. Nisbet's comments are relevant as noted in the following:

> Guilt, as we have known . . . throughout most of history, is individual, and thereby requires a *sense of the self*. But if the self is obliterated, if the organization takes command, reducing individuals to roles without responsibility, how can there be guilt. . . . Only 'the system' is responsible. [34] (*Italics* added)

Both Nisbet and Bandura, writing decades apart and with different wording, concur on 'moral disengagement'. Nisbet's 'self ' 'is noteworthy on two counts. First it engages the self of each of us since all are vulnerable to social cognition. But there is another self for whom vulnerability is of paramount importance. This other self is the patient. It is this 'self ' that medicine professes to serve that merits exploration.

Schweitzer's pre-occupation with the 'decay and restoration of civilization' began as the sun rose on the last century of the 2nd millennium. The genesis of Medical Aid in Dying came about as the sun set on that century. This opening Chapter invites the exploration of the most vulnerable self, i.e. the patient, as the sun rises on the first century of the 3rd millennium. The first step on this exploration begins in the next Chapter 'Philosophy in Medicine'.

Chapter 2

Philosophy in Medicine

> It is a lame creature who calleth himself a physician and . . . of philosophy . . . know her not. [1]
>
> Paracelsus (1493-1541)

I. Introduction:

Much has changed in the worlds of medicine and philosophy since Columbus discovered the New World the year before the birth of Paracelsus. What the Swiss physician - philosopher posed to his medical colleagues may have been daunting at that time. However, it must be considered more so some 500 years later for medicine today with its scientific advances could not have been imagined then. In addition, since every epoch in history stimulates thought, philosophy, too, has evolved. Thus, just as the task of 'knowing' medicine today is of a greater magnitude so, too, is the task of 'knowing' philosophy. In brief, there is so much more to know. But perhaps Paracelsus is wrong. A 'creature' who is a physician may not have needed to know philosophy then. And so, if not then perhaps not now.

Kolakowski (1927-2009) considered the thought of 23 great philosophers beginning with the pre-Socratic era of the late 6th and early 5th centuries BCE. Noteworthy is that 11 post-date Paracelsus - René Descartes (1596-1650) to Bergson (1859-1941). [2] Schwenkler, citing Kolakowski's 1982 Tanner Lecture 'The Death of Utopia Reconsidered', notes that . . .

> (p)hilosophers neither sow nor harvest, they *only move the soil*. They do not discover truth; but they are needed to keep the energy of the mind alive, to confront various possibilities of answering our questions. [3] (*Italics* added)

It would appear that philosophy, not being a practice, would

have nothing in common with medicine. However, tilling the soil is an essential part of cultivation. And so, philosophy does belong in the garden of humanity. Noteworthy is that truth is not discovered. And so, not everything can be discovered for some things are beyond our reach. Thus, that which is beyond our reach ought not be pursued. However, understanding, while always incomplete, is never beyond our reach. And so, tilling the soil resonates with the pursuit of understanding.

Schwenkler continues in noting that philosophy is neither a doctrine or even a method but rather an . . . "activity and state of mind: an inquisitive probing, a constant search for deeper explanations." [4] But is 'explanation' akin to 'discovery' and 'understanding'? Science in the medical realm carries explanatory power. It would seem more fitting to say that 'moving the soil' is an activity in pursuit of greater understanding rather than 'deeper explanations'. And so, if philosophy's home is in the garden of humanity, its role is to cultivate thought in the service of understanding. This was acknowledged in the Tanner Lecture in the following:

> The *cultural role* of philosophy is not to deliver the truth but to *build the spirit of truth*, and this means: never to let the inquisitive energy of the mind go to sleep, *never to stop questioning* what appears to be obvious and definitive, *always to defy* the seemingly intact resources of common sense, *always to suspect* that there might be "another side" in what we take for granted and *never to* allow us to *forget* that there are *questions* that lie *beyond the legitimate horizon of science* and are nonetheless *crucially important* to the *survival of humanity* as we know it. [5] (*Italics* added)

Noteworthy is the phrase 'humanity a we know it'. It is this 'never' and 'always' which 'moves the soil'.

Frankl has noted that physicians are not philosophers. However, he also notes that . . . "patients themselves bring us philosophical problems" [6] in the sense that patients present with questions that are ultimately but not exclusively philosophical. It is these questions that all humankind asks and which patients in particular either ask or are asked of them,

implicitly or explicitly, in facing critical illness. The question is: 'What is life asking of me?' On this Frankl cites the dramatist / poet Friedrich Hebbel (1813-1863): "Life is not anything, it is only the opportunity for something." [7] Thus, life is not simply a given but rather is an assignment. Frankl frames this in terms of responsibility to life rather than for life where 'responsibility to' is the assignment. It is here that meaning can be expressed. And so, concerning life as it presents itself to us, two 'responses' are put forth: one is '*to*' life, the other '*for*' life. [8]

Frankl's question resonates with Kolakowski's insight of science as both legitimate and limited, the latter indicating that there is a 'beyond' where science cannot go. It is this beyond which is 'crucially important' for human survival. But the modern physician is trained in and focused on questions (and answers) which lie primarily within the scientific realm. This is a reflection of the dominance of science in society. The 'beyond' is where we would rather not go but, in Frankl's view, it is where we are compelled to go. He notes . . . "medicine, and psychiatry in particular, has thereby been compelled to cope with a new field." [9] However, more than 50 years later, this, to a large extent, is still unchartered waters.

The conclusion is that philosophy does have something to say to medicine. However, philosophy, like medicine, has its own specialization, e.g. metaphysics (nature), existentialism (existence), and moral (human behaviour), epistemology (knowledge) and logic (reasoning) among others. This raises two questions: 'Which philosophy speaks?' and 'What does philosophy say?'

Medicine as a practice is about reasoning, human knowledge, human behaviour, human existence, and human nature. And so, the questions and the branches of philosophy speak to medicine and in turn medicine needs to not only hear but to listen. However, the voices do not always speak clearly, i.e. sometimes with reason and at other times with rhetoric. Nor do they always speak and listen to each other. Thus, it is for medicine to discern what its needs are, more specifically what are the needs of the patient for the physician's sole purpose is to serve the patient.

There are three ways to envision how philosophy can

relate to medicine. One can consider medicine ***and*** philosophy whereby the two are not only independent disciplines but estranged in the sense that there is no common ground. One can consider philosophy ***of*** medicine whereby medicine is the object of thought but not as a 'subject' with agency. Medicine, then, as a practice would be sacrificed for medicine as a concept. The third view is philosophy ***in*** medicine. It is this which will be engaged here for it gives each, i.e. medicine and philosophy, a place.

II. Philosophy ***in*** medicine:

It is here that medicine and philosophy not only co-exist but also find common ground. It is here that activity of the mind meets the practice of medicine. It is in this realm that the voices of philosophy speak to medicine and medicine listens. But philosophy has more than one voice.

The voice of epistemology (*epsitémé* - the Greek term for knowledge) is indispensable for without knowledge medicine cannot be. In medicine this *epsitémé* exists for the sole purpose of serving the patient. In medicine of our time this knowledge is largely a product of the scientific method applied to human biology. The strength of this knowledge is founded on experimentation which carries twin features of reproducible and verifiable information. This is science of causation whereby knowledge is gained by determining the pathway of disease and finding strategies to interrupt that pathway. Causation is at the beginning of science for 'discovering' the cause is the motive of science. Democritus (460-370 BCE), considered by many as the father of science, is accredited with the view that he . . .

> would rather find one *cause* than sit on the throne of Persia. . . . apparently realized that a man who learned to recognize precisely calculable causal connections would be mightier of the two, for though an emperor might command the lives and deaths of subjects, he would not know the source of his power. [10]
> (*Italics* original, Underline added)

This frames the quest for causation as a quest for power.

Science, thus, operates in the sphere of explanation governed by the intellect. This is the domain of the rational mind. The explanatory prowess of science in medicine is known as 'explanatory power' and reflects the goal of Democritus.

In a sense the person-as-patient is the substrate of this experimentation. The knowledge gained is human biology, i.e. our *bios*. While this provides enormous benefits to the patient, it says nothing about human life, i.e. *zōé*. This is important for *bios* subsists within *zōé*. This distinction is captured by the difference between 'disease' which occupies the realm of *bios* and 'illness' which occupies the realm of *zōé*. A disease is what a patient has; an illness is what a patient lives with. And so, while knowledge of *bios* is necessary, it is, in itself, insufficient.

Philosophy as logic is voiced by reason. It was Socrates who championed reason as the tool of persuasion. This was a departure from the Sophist School in which rhetoric was the tool. Sometimes rhetoric is dressed up as reason in which case one is not led but misled. In addition, a conclusion derived from reasoning requires that the premises connected in a syllogism be both well-defined and true. Errors occur in reasoning through rhetoric replacing reason or if premises are not well defined and true. Logic requires that one argue <u>to</u> conclusion <u>not from</u> conclusion.

Three other voices of philosophy in medicine merit more extensive consideration. Of the three, it is moral philosophy, i.e. ethics, specifically bioethics, which has priority of place in medicine at the close of the 2nd millennium. As the role of science and technology became more central bioethics also came to occupy a central place in medicine as a practice.

A. Bioethics:

Moral philosophy deals with matters of human conduct. Bioethics concerns itself with matters of human conduct in the medical realm. Moral philosophy apportions to itself the authority to make moral judgments. This carries enormous power. It is power which is a common denominator with explanatory power of science in medicine. However, the powers do not share common ground for the two features of scientific power, i.e. reproducible and verifiable, are lacking in

moral philosophy. While bioethics may not be immune to critique, it has become immune from accountability. It is this way because bioethics is not a practice.

An image of a 'door' and a 'window' illustrates this. The clinical encounter, i.e. the 'bedside', occurs when the physician or other health care provider and the patient enter the shared space though a 'door', albeit by different pathways. Both are participants in the encounter. In contrast, the ethicist looks at the 'bedside' through a 'window', metaphorically-speaking, and, thus, is an observer and not a participant. As a participant a clinician is accountable to the patient whereas an observer is not. This is the basis of the ethicists' immunity.

Stephen Toulmin (1922-2009) penned '*How Medicine Saved the Life of Ethics*' (1982) not as a question but as a statement. [11] This garnered much attention in the subsequent years. At a memorial held in his honour at the MacLean Center for Clinical Medical Ethics a colleague reversed the dynamic and posed it as a question: '*Did Ethics Really Save the Life of Medicine?*' Later Neuman (2015) rephrased the question: '*Can ethics save medicine?*' [12] She notes that . . .

> (a)fter the early decades of the 20th century, when ethics and the practice of medicine *institutionalized themselves* dogmatically pulling away from *public discourse*, medicine's advancements and changing landscape have dragged it back. [13] (*Italics* added)

And so, both medicine and ethics, having become 'institutionalized' and isolated, needed saving.

Scientific and technological advances contributed to the isolation of medicine. Ethics with its home in the academy had already been isolated from the public square. But bioethics moved from the academy where its function was analytical to the bedside where it identified itself as 'applied bioethics'. Caplan (2015) presents this as follows:

> *Bioethics* gained *social legitimacy* by not following the British *analytical philosophy* tradition into the ivory tower, but, rather the Socratic tradition of engaging the public in the *marketplace*. [14] (*Italics* added)

The emphasis on patient autonomy in the early stages of applied bioethics was an effort to address medicine's isolation and bring it back to the 'public discourse' and, at the same time, place ethics at the bedside.

However, by associating Socrates with the 'marketplace' Caplan misconstrues the Socratic tradition. While Socrates (470-399 BCE) was in favour of philosophy having a presence in the public domain, hence the importance of reason, his 'public square' was not the 'marketplace' but the academy. Kolakowski indicates that for Socrates the pursuit of truth was in the service of the good. (See Note 21.) However, the good pursued in the 'marketplace' is the pursuit of profit which can take several forms, e.g. money, prestige, or power. Bioethics in our time changed focus from patient autonomy to utilitarian theory whereby cost-benefit analysis became central. Thus, bioethics became aligned with the marketplace. (See Chapter 1.) A full reading of Caplan's 'Done Good' indicates that this is what bioethics achieved. This, he applauds. And so, Caplan's view of bioethics is revealing not for its association with Socrates but rather for its association with the 'marketplace'.

Where Caplan invokes Socrates, Toulmin turned to another Greek philosopher Aristotle (384-322 BCE) who follows a century after Socrates but in the same tradition of respecting reasoned discourse. He notes this in the following:

> By introducing into ethical debate the vexed topics raised by *particular cases*, . . . (medicine) has obliged philosophers to address once again the Aristotelean problem of *practical reasoning* which had been on the sidelines for too long. [15] (*Italics* original)

Toulmin's view is that it was through the return of practical reasoning, a reasoning that is characteristic of and necessary for medicine, that medicine as a practice saved ethics from the 'ivory tower of British analytical philosophy'. The discourse within ethics subsequent to Toulmin's 1982 article is noteworthy.

Several years ago the Board of Trustees of the University of Tennessee decided to 'discontinue academic units', specifically the Medical Ethics Department. The void

was to be filled by senior physicians mentoring physicians-in-training. The response of the Department noted that ethics had become a standard component of the medical school curriculum. More relevant was the Department's comment that there were no physicians with advanced qualifications in ethics at the institution implying that no physician could 'qualify' to be mentors. But this argument cuts both ways and more sharply in the opposite direction. Do the 'ethicists' at the institution have any advanced training in medicine? This is a grave shortcoming for anyone trying to understand the clinical encounter and teach the ethics of that context. Furthermore, this gap could be closed in one direction, i.e. medicine to ethics, far easier than in the opposite direction. Using the same logic as the respondent, a negative response would preclude them from a teaching role in the medical curriculum.

But problems exist even for those who hold dual 'qualification' for one has to decide which role is being fulfilled at the bedside - participant or observer - and whose interest is being served - patient or institutional? Aristotle's practical reasoning noted above speaks to this observer - participant element. A further concern, not unrelated to the above, is what 'ethics' would be taught for there are several ethical theories, e.g. utilitarianism, virtue ethics, etc. In addition, there are no standards by which to measure ethics. And so, the issue is not simply ethics in the medical curriculum but which ethics. The perspective of French philosopher Alain Badiou (1937) is germane to this.

Badiou has critiqued bioethics (2001) on the grounds that it has considered the person as an object and not as a subject. But this did not happen overnight. Badiou cites three sources which articulate this development. He notes that the French philosopher Michel Foucault (1926-1984) considered . . . "(m)an, in the sense of constituent *subject*, was a *constructed historical concept* peculiar to a certain order of discourse." [16] (*Italics* added) In this view man was not a subject with agency but an object of a social construct and destined to function within that construct.

Louis Althusser (1918-1990), a colleague of Foucault, held the view . . .

> that history was not, as Hegel . . . thought, the absolute development of Spirit, nor the advent of a *subject - substance* but a 'process' *without a subject,* and which could be grasped only through a particular *science*, the science of *historical materialism*. [17] (*Italics* added)

Here, too, we see that man is not a subject but merely an ingredient in a scientific matrix called history. This relates directly to modern medicine whereby the person-as-patient is reduced to its material part, i.e. the body (*bios*), in a process called scientific materialism.

A third source is the French psychiatrist Jacques Lacan (1901-1981) who, in critiquing psychoanalysis, showed in Badiou's opinion, that the patient was a . . . "subject without substance or 'nature', being a function both of the contingent laws of language and of the. . . history of objects of desire." [18] Common to all three is the marginalization of the subject. While bioethics did not create this situation, neither did it address the matter. Rather it continued in this trajectory. This, in part, is the basis of Badiou's criticism that bioethics treated the person as an object to be acted upon and not as a subject with agency.

But this is not a claim without foundation or a foundation among philosophers only or the occasional clinician. The convergence of bioethics and managed medical care in the 1990s culminating in the study (2015) led by an institutional-based ethicist showing cost savings of palliative care published on the eve of the MAiD legislation (2016) exemplifies this stance toward the patient as an object rather than as a subject. (See Chapter 1, Note 10.) This 'activity', the product of an alliance between bioethics and corporate interests, suggests, contra Kolakowski, that philosophy as bioethics is more than 'moving the soil'.

Comment:

Toulmin's view was that medicine and ethics were linked such that medicine saved ethics. However, this relationship takes on a new perspective when seen through the lens of history of 30 years and more since. Neuman engaged

the same medicine - ethics dynamic but framed it differently in two ways: reversal of subject and object and in the form of a question - '*Can Ethics Really Save the Life of Medicine?*' This question cannot be answered definitively and perhaps was not meant to be. However, it does invite reflection on ethics and medicine. In this regard several points are noteworthy.

In the early days of its ascent in the 20th century the voice of bioethics spoke of patient autonomy. However, in the later decades it spoke of utilitarian ethics which is the language of cost - benefit analysis. This moved ethics from the bedside to the boardroom from which emerged managed medical care (MMC) and resource allocation with the *moral imprimatur* of bioethics. And so, while medicine may have saved ethics as *per* Toulmin's view, medicine enabled bioethics to operate in a similar manner as other aspects of the modern world. This way is unreservedly endorsed by Caplan's 'Done Good'. However, this voice speaking the language of MMC has brought serious challenges to medicine's traditional ethos and, hence, to medicine as a practice. This is the background out of which Neuman's question emerged.

Borrowing a term from the British philosopher Michael Oakeshott (1901-1990), Pellegrino (1920-2013) sees medicine as an encounter *interhomines* which he (Pellegrino) considers to be a moral encounter. [19] Cassell also sees medicine as a moral encounter in that it is a . . . "moral enterprise devoted to the welfare of the patient." [20] This suggests that ethics not only has a presence in this encounter but is at its very centre. However, as noted, the ethicist is not a participant but an observer.

Another way to characterize this distinction between clinician and ethicist is to frame the matter in terms of 'analysis' and 'synthesis'. A physician analyzes the history, physical examination, and laboratory data to arrive at a synthesis aimed at a practice. An ethicist does an analysis of what was observed but no synthesis for even in 'applied bioethics' ethicists, being observers, do not practice. However, the power that ethics wields plays a role in that it seeks to inform the practice of medicine. But the knowledge gained as an observer is not knowledge learned through a practice. This

speaks to Aristotle's 'practical reasoning'. A further note of importance is a corollary of practice which is accountability. This also separates the physician from the ethicist.

And so, as the sun set on the 20th century and rose on the 21st rather than medicine saving ethics one can consider that bioethics placed medicine in jeopardy. This casts doubt as to any affirmative answer to Neuman's question. Without denying the validity of the view that medicine is a moral encounter, what is suggested here is that bioethics is miscast as the solo voice of philosophy at the bedside, i.e. in medicine. It is this way for while an encounter *interhomines* is a moral encounter, it is that and more. While ethics has a legitimate presence in the clinical encounter, the moral framework cannot itself completely characterize this encounter.

With respect to 'philosophy in medicine' the bioethics experience invites looking elsewhere in order to find how philosophy can 'move the soil' and contribute to the cultivation of medicine as a practice in a manner which honours the medical profession's traditional ethos of serving the patient without which medicine cannot exist. In this regard the two remaining areas of philosophy merit consideration.

B. Metaphysics in medicine:

'Metaphysics' is a composite of two Greek terms '*meta*' and '*physics*' where *meta* carries the literal sense of 'after', 'behind', or 'among' and *physics* the physical universe which includes the physical being of man (as *anthrōpos*). '*Meta*' as 'mind', and 'potentiality' suggests that we are more than *physics*, i.e. more than what we manifest. Metaphysics is the branch of philosophy that examines the fundamental nature of reality including the relationship, between mind and matter, substance and attribute, and potentiality and actuality where 'physics' is 'matter' and 'attribute' is its manifestation', i.e. the 'actuality' of matter. And so, nature, i.e. the nature of our reality, is more than what we see. In brief, the world and those in it are more than what it appears to be.

However, not only are there many ways of comprehending the universe and those in it, each of us has a 'certain' view of that universe. The term 'certain' can be

understood in two ways. One is a 'particular' view of the world. The other is that this view is 'definitive' whereby the particular is 'certain' in that it is 'certified', 'verified', and 'true' and, therefore, irrefutable and beyond modification.

Two important points are noteworthy here. Every epoch in history espouses a metaphysics. In addition, each of us has a view of how the world is supposed to be. This presupposes a metaphysics i.e. a view of reality not as it actually is but as potentiality which is harboured in the mind. While this may not be acknowledged or expressed, it is, nevertheless, present. There are no metaphysical voids either culturally or personally. However, when the 'particular' becomes 'definitive' metaphysics takes on the aura of a religion in the sense of 'to be bound to' (*re ligare*) and generates a doctrine. It, thus, becomes prescriptive rather than descriptive.

Kolakowski's review of the great philosophers is relevant as it presents, albeit briefly, how philosophers of note over 24 centuries have understood reality. While the scope of Kolakowski's work is beyond the capacity of this document and this writer, it is worthwhile, nevertheless, to consider some comments in his text that are relevant to medicine. He begins by noting that the younger Socrates sought truth through the physical reality of the universe, i.e. the changing world**,** whereas the mature Socrates pursued truth in the world of ideas. This was not an abandonment of the physical for the abstract but a movement whereby the physical, i.e. practical, and the abstract, i.e. ideas, informed each other. Medicine as a practice is such an example.

For Socrates the truth that mattered was always the truth about the good life. This involved the use of reason in learning to distinguish between good and evil. This pursuit was not for its own sake but rather to learn how to serve the good. On good and evil Kolakowski notes that . . .

> what we call good and evil is not a matter of convention or agreement, nor even the result of divine decree. The sacred or good is that which is sacred or good in itself. [21]

He attributes to Socrates the view that evil arises through ignorance, i.e. failure of reason, and not the will, i.e. a

voluntary choice of an informed will. The key elements of his distinction are 'reason' 'will', and 'informed'.

In contrast, Schopenhauer (1788-1860) saw the world not as willed but rather as a world without intention and, therefore, is merely a blind, aimless and an impersonal all powerful force upon which everything depends but which itself depends on nothing. The world simply is. Everything is governed by necessity. For Schopenhauer the true reality is the world that is independent of our mind, and, therefore, the 'will' is unknowable, aimless, and impersonal. Kolakowski comments:

> Here is true metaphysical horror. We cannot subject this will to our control and we cannot know anything about it, and yet we must believe that it is will, and nothing else. [22]

And so, if all is necessity there is no intention. Thus, contra Socrates, the world of the good is not learned. And if not learned, then, reason is not necessary. The most fundamental drive of humanity, then, is to survive.

This void is occupied by Friedrich Nietzsche (1844-1900) [23] for whom, contrary to Socrates, there is no distinction between good or evil. And so, power is neither good nor evil but simply necessary for survival. The 'will-to-power' is the fundamental feature of Nietzsche's metaphysics. It is a drive and not a choice and, as such, fuels the scientific evolutionary theory of Darwin.

Kolakowski then proceeds to the thought of Henri Bergson (1859-1941). [24] It is here that human consciousness, i.e. the human mind and spirit, come together and operate with but independently of matter. Since human consciousness is free, it creates new things. However, matter can neither create, anticipate, nor predict. And so, 'what is' is because of a mechanistic process driven by energy but not directed by purpose other than survival. If everything exists by necessity and will-to-power, existence, then, has no meaning other than what meaning we give it. The will wants only to survive and has no interest in finding meaning in that existence. Therefore, asking questions of meaning is meaningless. But for Bergson the mind and spirit, while independent of matter, are not

foreign to matter. Thus, we do not live by necessity but by choice.

In contrast to Nietzsche's 'will-to-power' and Schopenhauer's 'reign of necessity' governing reality including evolution on the one hand and to Socrates on the other, Bergson saw the world as a 'creative process' driven by a divine conscious energy via a struggle of will with chaos. This is not a mechanistic process that is powered from outside the mind for such a process destroys creativity. Bergson is the last stop on Kolakowski's philosophical journey. (See Note 2.) However, the journey does not end there for philosophy continued. In this regard the thought of Martin Heidegger (1889-1976) contributes to the discourse on metaphysics.

Thomson notes that metaphysics for Heidegger is not simply a concern of philosophers isolated in an academic environment. Rather . . .

> (m)etaphysics grounds an age . . . . (B)y giving shape to our historical understanding of 'what *is*', metaphysics determines the most *basic* presuppositions of what *anything* is, including ourselves. Western humanity . . . is in every respect sustained and guided by metaphysics. [25] (*Italics* original)

Thomson continues by noting that in Heidegger's view the . . . "metaphysical tradition establishes the *foundations* for every epoch of intelligibility . . . of our changing historical sense of what is." (p.9, *Italics* added) Note that while history brings changes to the intelligibility of an epoch, metaphysics provides a foundation of that intelligibility. While this foundation is a constant in that it is always present, its content is not fixed or static but rather also open for interpretation and understanding. This is the 'intelligibility' which speaks to the basic human desire to know in the sense of to comprehend or to understand. The object of this 'intelligibility' is an understanding of what it means for something to be. Thomson cites Heidegger: " Metaphysics is the truth of the *totality* of entities as such." (p.11, *Italics* added) Since this truth is the 'totality', it is not limited to '*physics*', i.e. the physical universe or as applied to medicine the biology (*bios*) of human existence, but also includes '*meta*'.

The cornerstone of Nietzsche's metaphysics is the sovereignty of the will which is manifested in the exercise of the 'will-to-power'. This resonates with Democritus's desire to know the cause of reality for therein lies power. This metaphysics of a 'sovereign becoming' is a false construct on two related grounds. First it is a construct that involves physics only. It is also false in that it ignores all that is 'after' / 'behind' / 'among ' (*meta*) physics. But in this construct not only is physics all there is, physics is all there needs to be. The Nietzschean construct . . . "enact(s) the final fulfillment and collapse of metaphysics." (p.21) This unravels metaphysics such that physics alone is left standing and stands alone. Philosophically, Nietzsche inaugurates the era of 'physics' in that physics is the sole determinant of 'what is'.

1. Metaphysics and technology:

Heidegger understood Nietzsche's philosophy as a . . . " 'being of entities' as will-to-power with no end (goal) other than self-augmentation by which . . . forces perpetuate themselves." (p.44) Two components are noted here: 'will' and 'power'. The problem lies not with power itself for humanity depends on the exercise of power. Nor is the will in itself a problem. However, the end which power serves and the will seeks can be problematic. In Nietzsche's 'will-to-power' the will is aligned with power such that it is not only a single entity but enjoys sovereignty, i.e. it is the only reality. Thus, it operates with complete autonomy and independence. The problem is that will-to-power may usurp the pursuit of the good which is the core of Socratic thought. Heidegger foresaw that the will-to-power would become permanent. All reality, then, would be constructed on this basis. Note that for Socrates reason was involved in learning to distinguish between good and evil.

The success of this Nietzschean concept produced our current understanding of being which is described as . . . " 'ontologically reductive' by which is meant that all entities, including man as *anthrōpos*, are treated merely as resources to be optimized with 'maximal efficiency". (p.44) In brief, we are not just treated objectively but are treated as objects. And

so, since everything is an object, everything is meaningless. It is this way because meaning is not discovered but rather is revealed. Moreover, meaning exists in order to be acted out. This requires that a person be a subject with agency. But treating a person as an object precludes such agency. Heidegger holds Nietzsche's . . .

> metaphysics responsible for our nihilistic "*technological*" understanding of the being of entities and its devastating historical consequences. (p.44, *Italics* added)

The result is that a technological understanding of 'being' leads to a " technologically-levelled world civilization." (p.41) This metaphysics, characteristic of the atomic age, is even more prominent in the digital age of our time.

But what do we mean by 'technology'? Weber and Habermas see the essence of technology as . . ."rational control and efficiency." (p.49) Heidegger sees it as 'the reduction of everything to functions and raw materials'. (p.49) These views are not mutually exclusive but compatible. Heidegger and others before him, saw . . .

> technology as an 'autonomous force separate from society, . . . impinging on social life from the alien realm of *reason*'. . . . (T)he essence of technology seems to be *shaping history from outside*, *imposing itself* as though from some metaphysical beyond that entirely escapes human control. (p.49, *Italics* added)

One can understand 'reason', as used here, is in contrast to the Socratic sense of reason as pursuit of the good in which human agency occupies a central place. However, Heidegger suggests that technology is so dominant in our lives that human agency is compromised by the very product of reason. The product of this reasoning is a functional understanding of the universe and all that is in it such that all entities, including man as *anthrōpos*, are 'valued' through the lens of function.

In this world Heidegger sees . . . " a 'technological' understanding of the being . . . no longer in the service of any person or goal. . . . (but) increasingly stripped and divested of their meaning." (p.22) A pre-occupation with measurement which technology demands relates to this lack of meaning. This

renders entities less than what they actually are. Wittgenstein's '*paradox of the measure*' speaks to this error. Thomson puts this somewhat awkwardly but with significance as follows: "(T)hat which defines the measure cannot be measured *meaningfully* by the metric it defines." (p.52, *Italics* added) I take this to mean that defining humanity by measure cannot be done meaningfully for there is no meaning in measure. An so, to 'define' humanity as a measurement is to remove any possibility of meaningfulness for one's existence.

Two points are worthy of note here. Measure cannot define for it only circumscribes what it measures. But what is measured is, in reality, beyond measure for humanity is immeasurable. But in a universe dominated by *ratio*, understood as a calculation, everything is reduced to its measure. However, such an approach does not 'capture' the essence of being. And, yet, in another sense the use of the term 'capture' is appropriate because it carries the notion of imprisonment, i.e. measurement imprisons being within the confines of the measurement. By merely circumscribing the entity (object) measured one comes to only 'know of ' that something that is measured but not 'know' that something.

The leads to the second point which is that the essence of what is measured cannot be known by its measure. It is this way for meaning cannot be uncovered, understood as discovery, but rather is revealed, understood as unveiled by reality. But the term 'measurement' itself has boundaries beyond which it cannot go. Therefore, the reductive thinking that is calculative confines one to these parameters outside of which nothing exists and inside of which nothing has meaning since meaning defies measurement.

And so, this reduction of man as *anthrōpos* to a measurement leads, on the one hand, to a meaningless existence for there is no meaning to unveil and, on the other hand, to an existence solely determined by function. This is to treat man as an object to be acted upon and not as a subject with agency. The object's 'agency' is strictly functional in which the function is determined by forces outside of the self. In a metaphysics reduced to a calculation there is place for function only but no place for meaning. Thus, the legacy of

technology is twofold: function and meaninglessness. These are the metaphysical pre-suppositions in technology.

And so, measurement merely circumscribes an entity but entities that are animated surpass such circumscription while living in a scientific matrix that is measured. Coupled with this shortcoming is Heidegger's view that we are shaped by what we know. And so, if what we know is determined by technology, then, technology, while not actually shaping who we are for that it cannot do, shapes our world-view. This is the 'technologically-levelled world' noted above. While some may not see themselves and others that way, in such a climate when dominant others see us that way. In brief, while that may not be one's world-view, in a technological world it is the world's view.

2. Nietzsche's metaphysics and medicine:

Both science and technology have been a part of humanity for centuries with its reach always expanding. Beginning in the 16th century this reach gained momentum. [26] Several centuries later this prominence continues to expand. Common to both is that neither consider the person as a subject with agency. However, while science considers the person objectively, technology considers the person more as an object. Science differs from technology in that it is a process whereas technology is aligned with technique which generates the notion of tools understood in the human context as instruments.

The activity of science as it pertains to medicine is to determine the pathway of disease and explore ways of interrupting that pathway by eliminating or mitigating the negative sequela of a defective pathway. The scientific process, then, is a process of experimentation. In this process the person as patient is treated objectively so that the information forthcoming will be reliable. Explanatory power is assigned to science on the basis that this information is reproducible and verifiable. This is the science of causation which resonates with Democritus' quest for power noted above. It was in the last quarter of the 20th century that technology came to occupy a central place in our consciousness and in society. This central

place was especially relevant to medicine. (Chapter 1, Note 3) While Heidegger did not live to see the pervasive presence of technology in the closing decades of 20th century, his understanding of technology was prescient for it resonates with what would come later.

The 'foundation of intelligibility' in Nietzsche's metaphysics is the 'will-to-power'. In this intelligibility reality has no inherent meaning. This is the 'sovereign becoming' of the Nietzschean construct. In the context of medicine this leads to Angell's 'meaningless suffering' and to 'pointlessly living'. (Chapter 1, Notes 1 and 6) In essence Medical Aid in Dying is a claim to sovereignty in the face of suffering as a meaningless reality. But in exercising this claim Medical Aid in Dying forecloses on any future sovereignty. This is Pellegrino's 'exercise of freedom to end all freedom'. Thus, the Nietzschean doctrine of 'will-to-power' aligns with a rationalization of active euthanasia.

The 'objectification' of science is a necessity and not a choice. The role of the experimental process is to serve human biology, i.e. our *bios*. But biology is not who we are. It only appears that way in the sense that *bios* is how we present ourselves physically to the world. Biology is situated within life (*zōé*). This *bios - zōé* reality resonates with metaphysics whereby *bios* (the physical) is 'physics' which is measurable and *zōé* is '*meta*' which is immeasurable. But in a technological era such as ours what is immeasurable has no standing. And so, to the degree that medicine separates biology and life the patient as subject is not served. This separation, characteristic of modern medicine, presupposes a metaphysics which can be traced back to Nietzsche's 'will-to-power'. And so, metaphysics is relevant to medicine. But which metaphysics might that be?

3. Rehabilitating metaphysics:

Heidegger sees Nietzsche's metaphysics of the 'will-to-power' as having the potential to alter metaphysics. There is no room for a new or renewed metaphysics to replace that of Nietzsche for through him that room has been closed, the door locked, and the key discarded. Thus, no new epoch will rise out of the ashes of Nietzsche's eternally recurring 'will-

to-power'. It has been said that Plato (428/27-348/47 BCE) was the first metaphysician and Nietzsche the last. If Nietzsche is to be the last metaphysician, it seems, then, that we are obliged to accept his sovereignty of the will.

But Heidegger seeks to go where Nietzsche would not. Thomson notes: "Heidegger's deconstruction of metaphysics clears the way for recovery of what remains of any original understandings of being." (p.39) What is deconstructed is Nietzsche's metaphysics allowing, then, for the 'original understandings of being' to emerge. Heidegger sought the source, i.e. the original thought, upon which one could build. His 'deconstruction', then, is a re-construction in the light of the past shone on the present.

This led Heidegger not to Plato but to Heraclitus and Parmenides, two 6th - 5th BCE Greek philosophers. However, the paths proposed by these two philosophers who pre-date Socrates were not pursued either by their contemporaries or by their successors. Thomson cites Heidegger:

> In the inception of its history, 'being' clears itself as emerging (*phusis*) and disclosure (*alétheia*). From there it acquires the cast of presence and permanence in the sense of enduring (*ousia*). Thus begins metaphysics proper. (p.40, *Italics* original, Underline added)

Heidegger names this . . . "the inceptive essence of being." (p.40) Thus, Heraclitus and Parmenides, not Plato, can be considered the first metaphysicians.

Heraclitus contributed *phusis* (emergence) and Parmenides *alétheia* (disclosure). *Phusis* is understood . . . "as a 'self - opening unfolding' or 'self - blossoming emergence' of . . . intelligibility (of what presents itself to us)." (p.40) Heidegger views Parmenides' *alétheia* (truth) as 'unconcealment' or 'disclosure'. (p.40-1) *Phusis* (emergence) can be seen as the physical which is discovered as in measurement by science and used by its offspring technology. *Alétheia* (truth) can be understood as revealed as in meaning of that which cannot be discovered, i.e. cannot be measured.

Heidegger's metaphysics, then, is a re-construction grounded in the twin pillars of 'emergence' and 'disclosure' first put forth some 26 centuries past. This returns

metaphysics to its roots. And so, in Heidegger's 'construct' that which 'emerges', i.e. reality, is presented to us and carries within it, i.e. 'discloses', a truth. Thus, truth is what is disclosed in what appears to us, i.e. in what is presented to us. This introduces the idea of 'unconcealment' or 'presencing' understood as being present to what emerges. It is this 'presencing' (being present to) which can play a role in a metaphysics of medicine whereby biology as *bios* is 'emergence' (*phusis*) and life as *zōé* is 'disclosure' (*alétheia*). The two - emergence and disclosure - are not separate but one. And so, *bios*, i.e. biology, is not merely what we appear to be but within that appearance lies a truth of who we are.

Comment:

The relevance of this to medicine becomes clear when we consider 'disease' and 'illness'. Disease (what a patient has,) pertains to *bios* whereas illness (what a patient lives with) pertains to *zōé*. Disease is what emerges (*phusis*); illness is what discloses (*alétheia*). The former pertains to discovery; the latter to revelation. It is in revelation that the meaning of what is discovered is situated. Seen this way medicine is a metaphysical encounter. It is the physician's humbling privilege to participate in this encounter.

Three points are worthy of note. Metaphysics puts to question the notion that frames medicine as a moral encounter. While medicine is a moral encounter, to consider medicine solely or even primarily through the lens of ethics fails to see the patient in the fullness of the person and, hence, affects medicine as a practice. And so, while ethics is germane to medicine, it does not encapsulate the whole of the person or of medicine. In brief, the person is more than ethics and so, too, is medicine. Second ethics is about function as in human conduct, i.e. 'what a person does', whereas metaphysics is about 'who a person is'. The disease - illness dyad is another dimension of this distinction.

Finally, the alliance of ethics with technology and corporate interests at the close of the 20th century exhibited the preoccupation of ethics with the person-as-object rather than the person-as-subject. This is significant for it means that

ethics cannot stand alone or even stand out in the sense of standing above other aspects of philosophy, e.g. metaphysics. On ethics and metaphysics Platt notes: "Metaphysics is a *person* without whom *no ethicist can reach conclusions*, yet he or she is ashamed to be seen in public with that person." [27] (*Italics* added) Platt characterizes metaphysics as a person. Understood in its narrow sense this is incorrect; however, it does reflect that metaphysics is personal.

While metaphysics puts questions to ethics, it has its own internal question: 'What metaphysics might that be?' Nietzsche bequeathed a 19th century metaphysics to the 20th century. Medical Aid in Dying is a product of this metaphysics and so, it is a legacy, in part, of Nietzsche's thought. As a response to this question the introduction of 'presencing' in Heidegger's metaphysics suggests a way forward. However, there is more philosophy to consider.

C. Existentialism:

In the latter years of his life Gabriel Marcel (1893-1973) penned Problematic Man (1967) where he notes that in antiquity man as *anthrōpos* asked questions of himself regarding origins, nature, and destiny. In posing these questions the inner mirror reflected an image in which the self was recognized *but* was not disturbed. Just as such questions have been asked of man throughout history, so, too, are they asked today. However, Marcel notes that today differs from antiquity. The difference being that in the closing decades of the 2nd millennium man does not recognize the reflected image and is thereby disturbed. Marcel describes this disturbance as interrogative in that it asks '*Who are you?*', '*Where are you from?*' and '*Where are you going?*'

But man cannot provide an answer. And so, humanity has moved *from* recognition of self and lack of disturbance *to* disturbance due to lack of recognition. Thus, our existence is called into question. In brief, man is a stranger to himself; he is alienated. This weakens the sense of personal dignity and spawns a sense of meaninglessness. This is a consequence of what Marcel calls 'metaphysical necrosis'. While Marcel's critique of metaphysics may differ in language from that of

Heidegger, both trace this metaphysic wasteland to Nietzsche. However, instead of seeing Nietzsche in a negative light only, Marcel sees him as a major intellectual force who contributed to a renewal of the intellectual horizon not by the content of his metaphysics but rather but by the vacuum that his metaphysics created. Of this 'intellectual force' Marcel notes: "A higher demand of intelligibility arises in us to which the answers of science can provide no genuine satisfaction." [28] Heidegger is part of that 'renewal' which seeks to fill the vacuum.

This renewal was provoked by a huge devaluation whereby former values were no longer acknowledged and were, in fact, disintegrating. Values that were previously endowed with independent reality were now created by man. This is Nietzsche's 'will-to-power'. Where Marcel sees this renewal stimulated in part by science, his contemporary Heidegger sees technology as the stimulus. But science and technology have much in common in this regard. Both are incompatible with human agency. For science this is by necessity, i.e. as a consequence of experimentation, which requires engaging the research subject objectively whereas for technology it by choice, i.e. treating man as an object to be acted upon or merely as an instrument of technology but with no internal agency. And if there is no internal agency there can be no meaning.

While science and technology give man more agency in the sense of function, this is understood primarily, if not entirely, in mechanical terms. Neither furthers purpose or meaning of that agency. And so, in a situation where science and technology dominate, man is increasingly seen solely as a functional unit whereby science and technology become the norm. In a world in which the functional triumphs all planes, the meaning of being is reduced to, identified with, or even subsumed into function. This is the triumph of utilitarianism, a concept which came to dominate bioethics as the 2nd millennium closed. This ideology of function is pervasive in that it is organic, psychological, social and professional. This generates what Marcel calls an 'uneasiness'. He describes this dominance as follows:

(A)n impression of oppressive sadness . . .

> emanates from a world centred upon function. . . . There is the dull, intolerable malaise felt by . . . one who sees himself reduced to living as if he were . . . identical with his functions. (p.138-9)

But this uneasiness is not a cause but an effect of a cause which lies outside of the 'patient'.

> Marcel continues noting that . . .
> (t)his malaise suffices to prove that there is an . . . error or abuse of interpretation which a more and more inhuman social order, and a philosophy inhuman as well, have . . . tended to instill in *defenceless intelligences*. (p.139, Italics added)

The source, then, lies in the interpretation in the sense of what role is given to science and technology. This role is 'inhuman' on three fronts, psychological, social and philosophical, each of which overwhelms man's intelligence. Worthy of note is that Marcel sees that philosophy was, at least in part, responsible for this 'ideology'. This resonates with what Kolakowski says about philosophy and philosophers. (See Notes 3-5.)

Marcel notes that the abstract thinker operates without worrying about the needs or dispositions of one's being. However, the thoughts of the existentialist are influenced, if not determined, by the tasks and difficulties of one's life. These thoughts are at the service of one's own existence. And so, unlike the abstractionist who is disinterested, the existentialist cannot but be interested for one is deeply committed to and interested in something which is at the heart of one's own existence. As a practice medicine does not deal with the abstract.

These existential thoughts also provoke an uneasiness, that differs from while, at the same time, accompanies, the uneasiness provoked by the ideology of function. However, the two are interdependent. Marcel sees this uneasiness of science and technology in a positive light as noted in the following:

> (I)t is . . . *uneasiness* which is the inner spring of . . . progression, and no matter what those say about it who, in the name of a technocratic ideal claim to prohibit it, man cannot lose this *stimulus* without becoming *immobilized* and

dying. (p.143-4, *Italics* added)

On first reflection this reveals a profound ambiguity in the heart of man, not in the abstract sense, i.e. in the essence of humanity as classical philosophy would have it, but in the reality of one's existence as *a* person. This ambiguity demands resolution for just as power abhors a vacuum neither can this ambiguous uneasiness exist without being addressed. Marcel sees that this uneasiness as a stimulus.

Uneasiness comes from two sources. One is an uneasiness of dysfunction which relates to disease. The other is an existential uneasiness which relates to illness. While the dual uneasiness may be interdependent, the relationship is not one of equals for we live in a time of scientific progress and 'metaphysical necrosis' where function occupies primacy of place if not the entire place. To address this imbalance philosophy will need to rehabilitate metaphysics. This, it seems, was Heidegger's intent. But our concern here is the existential in the context of medicine as a practice and, therefore, is more immediate.

However, as noted, uneasiness is also a stimulus to overcome immobilization. This mobilization can be seen as 'aspiring to be-come'. This resonates with the patient as a person-with-an-illness who is simultaneously situated in the 'dysfunction' of a person-with-a-disease and, therefore, has uneasiness on both accounts. When science and technology is successful the uneasiness of disease is alleviated. However when its explanatory power is limited an uneasiness not only remains but becomes prominent as the patient lives with illness.

The uneasiness of dysfunction then comes to be seen as pathological which carries an imperative of intervention. In today's world this 'pathology' is medicated with drugs such as Librium, a 'label' derived from the term 'equilibrium' and Atarax derived from the Greek '*ataraxia*' which means 'calm'. Each is meant to counteract a 'disequilibrium', i.e. an uneasiness. Marcel describes this as 'quietism' which becomes the standard of normalcy. This stance is aided by our trust in science and technology to meet all our needs which when unmet receives symptomatic treatment.

But Marcel suggests that replacing uneasiness with

'quietism' neutralizes the stimulus that accompanies uneasiness and which motivates an active engagement of life. While the reflective physician may be inclined to discern between the negative and positive constructs of uneasiness, the scientific and therapeutic imperatives discourage any such discernment and encourage only the uneasiness of dysfunction which must be neutralized by whatever means possible. In the context of alcohol and drug addiction this 'quietism' becomes *primum non nocere* manifested as 'safe drug sites'. This is an example of metaphysical weakness operating in the context where scientific strength is no longer present. This 'weakness -strength' dyad is the context of medicine today. And so, physicians and patients face metaphysical challenges when scientific strength has been exhausted. In brief, uneasiness does not lead to stimulus but to 'quietism'.

In the context of illness thoughts turn to existence in a very focused manner. Thus, the person-with-an-illness operates in an existentialist mode for the patient cannot but be interested in her / his existence. It is this which makes the 'bedside' an existential encounter. It is this way because it is here that the patient confronts the limits of existence. The uneasiness of the existential realm is one of 'aspiration of being' in the sense of 'be-coming'. This is not the 'quietism' offered by Librium, Atarax and other symptomatic measures. This uneasiness is not within the reach of the authority and certitude of explanatory power of science and technology for it extends beyond biology (*bios*) to life (*zōé*). Nor was this uneasiness engaged by bioethics. Moreover, it lies not outside, as in beyond, ethics but rather beneath, as in primary to ethics. But existential uneasiness cannot be ignored by medicine for it speaks to medicine through the voice of illness.

Just as Marcel saw a positive uneasiness grounded in function, so, too, there is a positive in the limits of science. This positive directs us to the door of the narrative. Since each person's narrative is unique in person, place and time, the words of Heraclitus "One cannot step into the same river twice" ring true. The narrative of the person-with-an-illness belongs to that patient. It is this way because the illness belongs to that patient. It is in this narrative that the person-as-patient is no longer an object as technology would have it or is treated

objectively as science would have it but becomes a subject with agency. Thus, the patient narrative fosters agency. It is this agency that the stimulus of uneasiness motivates.

This introduces the notions of text and context. The foundational feature of an existentialist stance is a deep interest in something that is at the heart of one's existence. This makes the patient an existentialist. While the narrative is the text, this existence is contextual. For a patient the immediate context is disease and / or illness. But this context comes with an understanding of the world, i.e. how we see the world, which informs how we engage that world. It is also the lens through which the world sees us. In our time the lens through which we view the world is the lens of science and technology. Moreover, it is the only lens for alternative views available in the past, e.g. metaphysical, are presently dysfunctional. This is the 'metaphysical necrosis' noted by Marcel.

Uneasiness, then, becomes not a problem to be solved and medicated by science or by default to be ignored but rather may become an opportunity to fullness. In closing Marcel notes:

> Philosophies of existence founded on anguish have seen their day. . . . (I)f they can renew themselves, it . . . does not exclude uneasiness. . . . For this uneasiness is . . . the *aspiration* of a minus - being towards a plus - being, and it is quite possible that it can only find its term beyond the narrow limits within our . . . existence. (p.143, *Italics* added)

For Marcel 'uneasiness' is the inner spring of a voyage which serves as the springboard (stimulus) for motivation (aspiration) from a 'minus' to a 'positive' existence.

III. Conclusion:

Rather than being philosophers Paracelsus's view was that physicians should 'know of ' philosophy. The basis for needing to 'know of ' philosophy is, as Frankl has noted, that patients come with philosophical concerns. But centuries before Paracelsus the Roman-Greek physician-philosopher Aelius Galenus (129-216 CE) noted that . . . "the best physician

is also a philosopher". [29] However, Kolakowski's view is that philosophy, not being a practice, excludes philosophers from being physicians. But this does not make the two incompatible or antagonistic for medicine 'sows and harvests' while philosophy 'moves the soil.' And so, Paracelsus is more, not less, relevant.

The notion 'know of ' is relevant to medicine in our time in two ways. Science gives 'knowledge of ' disease in the sense of how what is came to be. But science does not provide 'knowledge of ' illness for this only comes about through the experience of living with what is. This lived experience is illness. Only the patient can 'know' illness. And so, philosophy has a legitimate presence in medicine as a practice. But what might that presence be?

While what has been presented here falls well short of expectations of a philosopher, it is intended to give one a 'knowledge of ' philosophy compatible with a standard set by Paracelsus. Looking at philosophy through a prism brings to light five 'colours' of the philosophical spectrum that pertain to medicine - not to medicine exclusively but to medicine in a particular way. The practice of medicine requires that all these colours be present. Each has a role which is unique and indispensable. Of these *epsitémé* (knowledge) and logic are not controversial and, thus, were given only passing mention. Three are especially relevant to the matter at hand: ethics, metaphysics, and existentialism. These were considered in more detail.

This requires that each occupy its proper place, understood as the place where each belongs, and not usurp the place proper to another. And so, while it is correct to say that medicine is a moral encounter, it is inaccurate to 'define' medicine as such for that is to place bioethics in a place beyond its proper borders. This error is twofold. It is an error on the grounds that other parts of the spectrum, specifically metaphysics and existentialism, are thereby displaced. It is also an error on the grounds that bioethics cannot fill the void created by displacing metaphysics and existentialism. The paradigm of medicine of the 20th century manifests these twin errors: the over-reach of bioethics and the place vacated by metaphysics and existentialism. However, the answer is not

the suspension of ethics as some suggest. [30]

Bioethics did not create the void. Rather it occupied the void. But occupying a space is not the same as filling that space. The responsibility for these voids lies with philosophers in the metaphysical and existential realms. Heidegger and Marcel, each in his own way, address this in an attempt to fill the void for only a philosophy which has vacated its space can fill that space. And so, each of existentialism, metaphysics, and bioethics has a rightful place. The clinical encounter, then, can also be seen as a metaphysical and an existential encounter. An image of a triangle expresses these dimensions.

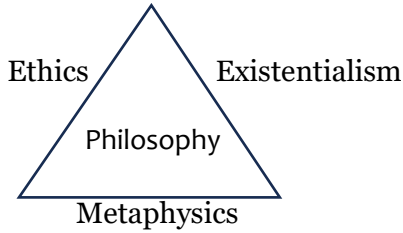

Figure 2.1 The Triangle of Philosophy

However, as noted, metaphysics is in need of rehabilitation. Heidegger speaks to this metaphysical renewal. Marcel acknowledges this 'metaphysical necrosis' but sees in this a place for existentialism in medicine. And so, medicine of the 21st century is not destined to live with what it has inherited from the 20th century. But given the reality of the paradigm - both medical and cultural - of the 20th century this challenge is as daunting as the opportunity is sobering.

Today the practice of medicine faces a promising future not only in the sense of a promise as certitude of more progress in science and technology but as a potential of a future which differs from the past. In this regard two aspects of philosophy in medicine are promising. Heidegger's renewal of metaphysics is based on the notion of 'presencing' in the sense of being present to what the world presents to us. This speaks to illness understood as what a patient lives with for it is illness which presents itself. Marcel's existentialism is grounded in 'uneasiness' which in the context of medicine as a practice is twofold. One aspect is uneasiness of dysfunction

which aligns with science; the other is an existential uneasiness which aligns with illness. This makes medicine an existential encounter.

But Paracelsus speaks to this twofold uneasiness of our time for philosophy is implicated in how this came to be and, thus, is implicated in how this might be addressed. Medicine is involved in both aspects not by choice but by necessity. It is this which is philosophy *in* medicine. As Paracelsus noted five centuries past philosophy and medicine belong together. To adapt Paracelsus, cited at the outset of this Chapter, and Platt's comment on metaphysics (Note 27) one can suggest the following: '*Existentialism is a person without whom medicine cannot exist. And so, a physician cannot know her not.*'

But Platt's comment was an adaptation of a view attributed to von Brueck: "*Teleology* is a lady without whom no *biologist* can live, yet he is ashamed to show himself in public with her." [31] (*Italics* added) This disconnect of teleology and biology is fundamental to our time. Biology refers to human *bios* which is the realm of science and technology. Teleology is grounded in the Greek term *telos* which Heidegger notes is commonly rendered 'purpose' or 'aim'. However, he indicates that its proper sense is 'to complete'. [32] This completion carries the sense of maturation or fullness. It is this maturation which applies to the person and the lived experience of illness for it is in this experience that one seeks 'maturity' of the person. From 'Philosophy in Medicine' one now turns to human nature by 'Re-thinking Human Nature'.

Chapter 3

Re-thinking Human Nature

I. Introduction:

In common discourse human nature is usually considered as a triad of body, mind, and soul. This classical understanding of the nature of man as *anthrōpos* that has influenced Western thought comes from the Greek, Hebrew, and Latin worlds. Each world has its own language for each part. The 'body' is *corpus* (Latin), *soma* (Greek), and *basar / gviyah* (Hebrew). The 'soul' is *anima* (Latin), *psyche* (Greek), and *nephesh* (Hebrew). However, with respect to 'mind' things become complex. '*Nephesh*' carries the sense of being animated by the breath of life, hence, the Latin '*anima*'. The soul is seen, then, to animate the body. This resonates with the Hebrew term for 'spirit' (*ruah*). In addition 'the breath of life' resonates with *pneuma*, the Greek term for 'spirit'. [1] Latin has *spiritus* for spirit. As for the 'mind' Latin has '*mentis*' and Greek has '*nous*'. In Greek philosophy *pneuma* and *nous* have some relationship which is reflected in the Latin *mentis - spirit*. And so, the classical understanding of human nature can be considered as body, mind, soul, and spirit. These are the traditions from antiquity which influenced Western thought for centuries.

However, there is another tradition, little known in the West until recently, which makes a contribution to our understanding of human nature. The Jewish tradition is a Semitic tradition. The Syriac tradition is also a Semitic tradition. However, for the first four centuries of the Common Era this tradition was not influenced by Greek philosophy. Human nature in the Syriac tradition is threefold: *gushma* (body), *naphsha* (soul), and *tar'itha* (intellectual spirit). [2] Note that *tar'itha* sees the spirit and mind (intellect) as one. Of further interest is that the Syriac tradition is uniquely situated

in that it is . . .

> free from the specifically European cultural, historical, and intellectual trappings. . . . (and, therefore,) can . . . serve as a link and meeting point . . . between East and West . . . (providing) . . . a counterbalance to an *excessively cerebral tradition*. (p.15, *Italics* added)

I take by "excessively cerebral tradition' Brock means the Latin and Greek cultures. He refers to the 4th century Syriac poet- theologian Ephrem (306-373 CE) as an example of this 'counterbalance'.

Poetry is an expression of thought whatever its source and wherever it leads. Von Tongeren notes a comment attributed to the poet W.H. Auden (1907-1973): "(P)oetry makes nothing happen." [3] This resonates with Kolakowski's view of philosophy. Continuing in his own words von Tongeren notes: "(B)ut that must be complemented that 'without poetry nothing will happen'. As the Greeks well knew without poets nothing happens." (p.207) This, too, resonates with Kolakowski. However, the issue is not poetry as an expression of thought but rather of the relationship between mind, spirit, body, and soul. But in its own way poetry as a creative activity does speak to this as does the Syriac understanding of the relationship of spirit and the intellect captured by *tar'itha*.

II. The emergence of science:

But Western philosophy did not end with the Greeks; it only began there. And so, philosophy continued over the centuries from ancient Greece to Paracelsus (16th century) and beyond into the 21st century. Dupré's Passage to Modernity presents a history of the philosophy of nature. For our purposes what is of importance is the 'emergence of objectivity' of nature in philosophical thought over the centuries. What follows are salient points of Dupré's account of this transition. [4]

The fundamental aspect in this discourse is the Greek term *kosmos* (cosmos). It was cosmology which engaged the interest of Greek philosophy. This interest continued in

thepost-Hellenistic cultures; however, cosmos was understood differently in these cultures. Hillman notes that in contrast to the Greek *kosmos*, the Latin culture had 'universe' which carried a sense more in keeping with the explanation of the scientific exploration of nature. [5] Dupré notes that scientific method and discipline was not part of philosophical discourse on nature in the 15th and 16th centuries. This was the time of Paracelsus. However, this changed in the 17th century which produced a new relationship between art (aesthetics) and science with its impact on culture. This is expressed in the following:

> In the course of the 17th century . . . the weight shifted heavily toward science and scientific philosophy; aesthetic theories were forced to conform to mathematical norms. The engineer replaced the artist as model of the age. (p.66)

Thus, expressions of interiority, i.e. of creativity, such as poetry became marginalized. Dupré continues noting that . . . "(t)o understand nature no longer meant to describe its outward appearance but to penetrate its inner secrets." (p.66) Thus, the drive to master nature began. From then on man as *anthrōpos* has been compelled to conform to science and technology. Thus, . . . "(t)he idea of an independent nature with its own *teleology* makes room for a mechanical one mathematically constructed and subject to human purposes." (p.66, *Italics* added) The *kosmos* of the Greek world that was a given was now displaced by a construct grounded in explanation. Moreover, this construct was ordered to, i.e. ordained to, human purposes expressed in terms of function. And so, the purpose of the cosmos was now to be constructed such that purpose aligns with function. This constructed purpose speaks directly to 'meaning' of the universe and all that is in it such that function came to identify, i.e. define and determine, meaning.

Like other humanists of the time, Galileo (1564-1642) accepted Plato's notion of *kosmos* that . . .

> the essence of reality must be ideal. Yet while Plato . . . had separated the essential form from its nonessential *participation* in the physical, world, Galileo assumed the ideal form to *reside*

within the physical." (p.66, *Italics* added)

Thus, an understanding of the physical universe as participating in the essence of 'what is' was replaced by an understanding that the essence of 'what is' resides in the physical. The physical, then, becomes the route to the essence of reality, i.e. 'what is'. The seed of 'function' as the manifestation of reality is planted. This resonated with the desire to master nature. That seed has since germinated and is now harvested in medicine of the 20th century with the notion of 'quality of life' and other phraseology which entered the public discourse leading to Medical Aid in Dying.

Dupré continues in noting that . . .

> Galileo postulated a mathematical core at the root of physical being. To know a phenomenon, then, requires that we first break it down into its quantifiable elements. . . . What remains may be discarded as ontologically irrelevant. (p.66)

And so, out of this comes a new way of looking at the *kosmos* (universe), ourselves, and others. This is noted by Dupré:

> But . . . what Galileo misconstrues with these elements is . . . not the original reality but one reduced to fit the mathematical grid. . . . (N)umerical proportions had constituted the rule and perfection of the cosmos. (p.66-7)

It is this 'mathematical grid' which is . . . "the common thread that holds all aspects of science together in the 17th century." (p.66) The standard of knowing 'what is' had become a mathematical standard. Thus, one comes to know 'reality by measurement of 'what is'. Since reality is that which is measured, what cannot be measured cannot be as real - if real at all - as what is measured. The ideology of scientific materialism follows from this.

However, Galileo's contribution was not an 'escape from' but rather a 'embrace of ' the physical universe as the essence of reality. Dupré expresses this as follows:

> (t)he ideal mathematical pattern Galileo used in calculating movements in the cosmos was not an escape from the intractable irregularity of the physical world into an ideal order but an attempt to use that order to *grasp the essence*

> of the real world. Mathematics constitutes the ideal physical core of the universe. (p.67, *Italics* added)

The essence of reality resides within the boundaries of what is measured. Galileo, then, did not leave the physical world with all its irregularities but rather began with the ideal order *en route* to apprehending the essence of the physical world. What is real is what is measured. This resulted in uniformity whereby everything is assessed by the same standard which is mathematical. Measurement not only measures reality but determines reality. Harmony between the essence and participation of the physical as *per* Plato has been abandoned. Dupré notes that . . . "the mathematical model used universally for measuring motion would, in principle, abolish the traditional distinction between celestial and terrestrial mechanics." (p.67)

As with Democritus 20 centuries earlier Galileo was concerned about knowing causality. This along with removing the distinction between 'celestial and terrestrial' factors leads to Dupré's concluding remarks on Galileo:

> The main issue was causality. One revolutionary conclusion of Galileo's new system was that power need not continuously flow from God once nature became endowed with a uniform *intrinsic* necessity of its own (p.68, *Italics* added)

He continues: "The new science of mechanics did not dispense with a Creator who would initiate motion, but it appeared to withdraw God from nature after his creative act." (p.68)

The German philosopher Hans Jonas (1903-1993) puts this development as follows:

> For the modern idea of understanding nature, the *least intelligent* has become the *most intelligible*, the *least reasonable*, the *most rationale*. At the bottom of all rationality or 'mathematics' in nature's order lies the mere fact of there being quantitative *constants* in the *behaviour* of matter. (p.69, *Italics* added)

Jonas names these 'constants' 'the principle of uniformity'. (p.69) He sees this 'principle' as being the most 'intelligible' in

that this reality is the most easily measured but the least 'intelligent' in that it fails to engage the essence of that reality. The latter is sacrificed for the former. In addition, the reference to 'behaviour' plants the seed of behavioural science which will surface as science further extends its reach into the 20th and 21st centuries.

This principle is grounded in the sense of the Latin *ratio* understood as a numerical entity rather than *rationis* (rational) as in reasoning with logic which includes but is not limited to quantification. Jonas sees *rationis* as being more intelligent for its use of reason. In brief, he sees quantification (a mechanical process of measurement) undermining human reason (a process of evaluation by the mind). However, when science of physical nature, i.e. nature in its narrowed measurable sense, . . .

> severed itself from philosophy of the cosmos. . . . (it) became reduced to a metascience that articulated the presuppositions of what science actually did without itself being actively engaged in the study of nature." (p.69-70)

Thus, science being preoccupied with measuring nature, no longer studied the essence of the subject it measured. It is this measure, then, which is the measure of man as *anthrōpos*.

Dupré next turns to Galileo's contemporary Francis Bacon (1561-1626). In considering natural philosophy Bacon sees two ends described as follows: "Some . . . care only to know Nature, others desire to command Her." (p.73) The former is disinterested knowledge; the latter is ordered to practical ends. Bacon's preference was for the latter. Note that since medicine is a practice, Bacon's views resonate with medicine. He called for . . .

> unlimited control over nature . . . on the assumption that . . . (it) possessed *no purpose of its own*. . . . (He) tends to transfer the theoretical question: In what does a thing's nature consist? to the *functional* one: How does it work? and ultimately to . . . What human *purpose* does it serve? (p.72, *Italics* added)

However, the sense of purpose is not 'meaning' of 'what is' but its function such that the latter determines the former. The

central thought here is 'purpose' understood as 'function'.

In the mechanical realm of the physical universe this is 'intelligible', i.e. makes perfect sense, since an instrument is aligned with its purpose. However, everything is reduced to function when such an approach is a principle which becomes accepted as an ideology. But this is more than a 'reduction' for it eliminates anything that does not conform to the 'principle of uniformity'. This is Robert Boyle's (1627-1691) . . . "preference for the experimental method of investigation." (p.73)

Philosophy in the 17th century gave priority to knowing nature in order to command nature. Dupré describes this in the following:

> With . . . most 17th century philosophers, method turns into a screen imposed upon the subject matter that restricts investigation to what will most effectively and most speedily yield reliable results. The *mind systematically selects* what it desires to learn while discarding those elements it considers irrelevant to its investigation. (p.73, *Italics* added)

The result is that . . . "method gave birth to the *idea* of science that in the 17-18th centuries assumed an importance greater than science itself." (p.73, *Italics* original) However, contrary to Bacon and many of his contemporaries, Aristotle articulated the Greek view that the . . . "philosophy method required conforming the mind to the nature of the subject." (p.73) Thus, two views of 'method' exist, each of which presupposes a stance toward nature.

III. From science to technology:

Bacon's orientation was inspired by motives . . . "to develop knowledge that would benefit the entire human race rather than providing contemplative satisfaction to privileged individuals." (p.74) In contrast to theoretical knowledge, the practical orientation was not disinterested. Dupré notes that . . .

> (s)cience offered the most practical as well as the least expensive solutions to basic human problems. But *without* a common *teleology* that *integrates* humanity with nature, the mastery of nature becomes its own end and the purposes originally pursued by it end up becoming secondary. (p.74, *Italics* added)

The use of 'purpose' here is in the original sense of 'meaning' rather than 'function'. However, since the mastery of nature became an end in itself, the purpose of this mastery was open-ended such that it could be used for any purpose one chose. Dupré notes that this was not Bacon's doing but rather that of his followers:

> For Bacon knowledge still preceded its practical application. (However), once his followers implemented their *utilitarian principles* by means of a mechanistic physics, science was destined to give birth to the *most comprehensive feature of modern life* - namely *technology*. (p.74, *Italics* added)

Technology then became a whole new way of understanding and interacting with culture. This is expressed as follows:

> By shifting from a given, pre-established order of nature to one determined by individually or communally experienced needs, they . . . transformed the attitude toward the cosmos that had prevailed since the Greek classical age. More than applying conclusions of a theoretical science to the solving of practical problems, *technology* construes an *alternative order of reality*. (p.74, *Italics* added)

Nature was no longer a given to contemplate as an interiority (Hillman's Greek *kosmos*) but merely an object to dissect and manipulate in order to address 'practical problems'. This is the world of 'explanation' (Hillman's Latin 'universe'). This makes it appealing and beneficial to medicine in treating disease.

In the Greek world . . . "the process of knowing the form enters the mind from without and in *techné* (art) it leaves the mind to enter matter." (p.75) This describes creative activity

such as poetry, sculpture, music, painting and more for the work of art is present in the mind of the artist before it is expressed. This is the 'form which enters the mind'. On this Dupré cites Aristotle: "From art [*techné*] proceed those things of which the form [*eidos*] is in the soul of the artist." (p.75, *Italics* original, Underline added) Now one may consider that this process pertains to science and technology also. However, there is a major difference which the following example illustrates.

> (T)he house built by the architect comes from the house that pre-exists as pure form. . . . (T)he house [in reality] proceeds from the house [in the mind]. . . . (However, in) the new perspective meaning of form lies *entirely* in the *function* if fulfills. (p.75, *Italics* added)

The key point here is the central, indeed exclusive, role given to 'function'. It was from this that mechanistic comparisons of nature to a machine emerged. While in a machine . . . all parts serve the functioning of the whole , . . . the whole is not determined by an inner teleology but by an external agent." (p.75) (On teleology see Chapter 2, Note 32.) The dominance of the machine means that . . .

> (n)atural processes . . . are exclusively determined by *efficient causality*. Purpose and means become relative concepts in the functioning of this *closed system*. . . . The instrumental attitude allows *no definitive distinction between ends and means*. . . . Within this closed circuit of instrumental thought the very idea of final end becomes *meaningless*." (p.75, *Italics* added)

Several points are noteworthy here. First the 'distinction between ends and means' from which 'meaningless' emerges recalls Rachels' merger of active and passive euthanasia whereby the distinction between ends and means had been eliminated. (Chapter 1, Note 16) Also relevant is Angell's 'meaningless suffering' which justified euthanasia. (Chapter 1, Note 1) Of further relevance is the conversation at the palliative care bedside, e.g. 'pointlessly living' and QALYs. (Chapter 1, Note 6) A final note is the emphasis on causality.

This resonates with the views that Boss attributed to Democritus. (Chapter 2, Note 10) Dupré also refers to Democritus noting that . . .

> (t)he idea of reducing the essence of nature to a small set of properties that must account for all other qualities goes back to Democritus but in *modern thought* this reduction leads directly to the *opposition between subject and object*. (p.77, *Italics* added)

This citation has relevance for it links Democritus, who many consider to be the father of science, with 'modern thought', the hallmark feature of which is a divide between subject and object. This divide is a central feature of modern medicine. (On this division of subject and object see Badiou's comments in Chapter 2.)

The properties referred to are spatial for Dupré notes that . . . " the primary qualities in defining what is real in our knowledge of nature favours *spatial* intuition over all others." (p.77, *Italics* added) Aligning the spatial with measurement suggests a closed space. Since space is measurable, it is spatial qualities that lend themselves to mathematical analysis which science demands. But Dupré argues that this . . . "(is) no ground for granting these qualities an ontological priority . . . as if they defined the essence of the natural world." (p.77)

Note that Greek language has two terms for 'time': *chronos* and *kairos*. The former is measured time as in chronology. Events occur in *chronos* time. However, it is *kairos* time that gives significance to those events. And so, time cannot be conquered. The twofold movement of placing space not only at the centre but as the exclusive priority, on one hand, and not just marginalizing time but removing it altogether, on the other hand changes how we see nature. (On 'space' and 'time' see Chapter 7.) It means that history, i.e. the story of our existence as a lived experience is not central but marginalized. Dupré puts this as follows:

> By regarding *some properties* as *inherent* in nature itself and *others* as *attributable* to nature only as the cause of subjective sensations that do not correspond to the original substance, we detach the observer from

> nature in such a way that . . . (the observer) ceases to remain an integral part of it. (p.77, *Italics* added)

'Attributable' resonates with 'Death with Dignity' whereby dignity is 'determined' by attributes that one possesses such that by lacking certain attributes one also is deemed to lack dignity. Thus, dignity 'ceases' to be 'integral' or inherent to human existence. (On dignity and attributes see Chapter 1, Note 14.)

Dupré continues noting that nature understood as such . . .

> then becomes an independent substance defined by permanence in space and void of those qualities that characterize the life of the mind." (p.77)

Science, then, . . . "effectively limits knowledge of nature to what is accessible to the method of mechanical physics." (p.78) Thus, anything outside of this domain is outside of nature. This is a departure from past philosophy which endowed the physical world with an 'internal teleology'. It was René Descartes (1596-1650) who set the course of this departure.

But Isaac Newton (1643-1727) . . . "questioned the notion of a perfect geometrical order in nature . . . (and) rejected the metaphysical assumption accepted by earlier philosophers that science defines the essence of its object." (p.78) Blaise Pascal (1623-1662), in critique of Descartes, showed that . . . "(n)o rational argument can securely relink the mind to reality after we have defined it as an isolated entity." (p.86) Referring to the work of Alfred North Whitehead (1861-1947) Dupré notes that . . .

> this concreteness, consisting of one component detached from a complex totality, is misplaced. Its spatial homogeneity rules out development: the laws of the natural world thereby attain the fixed character that . . . once had been the exclusive privilege of the . . . realm of ideas. (p.78)

The problem is the separation of 'ideas and reality'. (p.81)

Michel de Montaigne (1533-1592) noted that . . . "when reason fools us, we make use of experience." (p.82) Dupré comments:

> (T)he nature of *experience* had become the question. When evidence loses its ultimate *trustworthiness* as a criterion of truth, then truth needs a foundation beyond itself." (p.82, *Italics* added)

The crucial terms here are 'experience' and 'trustworthiness'. And so, when experience is no longer trustworthy a new foundation of trust is required. Science provides this 'trust'. But it does so at the expense of discounting experience. The introduction of 'experience' is noteworthy for living with illness is an experience. Noteworthy also is that this experience resides largely outside of the science of disease, i.e. is outside of the boundaries of science.

Aristotle's views are relevant to the matter of certainty. Dupré states that . . . "(t)o devise norms of certainty inappropriate to the mind's contact with its object is to set up impossible standards of truth." (p.85) The mind is in contact with a reality greater than the physical universe. Science, then, cannot be a standard of truth. To address this quandary of 'science lifting beyond its weight' Dupré turns to . . . "Aristotle's rule for prudential judgment: the degree of certainty must be *proportionate* to the nature of the object." (p.85, *Italics* added) Thus, the object must be considered as it is and not as man has constructed it to be. The Greek term *phronesis* carries the sense of prudence which is understood as practical wisdom. [6] On the matter of practical judgment this principle states:

> One must know *when* it is right to doubt, to affirm, to submit. Anyone who does otherwise does not understand the force of reason. Some men run counter to those three principles either reaffirming that everything can be proved because they know nothing about proof, or doubting everything because they do not know when to submit or always submitting because that do not know when judgment is called for. (p.85, *Italics* original)

These aspects are presented below where each side of the triangle represents an aspect required for the proper use of reason with each in its rightful place. This can also be seen as

aligned with judgment and prudence, i.e. practical wisdom, whereby reality is viewed as 'proportionate'.

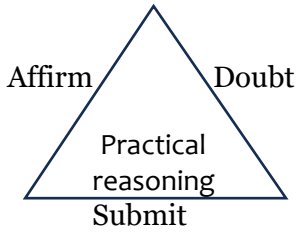

Figure 3.1 Aristotle's Triangle of Practical Reasoning

Toulmin noted that medicine saved ethics in that it (medicine) brought Aristotle's practical reasoning back to the forefront of philosophy in medicine. (Chapter 2, Note 15)

However, the scientific method and its companion technology did not rule everywhere or everyone. Those for whom the mind was an integral part of a unified all encompassing reality, e.g. artists and some philosophers, continued to relate to nature. Dupré notes that . . . "increasingly the assumption that the *human mind alone* conveyed meaning and purpose began to dominate modern thought." (p.89, *Italics* added) He continues stating that . . .

> (t)he first discomfort with the mechanistic view of nature surfaced when the concepts of extension and *mechanical force* were *applied* to *organic nature*. . . . Naturalists . . . reintroduced the *teleology* that had been exiled from a strictly mechanistic science. (p.89, *Italics* added)

Note that 'mechanical force applied to nature' speaks to the environmental challenges of our time. The Fables of Jean de la Fontaine (1621-1695) are an example of this. This is the aesthetic (art) noted earlier. However, the challenge was beyond the capacity of the Naturalists since . . .

> the mechanistic model proved to be too firmly entrenched in science to be easily dislodged. . . . (for) the very purpose of the mechanistic universe is to serve those living forces. (p.89)

Dupré cites the French zoologist George - Louis Buffon (1707-

1788) who increased this entrenchment: "Space and time are means, the universe its object, motion and life its scope." (p.89) Noteworthy here is the inclusion of time with space, thereby giving the mechanistic understanding of the universe more scope. (On the clinical relevance of the 'spatial' and time as temporality see Chapter 7.)

The 17th and 18th centuries were witness to a new way of understanding nature. With the success of the scientific method this became the dominant view. This dominance is twofold. It is dominant in that its successes go beyond alternative understandings of nature. But it is also dominant in that the scientific method dominates nature itself. And so, the seed planted in the soil of 17th century, tilled by philosophy in the 18th and 19th centuries, have come to harvest in the late 20th century and become the legacy of the 2nd millennium bequeathed to the 3rd millennium.

IV. From 'then to now':

Bishop (2010) signals the journey from 'then to now' by noting that nature has . . .

> lost its meaning such that we can no longer speak of nature. All that *is* is artifice of the chaotic creative forces of becoming. . . . Thus, . . . it is difficult for us in our time to say what is natural. [7] (*Italics* original, Underline added)

Since we can no longer say what is natural, 'nature' is no longer part of an intelligible discourse.

However, his colleague takes a different view noting . . . "that the inverse is true; all is natural." (p.19) This suggests that since all is natural, we do know what natural is. But if something (A) is everything, then B-Z is redundant and nothing more needs to be said. This resonates with the thought of Jonas noted earlier re 'intelligent' and 'intelligible'. On nature Bishop concludes that . . .

> (a)ll is chaotic artifice and if that is the case, perhaps then, everything can be said to be natural and at the same time . . . *nothing* can be *coherently* said about what is natural. (p.19, *Italics* added)

The term 'nature', then, is meaningless today.

This says much not only about the present, i.e. 'chaotic artifice', but it also forecloses future discourse since 'nothing coherent' can be said. But Bishop's colleague may not be right in which case 'chaotic artifice' not only invites but demands a response. Indeed, medicine as a practice requires no less. To explore this 'artifice' it is worthwhile to go back a generation pre-dating Bishop.

A voice from within psychiatry testifies to the incoherence of which Bishop speaks. Kleinman, an academic psychiatrist with an interest in anthropology, had noted in Rethinking Psychiatry (1988) that . . .

> (p)sychiatry is split into *often irreconcilably opposed* "schools" - biological, psychoanalytic, behavioral, social and so forth. . . . Each school teaches a *different view of human nature* and a *distinctive value paradigm* for professional practice.[8] (*Italics* added)

Two points of note follow from his position. First no single notion of the nature of man operates within psychiatry. How psychiatry understands human nature determines the clinical approach to the patient. In brief, a patient is treated in accordance with a specific 'school' of human nature to which that practitioner belongs or subscribes. In addition, however 'nature' is understood, it is irreconcilable with other views. Conflict, then, is common if one ventures outside of one's 'school'. However, while this may apply to psychiatry in a unique manner, it is not unique to psychiatry. This introduces a second point.

Kleinman's position speaks to anthropology within which psychiatry, as is all of medicine, is situated. A key source of his views of human nature was The Battle for Human Nature: Science, Morality and Modern Life. (Schwartz, 1986) By way of introduction Schwartz, a professor of psychology at Swarthmore College, identifies this institution as engaged in a pursuit of understanding not limited by disciplinary boundaries. Tradition at Swarthmore mandated a course on moral philosophy - usually taught by the College president - offered exclusively to senior year students. This course aimed . . .

> not only to integrate the various fields of learning, including science and religion, but even more importantly to draw the implications for the living of a good life individually and socially**.** [9]

By 1986 this course was no longer offered!

In The Battle for Human Nature Schwartz presents three views of human nature that have come to dominate culture in the late 20th century: i.) economics, ii.) evolutionary biology, and iii.) behaviour theory. Each is a 'science of human nature'. A detailed review of these areas is beyond the scope of this document. The 'battleground' considered here will briefly look at science and economics as presented by Schwartz.

A. Science and human nature: (p.23-53)

Institutions that once guided and informed society no longer offer that guidance. Schwartz captures this reality in citing the novelist Milan Kundera (1929-2023) who described man as *anthrōpos* as . . . " 'the unbearable lightness of being', to float without anchor or direction through space and time." (p.29) Coincident with this modern malaise is a rise in science as a new authority. But this is not a recent phenomenon for it has been on-going for several centuries, albeit recently at a markedly accelerated pace and reaching new heights. The new ultimate authority is the scientist armed with the scientific method. This method has been applied to an ever - expanding substrate: from non - living matter to living matter, e.g. to biology and to the human sciences of economics, anthropology, sociology and psychology.

This is reflected in modern society, arguably nowhere more so than in medicine. Formerly, human capacity to reason and the human soul gave man a place outside the bounds of physics and biology. Now all aspects of the universe - including all aspects of human life - are under the power of scientific scrutiny. In the later years of the 2nd millennium we have entered the era of neuroscience which attempts or promises to discover the key to human behaviour and thereby control human activity. Thus, science comes to replace traditional

sources for informing human conduct. Science dominates the landscape. A question arises: From whence does this authority of science come?

Science is about knowledge and a method of inquiry which generates that knowledge. While all disciplines pursue knowledge, the knowledge pursued may differ among the disciplines. What sets science apart is its method of inquiry. This merits consideration in order to understand the prestige and dominance of science today. The method of inquiry in science is a process applied to a set of phenomena in an attempt to make sense of the world. But this itself does not give science its stature.

What science offers, or purports to offer, is a causal explanation of the world. Its goal is to describe causal laws applied to a wide range of phenomena. What science extracts from a limited observation it applies to the whole. In brief, science explores a unique phenomenon and extrapolates to all phenomena of that class. This presupposes that nature is sufficiently orderly and repeatable which, in concert with the precision of measurement, produces certainty. A triad of causality, laws, and certitude provides science with an explanatory power which is the foundation of its authority. No other pursuit of knowledge can speak with similar authority. But this explanatory power is grounded in an assumption that all objects of a class are identical and will behave accordingly. This carries an 'assumption' of uniformity rather than universality. This resonates with the 'principle of uniformity' of Jonas noted earlier.

The success of science has replaced the traditional sources of informing how we understand human nature. The importance of this development is that our idea of human nature informs our moral decisions. In today's world the concept of human nature seems to depend not on what people 'are' but on what man as *anthrōpos* 'can do' which is considered through a lens of function understood in its narrow sense of capacity, i.e. what one is capable of doing. The dominance of science increases the latter and, thus, any consideration of the former is lost, diminished, marginalized, or interpreted in terms of the latter. In brief, *homo sapiens* is replaced by '*homo faber*.'

In addition, science seems to have dismissed the '*is-ought*' principle of David Hume (1711-1776) . This principle states that one cannot move from an '*is*' in the sense of 'what can be done' to an '*ough*t' in the sense that what can be done 'ought to be done'. Science bestows value on the 'what' by the fact that if it can done, then, it is done. This value is self-justification in that 'what is possible' justifies 'what is' done. The realm of fact generates and determines the realm of value. This resonates with Bandura's moral disengagement and social cognition. (See Figure 1.1.)

And so, since we know more, we 'can' do more. In the absence of reflection this appears to claim that we 'should' do more. Alternatively, it can demand an answer as to why something 'should not be done'. However, since the 'ought' carries an inherent prejudice of acting, a convincing answer to not doing is absent. The proper sense of 'prejudice' is 'pre-judgment'. Thus, a green light is given to do what can be done. There exists, then, a presumption of activity.

This dynamic from 'is' to 'ought' is a journey from 'fact' to 'value' whereby the 'fact' is implemented, i.e. manifested in reality without question, because it is valued. But this 'value' is not evaluated by reason as understood by Aristotle. (Figure 3.1) Science, then, has an implicit imperative for power of any kind abhors a vacuum and, therefore, has an inherent dynamic. Explanatory power is no different in that regard. It cannot not be manifested. Thus, science becomes an ideology with its own internal dogma. Since things are ordered in a certain way, i.e. *as per* the determinations of science, it blindly follows that things ought to be this way. Facts are valued beyond anything else. Science, then, determines reality. The digital and technological worlds are modern expressions of this situation.

The goal of science is to discover causal laws applied to a wide range of phenomena. This approach, when applied to man - or imposed on man - neutralizes dynamic elements which are unique to man. Imposed on man as a sole mechanism of understanding humanity distorts humanity and culture. In this way a uniformity is generated which operates in a widespread diversity in humanity. This favours a unifocal concept of the person in a monoculture.

B. Economics and human nature: (p.54-84)

The term *'oeconomics'* is rooted in the Greek *oikos* meaning 'house' which originally referred to management of the household. Specifically, *oikos* referred to activity that sustains life. This was based of the principle that man should act rationally where the Latin '*ratio*' in the Greek world is understood as 'proportional', i.e. keeping things in proportion, which resonates with Aristotle's 'prudential judgment'. (See Figure 3.1.) Economics, understood today as exchange value, is somewhat more recent dating back three centuries. Schwartz briefly sketches this history.

In the 17th century the majority of people were peasants subsisting by farming common lands. This activity tied the peasants to a community. Land was inalienable and neither labour nor land were objects of commerce as neither were commodities. However, Enclosure Laws transferred these common lands to the English nobility. This produced two effects: i.) agriculture production became much more efficient and ii.) peasants were driven off the land left to roam the countryside until they found work in the factories a century later. Coincident with this was the development of long distance trade which was to exist without regulation. The Industrial Revolution of the 17th century led to specialization, increase in exchange activity, and a market economy. Adam Smith's (1723-1790) Wealth of Nations (1776) noted that economics concerned itself not with production for daily life, i.e. what is sufficient for the household, but rather became an activity of exchange where goods were traded with the goal to maximize one's benefit in the exchange. The market created to maximize self-interest became institutionalized.

But self-interest was not isolated. The appendage 'maximization' carried a message of unlimited wants which metamorphosed into 'needs'. However, since there is no intrinsic way to evaluate these wants / needs, they would be determined by market value. This became an efficient way to organize exchange and means of determining economic value. The goal of economic 'rationality' is to maximize utility. This 'utility' resonates with utilitarian ethical theory which played

a prominent role in the genesis of Medical Aid in Dying. On utility Stanley Jevons (1835-1882) comments:

> To satisfy our wants to the utmost with the least effort - to procure the greatest amount of what is desirable at the expense of the least that is undesirable . . . to maximize pleasure, is the problem of economics. (p.73)

Of perhaps more than a passing coincidence to Jevons' reference to 'maximizing pleasure' is pleasure as the fundamental instinct of humanity which is the cornerstone of psychology as understood by Freud (1856-1939). But in the rationality of the market whose utility is maximized?

Economic value, then, came to be exchange value. Leder describes this as follows: "Concrete objects have 'use values' . . . (which) becomes subordinated to its abstract 'exchange value' translatable into a price." [10] However, not everything is a commodity since not everything can be exchanged. Slavery is the classic example of the fallacy and harm of commodification. And so, what about social interests? In theory these interests are protected by the 'invisible hand' of the market which is claimed to be a natural process which generates efficient results. In his Theory of Moral Sentiments (1759) Smith writes:

> All the members of a human society stand in need of each other's assistance. . . . (W)here the necessary assistance is reciprocally afforded from love, from gratitude, from friends and esteem, the society flourishes and is happy. (p.64)

However, as well meaning as this sentiment may be, events such as the COVID-19 pandemic, the recession of 2008, and earlier recessions / depressions indicate a disconnect between the market on the one hand and charity, good will, and self-sacrifice on the other.

Smith proposes a twofold schema. The economic part is based on self-interest; the moral part on sympathy. In theory the two could co-exist but over time, i.e. two centuries, it has been noted that one part (economics) flourished while the other part (moral) withered. Economics became a discipline of measurement. In this regard it mimics science. It is a

science of means not ends. Its laws are laws of 'economic man' (*homo economicus*) while claiming to be laws of human nature.

Schwartz notes that an assumption of economics is that economic rationality is a characteristic of human nature. (p.80) This rationality is seen as a gateway to claiming that economic rationality is natural. Since man (*anthrōpos*) in his natural state is rational, the market, by claiming rationality, can claim also to be both natural and rational. In every dynamic there is an imbalance of power. Rationality is at the service of the dominant party in whatever dynamic that presents itself. The free market is a creation of man to serve the dominant entity in that dynamic. In addition, rational economic man is new and exists only under certain circumstances which are determined by man. The technical argument concerns the most efficient / effective way to achieve goals of the dominant entity. This places the vulnerable at risk.

Ratio in its original use carries a sense of proportion as in evaluation of meaning. This is a process of deliberation which is a discernment of the circumstances which are present. Within the term 'deliberation' is found the term 'liberty'. But this evaluation is not a measurement for what is evaluated cannot be measured. This process, then, is not a calculation but a judgment. Aristotle's notion of 'proportionate' aligns with practical reasoning and judgment. (Figure 3.1) But *ratio* understood in economics differs in that 'proportionate' is a measurement. Thus, the process reduced to quantification not only lends itself to but also necessitates commodification of everything that the market engages. It is this measurement which determines the value of what is measured. This allows for comparison of the value of objects which cannot occur in evaluating subjects. But the person, including the patient, cannot be reduced to a commodity, i.e. object.

And so, proportionate in the realm of economics differs from proportionate in the realm of the household (*oikos*). Economics is how we relate to the world and how the world relates to us. The household is how we live with each other. The former is a quantitative process grounded in measurement; the latter a qualitative process requiring judgment. Although both are grounded in the Greek *oikos*, the two processes differ

just as subject and object differ whereby the subject pertains to the 'household' and object pertains to 'economics'. Medicine as a practice is more aligned with the patient as subject, i.e. one with agency. By embracing QALYs palliative care brought quantification to a reality which is inherently qualitative. It brought the object to where the subject belongs. While note has been made of human desires, it should also be noted that the market has desires to bring all human activity under its wing and, thus, its influence. In this it operates much like science and technology in medicine.

For an economist these concepts are not mere measurements but are scientific laws expressing fundamental truths about human nature and the human condition. However, Schwartz notes that Charles Dyke (Philosophy of Economics - 1981) describes two kinds of laws: natural and created. The law of gravity is a natural law and, as such, cannot be repealed and need not be defended. (p.180) But it is problematic to invoke a similar standard for something which is created by man or to base a human right on created laws. It is problematic because to invoke such a standard to human constructs is to claim for that construct the status of what is natural. This confuses, i.e. fuses, what man has been given through nature with what is fabricated through human intelligence. The result is that the latter is considered beyond critique and, therefore, to be accepted as a given of nature. But natural man and *homo economicus* occupy two different worlds - one world is natural, the other is artificial. Milbank refers to 'metaphysical assumption' by which he means that behind each and all worldviews resides an 'assumption' about human nature and how the world is but such assumptions usually remain hidden.

A fitting closure to economics and human nature presented here comes from opening citations of Chapter 2 in The Battle for Human Nature. Schwartz cites economist Gary Becker (1930-2014) : " I . . . believe that the *economic approach* is a comprehensive one that is applicable *to all human behaviour*, be it . . . patients or therapists." (p.54, *Italics* added) Regarding this 'economic approach' Schwartz cites the political economist Francis Edgeworth (1845-1926): "The first principle of economics is that every agent is actuated *only by self -*

interest." (p.54, *Italics* added) This sees that every agency of a subject is directed to the benefit of the self and not to the other. This describes human nature as seen through the lens of economics. Both citations resonate with 'behavioural economics' championed by Ubel as noted earlier. (Chapter 1, Note 9)

V. Conclusion:

The classical understanding of human nature that was dominant for many centuries changed with the emergence of science and technology in the 16th and 17th centuries. Given the status that science and technology have today, this becomes important in how we understand ourselves and the world. It is as though these centuries represent the beginning of a transformation of science from adolescence to adulthood. This transformation continues with its reach into the cyber universe and into the culture of our time.

The salient features of this migration of the person as a natural entity whereby the classical understanding of human nature was reduced to and defined by function were presented. The physical became the sole constituent of the natural order. In medicine this translates to the body. This reduction views the essence of our humanity as determined by the physical rather than residing in the physical. Science, enabled by an ability to measure and quantify the material, i.e. the physical world, sought to master nature. The feature of measurement provided a standardization such that if one thing of a class could be measured, then all things in that class could be assessed by the same measure. There was an assumed uniformity which was reproducible and verifiable by the standard of measurement. Such uniformity in any sphere generates an ideology whereby reality must conform to its orthodoxy. The success of science and technology gives credence to this understanding of ideology.

A consequence of this reduction of nature to the physical led to understanding the purpose of the physical being defined by and confined to function. And so, by this construct if function is compromised, for example by disease, so too, is purpose compromised. Thus, purpose as meaning

exists only in the context of function. The scientific method, then, understands nature in functional terms only, thereby fostering a monoculture in which what is natural has no inherent meaning. The seeds of science and technology of the 16th and 17th centuries produced fruit in the 20th century.

In Rethinking Psychiatry Kleinman noted the different and irreconcilable views of human nature that exist in psychiatry as a practice. Some of the dominant views of human nature were expressed in detail in The Battle for Human Nature. A recurrent element in this 'battle' is the understanding of a person as an object to be acted upon and not as a subject with agency. This can be traced back to the 16th and 17th centuries where function as determined by measurement was the 'measure' of the person *qua* person and any inherent meaning in the natural was abandoned. Since purpose equates with function, understood in mechanical / technical terms, agency, understood as coming from within the subject, does not exist. And if agency does not exist neither does the subject. Everything, then, is an object to be acted upon. This understanding of human nature present in medicine in the closing years of the 2nd millennium was expressed by Bishop in the early years of the 3rd millennium in noting that nothing coherent can be said of what is natural.

Going forward further into the 21st century comments from Boss merit mention. He notes that Norbert Wiener (1894-1964), the founder of cybernetics, held the view that . . .

> (c)ybernetics and information theory legitimately fell . . . entirely within the dimensions of scientific calculability . . . and, therefore, under the rule of the *causal principle*.[11] (*Italics* added)

Boss continues noting that Weiner defines . . .

> the *human being* as a 'message' which, as the term is used in information theory, means nothing but a spatially or temporally ordered *system* or model of *chemical particles or electrical impulses* that is *absolutely quantifiable* and *exactly measurable*. (p.21, *Italics* added)

Here we see the seeds of artificial intelligence (AI). Thus,

cybernetics adds to an already high degree of explanatory power of the scientific method. However, in the cyber universe the substrate is artifice, i.e. fabricated from the outset, and not raw organic material, i.e. nature. Boss concludes:

> One could hardly find a more radical formulation for the intent of the natural scientific research method to secure exclusive, absolute and unconditional rights to medicine. (p.21)

The trajectory from Descartes' Law of Cognition to its extension to the organic world of medicine and beyond expanded the explanatory power of the natural scientific research method. Putting these views together one finds that the human is rendered quantifiable and measurable. But Boss also cautions that manipulation and quantification of an object, e.g. a human being, is no guarantee that the object is fully comprehended. He notes that . . .

> Kant . . . recognized that scientific thought, which applied *only* the principle of *causality*, did not suffice to comprehend *living things*. The very simplest beings . . . [Kant] tells us, demand to be understood from a second and *teleological* perspective. (p.20, *Italics* added)

Kant (1724-1804) is not denying the success of the natural scientific research method applied to human disease but rather is placing its explanatory power in a context such that its power is not abolished and perhaps not even diminished but is certainly, at least, incomplete.

Noteworthy is the reference to 'living things' which means the organic world. And so, while causality may apply to inorganic matter, it cannot be the sole pathway to understanding the organic world without extracting a major cost to those 'living things'. Medicine as a practice pertains to living things. It is the 'teleological perspective' which is lacking. It is this perspective which not only protects one from the excessive use of power designed to be exercised in a narrow inorganic mode of function but also places the use of that power in a context of the organic world.

This inorganic - organic divide is captured by object-to-be-acted-upon and subject-with-agency in the context of medicine with the former aligned with the 'inorganic' and the

latter with the 'organic'. In the context of medicine the object - subject divide becomes the disease - illness divide. The scientific method with its sole focus on the principle of causality and its accompanying explanatory power pertains to disease. However, in the context of illness the shortcoming of the search for causality is encountered. This shortcoming is that while as science advances more of 'what is', e.g. disease, can be explained, the meaning of 'what is', e.g. illness, remains untouched. This is the teleological perspective which is a prominent feature of re-thinking human nature. As noted, the Greek *telos* carries the sense of completion / maturation / fulfill. (See Chapter 2, Note 32 re teleology.)

Beginning in the 16th century the classical view of human nature was displaced by science. In the 20th century the former has been replaced by the latter. This 'replacement' is pervasive for it touches all aspects of modern culture. To borrow and adapt Frankl's insight no one person is responsible *for* this but all are responsible *to* this. Philosophers will respond according to their art of reasoning. And so, too, medicine will respond in accordance with its art. Since medicine's art is a practice, its response must be at the bedside, i.e. the clinical encounter. It is to this encounter that one brings the teleological perspective in order to complete, i.e. fulfill, the patient's presence in medicine. This begins by considering 'How We Know What We Know and Why We Know It'.

Chapter 4

How We Know What We Know and Why We Know It [1]

I. Introduction

There are three aspects to knowledge: 'How', 'What', and 'Why'. In order to evaluate knowledge one first needs to know '*how*' knowing comes about. And so, the '*what*' comes from the '*how*'. But knowing something is not sufficient for one needs to also know '*why*' as in what purpose does the knowledge serve. The goal is not knowledge itself but its purpose. The '*what*' of knowledge exists to serves the '*why*'. Since medicine is a practice, the '*why*' is to serve the patient. Each aspect of the knowledge triad is unique and indispensable and, therefore, none stands alone. This provides a basis for understanding the ground on which medicine as a profession stands and prepares the ground on which medicine as a practice walks.

A further note of fundamental importance is the content of knowledge itself, i.e. its subject matter. On this there are two types of knowing. One is 'knowing of ' something; the other is 'knowing' that something. Both belong to medicine. Science produces 'knowledge of ' disease. However, through illness the patient comes to 'know' the person with the disease. This is a different genre of knowledge. Knowing the art of medicine, like any art, is learned through the application of 'knowledge of '. But the application itself is also knowledge for every art is more than mere 'application of ' knowledge; it is 'knowing' the art as art.

Related to this application of knowledge is the notion of prudence as practical wisdom. It is practice which begets this wisdom. 'Knowledge of ' something is necessary but is, in itself, insufficient. Practical wisdom is learned by practicing a

craft for a craft is learned by doing and not by studies. Practise is a different kind of knowing. By way of analogy one learns the trade of being a chef not at the kitchen table reading recipes but by preparing food at the stove. It is this way for every craft. Medicine is a craft in the art of living. In the practice of this craft the physician comes to 'know of ' disease and to 'know' the person who lives with the illness. 'Knowledge of ' disease comes from the experimental; 'knowing' the illness comes from the experiential. And so, knowledge in both its forms pertains to the participants in the clinical encounter.

II. The knowledge pathway:

A. The '*How*' of knowing:

Observation is not knowledge but rather is the key to the door which opens onto knowledge. It is passing through the door that one finds knowledge. The difference being that observation comes to us and knowledge comes from us in that it is what we learn through observation. This observation, understood in its broadest sense, is participation in reality. This is experiential be it visual, auditory, or some other means of experience. Knowledge comes from a process of reasoning. But there are two doors to knowledge for there are two ways of reasoning. One way of reasoning is deductive; the other inductive. Observation, then, is the raw material, i.e. the substrate, upon which we apply reason from which comes knowledge.

Both ways of reasoning provide knowledge but each functions differently. The results are not interchangeable for the processes differ but neither are they incompatible for each is suitable for the circumstances in which it operates. However, they do not have the same standard of conclusions for some things lend themselves to firm and irrefutable conclusions via deductive reasoning and others things do not. However, when applied appropriately, i.e. in circumstances proper for that reasoning process, the conclusions are useful in knowing reality. Conclusions, whether irrefutable or not, require judgment which is called prudence understood as

practical wisdom. (Figure 3.1) It is this way for medicine is a practice. And so, while the reasoning processes may differ, observation is common to both. There is also a common destination for in the practice of medicine there is only one destination - the patient.

In its literal sense observation is limited to the organ of sight. However, as Boss has noted, vision also encompasses visualization which can be considered as seeing with the mind's eye. (See Chapter 7.) By way of examples, one notes that a poet visualizes the poem before it is written, a painter the painting before the paint is applied to the canvas, a sculptor before the stone is sculpted, a potter before the clay is a vase, and a musician before sound is produced etc. (See Chapter 3 Dupré on Aristotle re art [*techn*é] and form [*eidos*].) This is inductive reasoning for while there is something in the mind, it is a one-of-a-kind for each work of art is unique since no work of art is ever repeated.

Deductive reasoning applies to the philosopher who sees the logic, i.e. the syllogism 'if A then B' in the premise A in relation to B. If premise A is correct deductive reasoning concludes with a logical syllogism. Deductive reasoning when used properly in philosophy argues to conclusion. However, it is sometimes used incorrectly whereby rhetoric replaces reasoning when one argues from conclusion. (See Rachels on active euthanasia - Chapter 1, Note 16.) This is not infrequently the case in the Courts where lawyers argue to a conclusion which is to advance their client's interests. However, it is the duty of the Court to asses the reasoning through a deductive lens untainted by rhetoric. Similarly, hearing also includes listening which opens out to interpretation which is knowledge. Observation also operates in the realm of experience. Since every experience is real, every experience speaks to us. Knowledge is knowing what it says, hence, the importance of listening and speaking in whatever modality that is suitable for that experience.

While observation, in whatever form, is the *sine qua non* of knowledge, it is inductive and deductive reasoning which produce knowledge. Inductive reasoning is observing one event. If a person sees this event clearly knowledge ensues. However, since the observation is one-of-a-kind, different

observers may see things differently. With deductive reasoning a person looks for a pattern in several similar observations. If a pattern is established, observation leads to a theory which is tested in experimentation. The observation is tested and proven to determine if it is one-of-a-class phenomenon. There is no comparable 'proof ' available in inductive reasoning. While both processes begin with observation, thereafter, they follow different paths. Both processes operate in medicine and are the foundation of '*How*' we know which opens onto '*What*' we know.

B. The '*What*' of knowing:

1. The realm of the *bios* sphere:

Deductive reasoning is a three step process: observation of an event (Step 1) → exploration of the cause (Step 2) → effecting a new reality (Step 3). This dynamic is captured by the phrase: '*from* cause *to* effect'. This is understood as the 'science of causation' in that an event is observed, its cause determined, and measures are then taken to reverse the cause or mitigate its effect and thereby effect a new reality. This is the scientific method and accounts for its explanatory power. In the biological realm of medicine this is the disease arising from the pathophysiology which in the scientific method matures into a theory which is tested in experimentation. It is deductive reasoning which accounts for the success of modern medicine in dealing with disease. This is best described as the 'experimental text'.

The body (*bios*) lends itself to this approach for each body is seen as one-of-a-class since the same organ in different individuals functions in the same way in normal circumstances and is assumed to do so in the same disease affecting different individuals. This is the body as a machine of Cartesian philosophy. In the realm of human biology a pathway from Step 1 to Step 2 is identified, a 'mechanism of injury' is found, and intervention identified and addressed by intervention (Step 3) such as reversal or interruption of the mechanism. Each step is essential.

This knowledge, grounded in the 'experimental',

carries the highest degree of explanatory power through measurement and verification which has application to that class of observations. This is known as numeracy and generates great confidence among physicians and patients. Science of causation is the gold standard of this knowledge. In the realm of *bios* this is '*what*' we know.

Epidemiology also relies on scientific analysis of human biology. However, this is 'science of association'. While this, too, involves numeracy, it is numeracy applied to a larger population. Since no population is entirely homogenous, strictly controlled conditions are not possible. Thus, given that there are many variables within any population a 'pattern' can be neither tightly defined nor confined. While valuable in its own right, numeracy emanating from this science lacks the gold standard of science of causation. Nevertheless, science of association is beneficial in the context of the public's health. The recent experience with the COVID-19 pandemic exhibits this difference and this value. The science of causation provides a high standard of experimental evidence as to the causal agent and the development of vaccines. The science of association generates public health measures and evidence of efficacy of such measures and vaccines. Each serves a necessary function but has different standards.

2. The realm of the *psyche*:

Observation and knowledge operate differently in matters concerning the psyche. On this several points are noteworthy. Psychiatry, via Freud, came into existence in the late 19th century more than two centuries after science and technology began its ascent to dominance in our world view. The mechanistic view of the person had been well established by that time. In this milieu Freud considered man to be more akin to an animal than having a nature specifically human. [2] The psyche, operating on instinct, was seen as another part of the machine. The instinct represented a pathway. And so, the mechanism of injury of a distressed psyche could be reversed by identifying the defect in the pathway. In Freud's construct the defect lie in the parts of the psyche, i.e. the *id*, *ego*, and *superego*. This was the application of deductive reasoning to

the psyche. However, while this construct was theoretical, it was given the status of explanatory power even though, unlike matters pertaining to the *bios*, it lacked verification by experimentation.

Since medicine's knowledge of the psyche does not include a pathway 'from cause to effect', the science of causation useful in human biology does not and cannot pertain to the psyche. Lacking a knowable pathway of physiology and pathophysiology the *pysche* is particular to the person and not generic to a class. This makes deductive reasoning less useful, if useful at all, in matters of the psyche. The psychic effects of an event can only be known 'after-the-fact'. It is inductive reasoning that has a central role in matters concerning the psyche.

There are three key features of '*what*' we know concerning matters of the psyche: i.) its source is the patient, ii.) the knowledge is one-of-a-kind, and iii.) it is after-the-fact knowledge. Not unrelated to this is that the text emanating from the psyche is a literacy text in that it comes out of the patient's experience and not numeracy which comes out of experimentation of a class event. And so, what we know in matters of the psyche is literacy grounded in inductive reasoning. While the explanatory power may be downgraded from the causation mode of the *bios* sphere, the authority of this text is both significant and indispensable.

3. The mechanism of the injury:

Falling on an outstretched hand may result in a fracture of the distal radius whereby the bone is displaced at the fracture site in accordance with the forces of impact. The mechanism of injury can be seen as a 'cause and effect' event. This example offers two lessons. The orthopedic surgeon reduces the fracture by reversing these forces. In medical parlance this is called 'reversing the mechanism of injury'. The second lesson is that the healing of the fracture, i.e. making whole what was broken, is a natural process. The intervention of the surgeon does not, in itself, heal the fracture but rather aligns the fracture site so that it will heal properly. In brief, the surgeon facilitates the healing.

While this is obvious in the example of a fractured radius, it is also the basis of science of human biology. What the physician does at the local fracture site scientific rationalism does systemically, i.e. the biochemistry and physiology of distressed human biology, *and* systematically, i.e. in a step wise approach to the 'injury' of the distressed body. However, in matters pertaining to the psyche there is no pathway and, therefore, no mechanism of injury. And so, reversal of the mechanism of injury is not possible. In brief, the notion of 'mechanics' does not pertain to the psyche. Two related points follow from this observation. One is that the numeracy is unreliable in matters of the psyche. Second knowledge is determined subjectively rather than objectively. This raises a question to be addressed later as to how to deal matters concerning a distressed psyche.

C. The '*Why*' of knowing:

The '*How*' and '*What*' we know exist for a '*Why*' which is the application of knowledge. In medicine as a practice this ''*Why*' is the patient for the patient is the *raison d'être* of medicine as a profession. Both the *bios* and the *psyche* are part of this '*Why*' for both pertain to the patient. And so, while this knowledge may be 'knowledge of ' something, e.g. the science of disease, it is more for it is also knowing the person with an illness. It is understanding the context in which knowledge is applied. Knowledge resonates with disease; understanding with illness. However, the demarcation lines are not rigid but fluid. In a sense 'knowledge' is a noun and 'understanding' is a verb in that it is dynamic for understanding is never complete but like water in a river is ever-flowing. Illness speaks to this dynamism. Both deductive and inductive reasoning have a role to play in this understanding which gives life to knowledge in that it is applied to a lived reality which is medicine as a practice.

Comment:

As the result of a process that began in earnest in the 16th century and continues today science and technology

dominate modern culture including the practice of medicine. This has brought many benefits to patients. This is especially relevant in engaging matters of the *bios* sphere, i.e. a 'distressed body'. It is here that deductive reasoning has a central role. Based on the event being one-of-class the features of this role are experimentation, numeracy, and objectivity. However, this process carries, and even demands, a narrowed view of the person. Given the success of this approach the *bios* has come to define our humanity.

The psyche lends itself not to deductive reasoning but rather to inductive reasoning. This is a one-of-a-kind phenomenon the features of which, after-the-fact, literacy, and subjectivity. In brief, this is experiential. And so, the approach to a 'distressed psyche' differs from that of a 'distressed body'. And yet, both find a home in the patient. Moreover, the psyche is integral to our humanity.

Knowledge can be depicted in a geometric image of a triangle with each border consisting of three couplets: inductive / deductive, literacy / numeracy, and subjectivity / objectivity. One element of each couplet speaks to the experimental which is the realm of disease; the other to the experience of living with an illness.

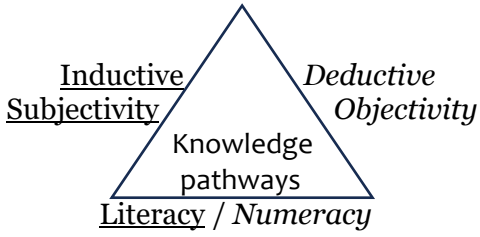

Figure 4.1 The Pathways to Knowledge

Just as the experimental and the experiential have their proper place so, too, does each element of each couplet have its proper place. It is the principles of medicine that may help determine what that place may be.

III. Principles of medicine:

An architect's blueprint provides detailed instructions

about how to proceed. In a sense it is prescriptive. A map also provides directions on how to go from A to B but need not be prescriptive for there are often several paths to the same destination. Moreover, there are a variety of scenes to observe along the way. Principles are neither a blueprint nor a map but are best understood as guideposts which serve an markers along the path of practising medicine. Principles serve medicine well for medicine is an art and so too, is living with an illness and, as such, there is no map or blueprint. However, guidance may be required for one may benefit from guidance periodically but not require a map or blueprint.

The three principles presented here are to help the physician - and all health care providers - to accompany the patient on their journey. This accompaniment goes by the name 'compassion' (*cum passio)* which literally means 'to journey with' but is more often erroneously rendered 'to suffer with'. (See Chapter 1, Notes 12 and 13.) These principles help to understand both disease and illness and contribute to an understanding of medicine.

A. *Identifying the problem is the first step to a solution*:

This principle is central to medicine for every clinical encounter begins with a 'chief complaint'. While this is central to science of causation, it is also relevant to matters of the psyche where exploration of causation is not possible for inductive reasoning also relies on identifying the problem. In the realm of *bios* the process of engagement is through experimentation and numeracy whereas in a distressed psyche it is engaged through patient's experience. This is the realm of literacy. The first lesson in literacy, then, would be to ask the patient how the trauma affected their psyche. This is the introductory chapter of the patient's history. This approach may seem to be ineffectual. However, like any literary work, one can only know one page at a time and not the whole book. In fact, not even the patient knows the whole book for it is a work in progress.

While '*identifying the problem as the first step to a solution'* may seem an inauspicious beginning, in reality it cannot be because for the patient every step - even a misstep

- is important. And so, the first step can be seen as stepping onto a journey with the patient. In one whose psyche is distressed this journey, while possibly enlightening, can be disturbing. And so, while both patient and physician may want to avoid such a journey by denial and /or diversion, e.g. biological responses or transference / counter-transference, such measures may either fail to identify the problem or refuse to take that first step to a solution.

The matter at hand illustrates this principle. Science and technology have elevated the physical to the status of defining our existence such that function becomes the standard of evaluation of our humanness. This has resulted in the psyche being marginalized. The problem can be identified in two ways. One is that the natural is limited to the physical. The other is that such a view is deficient for it ignores the psychic. This presents two 'solutions'. One is to restrict the physical. But this does nothing for the psychic and decreases potential benefits that come from addressing the physical. The other is to promote the psychic. And so, identifying the problem requires a judgment. This is Aristotle's practical reasoning. (Figure 3.1) However, the more clearly the problem is identified, the better the judgment will be and the more efficacious the solution may be.

The pathways of Figure 4.1 identified three couplets. To understand one element of each pairing as an absolute or dominant becomes problematic for it discounts the other element. This illustrates the principle of identifying the problem as first step to a solution. It also serves as an introduction to the next principle.

B. *The theory of opposites*:

This principle, grounded in the thought of Thomas Aquinas (1225-1274), considers how two or more things may relate. Aquinas presented two possibilities of relationships. One is by way of 'contrariety' whereby nothing is held in common and, therefore, the two cannot co-exist in the same place at the same time. This is the definition of a contradiction. The intent of Medical Aid in Dying is contrary to the intent of Medical Aid in Living. Thus, MAiD and MAiL is an example

of opposites by way contrariety.

Alternatively, things can co-exist by way of 'polarity'. In all polarities there is a whole; however, this whole can be understood in two ways. In the 'distinct *and* separate' mode each part fits 'alongside' the other part(s) such that the parts belong together but nothing holds them together. Thus, the whole is the sum of the parts. In sociological terms this describes a collectivity with the whole being a series of collectives. In the 'distinct *but not* separate' mode the parts fit with each other for each component belongs with the other. This 'within' can be understood in two ways. One view sees the parts as integrated toward the goal of completeness and fulfillment. This integration suggests a process through which parts are being held together externally by human activity. Thus, integration aligns with the moral realm, i.e. what man does.

Another view sees the 'not separate' as a continuum such that the parts are bound together internally as a given by nature and not externally by human construct. This places the parts in the existential realm for each part inheres in the other. And so, while there may be opposites, there is no opposition since there is a whole either by integration or by continuum. This whole is a whole greater than the sum of the parts. This describes a community.

However, as life presents itself what began as a whole can disintegrate such that opposition ensues. Furthermore, while life may have begun as a whole, it may not have materialized as such. In fact, the realization, in the sense of manifestation, of this wholeness is an on-going process always with potential for unfolding. Note that *telos*, the Greek root of teleology, is understood as completeness or maturity which is best understood as a verb as in becoming mature and not as a noun, i.e. a state of maturation.

The opposites speak to culture. Contrariety speaks to isolation and individualism. Both 'distinct *and* separate' and 'distinct *but not* separate' also speak to culture but what is cultivated differs in each. The former cultivates a collectivity of parts; the latter a community of a whole. This cultivation operates at three levels: within medicine as a practice, in medicine as a profession among other professions, and present

in and to the culture of society at large. This principle becomes significant at all levels. It is for us to determine what culture we wish to cultivate and how to cultivate it. However, the concern here pertains to medicine, i.e. the patient and the physician.

Contrariety has resonance with modern medicine as a practice. It was noted that in fiduciary trust, one of the two pillars of medicine's traditional ethos, the physician is to act only in the patient's best interest. However, in managed medical care (MMC), a step on the road to Medical Aid in Dying, interests other than a patient's interests e.g. institutional and corporate, were introduced. This is an example of opposites by way of contrariety for both interests cannot be served in the same place at the same time.

Other couplets, e.g. object - subject, disease - illness, and *bios* - *psyche* illustrate polarity that resonates with medicine. Some may consider these examples of polarity as distinct *and* separate and others may see them as distinct *but not* separate. However, more important than how this polarity is viewed is how it functions. In brief, it is not how the couplet is perceived *in vitro* that matters but rather how it is experienced *in vivo*. The distinct / separate language can either open onto a deeper understanding and appreciation of reality including, or rather especially, medicine as a practice or closes the door to any opening resulting in a permanent divide of polarity.

The difference between integration and continuum can be found in medicine. Science and technology belong to integration for they arise from human activity and, therefore, are external. In addition, while each part is part of a whole and may operate in conjunction within that whole, it can be replaced by a replica of that part. The philosophy of Descartes promotes the view of the body and science (disease) as distinct and separate from the person-as-patient (illness). The success of science has made this view dominant in our time.

A person understood as body, soul, mind, and spirit is a continuum such that 'parts' belong together as a whole. In medicine, then, the person is a whole whereby *bios* and *psyche* belong together not as a construct but as a given. But science and technology is a construct in which only the *bios* is

recognized. And so, there is neither contrariety nor opposites by way of polarity for in the realm of science and technology only the *bios* sphere has status.

C. *The patient as teacher*:

This principle is grounded in what one learns at the 'bedside'. It is expressed in its longer form as follows:

> *The academy bestows upon its graduates a degree in medicine. A licensing authority issues a permit to practice medicine. But it is the patient who makes one a physician for that is how one learns the art of medicine.*

It is helpful to explore this 'classroom' where the patient is the teacher and the physician is the student.

I cut my teeth as a clinician working for Health Canada's Northern Medical Services in the Canadian Arctic. It was there that the image of a triangle and rectangle came to mind in the context of a 'career'. [3] Years later William May put words to this image. This convergence of image and words is presented in the following image:

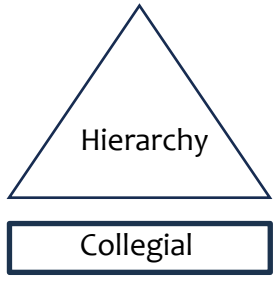

Figure 4. 2 Medicine's two cultures in the 21st century

Commenting on the 'marks of professionals' May noted that . . . "professionals should organize collegially and not hierarchically." [4] I have presented this such that the triangle sits above the rectangle. Collegiality relates to the rectangle; hierarchy to the triangle. The rectangle represents the 'bedside' where the movement is horizontal and the patient is served by the healthcare provider. The triangle represents the 'system'

within which medicine operates. Ofri's observation speaks to this triangle -rectangle dynamic. (Chapter 1, Note 27)

But movement in the triangle is vertical. This occurs in two directions. The occupant of each rung in the hierarchy is accountable to the person above. The movement here is upward. In the common understanding of the term 'careers' advance by upward mobility. But there is also a movement downward whereby decisions made in the triangle are to be acted upon in the rectangle. Policy provides an example of this downward movement. A 'policy' can be understood as person(s) A in the triangle directing B (care givers) what to do with C (patients) in the rectangle where B and C reside. Thus, A has the authority over B but no accountability to C.

An example of this is the Bioethics Table appointed by the Ontario Government to provide guidelines on admission to the ICU in the midst of the COVID-19 pandemic. Of the 12 member Table only a few were physicians. It is doubtful that the physician-members had clinical responsibility for treating COVID-19 patients in an ICU setting. [5] And yet, the guidelines impacted on how physicians (B) who have responsibility to such patients (C). Managed medical care functioned this way as a 'Head Nurse' was transformed to a 'Nurse Unit Manager'.

In addition, Medical Aid in Dying was a policy crafted in the 'triangle'. Its emergence in the rectangle illustrates the presence of the Court, of Parliament, of bioethicists, and of the media. In a sense these were emissaries from the triangle coming to the bedside. A further illustration of the 'policy - bedside' dynamic is when 'experts' in bioethics who occupy the triangle recommended against the conscience rights for those in the rectangle. [6] The image of the triangle and rectangle and how they interact within the practice of medicine speaks to this dynamic.

But there is a further movement whereby some may occupy a space in both settings. Some physicians may become Department heads and thereby 'wear two hats'. Since the cultures of the triangle and rectangle differ, this comes with challenges for the discourse in each setting differs. And so, while one may carry the culture of the bedside to the boardroom, serious challenges to the former may be encountered in the latter.

The rectangle is where the patient is the teacher, the physician is the student, and the subject taught is illness. It is here that the patient's 'experiential text' is written and the clinician becomes literate in the practice of medicine. This literacy is the art of medicine. In brief, occupying the rectangle with the patient is a 'career' path in its own right and while it is not measured by external parameters, it advances for it is there that much of the '*how*' and the '*what*' and all of the '*why*' a physician knows is found. But it also reveals the daunting challenge for both patient and physician of placing illness at the core of the clinical encounter which is, in effect, putting the patient-as-subject back in the centre of medicine. This is the context of 'the patient as teacher'.

IV. Analysis and synthesis:

Analysis and synthesis are critical elements of medicine in both the laboratory and at the bedside. The science of human biology analyses the problem, i.e. pathophysiology, in order to arrive at a position to effect a new outcome. The cause - effect couplet is a process which can be described by another couplet: analysis - synthesis. This is situated in the experimental realm. The knowledge gained through science is placed in the hands of a physician who in turn does an analysis of symptoms (history), signs (physical examination), and laboratory data. This clinical analysis is followed by a synthesis, also done by the physician, whereby intervention is proposed with the intent of addressing the problem. This is the clinical realm of disease informed by science applied at the bedside. And so, analysis - synthesis is also relevant to the bedside. This is the realm of the distressed body. But does analysis - synthesis pertain to the distressed psyche and if so how?

While illness and disease cohabitate in the patient, they occupy different places. Disease pertains to the *bios*; illness to the *psyche* in the sense that the illness aligns with how a disease impacts on the psyche. And so, in the distressed body, i.e. disease, implicates illness and illness implicates the psyche. In addition, the psyche may also be distressed as a primary event. While the distressed psychic as a primary event

may differ in details from a psyche secondarily distressed, there is common ground in that both are situated in the experiential realm. The experimental and the experiential also occupy common ground in that analysis - synthesis couplet pertains to both. However, they operate differently.

The analysis - synthesis of the distressed psyche, whatever the source, differs substantially from that of the experimental or disease context, i.e. the *bios* sphere. The major difference is the source, i.e. the author of the analysis and synthesis. In the domain of the psyche it is the patient who does the analysis and synthesis. It is this way because it inductive reasoning which has the central role in matters pertaining to the psyche. Illness, be it aligned with disease of the *bios* or with mental illness, belongs to the patient for it is what the patient lives with. Note that we commonly speak of mental 'illness' and not mental 'disease' for in the psyche there is no pathway of pathology or associated mechanism of injury. However, the analysis - synthesis couplet speaks to ownership which is the experience of living with a distressed psyche.

In the distressed psyche the chief complaint is determined not by describing the injury although that is important for context, nor by physical symptoms arising from the injury, nor by a checklist of signs / symptoms reflecting a distressed psyche but rather by exploring how the psyche itself has been affected, i.e. whatever is alive in the patient at that moment, e.g. vulnerability, worthlessness, meaninglessness. This is the beginning of ownership. The chief complaint is the beginning, i.e., the first step to a solution, of analysis which in turn leads to synthesis. It is this synthesis which produces the 'existential text' [7] of the distressed psyche.

Of further note is that in a distressed psyche the analysis and synthesis are 'distinct *but not* separate'. However, this is not by way of integration but rather by way of a continuum for the analysis and synthesis come from a single source, i.e. the patient. This is the second principle in action. The patient is the teacher when the physician becomes literate which occurs by learning to read the patient's text. And so, the patient's analysis and synthesis is 'the patient as teacher'. This is the third principle not in the abstract but in reality.

Comment:

The three principles lend themselves to a triangular image for they belong together in medicine as a practice. This is presented as follows.

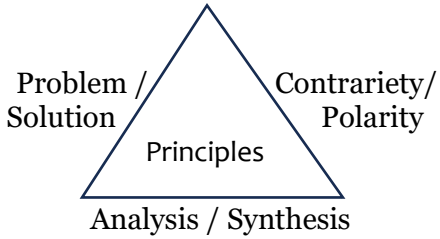

Figure 4.3 The Triangle of Principles

The borders of the triangle are the three couplets: problem / solution, opposites as contrariety / polarity, and analysis / synthesis. Given that analysis - synthesis is central to patient as teacher it is incorporated into the triangle of principles. Although this is not the exclusive purview of the patient as teacher, it belongs to the patient as teacher in a unique and indispensable way without which the ultimate goal of medicine would not be achieved. Of further note is that it belongs to inductive reasoning which is the definitive pathway to knowledge for the patient from which the existential text emerges.

V. Conclusion:

Everything that man as *anthrōpos* does emanates from knowledge. However, knowledge exists not for itself but rather to serve humanity. In medicine as a practice 'humanity' is the patient - the most vulnerable among us. Knowledge has a particular importance to medicine for without knowledge medicine cannot be. Knowledge, then, is central to the matter at hand. The triad of the '*how*', '*what*', and '*why*' of knowledge is the foundation of this Chapter. The '*how*' and '*what*' aspects were introduced via McHugh and Yalom to which the third aspect '*why*' was added here. This has widespread relevance for whatever we encounter demands of us knowing what that

is.

But this relevance is not new. Aristotle's 'practical reasoning', described as 'proportionate' or 'judgment', speaks to this knowledge. His triad of 'doubt', 'submit', and 'accept' (Figure 3.1) are the proportionate and judgment aspects of reality, i.e. what presents itself to us, which in medicine is the patient. Since medicine is a practice, Aristotle speaks to medicine. However, this practical reasoning is not grounded in measurement alone but requires evaluation.

Knowledge is not only essential to medicine but given the subject matter, i.e. disease and illness, this knowledge carries a sense of urgency. A further aspect adding to the complexity of medicine is that both the *bios* and the *psyche* are implicated. No other area of human activity faces similar challenges. For this reason the Pathways to Knowledge (Figure 4.1) are applicable to medicine in a special way. A 'pathway' is not place on which to stand but rather a path to follow. Aristotle's practical reasoning is walking this path. While the pathways may be similar in general terms in both the *bios* and a *psyche*, significant differences do exist. Three principles (Figure 4.3) were put forth to help one walk on whatever path is required, i.e. the *bios* sphere or the psychic realm. And so, too, while the Principles are not more or less relevant in a distressed body and / or distressed psyche, the relevance differs in the details. This is crucial given the division that marks medicine as a practice of our time. Identifying this division is the first step on the pathway.

Observation is the door to knowledge. Opening the door is the '*how*' we know. But since there are two doors, there are two ways of knowing. One is deductive reasoning; the other inductive reasoning. The '*what*' we know comes from the '*how*'. And so, each way of reasoning leads to a 'knowing'. But one way is neither inferior nor superior for each has its rightful place, i.e. the place where it belongs - the place that is 'proper' (appropriate) to its function. It is the challenge of medicine to find this rightful place for each way of reasoning. What has been put forth here is that the two are not opposites by way of contrariety or even by way of polarity understood as 'distinct *and* separate' in the context of medicine. Rather deductive and inductive reasoning are 'distinct *but not* separate'. It is out of

this reasoning that the '*what*' one knows emerges. Knowing the '*how*' and the '*what*' leads to the '*why*'. Of particular importance to medicine is the '*why*'. It is this way because medicine is a practice. And so, the patient is the '*why*' of medicine for the sole purpose medicine is to serve the patient.

It is commonly understood that the knowledge pathway is from '*how*' we know to 'what' we know to '*why*' we know. This is represented as follows: A (*how*) → B (*what*) →C (*why*). However, since medicine is a special kind of practice, the '*why*' has a special place. And so, there is another pathway where the '*why*' becomes the '*how*' from which comes the '*what*'. This is represented in the following: A '(*how*') → B (the '*what*') where A is 'patient as teacher' and the B is what is taught. The patient as the '*why*' now becomes the '*how*' a physician knows the art of medicine which is the '*what*' a physician comes to know through the practice of medicine. It is in this way that the patient makes one a physician. But where is the (C - *why*)? in this dynamic? Without a '*why*' we are left with *une étrange dynamique*. In brief, what is the purpose of the patient as teacher?

On the one hand, the purpose may be seen as the physician knowing the art of medicine. But on the other hand, the *raison d'être* of medicine is the patient and not the physician. It is in understanding 'patient as teacher' in terms of analysis-synthesis that one arrives at the '*why*' of this strange dynamic for the analysis and synthesis belong to the patient. It is this analysis - synthesis which is the *raison d'être*, i.e. the '*why*' of medicine. It is this way because the patient's interest is served by owning the analysis - synthesis.

It is this *étrange dynamique* which concludes not only this Chapter but this section. But it is also a preparation for and introduction to the next section of four Chapters which engage this dynamic by exploring the rightful place of the '*how*', the '*what*' and the '*why*' of medicine as a practice in our time. This exploration begins with the Distressed Body.

Chapter 5

The Distressed Body [1]

Re-framing Medicine by Re-thinking Disease

I. Introduction:

In the 1st century of the 3rd millennium medicine as a practice is largely influenced by science and technology. It is this way for many of the advances that now define medicine come from this source. This approach has focused on human biology, i.e. the *bios* of our human nature. It is in the light of these advances that the patient-as-object has become the hallmark of modern medicine. However, while the *bios* has been the focus of attention via science and technology, the *psyche* and the mind (*mentis*) have not. And so, while patient-as-object is a pillar of medicine today, it stands alone for the patient-as-subject is marginalized.

Munson notes that medicine is not science for the two are 'inherently different'. [2] However, this does not make them opposed. While centered on the person with a disease, medicine, far from being isolated from science, is, in fact, dependent on science. However, neither can medicine exist without reference to meaning. Thus, medicine is an interface between disease and illness. However, when science dominates, as it does today, the person *qua* person is marginalized. And so, physiology trumps ontology, defined as a branch of metaphysics dealing with the philosophical theory of reality. (Funk & Wagnalls) In brief, there is no dialogue between the two. This describes the relationship between science and medicine in our time.

The emergence of science beginning in the 16th century understood nature in physical terms expressed by function. This has gained widespread acceptance in the centuries that followed such that the defining mark of medicine in the 21st

century is patient-as-object. However, this comes at the cost of the patient-as-subject. This context is the basis for re-framing medicine by re-thinking disease.

II. The scientific framing of medicine:

Science and medicine have been companions for centuries. Medicine dates back to Hippocrates (460 - 360 BCE) considered the father of medicine. His contemporary Democritus (460 - 370 BCE) is considered by many as the father of science. Boss has noted Democritus' view regarding the power of knowing causality. (Chapter 2, Note 10) Thus, the appetite for knowing causes was motivated by power. Dupré has outlined how science over the past several centuries came to prominence as a way of understanding the cosmos and all that is in it, including man as *anthrōpos*. Thus, science and its companion technology became a culture such that it has reverential status. This makes them a 'religion' (*re ligare*) in the sense that one is 'bound to' the understanding of man fostered by science and technology.

In Greek medicine of antiquity the notion of disease as a disturbance co-existed with the ontological notion of equilibrium. Disease was seen as an imbalance in nature's forces. The scientific method is dedicated to understanding the forces that disturb nature and mitigating the ensuing imbalance caused by these forces. This is the realm of disease. The ontological is the search for meaning from which a re-balancing, i.e. equilibrium, of disturbed nature is sought. Ontology, as noted, concerns itself with the theory of reality. Illness is the reality in question. The physician treats the disease; the patient suffers the illness.

The scientific method dictates disease and diagnosis but says nothing of the person living with an illness. The following indicates how science frames medicine:

Figure 5.1 Scientific framing of medicine

In brief, science speaks to physiology as a function of reality

but does not speak to the meaning of that reality.

Cassell (1928-2021) noted that disease theory, which arrived from France in the 19th century, postulated that each disease had a singular cause and that all function, i.e. physiology, was founded on structure, i.e. anatomy - micro and macro.[3] Thus, pathophysiology combines the two as disease. Science applied in this framework became identified as *ratio* in the sense of 'measurement'. While science is often presumed to be neutral or value free, the facts, i.e. measured reality, in the scientific age of our time have come to define reality. These facts are not just valued as true but are seen as the entire truth. And so, as science became dominant the patient became identified with what was measurable. Quality of life years (QALYs) noted in Chapter 1 is an example of the dominance of *ratio* as measurement.

While science may deal with measurement of function and structure, medicine is not limited to these domains for medicine also concerns itself with how function and structure are lived. Measure circumscribes what it measures such that what is measured necessarily exists within the borders of the measure. Since the person-as-subject is immeasurable, a lived experience cannot be circumscribed by measurement for it belongs to a different order. Each person is unique and, therefore, not repeatable. And so, too, is each lived 'experience' of function and structure unique to its time and place. Cassell speaks of this in noting that . . .

> (s)cience cannot be the dominant force in medicine because it (medicine) is at the service of *something larger* than itself. Science properly understood, must be conceived as being . . . responsive to human needs. (p.28, *Italics* added)

The 'something larger' is the expression of how the *bios*, i.e. our human biology, is manifested in the lived reality. It is this lived reality which is immeasurable. That something larger is *zōé*, i.e. life as it is lived. The person is more than biology while at the same time is biology. This is not to say that medicine and science do not belong together. However, while science belongs *in* medicine, medicine does not belong *to*, as in 'owned by', science. And yet, science is the 'dominant force' in

medicine today. However, medicine as a practice serves something larger.

III. Some thoughts on re-thinking disease:

Several models, each presenting an understanding of medicine in our time, have been brought forth from various sources. While there are differences in some details, there is also significant common ground among many of the models. Of further note is that while some focus, either primarily or exclusively, on the 'problem', some also offer a solution. What is presented here is a kind of survey of modern medicine as understood from these sources in order to understand medicine as a practice in our time. This will serve as a building block for going forward.

A. Models of medicine:

1. The Biomedical Model of Medicine:

Cassell identifies three couplets in medicine: i.) the physiological / ontological, ii.) the physical / social, and iii.) the individual / societal. (p.3-15) This can be presented as a triangle of three couplets as follows:

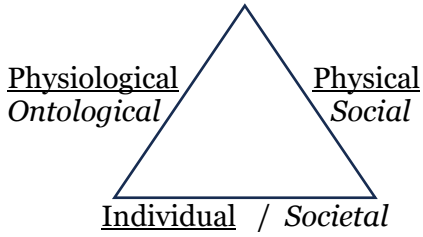

Figure 5.2 Cassell's Biomedical Model of Medicine

The first element of each pairing - physiological, physical, and individual - pertains to disease as fixed and static. The second element - *ontological*, *social*, and *societal* - identifies a reality that is dynamic. While the social and societal have a stronger public presence in this dynamic, it is the ontological, i.e. the intrapersonal, which is expressed, i.e. manifested, in

the social and societal settings. The scientific method engages man as *anthrōpos* understood as physiological, physical, and individual as a patient albeit one-of-a- type disease. While one may not see oneself that way, science does. Moreover, since science and technology dominate our culture, society tends to see us that way also.

Cassell sees conflict within each couplet. And so, the triangle is marred by conflict on every side suggesting that there are two triangles: one dominant and the other subordinate. However, since there is only one patient at every clinical encounter, there can only be one triangle. The triangle, then, is in tension and, therefore, at risk of instability such that dis-equilibrium, while not necessarily present, is a constant threat.

This conflict identifies a problem. As with all conflicts only two outcomes are possible: dominance of one part with a corresponding subordination of the other part or a balance of the two. These outcomes point to the possible 'solutions' in theory. But to go from theory to practice one needs to consider how the conflicting parts actually relate which may differ from how a culture makes them fit together. In a sense, then, Cassell's model presents a 'diagnosis' and sets the stage for a 'therapeutic' response. But there are other models to consider.

2. The Biopsychosocial Model of Medicine:

Engel (1913-1999) has noted the model of medicine in the late 20th centuty was commonly known as the Biomedical Model of Medicine. He speaks to this Model (1977) and offers a response. The dominance of science in medicine is noted in the following:

> The dominant model of *disease* today is biomedical, with molecular biology its basic scientific discipline. It assumes disease is fully accounted for by deviations from the norm of measurable biological (somatic) variables. [4] (*Italics* added)

This dominance is due to measurable parameters which are limited. This limitation is twofold. Measurement is inherently

limited by how something is measured. It is this way because measurement confines what is measured to the boundaries beyond which it cannot be measured. Engel names this the 'Reductionistic Biomedical Model' noting that . . . "it leaves no room . . . for the social, psychological, and behavioural dimensions of *illness*. (p.135, *Italics* added) These dimensions can be can be seen as aligned with the non-dominat elements of Cassell's model.

Engel's model is presented as follows:

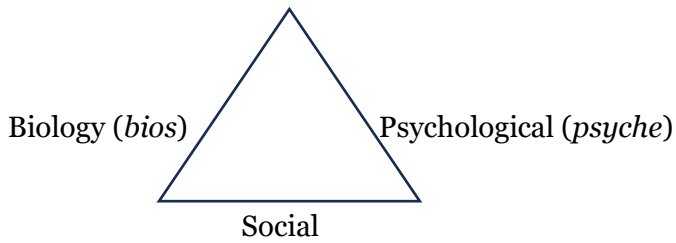

Figure 5.3 Engel's Biopsychosocial Model of Medicine

The use of the term 'disease' is noteworthy. It is not that the 'somatic variables' dominate disease for the somatic is what disease engages. And so, what Engel critiques is not the somatic dominating disease but disease dominating medicine at the expense of vacating 'illness'. Noteworthy also is his introduction of 'behavioural dimensions'.

The fundamental difference between disease and illnesss is described as follows: "(A) genuine *discrepancy* (exists) between *illness* as *actually experienced* by the patient *and* as it is *conceptualized* in the biomedical model. (p.135, *Italics* added) These are two ways of engaging a singular reality. However, where Cassell frames the difference between disease and illness as a conflict, Engel frames it as a discrepancy. Each identifies the problem but understands the problem differently. Noteworthy is that how a problem is characterized impacts on how a solution is sought, i.e. what steps to a solution are taken. The theory of opposites (Figure 4.3) informs the steps available and judgment (Figure 3.1) evaluates whatever options come forth.

3. The Scientific - Narrative Model:

While the 'Biopsychosocial Model' put forth by Engel may not have gained the traction that he had hoped, it has not been abandoned. Rita Charon (1949) has written extensively on narrative medicine. She notes (2001):

> A *scientifically competent* medicine alone cannot help a patient grapple with the loss of health or find meaning in suffering. Along with scientific ability, physicians need the ability to *listen* to the narratives of the patients *and honour* their meanings. . . . This is *narrative competence*.[5] (*Italics* added)

The view of medicine put forth here reaches beyond the scienitifc to the narrative but without abandoning the former for the latter. This is a 'both - and' approach. Crucial to this relationship which is best decribed as a synthesis is 'listening' aligned with 'honouring' what is heard. Listening is the clinician's role; providing meaning is the patient's role. The goal is to honour meaning and thereby honour the patient. This model is presented as a rectangle in Figure 5.4 whereby the scientific and the narrative competences occupy common space. This rectangle resonates with the rectangle of Figure 4.2.

The Competence Rectangle

Figure 5.4 Charon's Model of Medicine

Scientific competence aligns with Cassell's triad of dominant elements since these reflect what science does. Narrative competence resonates with the *bios*, *psyche*, and social of Engel's model as well as with Cassell's non-dominant elements. However, the scientific and the narrative are not in 'conflict' as Cassell indicates. While there may be a 'discrepancy' as Engel suggests, for Charon the scientific and the narrative are complementary. And so, Charon finds unity whereby no element dominates but each element serves the

whole with the whole being the patient. For Charon disease and illness share common ground and each has its own place while respecting the other's place. However, she recognizes that while this is how medicine as a practice ought to be, it is not always the way medicine is in practice.

The relationship, then, is not one of contrariety but one of polarity. Since the patient is the locus of both the scientific and the narrative, the polarity cannot be 'distinct *and* separate' but rather is 'distinct *but not* separate'. However, the polarity is, nevertheless, twofold. The scientific is the product of human activity exploring the realm of nature in search for intervention of a pathway gone awry. The narrative is created out of a given of our human nature. The former speaks to integration; the latter to a continuum. And so, in a sense Charon's model of polarity as 'distinct *but not* separate' is a hybrid of integration, i.e. a human construct, and a continuum, i.e. a given. It is this way because medicine is a practice in the service of the patient-as-a-person whereby the patient has a disease and yet lives with an illness. The former aligns with integration; the latter with continuum.

4. Biopsychological Model of Behaviour:

Engel's introduction of 'behavioural dimensions' into the Biopsychosocial model opened the door to another model. George (2018) notes cognitive neuroscience present in the Biopsychological Model of Behaviour. He comments:

> Psychologists have for some time emphasized a multi-tiered approach to psychological research in what has become known as Biopsychological Model of Behaviour. . . . Cognitive Neuroscience has grown to become one of the most dynamic fields of Psychological study. [6]

George continues by noting that our . . .

> place in the world can be viewed from perspectives . . . 'from sub-atomic through organismic to *cosmic*' is a unique feature of the behavioural sciences. (p. 6, *Italics* added)

This exists as a pre-requisite for . . . "(p)rogress in understanding the nature of brain and behaviour." (p. 6) Of note also is the threefold dimension of sub-atomic, organisimc (the person) and the cosmos.

A threefold dimension *bios*, *psyche*, and behaviour is noted. Considering 'behaviour' as a social dimension, this model resonates with Engel's triad of *bios*, *psyche*, and social. It also resonates with Charon's model whereby *bios* and *psyche and* social pertain to the narrative. This model is presented as follows:

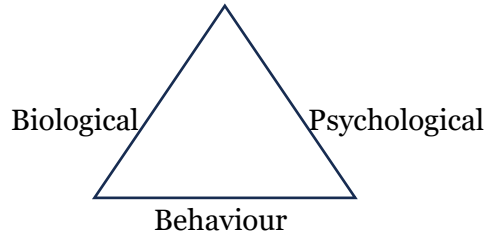

Figure 5.5 George's Biopsychological Model of Behaviour

But can science explain behaviour? Science explores a pathway from event to cause to effect. In the realm of nature as a given the physical follows a pathway. The science of behaviour does not flow from a vacuum but rather is a response to a situation in the here-and-now or with a view of a future there-and-then in mind. There is no uniform pathway in either situation. And so, there is no pathway to follow.

While cognitive neuroscience may offer a window to events, its window opens ***after*** the event for which no pattern exists with respect to behaviour. It is this way for behaviour is individual and personal and, therefore, one-of-a-kind rather than a one-of-a-class event. But this does not mean that behavioural science is a departure from science that has come to us since the 16th and 17th centuries. Behavioural science explores causation ***before*** the event. While the power that behavioural science seeks may be to understand reality, it can also be used to not just inform but also to form that reality

A sampling from the work of Cordelia Fine, a Professor of History and Philosophy of Science, gives substance to this 'science' and problems that come with it. She notes two

researchers from Princeton who in investigating what influences behaviour gave subjects two . . . "(*fabricated*) scientific articles." (1989) In another study (1987) university students were given . . . "*fictitious* descriptions of people who supposedly did well or badly at professional school." [7] (*Italics* added) This is noteworty on three counts.

First the standard of explanatory power of behavioural science falls short of the bar established by science pertaining to human biology. Informed consent, the cornerstone of ethical research, was breached for the research subjects were not fully informed. Indeed, the subjects were not just treated 'objectvely' as in science of human biology but as 'objects' to be acted upon, i.e manipulated. Furthermore, the fact that these studies were published in peer-reviewed journals testifies to the academic standard of behavioural science. In this sampling behavourial science, then, strives to be predictive rather than descriptive. Such 'science' lends itself to manipulaton of its subjects and hence of society. This carries cultural implications.

Three points are noteworthy with respect to this Model. First neurophysiologists saw the potential of their discipline long before 'behavioural science' reached its current status. Boss notes that neurophysiologists, e.g. McLean (1960) and V.S. Mountcastle (1966), bestowed upon their discipline the capacity to explain all human behaviour in neural terms. Rohracher (1953) held that 'excitation' in the nerve cells was the basis of all 'psychic' functions. [8] This puts the psyche in 'play'. However, with respect to behavoural science what is uncertain is for whose benefit - the patient or third parties? Second the advent of the cyber universe gives behavioural science more power to extend its reach into human activity. This elevates the concern as to whose benefit for while the psyche has a crucial role in how we live our humanness, it is also vulnerable to manipulation.

But the most serious issue regarding behavioural science is that, unlike Democritus who sought to know the cause of what happens, behavioural science seeks to 'determine' the cause in the active sense of 'determining' the behaviour before it happens. It is unclear, then, if behavioural science is in search of truth as understanding or is in search

of how to manipulate behaviour. Such power of this 'science' could be used to effect a desired outcome, i.e. a behaviour to serve third party interests such as corporate and / or political interests. In brief, behavioural science can be used to cultivate societies in a direction desired by such interests. In this regard it is noted that behaviour has been aligned with economics [9] and that behavioual science and behavioural economics had a role in the emergence of managed medical care. (Chapter 1, Note 9)

IV. Going forward by looking back: Re-thinking illness

Walter Benjamin (1892-1940) has noted that we back into the future by which he means that we go forward by looking back - not to live in the past but that lessons from the past may come with us. [10] Leder's The Distressed Body, the first chapter of which is entitled 'Rethinkng Illness', aligns with this. The Greek playwright Sophocles (497/96-406/05 BCE), a contemporary of Hipppocrates and Democritus, wrote the Greek tragedy '*Philoctetes*' first performed in 409 BCE. (Aeschylus and Euripides wrote a play of the same name but only that of Sophocles has survived.) '*Philoctetes*' is the cornerstone of Leder's work. He cites Sophocles in the following:

Boy let me tell you of this land.
No sailor by his choice comes near it.
There is no anchorage, nor anywhere
that one can land, sell goods, be entertained.
Sensible men make no voyage here.
Yet now and then someone puts in. [11]

And so, in the voyage of life neither disease nor illness is something that we seek; however, at some point that is where we arrive. Leder, referring to Cassell and others, notes that disease is not the same as illness. He comments: "As disease the condition is objectified, identified with an anatomical lesion or disordered physiology." (p.14, *Italics* original) Disease is defined by medical categories. And so, what 'sets in' is illness by which Leder means . . . "the suffering and

disability as *experienced* by the sick." (p.14, *Italics* added) He sees Sophocles as describing the illness and not the disease.

The play chronicles the loss suffered by Philoctetes, a soldier due to an infected foot unable to set sail with his comrades and journey into battle. Leder describes this loss as follows: "I read Sophocles' play as a reflection, literal and metaphorical, on how illness places us in exile - from our own body, our comrades, the cosmos." (p.5) This loss can be described as intrapersonal in that it affected Philoctetes in his person, interpersonal in that it affected his association with others, i.e. his comrades, and supra-personal (cosmic) in that it affected his place in the world. This describes the lived experience of Philoctetes. Illness is this lived experience. This is presented as follows:

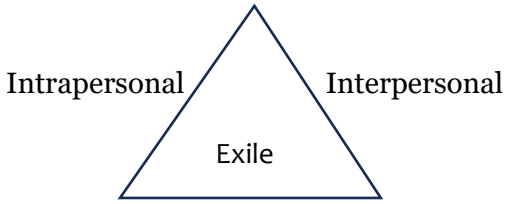

Figure 5.6 Leder's Exile Triangle of Illness

Centuries later Harvey Cushing, (1869-1939) in his own way, echoed this noting that . . . "(a) physician is obligated to consider more than a diseased organ, more than even the whole man - he must view the man in his world." [12] The philosophy of Martin Heidegger (1889-1976) follows this insight of Sophocles in his consideration of *da-sein* (German) which is rendered as 'presence' and 'being there', i.e. 'being-in-the-world'. [13] Both Cushing and Heidegger are consistent with the 'cosmic' dimension that Leder has noted. Heidegger's 'presence' also resonates with Rosenberg's being with the other. (Chapter 1, Note 13) Thus, Cushing (a physician) and Heidegger (a philosopher) follow the creative insight of Sophocles 25 centuries past, possibly, perhaps even likely, without knowing of *Philoctetes*.

On distress Leder notes . . . "it is in the nature of

distress that one is pulled apart, displaced - and also pressed inward (*stressed*)." (p.5, *Italics* original) It is this distress which leads to exile. He concludes that . . . "*illness is exile* (and) to compound the exile is to compound the distress." (p.19, *Italics* added) It is the triple exile which compounds. As much as the distressed body was the seat of the injury to Philoctetes, it also triggered effects on other aspects crucial for human existence to flourish. It is the context of this threefold exile that one can consider illness.

Leder makes further contributions which are fundamental to re-thinking illness. He notes that 'healing' has the same etymological root as 'wholeness'. (p.3) And so, healing implicates making whole what was 'displaced' and, thus, what pulled one apart. In brief, to make whole is to return from exile. Of further note is his reference to the Latin *texere* which carries the sense of 'to weave'. (p.112) The term 'text' has its etymological root in *texere*.

Leder identifies four 'texts' in medicine. The classical understanding of medicine includes the history, the physical examination, and the laboratory data. These he names the 'narrative text', the 'physical text', and the 'instrumental text' respectively. To these texts Leder adds a fourth - the 'experiential text'. (p.78-105) This 'text' is the experience of living with illness. This is illustrated in the following image:

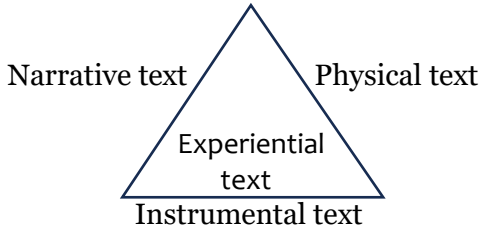

Figure 5.7 Leder's Triangle of Experiential Texts

I take Leder's use of 'narrative' refers to the patient's history in the realm of disease whereas Charon's 'narrative competence' is more encompassing and is more aligned with the experience of illness. The experiential text is placed inside the triangle, the borders of which are the three classical texts. The experiential text is the fullness in the sense of completion

of the threefold dimension expressed in the classical texts for while it includes science, it is not dominated by science. The experiential text, then, is a text of an experience of exile.

A final point relating to the experiential text is its interpretation. Leder cites Baron's response to a patient's comments made while he (Baron) was auscultating the patient's chest: "*Quiet, I can't hear you while I am listening*." (p.93, *Italics* added) This illustrates the difference between 'hearing' and 'listening'. Hearing is a function of the organ of sound, i.e. the ear, whereas listening is a function of the mind which is open to interpret what is heard. This resonates with the views of visualization *vis-à-vis* sight presented in the Existentials of Boss but applied to hearing. (See Chapter 7.) Listening, then, is the *sine qua non* of interpretation. This listening is 'literacy' for it is in listening that one comes to know the patient's lived experience. It is this literacy which relates to Charon's 'narrative competence' which, as noted, is to honour meaning'. (Figure 5.4)

Interpretation goes by the name of 'hermeneutics'. Leder notes that this invokes the name of . . . "Hermes, the Greek messenger of the gods and the mythical discoverer of language and writing." (p.106) In its early years of ascent in the late 20th century bioethics focused on patient autonomy. It is now turning its attention to hermeneutics. But this comes after its focus on utilitarian ethical theory which had a crucial role in the emergence of managed medical care (MMC). And so, when bioethics embraces hermeneutics one may question if its interpretation will align with MMC or with the patient? In brief, whose interests will its interpretation serve?

V. More thoughts on re-thinking illness:

One of Leder's triple exiles was cosmic. George also made reference to the cosmic regarding the Biophychological Model of Behaviour. Understanding the cosmic (*kosmos*) in Greek culture carries some insight into Philoctetes' exile. This has relevance to medicine of our time. On this subject the contribution of the American psychologist James Hillman (1926-2011) is relevant. Hillman notes that . . . " (t)he verb *kosmos* means 'to arrange, adorn, furnish'. Our word

cosmetics is closer to the original sense of *kosmos* than is the Latinate *universe*." [14] (*Italics* original) This contrasts two cultures: Greek and Latin. Hillman expands on this in the following:

> From the perspective of the Greek word the physical world is an orderly arrangement, a display of palpable things; and so it may be conceived as a *whole universe* only because of its *aesthetic* and *moral fittingness* . . . without [which] . . . the word today refers only to . . . an outer, empty, spacey and cold [world]. (p.293, *Italics* added, [brackets] added)

Three points are worthy of note here. The reference to 'whole' resonates with Cushing's comment 'the whole man in his world'. Hillman indicates that *kosmos* has dual features of 'aesthetic and moral fittingness'. The latter I take not to mean morality, i.e. a moral activity, but rather a pre-moral condition, i.e. an existential reality, which when manifested or exercised in human conduct becomes moral. It is these features of *kosmos* which give meaning and content to the universe, thereby making it whole. This is returning from the cosmic exile, i.e. Heidegger's 'being-in-the -world'. But this is not the 'universe' of the Latin world.

Hillman comments further on this contrast between 'universe' and '*kosmos*' noting that . . . " the mode of . . . *response* to the world as *universe* is to seek adequate *explanation*, to the world as *cosmos* to seek sufficient *appreciation*." (p.293, *Italics* added) This Greek (*kosmos*/ appreciation) Latin (universe/explanation) cultural difference is noteworthy for it resonates with our time and especially within medicine. Expanding on this difference Hillman notes:

> When *cosmos* is understood as the *arrangement and expression* of things . . . embellishing each event with its *own* kind of *time and* . . . *space*, cosmos becomes the *interiority* things bring with them rather than the *empty universal* envelope into which they must be brought. (p.294, *Italics* added)

Thus, the Greek understanding of *kosmos* comes with its own arrangement which is expressed in its own time and space.

This expression is the moral and the aesthetic. And so, whatever presents itself to man has its own inherent aesthetic and moral. It is this which is to be appreciated. By way of contrast, the universe of the Latin world is an empty envelope into which what presents itself is not for appreciation but for explanation and, thereafter, is to be enclosed in that envelope. And so, *kosmos* carries an inherent content whereas there is nothing inherent in an 'empty envelope'. What is placed in an empty envelope is a human construct.

Hillman's contribution is noteworthy. He presents several 'contrasts' which are germane to the question under consideration: i.) the cosmic - universal, ii.) the appreciation - explanation, and iii.) the fullness of the interior expressed as the aesthetic and moral of reality - the emptiness of the external with its functional analysis of that reality, i.e. of what presents itself to man. These contrasts can be presented in the image of two triangles as follows:

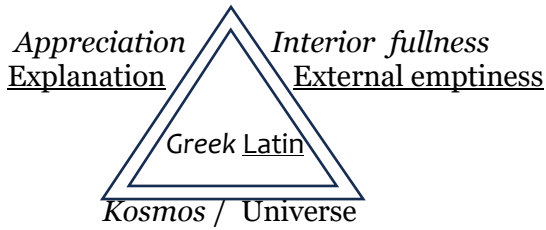

Figure 5.8 Hillman's Culture Triangles

Thus, both the Greek and Latin cultures as presented by Hillman can be seen as two separate contrasting triangles. The Greek triangle speaks of the cosmic / appreciation / interior aesthetic fullness; the Latin of explanation / universal / external functional emptiness. This distinction also speaks to the person-as-subject (Greek - *kosmos* - appreciation) and the person-as-object (Latin - universe - explanation). Framed this way the first element of each contrast speaks to the *psyche*; the second to the body - the *bios* sphere. But as with Cassell's triple couplets, the Greek and Latin triangles can be seen as one since there is only one patient.

Since each side offers two contrasting views, the triangle is under tension. However, the patient is not a

concept but a reality. This tension is what Leder describes as 'stress' with respect to the 'distressed body'. Both Hillman and Cassell speak of culture, albeit different cultures. Hillman speaks of a wider culture whereas Cassell speaks of the medical culture. Noteworthy is the congruence of conflicting borders of their respective triangles even in different contexts. Thus, Hillman's view suggests that the *kosmos* (Greek) and 'universe' (Latin) are opposites not by way of polarity but by way of contrariety. This is further congruence between him and Cassell. This congruence coming from diverse contexts gives credence to their views such that they speak to each other and to us as well. Of further note is that medicine operates within a larger culture. This Greek - Latin context informs medicine and medicine is an expression of the larger Greek - Latin context, a context which has been 'inculturated' (instilled) into Western societies.

However, Hillman, in referring to Swiss zoologist and philosopher Adolf Portmann (1897-1982), bridges the cultural divide between the Greek and Latin worlds. Portmann noted that . . .

> interiority is as essential to organic life as are the useful behaviours of survival. Animal life is *biologically aesthetic*. . . . The aesthetic is rooted in the biology. (p.294, *Italics* original)

This links the biological to the *kosmos*. But the aesthetic of *bios* also links *bios* with the *psyche*. This suggests an opening of including the body as 'aesthetic and moral fittingness' etc. within the context of medicine as the distressed body. To this one could add that this aesthetic of the biological generates appreciation, another feature of the Greek world-view, thereby establishing another link between disease and illness.

This places the distressed psyche *vis-à-vis* the distressed body in a singular focus such that they belong together. This makes the apreciation and explanatory modes and the other Greek - Latin contrasts neither as opposites by way contrariety nor by way of polarity as 'distinct *and* separate' but rather as 'distinct *but not* separate'. Moreover, this relatonship is not a construct, i.e an integration through human activity, but a given, i.e. a continuum within nature.

The Latin 'universe' resonates with the explanation of science found in Cassell's triad in the Biomedical Model of Medicine. (Figure 5.2) Hillman's understanding of *kosmos* aligns with the 'psychosocial' aspect of Engel's Biopsychosocial Model of Medicine, with Charon's 'narrative competence', with Cassell's dynamic aspect, and with Leder's 'experiential text'. Hillman's 'interiority of aesthetic fullness' is the narrative competence (Charon) and the experiential text (Leder) which fills the 'empty enveolpe'. In additon, Hillman's presentation of 'universe - *kosmos*' also relates to Cassell's three couplets of 'conflict'. But Hillman via Portmann bridges the Greek - Latin divide. In additon, Hilllman's views also address the 'discrepancy' put forth by Engel. Furthermore, *kosmos* aligns with the themes of openess and perception found throughout the Existentials. (See Chapter 7.)

Comment:

Several 'models' of medicine have been presented. Each contributes to an understanding of medicine as a practice. Added to these models are world-views in the Greek and Latin cultures. The world-view is relevant for medicine is practiced within a culture and every culture carries an understanding of how the world is and how it ought to be. Both the views and the models carry differences. These differences may be in language and / or in emphasis but also can be more substantial. Moreover, differences within the 'models', e.g. the Biomedical Model (Figure 5.2) and the Culture Triangle (Figure 5.8), are also noted. Each of the three principles presented in Chapter 4 have, to varying degrees, relevance to these differences.

Nevertheless, the common ground is more prominent than the differences. This is noted when considering the second principle, i.e. 'the theory of opposites' for it is through this principle that what may appear to be opposite by way of contrariety is more correctly seen as opposite by way of polarity, be it 'distinct and separate' or 'distinct but not separate' via integration or continuum. Cassell's Biomedical Model (Figure 5.2) and the Hillman's two cultures (Figure 5.8) each in their own way appear to present their borders as

contrarieties but are polar opposites. Thus, even examples of what appears as 'contrariety' contributes to clarity and understanding and suggests a way forward to a solution.

VI. Conclusion:

The scientific method has presented many opportunities to medicine as a practice. This comes about through deductive reasoning, experimentation, and numeracy. This speaks to function. The text emanating from this methd is best described as the 'experimental text' to borrow Leder's reference to '*texere*'. This is manifested in progress in treating disease. It has been suggested, then, that science and technology are the hallmarks of modern medicine. But the reality is that the hallmark of medicine is the great divide between subject and object. The scientific method considers the patient-as-object, i.e. one acted upon, at the expense of the patient-as-subject, i.e. as one with agency. Thus, the scientific method frames medicine as [DISEASE] which is what a patient has. (Figure 5.1)

The 're-thinking' is inductive reasoning. It is this which finds a home in the domain of 'illness', i.e. the experience of living with a disease. This is Leder's 'experiential text'. (Figure 5.7) This speaks not to function but to purpose which is expressed in literacy rather than numeracy. Thus, medicine's divide can also be seen in terms of function - purpose. It is in the experiential text that the patient becomes a subject with agency. It is in learning to read this text that a physician becomes literate. Thus, re-thinking illness leads to re-framing medicine person-as-patient. This is presented in the following:

Figure 5.9 Framing Medicine as Illness

The focus is not on the disease but on the lived experience of illness - the major difference being disease pertains to function whereas illness pertains to purpose. It is this re-framing which invites medicine as a practice in the

21st century to expand its horizon so that the 'empty envelope' of 'explanation' of the disease can be filled with 'appreciation' of the one who lives with the illness. This 'appreciation' resonates with Charon's honouring the patient's meaning.

The sequence of 'person to patient' is intentional and noteworthy for medicine operates in the realm of the patient. The person-as-patient can be considered in two ways. One is through the lens of a 'person-with-a disease'; the other through the lens of a 'person-with-an-illness'. The explanatory power of medicine, in keeping with the aspirations of Democritus, engages the 'how' of a disease but not the 'why' of the illness. This is not a condemnation of the scientific method because nothing (or no one) can be criticized for what it (or one) cannot do. And so, what the scientific method does it does well; however, it cannot do everything. This relates to the first principle which is to identfy the problem as the first step to finding a solution.

It is this imbalance which fosters a search for ways to rebalance medicine as a practice and restore its place as a profession. Understanding is dynamic in that it is never complete and, therefore, invites going forward by buildng on past and present knowledge. An example of this is in noting the three 'couplets' of Cassell's triangle, Leder's 'exile' triangle, and Hillman's views of the Greek and Latin cultures. There is a coherence in these diverse sources. Added to this are views of Charon and Engel. Taken as whole this presents a stronger case for re-thinking illness than each considered separately. However, this does not elminate or even marginalize the science of biology but rather places it in a wider, more inclusive, and more realistic context - a context in which it, too, rightfully belongs.

But this, too, is an introduction to how to view the object-subject division that characterizes medicine of our time. This is the principle of 'theory of opposites' whereby the division can be seen as opposites by way of contrariety or by way of polarity and if the latter as 'distinct *and* separate' or 'distinct *but not* separate' and if the latter by integration, i.e. as a human construct, or as a continuum, i.e. a given of our human condition. Moreover, if it is via a human construct, i.e due to human effort, it can be restructured in another way for

culture is not a given but rather a dynamic of pathways in which our humanness is expressed. How it is expressed is a choice. Several models of medicine and diverse cultures, e.g. Greek and Latin have been considered. These can be seen through the theory of opposites. The final principle is that it is the patient who teaches the art of medicine. It is this way because it is the patient who weaves (*texere*) the text of illnesss. It is the patient who makes the analysis and synthesis of the illness out of which comes the experiential text. This rebalances the great divide.

And so, while modern medicine offers many new therapeutic opportunities, it also comes with challenges which were previously unknown but are now made known. The 'opportunities' and the 'challenges' are a unit for they co-exist in the object - subject divide. This divide is captured in the image presented in the Pathways to Knowledge. (Figure 4.1) To this divide one could add function / purpose. The problem is the divide; the solution is the bridge of the divide. This bridge is both a challenge and an opportunity. Giving illness its proper place rebalances the great divide.

A crucial aspect of re-thinking illness was Leder's reading of *Philoctetes*. However, this was presented in the context of the 'distressed body'. This implicates the psyche as noted by Leder's comment on 'stress' which is 'pressed inward'. But the psyche can also be distressed as a primary event. It is this Distressed Psyche that one now considers in order to further explore the re-framing of medicine.

Chapter 6

The Distressed Psyche - Part I

Re-framing Mental Health by Re-thinking Psychiatry

I. Introduction:

Although the trajectory of this Chapter is in line with the previous Chapter, the three aspects put forth here in the title and sub-title place this Chapter in a different setting. First is that re-framing pertains to Mental Health and not to Medicine Of note is that we speak of 'mental health' and 'mental illness' and not 'mental disease'. While the previous Chapter considered a migration from 'disease' to 'illness', here the starting point is illness. And so, in a sense this expands on the previous material but in a distinct territory worthy of its own space. The second aspect is that it is psychiatry and not disease which is subjected to re-thinking. In order to frame mental health it is crucial to understand how psychiatry 'thinks'. This is an onerous task which can only be fulfilled from within that community and not by one such as this writer from the outside. Nevertheless, while acknowledging this, it is also noted that much of what follows here comes from within the psychiatric community.

The third aspect is the 'Distressed Psyche'. Leder's 're-thinking illness' is grounded in his reading of *Philoctetes*. But the 'distressed psyche' was not considered as such for while the psyche was part of Greek thought in antiquity, the psyche as a seat of pathology may not have been. And so, the distressed psyche may not have been in the consciousness of Sophocles when *Philoctetes* was written. However, Leder did note that the stress of a physical injury was a source of distress. And so, the distressed body implicates the psyche. This suggests that the triple exile noted by Leder and characterized here as personal in three ways - intrapersonal, interpersonal, and supra-personal (cosmic) - also applies to a distressed psyche.

However, while the intrapersonal of the distressed body and the distressed psyche share common ground, they operate in different realms. Leder views what has been named here the 'intrapersonal' as a separation from the body. In the distressed psyche the 'intrapersonal' is internal which may or may not have external physical manifestation whereas in the distressed body the realm is external with secondary internal effect. But a distressed psyche as presented here is a primary event. While other exiles exist, they arise from the intrapersonal. In a distressed psyche as a primary event the intrapersonal is particularly affected. It is this exile which will be considered here.

II. The birth of psychiatry:

Psychiatry was born in the 19th century by which time science, having progressed in the previous centuries, was well established. Descartes' notion of body as a machine gave science a framework in which to explore the natural world. This mechanistic understanding of humanity is described by the Swiss physician Paul Tournier (1898-1986) as follows:

> Just as an automobile is a combination of various machines - cylinders, ignition systems, carburetor headlights . . . so man is a complex ensemble of machines - digestive system, respiratory system . . . etc. - which . . . work together but are nevertheless independent. [1]

The parts of a machine function together but independently such that when malfunctioning a cylinder, headlights etc. can be replaced.

> Tournier continues in noting that . . .
> (t)he ideal of *science* . . . is to isolate these machines from the assemblage and to study them individually in order to understand how each of them *functions* Then each can be reduced to *physico-chemical* processes which are *neither* specifically *alive* nor *human*. (p.39, *Italics* added)

Just as life was reduced to physico-chemical processes so, too, was consciousness and thought. (p.39-40) Psychiatry did not

emerge out of this culture of physico-chemical processes but rather it was within this culture that psychiatry was born. Tournier notes that for Freud (1856-1939) . . . "man . . . is a machine in that he can be reduced to automatism and responds to alleged rigourous psychological determinisms." (p.41) For Freud the *id*, *ego*, and *superego* became the 'parts' of the psyche. It is in this way that the determinism of science came to be applied not only to *bios* and also to the *psyche*.

Two related and relevant points follow from 'then' and 'now'. Since the psyche can be subjected to stress independent of a distressed body, a distressed psyche merits attention in its own right as it is a part of medicine as a practice. Second the thinking that gave birth to psychiatry merits re-thinking.

III. Re-thinking psychiatry - Part I:

A. Introduction:

Science offered a new way of looking at nature. In the context of the human *bios* science has had great success; however, in the context of the psyche not so much. In many cases, but not all, we now know the pathway to disease in the distressed body. However, there is no comparable pathway in a distressed psyche. That is why with respect to the distressed body we differentiate between 'disease' and 'illness' whereas we frame the distressed psyche in terms of 'mental illness'. Since there is no psychic pathway to know, to explore a distressed psyche requires an alternative approach. In addition, since there is no pathway, every journey charts a unique route. With this uniqueness comes an individual variability such that no two distressed psyches are the same. Thus, a distressed psyche invites consideration on its own merit.

Kleinman's Rethinking Psychiatry (1988) makes an important contribution. Noteworthy to this re-thinking was how psychiatry was understood by its practitioners. He notes several 'schools of psychiatry' each with an understanding of human nature. Each school can be seen as a 'pathway' of understanding pathology. However, these schools had views of human nature that were irreconcilable with other 'schools'. (Chapter 3, Note 6) This speaks to the uniqueness of the

human psyche. Kleinman's Rethinking Psychiatry was an answer to a silent question asked of his profession in the closing years of the 20th century.

In the early years of the 21st century a voice was given to the question. In the opening statement of Try to Remember (2008) McHugh asks: "*What's wrong with psychiatry*? . . . I have been asking myself and others this question about the profession that has been my life's work." [2] (*Italics* added) McHugh expands on this:

> I ask it having repeatedly witnessed how . . . *misdirections of thought and therapeutic practice* sweep across the field to dominate opinion and action for years, only to sink from favour and fade away, leaving wounded patients and public scorn in their wake. One must wonder why psychiatrists learn so little from these misdirections . . . *seeing* in human mental disorders *things that do not exist*. (p.1, *Italics* added)

Kleinman and McHugh are kindred spirits in that both are aware of psychiatry's need to find its rightful place.

I take the difference in tone to indicate that the place where psychiatry found itself in 2008 was more urgent than in 1988. It may also mean that Kleinman's concern had gone unaddressed for the question while present was not voiced as it was by McHugh. In brief, it is the same fundamental reality in 2008 as it was in 1988 but with more acuity. And so, it becomes even more pressing for psychiatry to know where it belongs. But with this comes increased relevance of both Kleinman's and McHugh's position. Psychiatry's existential crisis cannot be addressed in isolation for how to understand mental illness is at the centre of its *raison d'être*. There is no modern day *Philoctetes* that expresses this reality. Nevertheless, the distressed psyche of our time is as real as the distressed body of that earlier time.

B. Psychiatry's first thought:

The Freudian school of psychoanalysis was founded on a construct of the unconscious, subconscious and conscious

and the *id*, *ego*, and *super ego*. Tournier sees Freud's thought as . . "a prolongation of rationalistic materialism, extending it to the whole of psychology . . . to reduce it entirely to animal impulses, the *instincts*." (p.40, *Italics* added) Dalbiez, cited by Tournier, noted that Freud . . . "goes almost to the point of regarding as natural in man that which he has in common with other animate beings." (p.40-41) It was in the milieu of man as machine that psychiatry was also considered as a machine. To use Tournier's image of an automobile, instinct fueled the engine that drove the psyche with the unconscious, *id*, etc. being the parts. This 'construct' was aligned with science of the body and, therefore, compliant with deductive reasoning. Thus, the *psyche*, like the *bios*, was given its own determinism. For Freud there was a pathway in the psyche. Since there is a pathway, it can be known and reversed. This is the basis of Freudian psychoanalysis.

> McHugh notes that . . .
> (i)n the 1950s'. . . Freudian psychoanalysis was the dominant *explanatory theory* in American psychiatry. . . . It was deemed the most coherent theory of the functioning mind. (p.23, *Italics* added)

This theory found a central place in the treatment of mental disorders allowing for the dominance of Freudian psychoanalysis to continue into the late decades of the 20th century. However, this approach relied on . . . "drawing out hidden thoughts and feelings of the patients in psychotherapy." (p.23)

In Freudian psychoanalysis the premise was that of a conflict between an 'infant's mental life', i.e. 'infantile desires', and social demands. Since the first social unit is the family, the conflict, according to this theory, existed between the infant and the parental authority. Clinically, this conflict was seen to operate as a repressed memory of sexual abuse by parents which the therapist considered was a 'given', i.e. was considered to be universal, among those who sought help. This served as the patho-psychological 'pathway' giving rise to explanatory power through the treatment of bringing to consciousness this sexual abuse.

The widespread application of this theory led to what

McHugh refers to as the 'repressed memory movement' (RMM) and the diagnosis of Multiple Personality Disorder (MPD). (p.5-22) This led to much harm to patients via psychiatric intervention and to others, e.g. family, through litigation generated by patients, usually women, against innocent adults, usually the male parent. MPD as a clinical entity has been discredited in the Courts where it was successfully challenged through the efforts of McHugh and colleagues and has since been removed from psychiatric practice. One must wonder how a 'repressed memory' can be the basis of distress and therapy for there is no memory! It was this unveiling of RMS (Repressed Memory Syndrome) which exposed the Achilles' heel of Freud's construct. In brief, Freud's theory was just that, i.e. 'theory' not grounded in reality. McHugh chronicles this unveiling in the story of Multiple Personality Disorder (See Try to Remember, Chapters 2-7.)

The veneer of deductive reasoning, the gold standard of explanatory power in medicine pertaining to the *bios*, gave the aura and gravitas of this standard to Freud's construct. However, McHugh notes that . . . "the psychiatrists and therapists did not know their patients. They were blinded by theory and saw . . . (patients) in an overly simple way - always as 'victims'." (p.125) This was following the orthodoxy of a theory which is a bias, conscious or unconscious, favourably disposed to its doctrine. This 'misdirection' led psychiatrists and therapists to seeing 'things that did not exist'.

> For McHugh the key point of this misdirection is . . . that a deductive as opposed to inductive *stance* has a far-reaching effect on a practitioner's mind-set, most evident when directing treatments or responding to challenges." (p.29, *Italics* added)

The key term is 'stance' - a term best understood as a disposition toward the clinical encounter in that one is disposed to interpret the experience in the light of the prevailing theory. McHugh describes this as a 'predisposition bias'. In this way it is theory dictating therapy. While this may be effective where a pathway is known, it is not only ineffective but harmful when there is no knowable pathway. But in the

Freudian construct it was accepted that a pathway was known.

The story of MPD is an example of deductive reasoning. In brief, Freudian psychoanalysis was grounded in a one-of-a-class theory. However, it was groundless for it was based on a psycho-pathological pathway that did not exist. And so, while Freud's theory purported to be explanatory and while it had power in the sense of influence, it had no explanatory power for it did not explain reality. The problem with Freudian theory is not that it was a failure of a deductive reasoning but rather it was not reasoning at all for it was not based on observation and without observation there is no key to unlock the door to knowledge.

To understand this complexity three points are noteworthy. The mechanistic understanding of *bios*, based in Cartesian thought of the body as machine, gives science an opening to explore mechanisms. It is in this exploration that pathways can be determined and possibly reversed. This notion of mechanism goes by the name of 'determinism'. While this may pertain to the *bios* where pathways are known, it cannot pertain to the psyche where pathways are unknowable. Thus, 'determinism' does not apply to matters of the psyche. (Chapter 5, Note 7 speaks to the 'determinism' of behavioral science.)

Dalbiez (1941) noted that psychic factors . . . "can only be demonstrated *a posteriori* and never allows itself to be foreseen." (Tournier, p.41, *Italics* original) Moreover, psychic events are a one-of-a-kind event and not one-of-a-class as proposed by Freudian psychoanalysis. McHugh notes that . . . "identical mental symptoms can emerge from very different provocations." (p.125) While this may suggest one-of-a-class, also expressed as one-of-a-type, category in that there is one destination, it also suggests that there is more than one pathway to a destination. Not only do these different sources preclude mental symptoms being one-of-a-class, it also means that, unlike the *bios*, there is no identifiable 'class' pathway that is open to reversal of the mechanism of injury. Since the psyche only reveals itself after-the-fact and since no pathway can be determined, deductive reasoning cannot provide explanation of a distressed psyche.

For Freud's followers psychic events understood as

after-the-fact revelations were signals of a defect that was based on instinct. Thus, psychiatry's first step was a misstep. But even a misstep is not without value for identifying the problem is the first step to finding a solution. And so, identifying deductive reasoning as the problem allows one to explore a solution. It is helpful to consider current thinking in psychiatry.

IV. What psychiatry knows:

The gold standard of causation was established in theory by Democritus. The science of causation has made this standard a reality. While this standard is not available to psychiatry as the psyche does not lend itself to exploration of cause, science also operates in the realm of association. The classic example of this science is found in Public Health. This is illustrated in the COVID-19 pandemic. While the science of causation gave rise to the diagnostic tests and vaccines, the clinical application relied on science of association to verify the efficacy of vaccines and other preventive measures. Typically, such science relies on studying large sets of populations within which while some standard features are present so, too, are numerous unique features some of which may not be identifiable. Thus, the population is by nature heterogeneous in spite of attempts at homogenization. While there is value to science of association in specific settings, this value is of a lower standard than science causation. Nevertheless, this standard has merit in the appropriate circumstances.

A. Psychiatry and science of association:

By the very nature of the limitation of our existence there is a *pathos* in the psyche. But this differs from the *pathos* of the body. Unlike the body, the psyche, in spite of proposed past theories, e.g. *id*, *ego*, *superego*, consciousness and sub- consciousness does not consist of easily demarcated parts. The distressed body reveals its pathophysiology and, hence, pathway. However, the distressed psyche reveals no such path (pathophysiology). Thus, the basis of therapeutic

intervention of the psyche must lie elsewhere than in science of causation.

The reference text for psychiatric practice is the Diagnostic and Statistical Manual of Mental Disorders (DSM). A cornerstone of clinical psychiatry consists of administering diagnostic scales to evaluate a patient's symptoms. In this regard a depression scale, of which there are several, provides the classic example. The patient is asked to evaluate, i.e. quantify on a numerical scale, the severity of a series of symptoms and signs with the score tallied at the end to give a 'depression rating'. The same scale can be used in follow-up visits to 'evaluate' progression, regression, or stability. This is a form, albeit somewhat weakened, of 'numeracy' that is encountered in science of causation regarding the *bios*.

However, a symptom or sign of the 'same severity' may be evaluated differently by different patients such that the 'numerical' scores between Patient A and Patient B are not interchangeable. In addition, while every symptom / sign evaluated is given equal weight on the scale, each symptom or sign may not be of equal significance to that patient. In brief, not only is the same score to a question not comparable from patient to patient, neither are the questions themselves of comparable significance. And so, two patients may have the same 'depression rating' but have very different distresses in the psyche. In brief, no two distressed psyches are the same. Furthermore, the design of such scales can carry a bias and, therefore, may generate an outcome bias. On the issue of checklists McHugh and Slavney have noted that mental illness requires more than such an inventory. [3]

A second example also illuminates the soft underbelly of psychiatry as a science. The DSM-V lists 9 traits of Narcissistic Personality Disorder (NPD), the diagnosis of which requires the presence of at least five of the traits listed. However, a review of the traits suggests that these features are more likely to be identified by a third party rather than by the patient, i.e. by self-reporting, or by the clinician through the clinical encounter. Thus, while NPD is listed in the DSM, it is under-diagnosed since few patients will self report these traits. Moreover, these traits are 'soft signs' open to degrees of presence and not as absolutes of presence / absence (Yes /

No). In addition, a narcissist may knowingly mislead the clinician. This complicates interpretation, thereby making the 'diagnosis' less reliable than science demands or the patient needs. It also leads to under diagnosis.

But there is another aspect of clinical importance to the NPD scale which goes unnoticed. Because of the factors noted above it is unlikely that many practitioners outside of forensic psychiatry where NPD surfaces have much clinical experience with NPD. And yet, a third party may suffer a distressed psyche due to 'narcissist abuse syndrome' whereby a patient not meeting the NPD diagnostic threshold inflicts harm on another. And so, not only may psychiatry outside of the forensic realm rarely diagnosis NPD neither is psychiatry attuned to the trauma that narcissist traits insufficient to diagnose NPD may cause a third party.

'Narcissist abuse syndrome' is not identified in the psychiatric culture of medicine but is commonly described in the psychological literature, both popular and professional. [4] While psychology may lack the standardization demanded by medicine, this does not, by itself, discredit what is reported in its literature if what is reported reflects a patient's experience. Therapists / counsellors situated outside of mental health institutions do not operate under the same diagnostic imperative of the DSM that governs those who work within such a setting. The two settings do not engage the patient through the same clinical lens. Thus, different clinical realities may emerge or remain hidden depending on the site of the clinical encounter. The 'narcissist abuse syndrome' identified outside of the DSM may be one such example.

'Narcissist abuse syndrome' has been missed and will continue to be missed by those who embrace the orthodoxy of the DSM as the standard of engaging patients with a distressed psyche. This speaks indirectly to McHugh's point about the reach of a 'deductive stance' that fails to understand where symptoms come from and not knowing this the clinician cannot know the patient. This speaks to a 'predisposition bias'. It also speaks to the point made about reliance on diagnostic scales.

A third development of note regarding the DSM was the debate within the psychiatric community concerning

'bereavement'. The context of this debate was updating the DSM from version IV (1994) to version V (2013). Under DSM-IV bereavement was an exclusion criterion for diagnosing a major depressive disorder (MDD). While bereavement is real, whether it constitutes a 'mental disorder' was open to question. [5] This question was answered in the affirmative by the psychiatric community. Moreover, it was concluded that grief lasting more than two weeks post-event was recognized in DSM-V as pathological, i.e. as MDD, and, thus, merited therapeutic intervention by counseling and / or medication. On this Elliott's comment may be of more than passing interest. [6] In addition, this, to use McHugh's language, would be considered as a mental disorder which does not exist and, therefore, be an example of a 'misdirection'.

Thus, interpretation of depression ratings is complex and standardization of the scales is elusive. The use of scales in personality disorders such as NPD where presence or absence (Yes / No) leads to - or not to - a 'diagnosis' depending on the number of traits identified is also unreliable and complex for reasons noted. These are the hallmarks of 'science of association' as applied to psychiatry. Such scales are an attempt to make a science out of a patient narrative. This serves the clinician's imperative for a diagnosis compatible with the DSM since DSM operates by symptoms. However, since the same symptoms can have different 'causes' or sources, this makes a classification on the basis of symptoms problematic. The result is that psychiatry bestows on the DSM the status of diagnostic orthodoxy while, unlike other areas of medicine, lacking the scientific foundation to support this position. [7] On this difference between the DSM and other medical manuals McHugh notes that the DSM . . .

> is not 'systematic' . . . being a diagnostic system based on *symptom patterns rather than causes*. . . . (T)his affects how one *must* think about any condition it lists." (p.144, *Italics* added)

Regarding classification of medical and surgical matters McHugh refers to the International Classification of Disease (ICD) originating in the mid 19th century which classifies systematically by cause and mechanism. He notes that . . .

> the ICD-10 describes the common symptoms of each disorder to identify how the condition *ordinarily* presents itself. *But* it *also stipulates* how *similar symptoms* can *arise from* very *different conditions* and so emphasizes that *symptoms don't tell* the *whole story*. (p.142, *Italics* added)

This suggests that the DSM gives more weight to the symptoms such that different sources of the same symptom are not considered. This speaks to the orthodoxy of the DSM.

The 'numeracy' of 'science of association' of symptoms characteristic of psychiatry's approach to a distressed psyche cannot provide the same reproducibility and verification as 'science of causation' applied do human biology. One concludes that any claim by psychiatry to be a science is suspect and any aspiration by psychiatry to be a science is mis-directed.

B. The psyche and the brain:

In referring to the 'schools of psychiatry' Kleinman included the 'Biological School'. This calls to mind the scientific method applied to our human biology and the many diagnostic and therapeutic advances in modern medicine that ensued. But psychiatry, rooted in the *psyche*, does not lend itself to this approach. It seems strange, if not incorrect, then, to locate or associate a biological school within psychiatry. But the advent of cognitive neuroscience brings biology to psychiatry. However, it should be noted that while every organ of the body is unique, the brain is especially so for it does not easily give up its biological secrets. It is this way for human behaviour is more complex than anatomy and physiology. It is through neuroscience that a distressed *psyche* is manifested in the *bios*. This has led to an approach by some such that 'biology' finds a home in psychiatry.

In his work on 'Trauma Care', van der Kolk (2015) relies on the *bios*, i.e. the physical, to address the distressed psyche. The core psychiatric diagnosis he uses to illustrate this is Post Traumatic Stress Disorder (PTSD). Advances in knowledge of the *bios*, notably neuroscience via neuroimaging and neurochemistry, allows for greater understanding of how

human biology responds to a psychic event. This fits the domain of psychosomatic illness whereby a psychic reality finds expression in the physical. This has led to numerous modalities of treatment which are frequently, directly or indirectly, physical, e.g. physiotherapy, art, music, dance, EMDR (eye movement desensitization and reprocessing) and yoga, augmented with psychotherapy. [8]

Common to both psychosomatic illness and Trauma Care is that the body is the physical manifestation of the psychic event such that the latter is addressed via the former. On the surface this appears similar to the scientific method of deductive reasoning which was so successful and powerful in the *bios* domain. However, on closer view the two are substantially different. In the distressed psyche neuroscience is a marker of the biological consequence associated with the event but does not and cannot open onto a pathway from the observed event to evaluation of its cause and then effect a new reality. The observation in psychic trauma is described as an 'after-the-fact' approach to a one-of-a-kind event. This is a *cul de sac* with respect to knowing a biological pathway. While biological knowledge emerged from neuroscience and while relevant to a degree, this knowledge falls short of the standard of deductive reasoning. Nevertheless, as van der Kolk shows, it has application to a distressed psyche.

Cognitive neuroscience provides a 'look into' the brain not to determine the source but to identify what part of the brain is affected by the event. This does not show a pathway, i.e. how one arrived at where one is, but rather only where one is on the road at that moment in time. While in theory this may help to inform modalities of therapy, such modalities are situated in the domain of antidotes. Such modalities, if effective at all, usually require continued application.

Central to McHugh's thought is that the same mental symptoms of a distressed psyche can have a different source. A corollary to this is that the same event may affect two people differently. This is illustrated by van der Kolk's example of a couple involved in a car accident in which different biological markers and different psychological symptoms of the same event emerged. (p.65-73) This indicates that people react to the same trauma in a way that is specific to their psyche. In a sense

the 'same' trauma is not really the same for any lived experience of a person is unique to that person since one experiences that trauma through one's psychic lens. This is a 'one-of-a-kind' response. This view is supported by different neuroscience findings in each subject which are after-the-fact signals.

While there is some correlation between signals and symptoms / signs in some cases, it is unclear if this is sufficient to target some physical therapies over others. However, even if that were possible, what it offers is an antidote to the injury and not its reversal. One limitation is that the physical treatments may be never ending. While this is not unlike the distressed body, e.g. diabetes etc., the distressed psyche is not or ought not be destined for chronicity at least not by default. The other limitation is that the biological response to trauma is individualized and not a pattern. But here, too, one notes that Leder's experiential text is also an individualized response to the distressed body. But the limitation of individuation in the distressed psyche remains and is significant in that there is no universal pattern, i.e. 'one-of-a-type' response, in the distressed psyche. It is this limitation which differentiates neuroscience applied to the psyche from science applied to *bios*.

Trauma Care as promoted by van der Kolk engages what he calls . . . "a bottom-up approach . . . to change the patient's physiology." (p.72) But this statement claims more than it can deliver. For 'bottom up approach' read after-the-fact. This suggests that the physiology can be changed after the fact. But to neutralize the physiology while engaging physical modalities is not the same as changing the physiology for the journey travelled by the distressed psyche is still on an unknown route. Such a claim, then, is similar to the Freudian example of appearing to be deductive reasoning but lacks evidence that it is. This view bypasses the reality that deductive reasoning not only does not but cannot operate in the realm of the psyche. Cognitive neuroscience does not provide Trauma Care with the explanatory power that comes with deductive reasoning. It provides what McHugh described earlier as a 'deductive stance'.

McHugh sees PTSD in a similar light to MPD in that

both are a 'misdirection'. It is not that the distressed psyche is not real but rather that it is misconstrued by the diagnosis. He also notes that those clinicians who were attracted to MPD as a diagnosis are also attracted to PTSD with similar enthusiasm and psychotherapeutic modalities. He comments:

> (T)he same colleagues . . . and others emerged . . . talking about the need for '*long-term psychotherapy*', the 'working through [of] traumatic memories' and even, reintroducing 'hypnosis' [as] useful in teaching patients about the *dissociative* nature of their symptoms. (p.195, *Italics* added)

The point for McHugh is not that the *pathos* of the distressed psyche is not real but rather how it is understood.

In the light of this van der Kolk's comments regarding one of the participants in the car accident noted above is of interest. One patient exhibited 'depersonalization' which is described as a symptom of . . . "massive *dissociation* created by trauma." (p.72, *Italics* added) He continues: "(R)esearch confirms what our patients tell us: that the self can be detached from the body and live a phantom existence." (p.102) This sounds like Leder's exile from the body. This comes with clinical challenges. In a therapy session with the patient van der Kolk speaks of this challenge:

> All the energy drains out of the room. . . . A *lifeless patient* forces you to work much harder to keep the therapy alive, and I often used to pray for the hour to be over quickly. . . . Conventional *talk therapy*, in those circumstances is virtually *useless*. (p.72, *Italics* added)

He continues noting that . . . "(w)hile *reliving trauma* is dramatic, frightening and potentially self-destructive, over time a *lack of presence* can be even more damaging." (p.73, *Italics* added)

There is much to unpack in these comments. A patient who is 'lifeless' is one who is absent even to themselves. This becomes problematic for the therapist can find it difficult to be present to another who is absent. Van der Kolk testifies to this. Given this reality the observation of the futility of 'talk therapy'

is illuminating for two related reasons. First it raises questions about the place of psychotherapy in PTSD. Second it indicates the limitations of the biological, i.e. neuroscience, in engaging the distressed psyche of PTSD. These concerns relate to '*what*' and '*how*' psychiatry knows.

Comment:

McHugh notes that the same symptoms can have different 'causes'. While this may suggest that there is no common pathway, it does suggest that there is a common destination. And so, the DSM system of classification is symptom-based, thereby making psychiatric treatment symptomatic. On the other hand, van der Kolk's example of the car accident shows that the same event can produce different symptoms and different neuroscientific findings. But here, too, treatment is symptomatic. Both positions resonate with the question: 'What does psychiatry know?' and suggests that the question remains unanswered.

This invites an exploration of '*how*' psychiatry knows. While McHugh and van der Kolk have different views on the dynamic of what psychiatry knows, they do share common ground. Both positions are based on the symptomatic realm. This is best described as the external domain, i.e. how reality is manifested. But just as the fruit of a tree is a manifestation of its root and the ethical is a manifestation of the existential, the external originates from the internal. And so, both McHugh and van der Kolk, each in their own way, identify the problem, which is the '*what*' question and suggest a way forward which is the '*how*' question.

V. Inductive reasoning and the *psyche*:

The previous section considered the '*what*' of knowing. Based on McHugh's critique and other elements presented '*what*' psychiatry knows is questioned and requires a re-thinking of psychiatry which is what Kleinman proposed. The starting point on this quest is to consider the '*how*' of knowing for the '*what*' follows from the '*how*'.

Common to all knowledge is observation. But that is

only the beginning. Knowledge emerges through reasoning for without reasoning one deals with opinion and not judgment. (On judgment see Figure 3.1.) In considering 'What does psychiatry know' the focus was on deductive reasoning. But in McHugh's view this revealed what is wrong with psychiatry. This was chronicled in MPD. Similar features were noted in how some clinicians approach PTSD. Common to both was the presence, more or less covertly, of deductive reasoning. But throughout his critique McHugh also noted an alternative approach that psychiatry may wish to consider. This approach is inductive reasoning.

The defining feature of deductive reasoning is a three step process from observation of an event to determining its effect on a pathway which leads to efforts to understand how to reverse or mitigate the injury. In schematic form this is written as cause → effect. However, since there is no cause → effect dynamic identifiable in the psyche, there is no pathway. This does not mean that reasoning has no role in psychiatry but rather that reasoning cannot be deductive. However, McHugh notes that teaching in psychoanalysis encourages students . . . "to work *deductively* from theoretical presumptions, Freudian suppositions, and particular key symptomatic presentations." (p.27, *Italics* added) For McHugh this pedagogical method is the problem which is a first step to a solution.

Boss speaks of the psyche and deduction in the following:

> Neurophysiological hypotheses, even when . . . helped along . . . by information theories are dead ends. . . . (The) natural scientific explanations *cannot coherently deduce* the psychic from the somatic. . . . (because) somatic processes never touch that realm which is the actual place of all perception, feeling, thought, memory, desire, and consciousness where everything psychic actually dwells. [9] (*Italics* added)

Not only does the somatic, i.e. neuroscience, not touch the internal realm in a pro-active sense, it arises from the internal. And so, neuroscience does not lead to the 'internal' but rather

comes from the internal. This is 'pathway' travelled in one direction only and travelled only once. It is akin to breaking trail snowshoeing with no two trails being the same and no two people breaking the same trail.

Thus, in spite of the introduction of neuroscience, deductive reasoning is not integral to psychiatry. This view is supported from different sources. First 'neurophysiological hypotheses' speak to behavioural science as noted above. But Fine's examples revealed how problematic this science is . (See Chapter 5, Note 7.) Second the comment from Boss resonates with Trauma Care as put forth by van der Kolk in three ways. One is the 'misdirection' of scientific explanations, i.e. neuroscience, in PTSD. Second is how psychotherapy, i.e. van der Kolk's 'talk therapy', was dismissed in the example of depersonalization. This dismissal was removing oneself from the place of all perception. Third there was no observation of the dynamic within the distressed psyche. Without this observation there can be no advancement of knowledge.

A final point is that through his exposure to neurology McHugh sees inductive reasoning as the preferred source of knowledge in psychiatry. This is not a default position but one based on what inductive reasoning offers. Boss continues noting that the place of perception is the . . .

> realm . . . (of) day-to-day existence in a world with all its . . . joys and sorrows. . . . But in such a world there is nothing at all that submits directly to measurement or calculation." (p.29)

The 'day-to-day existence' is what McHugh describes as the 'here-and-now'.

On this subject McHugh refers to the work of the German psychologist Kurt Lewin (1890-1947) . . .

> who held - in contrast to Freud - that most people's emotional and behavioural problems related to their current circumstances . . . and how they were *responding to* them. (p.207-8, *Italics* added)

This is the here-and-now in contrast to the emphasis on the known past trauma which is the basis of the PTSD and the unknown, i.e. 'repressed memory' of MPD. Also of note is the point of 'responding to' which resonates with Frankl's view

that one is not responsible ***for*** but rather ***to*** life. However, McHugh via Lewin reveals how difficult being 'responsible to' can be. Yalom, whose thought aligns with that of Frankl, has also noted the importance of the here-and-now in his practice and teaching. Here, too, Yalom reveals the burden of being responsible 'to'.

The importance of the 'present' to McHugh, Yalom, and Boss is noteworthy in contrast to the place given to memory in MPD and PTSD. This, it seems to me, is central to understanding psychiatry for the past, i.e. focusing on memory, is what is 'wrong' with psychiatry. McHugh, refers to the work of Elizabeth Loftus (1944) who noted that . . . "human memory is vulnerable." (p.203) The point that McHugh via Loftus makes is that this vulnerability is being vulnerable to 'suggestion' by psychiatrists and psychologists. The RMM (repressed memory movement) illustrates how problematic this vulnerability can be. I see this as the external position re vulnerability, i.e. the view from the outside. But there is another position which is the view from the inside, i.e. the patient's view. This is the internal position which will be surface later. (See Sections VII and VIII below.) And so, the problem is not memory *per se* but vulnerability. But it is also which vulnerability - external or internal. This speaks to the first principle: understanding the problem is the first step to finding a solution. Inductive reasoning is that first step. But through vulnerability it also speaks to the principle of 'patient as teacher'.

McHugh frequently refers to inductive reasoning in contrast to deductive reasoning. Since the latter is identified with what is wrong with psychiatry, the former, it is suggested, is how to right the wrong. The adjective that he often uses to describe inductive reasoning is 'empirical' which is defined in terms of 'observation' and 'experience'. [10] Inductive reasoning, then, is knowledge that arises from observation and experience. The patient with the distressed psyche is the observer and participant of that experience. '*How*' psychiatry can know, then, starts with knowing the patient with a distressed psyche. This introduces the second path to knowledge - inductive reasoning. Having shown how deductive reasoning is not a pathway to knowing the psyche, one

considers if and how inductive reasoning can cast light on the psyche. But first one turns to the '*why*' of knowing in the context of a distressed psyche.

VI. - The '*Why*' of knowing:

A distressed psyche is the '*why*' of knowing. Since illness pertains to *zōé* (life), what Leder says about the distressed body in re-thinking illness also speaks to a distressed psyche. However, there is a notable difference. A distressed body implicates the psyche. While this implication is real and merits attention, it is a secondary development. In brief, the *bios* also touches the psyche. But the psyche can be distressed as a primary event. This, too, merits attention. Leder's The Distressed Body (2016), grounded in the experience of Philoctetes, was necessarily limited to the *bios* for the *psyche* was, unlike our time, not part of the medical context of Ancient Greece. Although there may not be a modern day equivalent to Sophocles' literary character, Leder's medical insight to Philoctetes-as-patient speaks to our time in two ways.

Just as there is a triple exile with respect to a distressed body so, too, there is a triple exile in a distressed psyche. (Figure 5.6) However, while the image may be relevant, the substance differs. In a distressed psyche the injury is directed to the psyche - the seat of the emotions. The problem is not just with the emotions but rather that the emotions have no place to sit. Every injury that directly affects the psyche touches the intrapersonal first and foremost. This differentiates a psyche primarily distressed from a psyche secondarily distressed. This intrapersonal exile as the primary injury produces other exiles such that a primary injury to the psyche handicaps a person's presence in the interpersonal and cosmic realms. Nothing is untouched by a distressed psyche suffering a primary injury. And so, while everything needs to be made whole, this begins with the intrapersonal.

A second relevant aspect concerns the 'texts' of the clinical encounter. A major contribution from Leder is the 'experiential text' which is a text that the patient weaves out of the lived experience of illness in which the classical triad of

texts is present. (Figure 5.7) However, since deductive reasoning and science of causation are not applicable to a psyche primarily distressed, the text emanating from a psychiatric encounter is grounded solely in the patient's inductive reasoning. However, while the door to deductive reasoning is closed, the door to inductive reasoning is available. This is an invitation to psychiatry. It is this reasoning which defines the context out of which a 'text' emerges. This text is named here as the 'existential text'.

And so, re-thinking psychiatry is to reason inductively. But this is a new '*how*'. It is with this reasoning that one engages Kleinman's other 'schools' of psychotherapy in order to see to see if it leads to '*what*' psychiatry may come to know and if the '*what*' may lead to a '*why*' in the sense of purpose of knowing.

VII. Re-thinking psychiatry - Part II:

Among the schools of psychiatry that Kleinman mentioned were biological and psychoanalytical schools. The role of cognitive neuroscience was noted in biology applied to PTSD. Of the psychoanalytical schools three from the Viennese School were noted. Of these three the Freudian School of Psychoanalysis was the focus of McHugh's Try to Remember. This leaves two other 'Schools' to be considered, that of Alfred Adler (1870-1937) and Viktor Frankl (1905-1997). These will be considered not from the perspective of past, i.e. memory, but rather from the view of the present, i.e. the 'here-and-now'.

A. '*You cannot step into the same river twice.*'
Heraclitus 6th-5th century BCE

Adler's focus was on the feeling of inferiority as a defining feature of the human condition. This resonates with 'vulnerability' noted earlier. Adler's focus generated the view that the primary human drive is ordered to power such that the cause and the response are founded in power. This power motif resonates with Nietzsche's 'will-to-power'. (See Chapter 2, Philosophy in Medicine.) There is a power in the dynamic of

the water flowing in a river. This 'river' is the river of life. Heraclitus, thus, speaks to Adler's school of psychotherapy in which vulnerability and power are prominent.

Noteworthy is the comment of René Dubos' (1901-1982) on power and vulnerability. He notes (1968) that . . .

> (m)an is both the most powerful *and* most vulnerable of creatures possessing intelligence but lacking in protective instincts, master of his environment yet often its victim." [11] (*Italics* added)

By 'environment' Dubos means the social environment, i.e. culture. This vulnerability is not limited to the vulnerability to suggestion noted by Loftus but includes an internal and existential vulnerability. However, neither is it unrelated since, for Dubos, vulnerability is a part of the human condition.

Power can be exercised in different ways. It can be used to serve the self by exploiting others or to serve others. Its exercise, be it spiritual, psychological, intellectual, physical, financial, or professional etc., to exploit the vulnerable is an injury to the psyche. This is Dubos' 'victim'. But a third option is neither to serve others nor to exploit others but rather to forego its exercise altogether. This is 'non-use' of power. This is Dubos' 'vulnerability' amidst the lack of 'protective instincts'. This is presented in the following image:

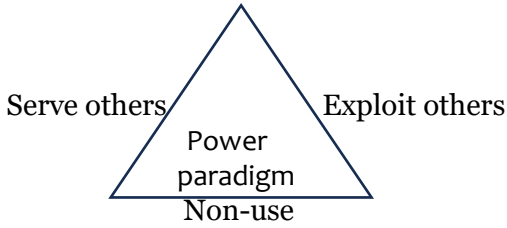

Figure 6.1 The Power Paradigm

It is in this light that Adler's 'school' is significant for it is this power, used or unused, which relates to a distressed psyche as a primary phenomenon whereby one is treated as an object to be acted upon and not as a subject with agency. This, too, can result in a depersonalization noted by van der Kolk.

And so, to respond to this 'lifeless' existence one needs to learn presence to oneself. This is McHugh's ownership and mastery. This means un-learning the non-use of power and learning its proper use which is to serve others. In a distressed psyche the most important 'other' is the 'self ' because it is this self who is the most vulnerable. It is this way because it is the intrapersonal which has been exiled.

The American psychiatrist Stephen Karpman envisioned the power motif as a drama in which a person can occupy one of three roles. This is presented in the following:

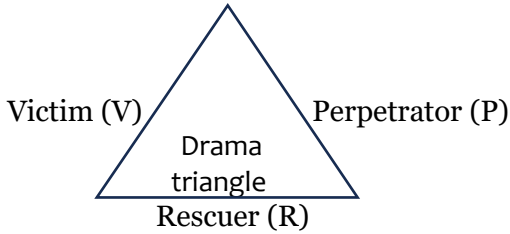

Figure 6.2 Karpman's Drama Triangle (1968)

Most notably is that the roles are interchangeable such that the same person can and does occupy another role in the drama but not at the same time. The dynamic is using others to meet one's needs. The features of this drama are power, powerlessness, and distrust. Each role is negative.

Choy adapted this to The Winners' Triangle (1991) in which the three points are V as 'voice' / 'vulnerabilities', R as 'caring', and P as 'assertive'. The introduction of V as vulnerability is noteworthy and resonates with comments above by Dubos and Loftus. The features are ownership, responsibility, and trust. Each role is positive. The dynamic is to assist V in taking ownership.

A further adaptation, TED (The Empowerment Drama) has the three points C-1 (creative =V), C-2 (challenger = P), and C-3 (coach = R). The features are creativity, ownership, and trust. Each role is positive. The dynamic is helping V find solutions. Noteworthy is the introduction of creativity and the facilitation of the creative process. Trust is key to ownership. However, that trust is not earned trust of others but rather is learning trust of the 'self '.

The 'Power Paradigm' can be seen as generic with the 'drama triangles' being specific examples of how the power may function. In addition, Karpman's Triangle can be seen as 'analysis' with the Choy and TED Triangles being examples of 'synthesis'. The features of all three 'drama triangles' are presented in the following Table:

Table 6.1 The Power Paradigm in the Drama Triangles

Karpman's Triangle	Choy's Triangle	TED Triangle
V - victim	V - voice	C-1 (V) creative
P – persecutor	P assertive	C-2 (P) challenger
R – rescuer	R - caring	C-3 (R) coach
-ve	+ve	+ve
using others	ownership	solutions

These Triangles illustrate how power can be used either positively or negatively and if used negatively to generate a distressed psyche how one may respond positively in addressing the injury. The point here is not to endorse any particular Drama Triangle but to note that in engaging the distressed psyche each Triangle acknowledges that power is activated. Common to all three is that in a distressed psyche power in one or more of its three forms, is present in the genesis of the distress and in its response. The non-use of power resonates with the 'sense of inferiority' as per Adler and with one's lack of 'protective instincts' as per Dubos. The 'Drama Triangles' speak to Adler' school of psychotherapy.

The citation of Heraclitus noted above is significant on two counts. First he is one of the two pillars from Ancient Greece upon whom Heidegger reconstructs a metaphysics. (See Chapter 2, II Metaphysics in medicine, 3. Rehabilitating metaphysics.) The dynamic of river water speaks to power. However, in the context of *interhomines*, i.e. the dynamic of human affairs, there is no pre-determined pattern but only effects of power used. This is the after-the-fact aspect of a distressed psyche. This makes inductive reasoning the preferred pathway to knowledge in psychiatry.

B. The Existential School

1. Yalom's existential psychotherapy:

For Freud the fundamental human drive or instinct is ordered to pleasure. For Adler it was drive was power. For Viktor Frankl the fundamental drive of the human condition is meaning. The American psychiatrist Irvin Yalom embraced Frankl's existential approach to psychotherapy. Two aspects attracted Yalom to existential psychotherapy. He comments:

> (A)s I explored the field of existential therapy, it became apparent that *empirical* research had less to offer: questions surrounding the deep subjective responses to the human condition do not lend themselves to *empirical* investigation. Consequently, much of my work in existential therapy is informed primarily by *philosophical investigation* - my own and that of others. [12] (*Italics* added)

Two points are noteworthy here. By 'empirical' Yalom means the scientific research method applied to nature understood as our human biology. This is what has been named here as the 'experimental text'. This understanding of 'empirical' differs from that of McHugh. (See Note 10.) A second and related point is that philosophy was seen as an alternative to 'empirical research'. This role of philosophy resonates with Heraclitus noted in Adler's 'School'. It also resonates with Chapter 2 Philosophy in Medicine.

On the 'existential' Yalom cites Rollo May who defines the term as an . . . "endeavour to understand man by *cutting below the cleavage* between subject and object which has bedeviled Western thought and science since before the Renaissance." (p.180, *Italics* added) This 'cleavage' is a divide between subject and object - a divide which is a feature of modern medicine. Thus, in following May's understanding of existentialism, one goes to go where science cannot go. Yalom names his approach 'existential psychotherapy' defined as a therapy . . . "*which focuses on concerns that are <u>rooted</u> in the individual's existence*." (p.169-70, *Italics* original, <u>Underline</u>

added) This approach, then, seeks to explore what is below the surface.

Yalom continues by noting that as a discipline this has . . . "underpinnings (that) are not empirical but deeply *intuitive*. (p.169, *Italics* added) This intuitive aspect resonates with Frankl's insight that patients come with philosophical issues which are perhaps even unbeknownst to them. The intuitive is crucial to existential psychotherapy for it is this which is revealed by cutting below the subject - object cleavage. Thus, therapy does not add anything but rather reveals, i.e. brings to the surface, what is already present. In brief, therapy is not prescriptive but rather illuminating. Regarding this illumination two aspects are noteworthy.

2. Yalom's 'existential position':

In his practice Yalom came to understand . . . "the *person* not as a subject who can, under the proper circumstances, perceive external reality but rather as a *consciousness* who *participates* in the *construction of reality*. (p.180-1, *Italics* added) Noted here is the contrast between 'perception' and 'consciousness'. However, it is uncertain if the two differ to the degree that Yalom suggests. Through perception what is perceived enters our consciousness from which what was passive can become a stimulus for activity. Yalom's 'person' is a subject with agency. This agency resonates with Adler's focus on 'power' as *dunamis* illustrated in various 'Drama Triangles' noted above. But Yalom's existential psychotherapy is also dynamic. This he grounds in the Greek term *dunasthi* which carries the sense of 'to have strength or power'. (p.171) On *dunasthi* he comments:

> *These forces exist at varying levels of awareness*. . . . The psychodynamics of the individual thus include <u>unconscious and conscious</u> forces, motives, and fears. . . . The dynamic psychotherapies are . . . based upon this dynamic model of mental functioning. (p.171, *Italics* original, <u>Underline</u> added)

Thus, while the intuitive is ever present, it is not always or entirely known, i.e. present in our consciousness. Yalom's

'existential position' is presented as follows:

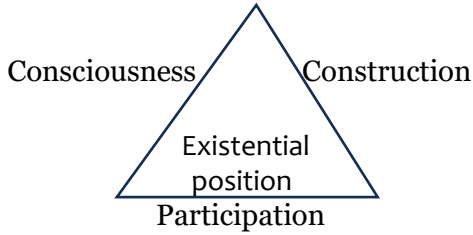

Figure 6.3 Yalom's Existential Triangle

This 'consciousness', 'participation', and 'construction' is Yalom's person as a subject with agency. It is this 'position' which informs his practice by informing the patient.

But the patient is not just *a* participant for he / she is *the* participant. And so, it is the patient's 'consciousness', 'construction' and 'participation'. Consciousness can be seen as 'analysis' and construction as 'synthesis'. It is through the patient's participation that analysis and synthesis are linked such that 'psychoanalysis' leads to 'psychosynthesis'. It is from this psychosynthesis that a text emerges. Although Yalom does not say so, this text is best described as an 'existential text'. Yalom's 'existential position', then, is not abstract and theoretical but rather a reality. It is this way for the person-as-patient responds to what is revealed below the subject-object divide. This revealing is an unveiling for it brings to the light of day what was already present.

A further point of note is also grounded in the intuitive. Yalom invokes the phrase . . . "apprehension of one's finiteness" (p.170) to capture the existential situation. This 'apprehension' is the emergence of 'awareness' of existential limitations into our consciousness. This is Dubos' 'vulnerability'. In revealing the intuitive what was present but unnamed in the subconscious comes to the surface. There is a shift in perspective. The most common catalyst for such a shift is when our existence is threatened. The reality of an illness (what a patient lives with) is a prime example of a catalyst for one's previous assumptions are annulled. When vulnerability surfaces from the subconscious new boundaries are also encountered.

'Apprehension' can be understood in two related ways. One is as a sense of what Yalom terms 'dread' which corresponds with Marcel's 'uneasiness' (Chapter 2 Philosophy in Medicine) of what has surfaced. The other is a corresponding fear of ownership of what one encounters. The patient identifies with both for both resonate with one's vulnerability. This disturbs one's 'existential homeostasis', i.e. equilibrium. This generates a question about one's existence and gives rise to conflict which is accompanied by choice.

3. The existential concerns:

In his clinical experience with existential group therapy which began in 1970 Yalom has observed four ultimate existential concerns in patients: death, freedom, isolation, and meaninglessness. (p.167-182) Also noted are several therapeutic factors in addressing these concerns. (p.4-41) When our 'existential homeostasis' is disturbed what was previously housed in the subconscious emerges. For a patient what emerges is an awareness of one's mortality. However, at the same time one wishes to continue to be. This presents a conflict which Yalom describes as follows:

> The incorporation of death into life enriches life. . . (and) enables individuals . . . to live more purposefully and . . . authentically. . . . Yet death is a primary *source* of anxiety; it permeates inner existence. (p.198, *Italics* added)

Note that the subject of 'death' is not the cause but the source of anxiety. The cause is that one wishes to continue to be. Conflict implies choice for conflict seeks resolution. And so, the two features of this concern are anxiety and living authentically.

A second 'concern' is 'freedom' which is often considered in a binary of freedom 'from' versus freedom 'for'. Irrespective of this understanding, Yalom has observed that freedom carries its own fear for to be situated outside of any given structure means that one is responsible to one's own life. However, for a distressed psyche the ground upon which to build a life has changed. Thus, a conflict exists between, the 'groundlessness' of a distressed psyche on the one hand and a

human desire for 'groundedness' on the other. (p.173)

A third 'concern' is 'existential isolation'. However, Yalom sees this isolation not as social, i.e. interpersonal, but existential. The conflict presented here is . . "the tension between our awareness of our *absolute* isolation and our wish . . . to be part of a larger whole." (p.173, *Italics* added) This articulates with 'groundlessness' and 'groundedness' noted above. And yet man as *anthrōpos*, is intuitively aware that this . . . "*gap . . . cannot be breached.* " (p.24, *Italics* added) This isolation, then, is neither ethical, i.e. interpersonal, nor psychological, i.e. intrapersonal, but rather one's place in the world, i.e. Heidegger's 'being there'. This is the cosmic dimension of Leder's exile. What Yalom is saying here is that the gap cannot be closed. This carries a sense of the isolation being permanent and absolute.

These 'concerns' - mortality, freedom, and isolation - coalesce into a fourth which is 'meaninglessness'. This is expressed in the following:

> *If* we must die [mortality], *if* we must constitute our world [freedom], *if* each is ultimately alone in an *indifferent universe* [existential isolation] *then* what meaning does life have? (p.173, Italics added)

Noteworthy here is that the universe is 'indifferent' indicating that it has no inherent meaning. While this indifference may not arise from the success of science and technology, it resonates with this success in that science and technology consider the natural world in purely functional terms. This surfaces when our vulnerability comes to the forefront as in a distressed psyche. The . . . "conflict stems from the dilemma of a meaning-seeking creature" (p.173) in an 'indifferent universe'.

VIII. The distressed psyche:

Both the Adler School via the 'Drama Triangles' and the Frankl School via Yalom's 'existential position' relate to a distressed psyche whether it is a primary or a secondary event. This is illustrated by their respective Triangles. What is presented here considers the distressed psyche as a primary

event. This does not make it irrelevant to a secondary distress for the fundamental dynamic is the same. However, the distressed psyche as a primary event brings a more acute focus which allows for clarity in how a distressed psyche may be addressed.

McHugh has noted that ownership is the proper response to psychic distress. This requires knowing how the distress came about. Aquinas has noted that the moral effect of any action rests on the agent of that action. And so, the moral effect of A's action on B rests with A and not with B. However, an unexpressed corollary of this view is that the existential effect is not on the agent but on the recipient of the action. While the existential of A is also implicated for while A's action comes from the core of her / his existence, the effect of the action falls directly and primarily on the core of B's existence. The exercise of power that harms another inflicts an existential injury to the one who was treated as an object-to-be-acted-upon. And so, the context of a distressed psyche is fundamentally existential. This is an intrapersonal exile. This is Rollo May's 'cutting below the surface' but where 'cutting' means an injury. The 'power paradigm', then, fits the genesis of this injury. It is these two features - power and the existential - which speak to a distressed psyche. This makes the Adler and Frankl 'Schools' relevant in addressing the distressed psyche.

The distress originates from the use of power which brings harm to the subject. But this is an injury without an internal pathway in the injured. Since there is no pathway, there can be no reversal of the injury. Ownership, then, becomes not a choice but a necessity if one is to address a distressed psyche. While power from the outside is the genesis of the injury, Dubos notes that there is also a power within our existence which can be exercised in response to a distressed psyche. But the power paradigm noted that 'non-use of power' is an option. (Figure 6.1) It is this which enables the power of another to harm a subject. This same non-use of power may inhibit a distressed psyche from exercising its power which is inherent in the existential. Ownership requires that this non-use of power be overcome from within.

But in addition to power there is a vulnerability which

also is inherent in human existence. McHugh citing Loftus noted this vulnerability in the context of being vulnerable to suggestion of the clinician / therapist. For Dubos this vulnerability is essentially internal which may be exploited externally by others. And so, a distressed psyche needs to be engaged by addressing both power and vulnerability, each of which has both an internal and an external dimension.

A not infrequent response of an injured psyche is ownership whereby the source, i.e. an event or person, e.g. person A above, tied to the event is challenged to own the 'cause' or a third party, e.g. the Courts, mandates some reparation. While these efforts may have some salutary effect on a distressed psyche, both focus on the other party to own the injury. Tied to this approach is a grieving in public for awareness of the injury has now entered the pubic square. This carries two shortcomings. First this is something that no 'other' can do for no one can suffer another's injury. Moreover, it diverts the person with a distressed psyche from ownership. It would seem, then, that the injured has no alternative but to own the injury. But is this inevitable and if so is it tenable?

Yalom's 'existential position' presents ownership through consciousness, construction, and participation. (Figure 6.3) The power dynamic of going from non-use, if that were the case for the injured, to proper use aligns with all three elements of this 'existential position'. But Yalom's 'existential concerns' also indicate how onerous the task of ownership can be. It is this way because the injury is existential affecting the *zōé* and not primarily physical affecting the *bios*. Moreover, the concerns coalesce in meaninglessness which indicates that in owning the injury there is nothing meaningful for a distressed psyche to own. Thus, any text arising out of ownership of the injury would be a text of 'meaninglessness'. McHugh describes the patient as being 'overmastered by life'. (p.209) And so, 'ownership' of the injury may mean that one is no longer 'overmastered' by the injury. But if ownership of the injury is meaningless, a distressed psyche continues to be 'overmastered'.

Another view of 'ownership' is owning the person with the distressed psyche. This offers the same dynamic but in a different focus which is the person with the injury and not

primarily the injury itself. And so, the avenues of holding another to account, of reparation as compensation, or of seeking support through public exposure of one's injury, i.e. grieving in public, are paths forsaken. This also speaks to Adler's power motif where one's power is used to serve others with the most important 'other' being the 'self', i.e. the self with the distressed psyche. It also speaks to the 'conflict – choice' dyad of Yalom's existential concerns. And so, the power is properly exercised to engage the conflicts and make the choice which promotes the ownership of the person. But vulnerability - both external and internal - are crucial to this ownership. This exercise of power is also owning vulnerability. And so, in 'owning' the person with the injury the patient assumes the role of master not only of the injury but of life. It is through inductive reasoning that one takes ownership It is this ownership of the person which frames mental health as follows:

PATIENT as PERSON

Figure 6.4 Re-framing Mental Health

As the patient weaves (*texere*) through this ownership, the text which emerges is not empty of meaning but is meaningful, i.e. 'meaning full' precisely because it is owning the patient-as- person. Yalom's 'existential position', then, can be seen as a process of analysis and synthesis. However, unlike the analysis and synthesis of the scientific method where the patient is not *a* participant, i.e. a subject with agency, in the 'existential position' the patient is not only *a* participant but is *the* participant. Since it is the patient's analysis and synthesis which gives content to the text, ownership of the text belongs to the patient. By the very fact of weaving the text via analysis and synthesis the patient exercises the power inherent in our existence and at the same time engages the vulnerability which is also inherent in our existence. Since the context, i.e. injury to the psyche, primarily affects the intrapersonal and in a particular way, the context is existential. This makes the psychiatric encounter an existential encounter. Thus, any text emerging from this injury is an 'existential text'. In 'reading'

this text the physician becomes literate regarding a distressed psyche and thereby comes to know the patient not simply as a patient but as a person returning from exile.

IX. Conclusion:

Rethinking Psychiatry introduced a critique in which Kleinman noted that irreconcilable views of human nature informed different 'schools' of psychiatric practice. This resonates with McHugh's Try to Remember written some 20 years later which opened with a fundamental question: '*What's wrong with psychiatry?*' And so, while they may differ in the details, Kleinman and McHugh share a common concern about psychiatry's place in medicine in the 21st century. While Kleinman proposed re-thinking psychiatry, McHugh put forth a re-framing of psychiatry grounded in a re-thinking which is inductive reasoning.

Both aspects can be considered in the light of the three fundamental principles noted earlier: identification of the problem, theory of opposites, and patient as teacher. These principles are present throughout the re-thinking and re-framing. The problem identified was found in the Freudian school of psychoanalysis, not only one of Kleinman's 'Schools of psychoanalysis' but the founding School and the dominant School in the closing decades of the 20th century. McHugh chronicled how psychiatry went wrong. By identifying what was wrong he took the first step to a solution.

In determining psychiatry's place both Yalom and McHugh raised two fundamental questions: '*What do we know?*' and '*How do we know it?*' While these two questions were asked of psychiatry, they are relevant to any area of knowledge. The '*what*' comes from the '*how*'. The knowledge arising from the scientific method is grounded in deductive reasoning. It is this reasoning applied to science of human biology which provides explanation which is the '*how*' and the '*what*' we know. But since psychiatry is not science, this 'h*ow*' and '*what*' do not operate in the same way in a distressed psyche. It is this way because the psyche does not lend itself to deductive reasoning. A distressed psyche is better engaged through inductive reasoning. This is re-thinking psychiatry.

However, as McHugh notes, inductive reasoning is not central to the practice of psychiatry or the formation of psychiatrists in our time.

It is re-thinking that leads to re-framing. It is this inductive 'thinking' which enables psychiatry to find its rightful place, i.e. the place where it belongs which is the sphere occupied by the psyche. This is the '*how*' and the '*what*' of knowing in psychiatry. It is by applying inductive reasoning (McHugh's contribution) to the 'schools' of psychiatry (Kleinman's contribution) that psychiatry may find its rightful place.

But this is shared space for it is also the patient's rightful place. On the one hand, the physician / therapist is the observer as in being present to the patient's experience. On the other hand, the patient is observer - participant in the experience of the distressed psyche. This also speaks to the importance of listening in that the patient listens to the experience and the clinician listens to the patient's text. This highlights the importance of knowing the patient that McHugh noted earlier. This rightful place is relevant in two fundamental and related ways.

This 'place' gives agency to the patient such that the analysis *and* synthesis of the lived experience of a distressed psyche is the patient's analysis and synthesis. The Adler and Frankl 'Schools' enabled this agency via the 'power paradigm' and Yalom's 'existential position'. (Figures 6.1 - 6.3) Second the analysis and synthesis are one as in 'distinct *but not* separate' via a continuum and not via integration. It is this way for the patient is one and is made whole through synthesis of the analysis. While psychiatry considers its discipline in terms of 'Schools of Psychoanalysis', it is more relevant to and consistent with a distressed psyche to speak of 'Psychosynthesis' for this better reflects the reality of the patient's lived experience. This 'psychosynthesis' comes from re-thinking psychiatry'.

Because of the nature of the injury the lived reality of a distressed psyche is best understood as an existential event. This cuts below the subject - object cleavage noted by Rollo May and leads to a patient's ownership of the self, i.e. one's person. The patient journeys from patient to person such that

the patient is no longer a 'person-as-patient' but rather is a 'patient-as-person'. And so, re-thinking psychiatry leads to re-framing Mental Health [PATIENT as PERSON]. (Figure 6.4)

Yalom's contribution is important on three counts. His understanding of the person as expressed in the 'existential position' invites the patient to see oneself in that light. This resonates with Adler's power motif and has practical relevance to the Drama Triangles. Although Yalom does not make this point, the 'existential' appendage to 'therapy', 'position' and 'concerns' supports the view that the distressed psyche is an existential injury. However, while Yalom's 'existential concerns' are grounded in clinical experience, they are presented in philosophical context if not language. In fact, the four concerns themselves - mortality, freedom, isolation, and meaninglessness - are identified as 'ultimate' and, thus, carry the sense of absolutes. The notion of an 'unbreachable gap' reflects this also. But the patient lives in the here-and-now where nothing is absolute and everything is relevant.

Of relevance to Yalom's 'concerns' are Marcel's comments on existentialism where similar ideas were expressed but in a different language such as 'uneasiness' 'immobilization', 'stimulus', and 'mobilization', and 'quietism'. (Chapter 2 Philosophy in Medicine, Section II.C) 'Uneasiness' resonates with Yalom's 'dread'. Ironically, the clinician (Yalom) sounds like a philosopher and the philosopher (Marcel) sounds like a clinician. While Marcel's language is not more clinically relevant than Yalom's 'concerns', it is more appropriate to the clinical encounter. Philosophy may 'move the soil' but it is not a practice. And so, while acknowledging Yalom's positive contribution, a criticism is also to be noted. His approach was to bring philosophy to the clinic. While the 'concerns' were grounded in the clinic, they were framed in a language more suitable to the philosophy. And so, this invites consideration of an existential approach to a distressed psyche. This is presented in the next Chapter – The Distressed Psyche - Part II.

Chapter 7

The Distressed Psyche - Part II

The Existentials of Medicine [1]

I. Introduction:

Before the ascent of science it was philosophy and theology that were the major contributors to how we saw the world and all that is in it including humanity. The ascent of science over the past centuries has replaced philosophy and theology as central sources of our understanding of the world today. But there were two movements. One was in science; the other in philosophy. While philosophy continued to 'move the soil', it changed how that soil was moved. The 'metaphysical necrosis' of 19th century thought is an example of this. But philosophy's influence continued such that by the end of the 20th century the classical understanding of human nature had all but disappeared from common discourse. Kleinman (1988) noted that irreconcilable views of human nature were embraced by different schools of psychotherapy. In addition, Bishop (2010) noted that nothing coherent could be said of human nature for 'all was artifice'.

In was in this cultural context of the mid 20th century that Medard Boss (1903-1990), a psychotherapist based in Europe, migrated to philosophy. Stern comments on this journey in critical terms noting that . . .

> (w)hereas internists, surgeons (etc.) . . . are apt to look at the perfectibility of specific medical techniques when intractable medical problems stop them cold, the psychotherapist perplexed by repeated failures . . . is apt to become a philosopher. [2]

The transition from clinician to philosopher is noteworthy but in a way that is more positive than Stern implies. This

migration was not a translocation but a transformation. In contrast to Yalom, who it was suggested brought philosophy to the clinic, Boss brought the clinic to philosophy. In brief, the clinical informed his philosophy. Since philosophy is not a practice but tills the soil, a migration of the clinical to philosophical helps to bring philosophy to reality in the sense of making thought relevant to the world. In his The Existential Foundations of Medicine and Psychology (1983) Boss brings the clinic to philosophy and engages a discourse relevant to the bedside. What follows here is a consideration of 'the fundamental characteristics of human beings' which Boss put forth in Chapter 7 of his 'Existential Foundations'.

II. The 'Existentials' of being human:

The 'characteristics', also named as the 'Existentials', open by presenting a *raison d'être*:

> Since human beings cannot *qualitatively perceive* or understand except in the light of *some prior insights* into the *meaning* and nature of what is *perceived*, we should . . . direct our attention to explicating the fundamental characteristics of human beings. (p.85, *Italics* added)

Three points are noteworthy here. The reference to 'qualitative' places the context outside of the quantitative domain in which the scientific method operates. The focus, then, is the qualitative as in evaluation and not the quantitative as in measurement. And so, from the outset the *forte* of explanatory power, i.e. quantitative assessment, of the scientific method is placed in abeyance. This is made explicit in the closing of the preliminary remarks where Boss notes: "It is a consideration of everything about the *actual mode of existence* that has so far been overlooked by, or been inaccessible to, the natural sciences." (p.85, *Italics* added) Note that while 'overlooked' may imply a willed blindness, Boss also suggests that the qualitative is beyond the reach of the natural sciences. And so, it is not that science fails but rather it is that there are some things science cannot do, and, therefore, cannot be asked to do.

The second point is the reference to 'perception' - a notion which is central to the Existentials. On perception Boss continues indicating that it involves . . . "asking in what *way*, and *as what*, man manifests himself." (p.85, *Italics* added) It is in this manifestation that perception operates. Third one notes that 'qualitative' and 'perception' are linked to 'meaning'. Of the 'way' and the 'what' Boss presents 8 fundamental characteristics of being human. It is these Existentials which give content to perception.

1. The spatiality of existence - 'closed' or 'open':

The first step to this 'insight to meaning' is to consider where man as *anthrōpos* is situated. The basic feature of the material world is that one is situated in a space. The human *bios* is man's physical presence in this space. In its common literal interpretation 'space' is circumscribed by three dimensions in the horizontal and vertical. Space, then, is both defined and confined. Thus, space as measurement is a 'closed' space. This is 'space' as understood and applied to the inanimate material world. But space in the human world of life as *zōé* is 'open' space. It is this way for two reasons. One is that man moves throughout space and is therefore, not confined to a space. More importantly, there are no dimensions by which man can be measured, for there are no dimensions by which life (*zōé*) can be measured. In brief, life defies measurement. Thus, there are two ways of comprehending space: 'closed' in the quantitative mode and 'open' in the qualitative mode. The world that man as *bios* inhabits is closed whereas the world in which man as *zōé* lives is open. 'Inhabiting' and 'living' are two distinct realities.

As an aside to Boss but not without relevance to his treatise on space is the cyber universe - a universe further from 'closed' could hardly be imagined for it, like *zōé*, is beyond measure. But the 'beyonds' of the cyber world and of *zōé* could not be further apart. Consideration of this cyber universe presents some interesting observations. The cyber universe is an inanimate world but, at the same time, in our modern culture it animates man as *anthrōpos*. On this account one may consider this world 'open'. However, computers, being

machines fabricated by man, have no capacity to understand 'contexts of meanings'. Neither does artificial intelligence (AI) have such a capacity. On this account the cyber universe may be considered 'closed' space.

While perception may be a goal of the cyber world, perception in this context is not inherent but a fabrication. The classic modern day example of the fabrication is the robot. While a robot is material in the mechanical sense, it operates in the non-material world of information. A robot may walk, it may talk, and while it may even sound 'reasonable', it cannot reason. No matter how much artificial intelligence it is given, its intelligence comes from without and not from within. Its intelligence is literally artificial and, therefore, is suspect - not in the moral sense but in that it can harbour error - and even manufacture error. But just as robots are not human neither is man a machine. To think otherwise is to place man as *anthrōpos* in a closed space because in the experience of both, i.e. a robot or man as a machine, the presence of others as subjects with agency is absent.

For Boss the key terms regarding space are 'context' and 'perception'. A universe is a world, Boss says, where space is 'geometric' and everything is defined by and confined to measurement where neither context nor perception is required. This resonates with Hillman's 'empty envelope' of the Latin culture. (See Chapter 5, V.) What occupies a space simply *is*. The scientific method *vis-à-vis* medicine is the application of the geometric to biology. Space, then, in medicine considered through a scientific lens can be viewed as 'bio-metric'. Within the success of this 'biometry' is found 'explanatory power'.

'Closed' space, i.e. space confined to and defined by geometry, is the natural world. But this is 'closed' world. Our world is a world of 'open' space where perception of our own presence and the presence of others is not only possible but is a central feature of our existence. This existence is neither defined by nor confined to geometry but rather is where our human existence is manifested. It is this way because human biology exits in a dynamic context and, therefore, transcends geometry. The fundamental feature of closed space is measurement. But this cannot give meaning. And so, lacking

intrinsic meaning, closed space has no 'internal teleology'. (On teleology see Chapter 2, Note 32.)

The space in which man 'lives' is an openness. It is in this openness that meaning and teleology, understood as maturation, can be found. This is the dynamic feature of space in which man as *anthrōpos* lives. On perception and openness Boss notes:

> A human being . . . is fundamentally openness in the sense of capacity to perceive something as something. . . . Human existence does not *possess* this openness in the form of one of a number of discrete properties. Rather, it (openness) *is* nothing other than being open to perceiving and understanding the things that it encounters for what they are. (p.89, *Italics* original, Underline added)

Human existence situated in a spatial world is 'capacity' and not 'possession'. In the animated spatial world human perception possesses nothing but is capable of anything.

Boss expands on these introductory comments on perception in the following:

> Human existence is *continually* open to the claim of each thing it encounters, is inherently open to *comprehending* the *possibility* of their being *something rather than nothing* at all. (p.90, *Italics* added)

While this openness leads to perception, it does not end there but rather only begins there. Human existence . . .

> is *not merely receptive* to the extent that it passively receives and records the presence and meaningfulness of whatever addresses it. Human existence is *responsive*, able to relate itself to things, answer them in particular ways. (p.90, *Italics* added)

And so, perception is more than reception for it is also responsive which means relating to what has been perceived in this openness. This response is a key aspect of openness. The 'responsive' aspect resonates with Frankl's notion of being responsible to life.

If there is reception and response, then, human

existence is 'something rather than nothing' in which case it has meaning.[3] But this is only a 'possibility' and not a given. Although Boss does not say so here, possibility depends on the exercise of human freedom. The introduction of 'response' implies responsibility understood not as a moral demand but an existential invitation. Note Yalom's 'existential concerns' have indicated how burdensome this response can be.

Perception is not limited to the senses. One can perceive by way of intuition. Note that Yalom comments on intuition. (Chapter 6, VII, B.1) But there are other ways also. In developing this Boss considers vision which commonly refers to what is perceived in the optical field in which the eye functions. But because the eye sees that which is confined to a closed space this vision is limited. This resonates with what was named 'bio-metric' and with 'function' determining the essence of what is. Perception and vision belong together. This is expressed as follows:

> The fundamental character of human existing, its perceiving openness, holds out possibilities of *many . . . kinds of vision*. As a "*being with* this or that," human vision ordinarily means seeing something which is physically present and thus sense - perceptible. Yet all of us engage in a kind of "vision" of something that is not physically present. (p.91, *Italics* original)

The terms that express this second mode of vision are 'visualization' and 'visualizer'. This is described in the following: "The peculiarity of visualization consists in the very fact that it permits the visualizer . . . to be *present* at what is visualized." (p.92-3, *Italics* added)

Three points are noteworthy in these two citations. The eye, as the organ of sight, functions to give one a vision of a closed space. But 'visualization' differs in that it is through visualization that one has access to open space which can lead to the meaning of what is visualized. This speaks not to the vision as function of the organ of sight but rather to another 'dimension' which is visualization understood as insight which comes forth through the 'mind's eye'.

This introduces the notion of 'image' - a term which carries several meanings. As a verb 'to image' is to imagine.

Unlike the noun 'imagination' which suggests something as not being real, 'to image' something is a creative process which is both active and real. 'Image', then, is openness not just in thought but also presence in a certain and creative way. This resonates with perception. And so, by visualizing something via image one establishes a relationship with what is imaged. The creative arts make this point for the artist has visualized - or in the case of music hears the sound - before the art is produced. But the function of vision / hearing differs from the purpose for while the function is anatomical, the purpose is 'an openness to being' present. Perception, then, is not limited to the senses, i.e. to our biology (*bios)* but also includes *zōé* (life).

Third is the introduction of being present to that which is opened, i.e. visualized, in the case of the ocular organ and 'listening' which corresponds with openness to what is heard. But is not being 'present' to something also an experience? Although Boss does not go there explicitly, it seems to me that 'present' as experience is compatible with and coherent with his notion of perception and visualization and to the extension made here to listening. The notion of being present resonates with Rosenberg's understanding of empathy. (Chapter 1, Note 13) It also resonates with Heidegger's 'being there', (*Da sein*), i.e. man's place in the world.

Perception, then, is both what we receive, i.e. what is presented to us, and our response to what is received. But on both accounts - reception and response - this openness is immeasurable for it is both too large and too small to measure. In brief, the geometric cannot 'compute' this domain. It is this way because perception is of a different genre than the quantitative. The qualitative to which perception belongs is the animated spatial world which is the world of human existence. In brief, perception is the gateway to experiencing human existence. It is this which makes space an Existential. But there are other Existentials which are part of our human existence

2. The temporality of existence:

Space, in its objective sense, is a 'where' issue. Time, in its literal sense, is a 'when' issue. Just as space as 'closed space' is measured, so, too, is time measured Time is measured in seconds, minutes, and hours. However, these are not three dimensions but multiples of one dimension, i.e. seconds. However, while none is a dimension in the strict sense of the word but a 'succession of now points', Boss refers to them as 'dimensions'. (p.94) While there is a unit of measurement, i.e. seconds, the dimensions are threefold - past, present, and future. Measuring time tells us nothing about the nature of time. Even a . . . " succession of 'now points' could never contribute to an understanding of human phenomena." (p.95) This resonates with closed space. And yet, man lives in time. The reality is that man is a being-in-time and exists in time. The 'being-in-time' is subjectivity; the 'existing in time' is objectivity. Cartesian dualism favours the latter at the expense of the former.

But just as space has a broader sense so, too, does time. Long before Descartes (1596-1650) the Greeks had two words for 'time' which made a similar distinction of 'closed' and 'open' space. *Chronos* time is calculated time. Boss names this '*datability*'. (p.94) Time as 'datability' is measured and, hence, is circumscribed, i.e. delimited by imposition of boundaries. Events occur in *chronos* time. But events also occur in *kairos* time which corresponds with man as a 'being-in-time'. The same event occurs in both *chronos* and *kairos* at the same measured moment of time. However, it is *kairos* which gives an event its significance. The term Boss uses to capture this significance is '*expansiveness*'. And so, *kairos* time is best understood as expansion which goes beyond the confines of measurement. *Kairos* resonates with space as open space.

The 'event' is the phenomenon. While the event takes place in the present, all phenomena also have a past and a future. This triad is engaged as follows:

> 'Having time' in this . . . sense of a threefold existence is a mode of human *being*. . . . Dwelling in the world is characterized by . . . what is coming to man, what he is aware of presently, and what has already been. . . . (H)aving time is *being* expectant of the future,

> *being* aware of the present, and *retaining* what has passed. (p.99, *Italics* original)

Thus, both the past and a future are present in the present. Time as *kairos* is a continuum of one reality which expands backwards to the past and forwards to a future. The expansion extends backward for this allows for understanding the past in a light not limited to that moment but also in the light of the present. But it also brings the past and present into the future. This is the expansiveness noted above and describes a 'being-in-time'.

This 'expansiveness' has two aspects. It not only includes the three 'dimensions' of time, the significance that is *kairos* time also expands in each dimension But *chronos* time has no expansion for it has only the present which is neither a repetition of the past nor to be repeated in the future but is limited only to the present which is only momentary. While time, is . . . "at our disposal for us to . . . (use) as we wish", (p.100) one must add that time as *kairos* is not ours to dispose of for such time remains with us. Boss continues in noting that . . .

> we are constantly bringing past, present, and future together in a unique way. . . . (D)welling in the world means extending ourselves simultaneously into the three temporal '*dimensions*." (p.100, *Italics* added)

But these 'dimensions' are not 'geo-metric' for the simple reason that while *bios* can be measured, *zōé* (life) cannot. 'Geo-metric', then, cannot become 'bio-metric' without reducing life to biology. For this reason no physical image can capture this expansion.

But there are times that these 'dimensions' are not equally present. In addressing this we see Boss the clinician present behind the Boss the philosopher. He notes that . . .

> (t)hese dimensions are not always equally open to each existence. At various times, one or another of the dimensions will be most commanding, and at those times we enter into it much more than the others. We may even be trapped in one of the three. Even then, however, the other two are never negated or

> destroyed but only deprived or concealed. (p.100)

This is the clinician speaking! The point made here is of such critical importance to medicine in general and to psychiatry in particular that it cannot be over-emphasized.

Although Boss does not draw a parallel with spatiality, one can be drawn. '*Datability*' corresponds to the lack of perception noted in the closed spaces of the inanimate world. This aligns with *chronos*. '*Expansiveness*' corresponds to openness to perception noted in the spatiality of the animated world. This aligns with *kairos*. *Chronos* relates to vision via the organ of sight which views closed space. *Kairos* time relates to visualization of the mind's eye which operates in open space. There is also a parallel here with time as *chronos* and 'function' and *kairos* and 'purpose' proposed in closed and open space respectively.

The notion of perception, then, applies to both space and time. This connection is made via Aristotle. Recalling that *anima* is Latin for soul introduces the following citation from Aristotle presented by Boss:

> It is worth examining how time is related to the soul. If the *soul* were not capable of *perceiving* and *expressing* itself about *time*, then time could not possibly exist unless the soul also existed. (p.96, *Italics* added)

Space is <u>where</u> our existence is lived out. Time is <u>when</u> our existence is lived out. It is this 'living out' our existence which pertains to medicine in general but to psychiatry in a special way. Both space and time pertain to the next Existential.

3. Human bodyhood:

In the realm of natural science bodyhood is limited to being a self-contained material object occupying a specific location. This is the 'vitalist' position which began in 19th century and continues today. (p.100-101) Boss describes this as follows: "(Vitalists) share the conviction that the human body has at least one chemophysical - cybernetic, purely biological component." (p.101) However, the challenge is noted in what follows:

> Yet no one has been able to surmise how two things as fundamentally different as *metaphysical life force* and *inanimate chemical substance* could ever merge to form a unity that is human bodyhood. (p.101, *Italics* added)

But this unity is a 'strange' unity in two ways. First it is 'strange' in that both aspects are unique. But the aspects are also 'estranged' in that there is a division not only in medicine of our time but also in modern culture. This division is systemic.

Boss indicates another kind of estrangement which is endemic rather than systemic. He comments:

> All of our experience tells us that just when a human being is existing in the most highly characteristic human way, . . . (which) means to be engaged body and soul by something that claims one . . . he is totally unaware of his body as such. . . . The human being completely loses his awareness of his bodyhood as a physical body when he *is most genuinely human*. (p.101, *Italics* added)

However, at the same time . . . "(t)here is no *manifestation* of human existence which is not bodily." (p.101, *Italics* added) The key term is 'manifestation'. And yet, there is something to human existence which is not body understood as a physical entity only. This 'something' is other and not more for this other existence is within the body and is not added to the body. It is this 'something other' that situates human bodyhood apart from animal bodyhood and from the world of inanimate matter. This something other is the psyche.

Boss develops this bodyhood as it pertains to human existence in noting that . . .

> (a) person's concrete dealings with other people and . . . direct perception of objects that present themselves . . . to his sight and touch are . . . obvious bodily relationships, but they are *not all* that is bodily. (p.101, *Italics* added)

The 'something other' is developed by introducing a notion first encountered with the spatial characteristic previously noted, i.e. vision - more specifically 'visualization'. This point

is made as follows:

> Visualizations of things the senses *do not perceive* are also bodily, though what we merely visualize may be visible only to the *mind's eye*. . . Everything we see in the *mind's eye* is seen, then, with the senses, is seen bodily. Nevertheless, we do not see it as physically present . . . but as *re-presented*. (p.101, *Italics* added)

In this understanding there is an organ of sight, i.e. the eye. But there is also a faculty of sight, i.e. the mind. This sight of the mind is insight and speaks to purpose and meaning of what is seen. The former is part of the physical body and, therefore, belongs literally to animal bodyhood. But the latter is also an integral part of human bodyhood.

To further develop this Boss considers what sets man apart from the world of inanimate matter. He comments:

> To understand the bodyhood that inheres in all human existential phenomena, we must distinguish between human bodyhood and the material nature of inanimate objects. We can approach this . . . from two different starting points. (p.101)

One starting point is to consider both in terms of 'limits'; the other in terms of 'fundamental differences'. The two are not unrelated. The physical 'limit' of the human bodyhood is the skin - the organ which houses human bodyhood. But this 'house' exists in relation to something outside of our skin. Therefore, the self has many ways of 'being-in-the-world'. This is described in the following:

> Human bodyhood is *always* the <u>bodying forth</u> of the ways of being in which we are dwelling and which constitute our existence at any given moment. Thus, there can be no self-contained, fundamental, and final human bodyhood. (p.102-3, *Italics* original, <u>Underline</u> added)

Human bodyhood, then, knows no limits. It cannot be circumscribed. By its very nature an inanimate object is circumscribed, thereby making it self-contained, i.e. delimited. This distinction of 'limits' directly impacts on the 'fundamental

differences'. In fact, one could consider that the difference of limitations *is* the fundamental difference.

'Potential' is the one word which articulates the distinction of limits and captures the fundamental difference. The nature of the inanimate world of matter is that it has no potential. By contrast, the nature of human bodyhood is nothing but potential. Boss indicates this by noting . . . " the special quality of human bodyhood as the *bodying forth* of the *potential* ways of being." (p.103, *Italics* added)

A second term, one not used by Boss, arising from 'potential' is 'dynamic' - *dunamis* in Greek carries the sense of power. Human being-in-the-world is dynamic. It is this dynamic which converts potential to reality. In brief, since nothing exists for itself, potential does not exist for itself but exists to be expressed. Boss captures this but in a different language. He notes that . . . "bodying forth presupposes perceiving and *acting* existence. . . . Existence is that which bodies forth." (p.105, *Italics* added) What 'bodies forth' is potential being exercised in a reality. Existence, then, is dynamic.

Human being-in-the-world is a presence to the moment in time and space. It is what man encounters in the moment and in the space of human existing. It is both spatial and temporal. This encounter is an openness of the self to time as *kairos* and to space as perception. And so, this self is not self-contained. However, natural science is present to time as *chronos* and to space as closed space. This is so because natural science is self-contained and, thus, has no potential-for-being.

4. Human existence in a shared world:

This Existential opens by introducing three elements: 'loneliness', 'co-existence', and 'a shared world'. Boss notes that the . . . "human capacity to be *lonely* is a good point to start from in understanding the *inherent co-existence* of human beings in their *shared world*." (p.106, *Italics* added) This 'inherent coexistence' he names 'existential co-existence'. There is a paradox in this 'loneliness' as a place from which to understand 'co-existence'. A paradox is not a contradiction; it

only appears that way. A paradox, in fact, harbours a truth in the disguise of a contradiction. Noteworthy is that man has a 'capacity' for loneliness. This is presented as follows:

> Loneliness *always points beyond itself* to some co-existence . . . (H)uman loneliness exists only as privation of man's primary togetherness with others. (p.106, *Italics* added)

Thus, loneliness and co-existence are partners for when lonely there is a co-existence implied by its absence.

He notes that this co-existence is grounded in an openness to the world. However, while this world is shared and is thus, 'commonly encountered', i.e. encountered in common, the perceptions may not be the same. Thus, while the perceptions may be held in common, they may differ in content by way of contrariety or by polarity. And so, whether there is going to be a community or a collectivity depends on openness which, as noted, has two features - reception and response.

But this also relates to an individual for one can harbour an openness to what is presented or a 'closedness' such that everything is viewed through the same lens. Openness can be an openness to anything and 'closedness' can be being closed to everything. The latter is a 'prejudice' in the sense of the French term *préjugé* whereby everything is prejudged and nothing is new. Thus, while there be reception in the narrow sense of the term, the response is limited to reaction as a reflex. Furthermore, it is possible that one's understanding of what is encountered may be imposed on another. However, one needs to be ever-mindful of the clinical reality for openness may be sealed off by psychic phenomenon such as autism or by the trauma of an injury to the psyche. Thus, the triad of loneliness, co-existence and shared world is more complex than it first appears.

Boss brings some clarity in introducing another point which is central to this characteristic: 'Where does existential co-existence fit?' This is presented in the following:

> The existential co-existence in a shared world should *not* be pictured as some kind of *collective presence* of *individual* subjects each consisting of a strictly delimited and spatially

> *localized* psychic or conscious capsule in which *representations* of objects of the *external* world are mirrored. (*Italics* added, p.106)

Unpacking this is a challenge but brings rewards. Existential co-existence is not a collection, i.e. a sum of the parts with each part circumscribed by boundaries. Nor is the external world defined by geometric calculation which gets mirrored in our psyche, i.e. consciousness. Boss notes that . . .

> in . . . *collective* human behaviour there is no evidence of individual psyches having dialogues about endopsychic material." (p.106, *Italics* added)

'Endopsychic' carries the meaning of something in the mind. A feature of a collectivity is that a monologue is present between similar parts and not a dialogue between different parts.

Existential co-existence is something other than a collectivity where external objects are mirrored. Existential co-existence consists of openness in which nothing is mirrored and where endospychic material is welcomed. For Boss openness defines human existence. Although the term is not used, this, it seems to me, describes a 'community' in contrast to a 'collectivity 'understood as a 'collective presence of individual subjects'.

Applying this to medicine as a practice Boss writes: "Medicine . . . needs to see this primary togetherness of human beings around the objects of their shared world." (p.109) In medicine this shared world is the clinical encounter which is an existential encounter - something more than a collectivity. Boss concludes by noting that this 'existential co-existence' is . . .

> *essential co-existence* . . . (and) is the basis not only of our joint undertakings of the things of our world but of every sort of relationship among human beings themselves. (p.109, *Italics* added)

Thus, this existential co-existence within, i.e. internal as inherent, is the nidus for co-existence without, i.e. external. And so, a relationship is grounded in an 'essential co-existence'.

5. The question of mood (attunement)

The previous Existentials had placed 'openness' as crucial to human existence. Boss places the characteristic of 'mood' in the same framework. The following introduces attunement:

> Because human existence is by nature an open and clear realm of understanding, it is *inherently attuned* in some way or other. This fundamental, ontological characteristic of attunement makes it possible for existence to be *permeated always* by some *disposition*. (p.109, *Italics* added)

'Attune' carries the sense of 'to bring into accord, to harmonize'. (Funk & Wagnalls) This accord belongs to our nature and, therefore, is inherent to human existence. Accompanying this is a disposition to that existence. While disposition is usually understood as internal by virtue of openness and perceptiveness, it is also external on the same basis by way of receptivity and response. This attunement, understood as accord, is a dual harmonization whereby the innate internal aspect, i.e. disposition, is manifested externally. While it is primarily internal in the sense of origin, it is external in the sense of manifestation. In this it resonates with the 'existential' and the 'ethical' noted in Chapter 2.

One can consider this dual harmonization as an equilibrium in two ways. The first is an equilibrium 'within'. This is presented in the following:

> There is no such thing as an initially unattuned existence in which a disposition . . . simply arises now and then through the intrusion of some internal or external cause. . . . All of the *dispositions*, or moods, of which a person is capable are given to him *innately* as *existential possibilities* and as such are always making up his existence. (p.109, *Italics* added)

Of note here is that there is no inherent initially 'unattuned existence' but rather only possibilities of attunement. These 'possibilities' resonate with 'potential' noted earlier. And so, when non-attunement does arrive it does so from the outside

rather than arising from the inside. For non-attunement read 'tone deaf ' or 'tuned out'. But here, too, one has to be aware of the psychic realities of the patient.

There is a dynamic between what is innate, i.e. the possibilities within us, and what is manifested in our existence. The openness and accompanying perception gives rise to 'presencing' in the sense of presenting ourselves to the world. But the world also presents itself to us and we respond by 'presencing' ourselves in the sense of how we present ourselves to the world. Since innate means coming from within, our dispositions (moods) come 'from within'. However, they are related to what is 'without' in two ways: 'coming to us *from* without', i.e. reception, via openness and perception, *and* 'going *to* without from us', i.e. response, in our 'presencing' ourselves in the world. This 'without' is the second equilibrium. The 'going from us' is observed . . .

> whenever we see someone enter a particular mood . . . we are actually witnessing . . . a *reattunement* of . . . existence from an old reigning disposition into a new one. (p.110, *Italics* added)

But attunement of our existence is not only rooted in . . . "particular . . . moods . . . . but also in our emotions, our feelings, our affects." (p.110) Attunement, then, for Boss, has two elements: moods and emotions and neither . . . "appear as isolated self-contained . . . entities . . . (but as) particular modes in which . . . attunement is fulfilled." (p.110) He continues:

> The prevailing attunement is at any given time the condition of our openness for perceiving and dealing with what we encounter. . . . (M)oods, feelings, affects, emotions and states are the *concrete* modes in which the possibilities for being open are fulfilled . . . (and) are at the same time the modes in which this perspective openness can be narrowed, distorted, or closed off. (p.110, *Italics* added)

The theoretical and the concrete, the internal and the external, meet in attunement in which, by definition, the two are in harmony. But in reality, this is not always the case since

. . . "(o)penness or *receptivity*, can only exist in conjunction with *restriction*." (p.110, *Italics* added) It is this way because . . .

> (e)ach predicates the other. . . . (Thus), every restriction is a particular privation of openness. . . (T)he openness that is our existence always determines . . . the . . . breadth or narrowness, brightness or obscurity of that existence. (p.109)

Openness, then, is neither an absolute as in 'all-or-nothing' for in life nothing is absolute and everything is relative in the sense that everything is relevant. Neither is openness an openness to everything such that there is an emptiness that can be filled by anything. Openness has a receptive aspect as well as a response aspect, the latter being active and not passive. The 'receptivity / restriction' dyad recalls the 'loneliness /co-existence' dyad of 'human existence in a shared world'. Being human is always to be open to perceiving what is being presented. This rules out 'prejudgment' (*préjugé*) where nothing new is welcomed and 'emptiness' where everything is welcomed. And so, being open to perceiving the external phenomena is not the same as being open to that reality.

This distinction is captured by the difference between a 'disposition' and a 'position'. In other words, being human is being open as a 'disposition' but as a 'position' being human requires being closed to some realities which while present should be dismissed. Going from a 'disposition' to a 'position' is not a given but a process which is sometimes navigated successfully and at other times not. Aristotle's practical reasoning (Figure 3.1) speaks to this process. How to navigate this process successfully pertains to medicine.

To this end Boss goes on to consider two sets of contrasting affects: anger - serenity and anxiety - sorrow. Recognizing that they are relevant to understanding the patient and, therefore, to medicine as a practice, these affects, as presented by Boss, will be considered in an Addendum at the end of this Chapter.

6. Human memory - the historicity of human existence:

Earlier perceptions are not only retained in memory but are retained as meaningful phenomena. The key term here is 'meaningful'. However, what is retained is present in a broader context which is not limited to the event etched in our memory but is seen in the context of the present moment and in the context of all events that occurred in the interval. This relates to the Existential of temporality in two ways. It is the 'past' aspect of the past, present, and future as a continuum. It also relates to *kairos* understood as 'expansiveness'. Thus, past events are up-dated in the sense that what 'was' is now seen in a new light which comes to both the past and the present.

While the events in the memory are events in *chronos* time, memory is in *kairos* time. It is this way because events remembered are significant and, as such, endure but not in the same way as they first appeared.. As *chronos* unfolds so, too, does *kairos* unfold. But *chronos* time never returns whereas *kairos* time never leaves. And so, the significance changes over time. It is this way because there is no such thing as two identical experiences even in the same person. And so, time - both *chronos* and *kairos* - never repeats itself. While time is renewed, the expansiveness of *kairos* is more than renewal of time. It is seeing the past in a new light. *Chronos* and *kairos* coalesce in memory to be present to the moment in time which is 'now'. This 'now' speaks to the importance that McHugh and Yalom placed on the 'here-and-now' but for Boss this 'here-and-now' is also the 'there-and-then' seen in a new light. This articulates with the notion of openness. This expansiveness can be seen as an integral part of ownership.

Boss introduces 'thought' as a constituent part of memory. This thought operates in two ways: as discovery and as revelation. As discovery thought is a cerebral activity. Science operates in this realm with the goal of determining how what is in the sense of how something functions. Thought as revelation is simply becoming aware of certain phenomena of our world which become present, i.e. reveal themselves to us. The distinction is a 'determining' which pertains to 'discovery' and a 'being aware' which pertains to 'revelation' in the sense of an unveiling of what is present. The former is a cognitive process of reason captured by the French term '*savoir*' (to know). The latter is a spontaneous event arising

from the unconscious which relates to the French term *connaître* (to be acquainted with). Revelation is what presents itself to our openness whereas thought grounded in reason is discovery. This 'discovery' –'revelation' couplet relates to *phusis* (emergence) and *alétheia* (disclosure) of Heidegger's reconstruction of metaphysics. (See Chapter 2, Philosophy in Medicine.) On thought Boss comments: "Thinking . . . is allowing what addresses us through the *openness* of the time - space of our world to arise again . . . of letting beings appear." (p.115, *Italics* added) This thinking allows a place for inductive reasoning.

While Boss claims science may do this in a particular way, revelation does this in a special way. Science occupies the domain of function whereas revelation pertains to the domain of purpose understood as meaning. Noteworthy is that the notion of openness operates in both modes but does so differently. Elaborating on this he notes that . . .

> (t)he openness of human existence consists of the capacity for perceiving the presence *and* meaningfulness of whatever appears." (p.118, *Italics* added)

Thus, openness and meaning are fellow travellers. But human existence . . .

> is equally receptive to what has been perceived at some former time and has been retained. What has once been present to a human existence is never simply past, finished, lost. What has been retained in the openness . . . . remains *constantly present* in the present, speaking into the present and *co-determining* all *present* conduct. (p.118, *Italics* added)

The key point here is the notion of permanence, i.e. a constant presence. This means that the reception and response noted earlier is permanent as in on-going but not fixed as in unchanging. This is the expansion of *kairos*. Because of this how one sees oneself, others, and the world is dynamic.

And so, . . ."this 'past', present as having been, together with the present *necessarily co-determines* all future behaviour." (p.118, *Italics* added) But this requires that memory be 'visualized' not in the sense of the function of the organ of

sight but through the mind which is the source of insight. Note that this 'co-determination' applies to both the 'present' and the 'future'. However, this determination requires explication.

In the realm of science of causation the sense of determination is more literal and narrow in scope in that science 'necessarily' determines the action which follows. This is the explanatory power of science. However, in the realm of revelation and purpose (meaning) 'determination' does not carry the same weight which means that 'necessarily' cannot apply to revelation. But the point is that the past informs the present and the future. In the realm of function that is science this 'informed' is a determination, i.e. 'determinism', which is a closed sphere whereas in revelation it is 'informed as in an open sphere in that the past does not determine the present. In brief, science forecloses and revelation is forever open. It is this way because while *chronos* time is a path travelled, it is not a 'path-way'.

In the 'determined' mode of thought as discovery humanity is not free for the present and future are prescribed. This resonates with the moral category understood in its narrow sense. But in the revealed mode of thought humanity is 'informed' out of which one forms conclusions which lead to human conduct. While this, too, is the moral category, it arises from the existential. And so, we build on what we have experienced, i.e. our memory, for one is always in the process of becoming in the sense of maturation. This is the proper sense of teleology. But one lives this in the present.

The other aspect of memory is 'forgetting' which is the absence of memory. Boss describes this as the . . . "deficient manifestation of memory." (p.116) He notes that . . .

> (w)hen something escapes me, my relationship to that thing is lost. . . . (R)elationships to what is present . . . make up my existence and make me what I am. The extent to which *presences* escape me and I forget them I am diminished as a human existence. (p.118, *Italics* added)

Note the plural of 'presence' refers to past presences. But forgetting understood as . . .

> falling out of an entity's presence from my essential realm of openness . . . carries . . . (a)

> possibility that . . . it can return into the openness of my being-in-the-world. (p.118)

Forgetting is the loss of relationship with reality such that the expansion of reality that accompanies memory no longer registers in the present. In a sense this is an 'existential disability'.

However, the point Boss makes is that memory is not simply retention but when present the past is always active in the present and in the future. One may think that there is nothing new in the past. But, on the contrary, the past, when present in the 'now' is always new and never simply renewed. Thus, man as *anthrōpos* dwells in tradition and history. This is because human memory dwells in tradition. It is this fundamental characteristic of historicity which distinguishes the human from all other beings making it a 'fundamental characteristic' of being human'.

7. Human mortality:

The characteristic of 'historicity' closed by noting that death belongs to human existence just as . . . "every border belongs to what it delimits." (p.119) Death, is . . . "the unsurpassable limit of human existence" (p.119) and, as such, occupies us within the limits of our existence. Common to the experience of being a patient is the presence of this mortality. A patient's vulnerability is an existential vulnerability. This we know from our human experience not of mortality itself for that experience we cannot know but rather of its presence. This distinction is noteworthy for death is not an experience but rather the end of all experiences - a reality that defies all experience and which, therefore, cannot be experienced.

And yet, being a patient is a lived encounter within this frontier, i.e. limit of human experience. Boss notes:

> Only human beings die having known from an early age of their mortality. . . . The knowledge of death leaves man no choice. He is compelled to exist in some sort of *permanent relationship* to death, for it is impossible not to relate to something which has once been *perceived*. (p.119, *Italics* added)

This 'impossibility' pertains to what is perceived, e.g. mortality even what is perceived is not experienced. Again we see 'perception' as the key to human existence. This relates to openness and to memory as historicity. Knowing the borders we live within puts death in our consciousness because it is the border beyond which our being-in-the-world cannot go. Try as we might to push it down to our subconscious it will not go. Man, then, is not only a 'being-in-the-world' but also a 'being-onto-death'. Openness, or lack thereof, operates in this 'being-onto-death'. One manifestation of this is . . .

> *flight* from death and from awareness of human mortality . . . (in which) people . . . deceive themselves about this most certain aspect of human life. (p.119, *Italics* original, Underline added)

However, there are other manifestations. Death may be seen as merely a change from one mode of being to another or . . . as "reverence . . . and deference in the face of something greater and more powerful" (p.120) than life. But in contrast to the awe of 'reverence and deference' is . . . "naked fear which lets death appear as the extinction of existence in an empty void, the end of all things." (p.120) Put this way there can be no greater fear than 'naked fear'. This resonates with 'deception' noted above. It also resonates with Yalom's existential concern of 'death'.

But there is another manifestation which Boss puts forth, one that is grounded in openness, which is . . . "an existential possibility *encompassing and consummating all existence*". (p.120, *Italics* added) He elaborates on this 'possibility' in the following:

> To the existence *liberated and expansive* enough to reach this serenity, human mortality shows that man's being is *open at all times* to that which is *wholly other than any finite ontic being* and which engages man . . . where *meaningfulness* is *perceived* . . . as *openness* which is the necessary precondition for the appearance of *presence* of *all* being. (p.120 *Italics* added)

It is here that Boss defines the essence of humanity which is

an 'openness beyond finite being in the presence of all being'. This is Yalom's 'freedom'. It is in this openness that 'meaningfulness is perceived'. A meaningful life, then, is . . . "actualizing all of its relational possibilities." (p.121) Here Boss goes from theory to reality.

He notes that . . . "(c)hildren do not see themselves as self-contained and independent subjects. . . .They let death extinguish their individual existence without resistance." (p.120-1) Existence as a finite ontic being is not part of a child's psyche. They (children) are part of something greater than themselves. In a sense Boss is indicating, without using the term, that they are not individualized. Children personify that the whole is greater than the sum of the parts. But things change. Boss goes on to note that . . .

> after puberty, a fear of death usually sets in, increasing in intensity the more an adolescent perceives himself in the modern spirit, as an *independently* formed, *insular subject*. (*Italics* added, p.121)

The adolescent, then, unlike the child, is individualized. This is the whole as the sum of the parts. But things can change again.

> (T)here are also . . . *unheroic* old people who are able to die as peacefully and as willingly as children for they have *used up* their existence by actualizing all of its *relational possibilities*.. . . (T)hey have completed the task given them. (p.121, *Italics* added)

And for these, too, openness was <u>the</u> feature that marked their existence. And so, the whole was greater than the sum of the parts.

But there are others, many of whom are elderly, who having . . .

> resisted entering full and caring relationships to what they encountered during their lives and, hence, became guiltily indebted to their own existence. These people are terrified of death as of something that comes far too soon. (p.121)

In openness to what is perceived lies the possibility of actualizing relationships. But to foreclose on openness is a

kind of death for it narrows the frontiers to less than they need be. And so, the potential for actualizing relationships does not materialize. And so, those who are afraid of living may choose death.

Boss states that . . . "mortality is an *innate potential* of human existence, the most thoroughly pervasive and peculiarly human trait of all." (p.121, *Italics* added) It seems counter intuitive to speak of death as potential. This challenges the common stance towards death in our current thinking. Developing this notion Boss continues noting that . . .

> (t)he most *dignified* human relationship to death consists in keeping the knowledge of personal mortality constantly in awareness, never fleeing from it or hiding it. (p.121, *Italics* added)

Noteworthy here is the introduction of 'dignity'; however, this does not mean 'death with dignity' but rather a dignified stance towards life in the awareness of death. Thus, what Boss says here is not a passive acceptance of the reality but rather an active engagement, i.e. an openness to reality, which does not necessarily preclude an exercise of power.

On the contrary, it can stimulate one to act This is presented as follows*:*

> In accepting mortality as . . . (a) certain existential possibility man first realizes his *responsibility* for *every instant of his existence*. If man were not finite and mortal he would never miss anything. There would always be time to catch up and make something good. But for someone who is mortal no situation happens twice in quite the same way. (p.121, *Italics* added)

This stimulus resonates with Marcel's views on 'mobilization' in moving from a 'minus-being' to a 'plus-being'. (Chapter 2, Philosophy in Medicine) And who among us is not mortal.

But one might clarify 'mortal' to 'one who is aware of mortality'. The notion of responsibility put forth here resonates with Frankl's notion of man being responsible <u>to</u> life rather than being responsible <u>for</u> life. It also resonates with openness and perception with its accompanying reception and response. This responsibility is best exercised when one is

present to the moment. Boss comments:

> If what he does is not in tune with the moment that moment is irrevocably lost . . . (and) his conscience will remind him that he has fallen behind in *fulfilling* his existence. (p.121, *Italics* added)

This is the guilt one has toward one's existence mentioned earlier. Note that the use of 'fulfilling' resonates with teleology as maturation.

The stance of open engagement rather than passive acceptance sets all existential potentialities in their place, i.e. their proper perspective. The term 'proper' is understood as 'appropriate' which means 'belonging to'. And so, 'perspective' can be re-tooled as a word to 'perspecting' meaning that we take ownership of what presents itself to us because we are open to it. Owning our potentialities by taking responsibility for them in being responsible to life. Boss concludes:

> The process of becoming *free* for the extreme potentiality of one's own death also *frees* a person with respect to others, letting him understand their existential possibilities on the basis of a solid foundation. (p.122, *Italics* added)

And so, the Existential of mortality is a preparation for the closing 'fundamental characteristic' of being human.

8. Freedom of the authentic human being (*Da-sein*): [4]

The final Existential is, in a sense, a synthesis of the previous characteristics making it more of a conclusion. The 'fundamental characteristics' are 'equally primordial'. Since life is dynamic, the presence of each is dynamic and, therefore, at any one time a particular characteristic may be more present than another. None is more crucial than another and all are indispensable. However, this is not structural but rather is contextual. Boss comments that . . . "(e)very . . . human phenomenon, no matter how trifling is *inherently* constituted in every one of these characteristics." (p.122, *Italics* added) These characteristics, then, are implicated in everything that touches humanity. While the characteristics form a whole, it is

recognized that they are not the whole of existential anthropology. Rather they are a 'whole' only in that together they resonate in a particular way with medicine as a practice.

The notion of perception, openness, possibilities, and presence noted in all the previous 'characteristics' coalesce in 'authentic human living'. Boss puts this together in the following:

> Thanks to . . . existential openness to any *presence* that *reveals* itself . . . a human being is able to *allow* whatever appears in the realm of . . . perception simply to be. This *allowing* does not mean benign neglect or indifference. It means entering into a relationship . . . in a way that permits it to fully *evolve* its particular *meaningfulness*. (p.123, *Italics* added)

And so, there is a union of openness, perception, possibilities, presence, relationship, and meaningfulness. What is revealed may be revealed passively; however, its presence is not passive acceptance but rather active engagement. This suggests that one participates in what is revealed. However, it is not in participation that one finds meaningfulness but rather it is meaningfulness that invites participation.

This provides an introduction to freedom which Boss now goes on to explore. He begins with the following:

> This is the condition of man's freedom. *Only* where there is a multiplicity of phenomena do choosing and deciding become possible. Moreover, experience demonstrates that man is capable of making free choices at any time. (p.123, *Italics* original, Underline added)

Several points are noteworthy here. Freedom of will (of choice) is the basis of one's obligation to fulfill one's existence. However, one's will can be influenced from various sources. It is this way for without freedom responsibilities to the self cannot exist. If there is no choice then, Boss says, there can be neither guilt nor therapeutic release. (p.123) In brief, without choice there is both moral immunity for what one does and, therefore, moral impunity, for what one will do. There is, thus, a vacuum of both responsibility and accountability.

Second while freedom is a basis of human existence, it

is not absolute since the contingencies of life inform us that human life is not absolute. Within the 'finiteness' of human existence and in spite of its deficiencies, restricted freedom is freedom nonetheless. (p.123) And so, this freedom, even if restricted by life's contingencies, not only functions but remains an essential feature of what it is to be human. This is presented in the following:

> (H)uman *freedom inheres* in an open realm of *perception* to the *presence* of what human beings encounter. The engagement of a human being by a particular phenomenon *moves*, or motivates, him *to respond* to what reveals itself to him, and to respond in accordance with the perceived meaningfulness of that thing. (p.124, *Italics* added)

But this Boss has said before. What is new here is the context of freedom. This sets the stage for his next point which introduces his closing argument. This . . .

> openness to potential engagement by meaningful presences - the precondition of human freedom - *lies entirely outside* of the arena of *causality* and that is why criticism (of openness etc.) from the standpoint of natural scientific *determinism* is *unable to penetrate* the realm of human *freedom*. (p.124, *Italics* added)

This presents causality and determinism, two features of science of nature, in a realm outside of human freedom.

The axiom on which science operates is that reality . . . "must exist in a faultless causal connection." (p.124) The 'explanatory power' of the scientific method occurs in the orbit of this 'causal connection'. However, while the 'engagement of meaningful presences' lies outside of causality, it does not lie outside of the realm of freedom. It is this way because this engagement deals with responding to what is present to us.

The precondition of human freedom, as noted above, is the sequence of openness, perception, possibilities, presence, relationship, and meaningfulness. To this one adds participation since meaningfulness invites participation. However, meaningfulness is not discovered as it would be in a

scientific world but rather, as has been noted, is revealed. Boss observes that . . .

> physicians schooled in natural science tend to misinterpret a thought sequence (noted above) as an attempt to *prove* one thing with another. They mistakenly . . . (presume) to have proven *human freedom*. (p.123, *Italics* added)

But human freedom defies proof . . .

> because openness and freedom of will are . . *elementary* phenomenon that reveal themselves directly . . . (and) as such they do not require any proof. (p.123, *Italics* added)

Elementary phenomena are a given and, thus, are not to be proven.

III. Medicine and the Existentials:

Boss presents this final Existential as well as the other 'characteristics' in the context of present day medicine. He begins by noting that compared to the . . .

> the currently dominant framework based on biological, physiological, and psychological determinations of human nature (the) existential foundation for medicine . . . *is sounder, on two counts*. (p.125, *Italics* added)

Here Boss posits the 'Existentials' in the light of the determinism of the scientific method applied to the natural world. Regarding the first 'count' he comments:

> (T)he findings of these three sciences do not really come into their own - as manifestations of human existence - until they are seen from the existential foundation . . . presented. For the Existentials pervade the empirical findings as *essence* without which they could not be what they are. (p.125, *Italics* original)

Noteworthy is the inclusion of the psychological as a science. But equally noteworthy is the need for this 'science', among others, to 'come into its own' which can be understood as finding its rightful place, i.e. the place where it belongs.

What is proposed here is not a confrontation but a

mutual engagement of 'essence' and 'empiricism', the latter understood as reliance on observation and experimentation rather than experience. Empiricism as understood by Boss resonates with that of Yalom rather than McHugh. (See Chapter 6, Note 10.) Not withstanding the confusion of the language used, the engagement envisioned by Boss is the subjective with the objective. There exists, then, a kind of symbiosis whereby a more complete picture is revealed rather than opposites by way of contrariety.

Expanding on this essence - empirical dynamic Boss comments:

> (I)t is far from the purpose of our existential foundation for medicine to detract from the importance of these "concrete" medical findings. On the contrary, this newer foundation makes possible an *interpretation* that is *more just to empirical fact* and *more adequate to human beings*. (p.125, *Italics* added)

Here we have a dynamic which is 'distinct but not separate'.

What is described here in this newer foundation are two cultures. One culture is the culture of science; the other is the natural reality of being human. One is the scientific order, the other the natural order. The former is the domain of the patient as a 'person-with-a-disease'. It is in this domain that empirical science operates. The latter is the domain the patient as a 'person-with-an-illness'. It is in this domain that the Existentials operate. But rather than being apart they belong together for these two cultures meet in the clinical world of medicine. This is the major contribution of the Existentials to medicine as a practice.

The second 'count' is more contentious but not without merit. Boss proclaims that the proposed Existentials . . .

> enable us to assail successfully the *unscientific vagueness* and mystification surrounding many of the standard concepts of the modern *science of healing*. (p.125, *Italics* added)

This view is complex and raises questions as to what constitutes 'healing' and whether healing is scientific. Criticism of unscientific vagueness in this matter is legitimate. In fact, one could question if there is such a science of healing.

However, a more relevant question is: 'Do the Existentials achieve what Boss claims?' Specifically, Boss notes that the Existentials avoid the traditional view of human nature, i.e. a unity of body, soul, mind, and spirit. Latin has body (*corpus*), mind (*mentis*), spirit (*spiritus*), and soul (*anima*). (See Chapter 3 Re-thinking Human Nature.) Of these only 'body' lends itself to scientific exploration of cause and effect. But the 'Existential' of bodyhood was considered as a united entity which implies something more than just a body. Note that in developing 'bodyhood' as an Existential Boss has eschewed the notion of personhood. It is this way for the former is a characteristic of the latter.

And so, Boss has veered away from the classical understanding of human nature and, at the same time, avoided the position of elevating science to the sole interpreter of human life. While his Existentials not only contribute to our understanding of what it means to be human, they also can serve as guideposts that contribute to the clinical encounter.

In his comments on 'attunement' he acknowledged "heavy damage" was done to a human being but nothing specifically was said about engagement or addressing this damage. But Boss is not alone in this regard. In The Nature of Suffering (1991) Eric Cassell identifies suffering as a problem. Angell (1988) refers to 'meaningless suffering' and palliative care in the post - Dame Cecily Saunders era embraced the concept of 'pointlessly living'. Suffering, is the universal experience of humanity. However, in spite of many attempts, there is no single experimental i.e. empirical method, or experiential, i.e. lived reality, which presents a pathway of engaging suffering. There is no deductive or inductive reasoning which establishes a pattern in response to suffering.

Suffering will always be found wherever humanity is encountered. Science cannot go over it, under it, around it or through it. What science does is turn its back on it. To the extent that medicine embraces science as the sole pathway to engage our human existence it, too, turns its back on suffering. This does not mean that the Existentials have no place in medicine but rather that they need to find their place. To this end openness to receive and to respond is both a challenge and

an opportunity.

IV. A conclusion with an opening:

The conclusion contains three points. The first pertains to the content presented. Boss has put forth 8 'Fundamental Characteristics of Human Beings'. He has eschewed any understanding of human nature as body, soul, spirit and mind. This is consistent with the observations of Kleinman and Bishop noted previously. This does not make the characteristics any less relevant. On the contrary, it makes the Existentials more relevant for they speak to the patient-as-person and, hence the clinician, at a time in history where the classical view of humanity has no standing in the public discourse. These 'Existentials' are not a blueprint that demands strict adherence but rather guidelines and, as such, are descriptive rather than prescriptive and may belong more or less in the clinical situation depending on the circumstances. In brief, they are not a checklist.

Relevant to this is Stern's comment in the Introduction: "The *restructuring* of a patient's existential situation by *external intervention* must be followed by the *labourious process* of appropriating *unrealized* modes of being." (p. xxi, *Italics* added) The 'external intervention' is the scientific method. The 'labourious process' of appropriation, i.e. ownership, speaks to the power paradigm which aligns with Adler's School and the 'construction' of Yalom's 'existential position'. ((Figures 6.1 and 6.3) Appropriation speaks to McHugh's ownership of one's being. The 'guidelines', then, align with openness to time and space. It is this openness which makes them 'labourious'. The 'Existentials', then, are an invitation to openness, to receive, and to respond. The response is to bring the Existentials to the bedside. They can be viewed as a clinician's guide since the existential is central to medicine as a practice.

The second point is that the contribution of Boss builds on what has been put forth by Yalom for the Existentials of one resonate with the 'existential concerns' of the other. While there is a resonance between the two, there is also a fundamental difference not in the goal but in their orientation.

Both embraced philosophy but in different ways. This is illustrated by an image of a chauffer and a 'back-seat driver'. Yalom as the chauffer transported philosophy to the clinic. However, as the 'back-seat driver' (philosophy) was telling the chauffer where the clinic was, i.e. the patient's existential address. Thus, Yalom brought philosophy to the clinic. As noted earlier, Yalom's existential concerns were framed and expressed in absolutes which are in keeping with philosophical discourse. However, in lived reality there are no absolutes for everything in lived reality is relevant.

Boss the clinician was the 'back-seat driver' directing the chauffer (philosophy) to the patient's existential address. This dynamic, in spite of appearance to the contrary, is bringing the clinic to philosophy. This is noticeable in the framing and language of the Existentials. But philosophy is not a practice. However, as Kolakowski has noted, it 'moves the soil'. While both Yalom and Boss share philosophical space, the Existentials present a clinical understanding of what it means to be human and, thus, speak to a distressed psyche in language more in keeping with a practice than the language of philosophy. This is germane to the role of psychiatry and psychology in medicine for both Yalom and Boss shared a professional home. The importance of understanding a psychic injury and the patient with a distressed psyche has been noted. The power paradigm and psychosynthesis by of the patient speak to this understanding.

It was noted in The Distressed Psyche - Part I (Chapter 6) that in re-thinking psychiatry a patient takes ownership of the self and moves from being a 'person-as-patient' to being a 'patient-as-person'. The Existentials, with their grounding in the human condition, are noteworthy in that they place this migration in the practical realm in that they provide guidance in how the possible may become reality. This brings 'closure' in the sense of completion to how one may understand a distressed psyche.

But Boss brings closure not just to our understanding of a distressed psyche but also to how we can understand a distressed body. Closure also pertains to how we understand medicine as a profession and, hence, medicine as a practice. This closure, then, is an invitation to openness, to receive,

and to respond. The Existentials have the potential to make a valuable contribution to medicine as a practice.

The third and final point is that the Existentials along with The Distressed Body (Chapter 5) and The Distressed Psyche – Part I (Chapter 6) are a preparation for how medicine might be re-framed. This is presented in Chapter 8 - Living our Humanness.

Addendum: Being out of tune (the 5th Existential)

Preamble:

Boss, as noted in the fifth Existential above, indicated that while our moods may not be in tune, understood as being in harmony, our disposition is in harmony with our existence. This leads to the view that disposition has a role in attunement. This harmony, Boss noted, is innate. Thus, there is no 'unattuned existence'. (p.109, *Italics* added) But disharmony, i.e. being out of tune, does exist. Yalom's four ultimate 'existential concerns' speak to this. The clinical reality, then, is that the disposition and the mood may not be in harmony. The notion of equilibrium and its opposite dis-equilibrium relate to this sense of attunement where initially there is only equilibrium as disposition but in the reality of lived experience there is also dis-equilibrium. In developing the Existential of attunement Boss presents two couplets each with a opposite moods.

1. Anger and serenity:

Anger is presented as an affect and as a passion. As the former it is a state of mind or mood. The latter, grounded in *passio*, is acting out the affect such that we are no longer masters of ourselves. (Note that *passio* carries the sense of 'movement'). Thus, harmony is absent and attunement is not possible. In this situation one has lost any . . .

> sense of proportion with regard to the open or closed perception which is that self. . . .(T)he affect laden individual has *lost* a *clear vision* of the significant *meanings* addressing him in his world. (p.111, *Italics* added)

Noteworthy is that perception is distorted in that it is disproportionate and meaning is lost. This resonates with Aristotle's view of 'proportionate' practical reasoning (See Chapter 3, III and Figure 3.1.) The passion can be either love or hate for perception can be distorted by the affect. The key, then, is in knowing the affect and the distorted perception from which it arose.

But even in attunement difficulties arise for it may just be in appearance and not in reality. This is a possibility when one is blinded by passion. Boss names this blindness 'masking'. But this masking is not of the other but of the self. This makes openness limited for a mask conceals. This . . . "masking process . . . derives from the fact that, in either of these states (love and hate) existence is concerned with its *own power*." (p.112, *Italics* added) Thus, loss of attunement, i.e. disharmony, is due to the exercise of power. This resonates with Adler's School and the Drama Triangles noted earlier. (See Figures 6.1 and 6.2 and Table 6.1.) Elaborating on this power Boss notes:

> In hatred, an existence experiences anything that stands in the way of its power as an obstruction to be overridden and destroyed. A passionately loving existence sees in the loved one the potential for togetherness that would offer a much greater store of human possibilities than its own single existence could ever compose by itself. (p.112)

This power, then, can and does operate anywhere and in anybody. In passionate hatred one loves oneself not at all and in passionate love one loves oneself not enough if at all. In both cases one seeks something from the other to serve the self.

Here openness as a phenomenon of existence is not a disposition toward the other but a position *vis-à-vis* the other as an object to serve the needs of the self. But within this lies a disposition toward the self also. This highlights the notion that openness (receptivity) exists in conjunction with restriction (limitations) in a sense that a certain restriction is necessary. This openness as receptivity and limitation as restriction is akin to Yalom's 'conflicts'.

In contrast to anger is the affect of a 'joyous serenity'

which . . .

> can give human existence the kind of receptivity that allows it to see in the brightest light the *meaningfulness* and connections of *every phenomenon* that *reveals* itself." (p.112)

Of this serenity Boss notes that it . . .

> is a clearness and openness in which a human being is *emotionally connected to everything* he meets, wanting not to have things in his own power but content to *let them be and develop on their own*. (p.112, *Italics* added)

But this open receptivity does not mean abandoning responsibility as in avoiding a response by non-use of power. Rather it means accepting the responsibility to respond to what presents itself to us not to control in the sense of directing the event but to own the event so that the event itself is not controlling.

In serenity the person is . . . "open (to) . . . the broadest possible responsiveness". (p.112) And so, power is not absent for it cannot be absent since life is dynamic. Rather than being channeled to serve the self by treating others as objects as in the passion aligned with the affect of anger, the affect of serenity channels power to serve the self by owning the event. It is in owning the event that one is not 'overmastered' (McHugh's term). This allows for owning the person. This is Frankl's being responsible <u>to</u> life rather than being responsible <u>for</u> life. Perception, then, has a crucial role in both anger and serenity.

2. Anxiety and sorrow:

In contrast to serenity is anxiety. Boss begins by recalling that . . . "existence consists solely in its possibilities for relationship." (p.112) However, in entering into these possibilities . . . "existence enters danger, for existence exhausts itself in the course of existing." (p.112) This danger is most prominent in the universal and ultimate possibility of death. Anxiety, in contrast to serenity, sees death . . . "as no longer being here, of perishing into emptiness." (p.112)

Existence, then, involves risk and risk begets fear; yet

existence invites freedom. All three - risk, fear, freedom - are in play in existence. This triad resonates with Yalom's 'existential concerns'. Boss captures this in the following: "Thus, people who are most afraid of *death* are those who have the greatest anxiety about *life*." (p.112, *Italics* original)

Anxiety is an integral part of this existential cocktail. Anxiety, he goes on to note, . . .

> is the attunement in which existence is both opened up *and* restricted to perceiving the possibility of losing its hold on all other being, of being thrown back entirely upon itself. (p.112, *Italics* added)

One is no longer a being in relationship and, thus, is in 'total isolation'. This is Leder's exile. Anxiety, then, is both an openness and a restriction. In this combination of 'both - and' lies a conflict. As noted, conflicts were a feature of Yalom's 'existential concerns'.

Traditionally, psychology made a distinction between anxiety as external and anxiety as internal - the former being realistic, i.e. grounded in reality, and the latter unrealistic, i.e. grounded in one's mind. But for Boss all anxieties are realistic because . . .

> it is always something actual that is feared, and the object of concern is the capability of continued existence in a human world threatened by the feared thing. (p.113)

Anxiety correlates, then, with fears. And fears correlate with vulnerabilities. It is this which has major importance clinically.

The final human state considered is 'sorrow' which Boss notes is neither depression nor egocentric self-pity. He comments: "Existence is attuned to sorrow when it experiences a break or rupture in its relationship to a close human acquaintance or cherished object . . . but the object is not lost with this rupture." (p.113) He goes on to note that had the object / relationship been really broken or destroyed sorrow could not arise since the object / relationship would . . . "no longer be there." (p.113) But then he changes course in what follows.

The rupture perceived in sorrow concerns some

> actual particular mode of being with the object which the rupture no longer allows. Gone is the possibility of ever again being with that object (relationship) in mind and body. While the bonds of the relationship may become more intimate than ever in the *mode of visualization*, the human existence is in fact ruptured and broken in a certain sense. (p.113-4, *Italics* added)

For 'mode of visualization' read the mind's eye.

Thus, while the other may be present in the spatial sense this space is not open but closed. Boss notes that . . . "(h)eavy damage is done. . . . Such an existence suffers a great reduction in the number of relationships once possible." (p.113-4) A reduction of the possibilities of relationships that our existence can be open to does bring sorrow. This is acknowledged in that . . .

> (s)orrow pervades human existence, no matter how often it is *drowned out*, at the painful insight into the *finite limits* of our existence. . . . (This is) the *pathological* phenomena of existence. (p.114)

This finitude is Yalom's 'apprehension of one's finiteness which is drowned out by denial in our modern culture. However, in spite of these efforts the *pathos* remains present. This *pathos* is explored in the last of eight fundamental characteristic of human beings - Freedom of the authentic human being.

Chapter 8

Living Our Humanness

Re-framing Medicine by Re-thinking Psychiatry

I. Introduction:

Medicine is an encounter *interhomines*. Many, especially ethicists, define this to be a moral encounter. While medicine, by virtue of being *interhomines*, is a moral encounter as is every human interaction, medicine is also an existential encounter. The Distressed Psyche - Part I (Chapter 6) made the case that matters regarding the psyche are primarily, i.e. first and foremost, an existential concern. This does not mean that the moral aspect is absent but that the existential is primary and the moral is secondary in that it follows from the existential. It is consequential in the objective sense of the term in that it is a manifestation of the existential. And so, the existential is central to the practice of psychiatry.

Yalom and Boss have shown how the existential belongs in matters of the psyche. Boss has suggested that the Existentials also belong in medicine. What is to be considered here is how the existential might belong in medicine as a practice. This would not only address concerns raised by Kleinman, McHugh, and others but also give psychiatry a central place within medicine. But most important of all is that it better serves the patient.

II. Medicine's great divide:

The hallmark of modern medicine is science and technology. This has brought many benefits to patients. And yet, there is a great divide within medicine today which either goes unnoticed or if noticed is unaddressed. Medicine commonly defines illness by its pathology. But this confounds illness with disease. However, disease is what happens to or

within the body whereas illness is what the patient lives with. It is more accurate, then, to suggest that pathology defines the disease and that the patient defines the illness. The scientific method frames medicine as [DISEASE] and the illness aspect is framed [PERSON as PATIENT]. (Figures 5.1 and 5.9) In a sense the great divide in medicine as a practice is the disease - illness divide. Another way of considering this divide is object - subject with the scientific method being the 'object' side of the divide aligned with disease and the clinical aspect being the 'subject' side aligned with illness.

Re-framing medicine by re-thinking disease (Chapter 5 The Distressed Body) presented the disease - illness reality in the light of reasoning. It is the scientific method with deductive reasoning operating in the realm of disease which has given rise to the benefits of modern medicine. But this reasoning is ill-suited to the realm of illness. Deductive reasoning was noted to be the defining process of reasoning in the Freudian psychoanalytical school. However, the explanatory power that came with deductive reasoning in dealing with disease of the body was not forthcoming in matters concerning the distressed psyche. In fact, deductive reasoning was noted to be 'what was wrong' with psychiatry.

Inductive reasoning was seen as the process appropriate for engaging the patient with a distressed psyche, be it secondary to disease, i.e. a distressed body, or as a primary event. This re-thinking of psychiatry re-framed mental health [PATIENT as PERSON] And so, the divide of modern medicine can also be considered as a divide between deductive reasoning and inductive reasoning whereby the former which addresses disease has the primacy of place and the latter which addresses illness hardly any place at all.

A further way to characterize this divide - one which resonates with the deductive and inductive reasoning - is a divide between 'function' and 'meaning' (purpose) with the former aligned with deductive reasoning and the latter with inductive reasoning. Boss acknowledges the dominance of the natural scientific method of modern medicine but despite its success *vis-à-vis* disease offers a critique. He notes:

> Because the natural scientific research method has not been able to bring forth an

> adequate understanding of human existence . . . it has not been able to give any goal or purpose to medical practice. [1]

But he also notes that this has not gone unnoticed or unaddressed. He continues by stating that a . . .

> dawning insight into the limitations and . . . the dangers of raising (natural scientific research method) to an absolute in biology and medicine . . . has been encouraging physicians to look for a sounder basis for medicine . . . more appropriate to the illness of human beings. (p.31, *Italics* added)

It is this 'sounder basis' that merits consideration in addressing the great divide of modern medicine.

III. The somatic - psychic dynamic:

Another way to charactrize medicine's divide is in terms of the *soma* and the *psyche*. This reflects the classical understanding of human nature which in modern discourse has been dismissed. Nevertheless, while modern culture may not be open to a somatic - psychic dynamic, the reality of medicine as a practice requires a *soma - psyche* framework. The mental orientation as a lived reality is a second and different area of reality existing alongside the somatic. On how the two relate Boss cites the German biologist Jakob von Uexküll (1864-1944), a contemporary of Freud, who noted:

> The matter of how psychic and somatic processes . . . influence and change each other can be answered neither with physical nor with psychological methods. Each . . . sees only its own domain and is *incapable of recognizing the affiliations* that exist between them. (p.40, *Italics* added)

This describes the divide in which the participants, i.e. the parts (somatic and psychic) are seen as 'distinct *and* separate' as in opposite ends of a pole with nothing that holds them together. It is not that they do not belong together but rather that the affiliations present are not acknowledged for they are not recognized.

Given this alienation of the somatic and the psychic von Uexküll continued in noting that medicine is confronted . . .

> with a *philosophical dilemma* . . . . (which) cannot be solved . . . with the traditional idea that reality is made up of somatic and psychic components. Medicine must instead look for its *own solution* . . . . (and) recognize that the psychic and somatic *methods* are nothing more than attempts to find our way in an unknown and puzzling reality. (p.40, *Italics* added)

Noteworthy here is the reference to 'methods', thereby indicating that the problem is not within the somatic or the psychic but in the methods used to explore the 'puzzling reality' of our lived humanness. Deductive and inductive reasoning speak to 'methods'. It is in exploring these methods that medicine may find 'its own solution' in a journey from disease to illness and beyond. A further point of note is the reference to a 'dilemma' which is philosophical.

> He (von Uexküll) continued by noting that . . . (b)oth methods take sections from reality and, depending on *fixed assumptions* built into them, interpret what is seen as chemo-physical processes or psychic events . . . . which confront each others (method) as *incommensurable opposites*. (p.40, *Italics* added)

Since the assumptions are fixed as in unchangeable, so, too, are the opposites fixed and unchangeable. Kleinman's 'irreconcilable schools' of psychiatry resonate with von Uexküll's 'incommensurable opposites'. Understood this way these 'fixed assumptions' are opposites by way of contrariety. But this, von Uexküll says, is a human construct and not an original part of reality. It is man as *anthrōpos* who . . . "carries the notion of opposition into nature" (p.40) for within nature there is no opposition. This is the challenge and opportunity confronting medicine and inviting its practitioners forward . . .

> to seek out aspects of reality which do not carry into *nature* the opposition between the psychic and the somatic and to develop methods which permit *differentiation without division* into psychic and the physical. (p.40,

Italics added)

This is noteworthy in two ways.

One is the importance of what is natural in contrast to what is a construct. Science and technology aligns with construct. In the context of medicine read 'nature' as the person-as-patient. Noteworthy also is the movement from 'incapable of recognizing affiliations', to 'incommensurable opposites' and to 'differentiation without division'. This is a movement from contrariety to polarity whereby the latter is 'distinct ***but not*** separate'. This makes the affiliation between the somatic and the psychic a natural reality. And so, while the somatic element may be a construct of the scientific method, its affiliation with the psychic is not by way of integration but by way of a continuum.

The somatic - psychic 'division' defines the object - subject division out of which a whole must be found. But the somatic - psychic couplet is not a division for the two belong together. And so, medicine is charged with the task of finding its own solution which requires journeying into territory in which its practitioners are ill-formed especially in medicine of our time.

IV. Existentialism in medicine:

A. Introduction

A 'philosophical dilemma' was noted by von Uexküll. However, if, as Kolakowski notes, philosophy is not a practice but simply tills the soil, this dilemma should be of no concern to medicine as a practice. And yet, Frankl has cited Paracelsus that philosophy is relevant to medicine. In addition, Frankl has noted that patients present with philosophical issues. And so, philosophy has a place in medicine. But which philosophy and what place?

Two independent sources from the realm of the psyche have provided answers. For both Yalom and Boss the philosophy is 'existentialism' and the place is the 'patient'. Each has engaged philosophy from different physical and cultural environments (America and Europe). However, they came to philosophy via different pathways: philosophy → to

the clinic for Yalom and the clinic → to philosophy for Boss. Furthermore it is quite possible that each was not familiar with the other's work.

But these factors make for a stronger not a weaker case for existentialism in medicine. And so, in spite of some differences in details between their views, there is agreement both of the importance of existentialism and its place in medicine as a practice. Relevant to von Uexküll's 'dilemma' and the somatic - psychic dynamic is Rollo May's view of existentialism as 'cutting below the cleavage of the object - subject divide'. It is there that what is divided is made whole. The challenge is how one might get there.

B. Living our humanness:

Humanness as living our humanity speaks to the person-as-subject, i.e. one who has agency. To consider humanness one begins with human existence. This is the domain of existentialism which in the context of modern medicine has become more relevant since, in spite of advances in medicine never before imagined, our humanness is more at risk than ever before. Dailey describes this humanness in the following:

> (A)n understanding of what a person is . . . leads . . . into the realm of philosophy. . . . (in which) questions about personhood concern what is *essential* (i.e. what <u>constitutes</u> a being as human?) ***<u>and</u>*** what is *existential* (i.e. how is our <u>humanness lived</u>?) [2] (*Italics* original, <u>Underline</u> added)

The distinction made here is between a noun and a verb. A noun relates to naming what exits whereas a verb relates to how that something is present in that it gives agency to what exists. The noun is the 'essential'. This aligns with an object. The verb is the 'existential'. This aligns with the subject and agency. This 'constitution' resonates with the classic understanding of human nature. Dailey recognizes this in noting that . . .

> (f)rom an *essentialist* perspective, the question about what constitutes a human being is

> variously described as the '*body-soul*' or '*mind-body*' problem." (p.112, *Italics* original)

But this classical view has not been carried over into modern medicine. Some may lament this and see it as needing reversal. However, noteworthy is Dailey's distinction between the 'essential' and the 'existential'. The former suggests a static reality (a noun), the latter a dynamic reality (a verb). Medicine as a practice cannot be other than dynamic.

The success of science in medicine considers the subject, i.e. patient, as an object with physical parts such that the object and function define today's 'person' including the person-as-patient. The views that nature is 'incoherent' (Bishop) and leads to 'irreconcilable differences' (Kleinman) indicate that the classical understanding of human nature is problematic in the modern clinic. Noteworthy is that both Boss and Dailey avoid the classical understanding for both speak to the practice of being human which is our lived humanness.

The existential, understood as how our humanness is lived, relates to ethics. Some may, thus, suggest that Dailey is describing ethics and not existentialism. But ethics as consequence as in sequence, i.e. distinct but not separate, avoids this misinterpretation. Existential and ethics are aligned whereby ethics is seen in the light of the existential. Elaborating on 'lived humanness', Dailey notes that in . . . "this existential perspective the historical rootedness of human beings raises questions about identity and action as they relate to our distinctiveness as persons." (p.113) He continues noting this lived humanness is . . . "ontologically distinct, rather than socially constructed: 'our actions . . . only *reveal* our personal nature; they do not *constitute* it'." (p.113, *Italics* original, Underline added) The key term is 'reveal' indicating that the dynamic is internal such that the person is revealed and not externally constructed. The dynamic, then, is from within to without and not from without to within. Thus, in this view man as *anthrōpos* is not cultivated but is a cultivator - is not determined by culture but rather determines a culture.

The 'fundamental characteristics' of our humanity (the Existentials of Boss) presented in Chapter 7 may appear to relate to what 'constitutes our humanity, i.e. Dailey's 'essentials'. However, the Existentials speak more to how our

humanness can best be lived which is Dailey's 'existentialism'. While a person may be constituted of 'parts' as in the classical understanding of human nature, what Dailey's 'existentialism' puts forth is how the parts are manifested as a lived reality, i.e. 'how humanness is lived'. This is dynamic and, as such, speaks to a practice and practice speaks to medicine. 'How humanness is lived' is noteworthy on two grounds.

In medicine this 'lived humanness' is the lived experience of illness which is Leder's 'experiential text' (Chapter 5 The Distressed Body, Figure 5.7) and what was noted here regarding the distressed psyche as the 'existential text' (Chapter 6 The Distressed Psyche - Part I). Second this implies function. However, 'function' understood as lived reality differs from function as understood and applied in science and technology where it is 'limited', as in circumscribed, to the objective and mechanical. Tournier's example of an automobile speaks to this restricted sense of 'purpose. (See Chapter 6, Note 1.) In the scientific domain function as purpose is determined externally whereas in lived humanness function is not circumscribed but open to internal input. This is illness as in living with a disease. It is this internal input which informs the 'how' humanness is lived and which speaks to the purpose, as in meaning, of 'what is', i.e. what presents itself to our person. It is this presence which defines the clinical encounter. The Existentials of Boss speak to this presence.

Boss notes von Uexküll's conclusion that . . . "(w)e can no longer assume concepts like 'body', 'world', 'mind', as if we were dealing with firm, established facts" (p.40-1) which the scientific world wishes to promote but rather need to assume a different posture *vis-à-vis* the world and our place in it. This posture speaks to disposition. Instead of the world being a mere fact independent of us, it presents itself to us as a phenomenon to be perceived. It is this perception which generates action which von Uexküll defines as 'intercourse with the world'. (p.41) There are two key concepts in this stance. First the world presents itself to us not simply as a given to be explored, dissected, and mastered as science and technology would have it but as a phenomenon to be experienced and acted upon. Illness, however, is always an

impairment or limitation of a person's freedom of movement, i.e. action. Thus, a patient's potentialities are limited by illness. This brings us to medicine.

The current basis of medicine ordered as it is to addressing pathology is not ordered to addressing the constraint that illness places on the patient's ability to live one's 'humanness'. It is the challenge of medicine to address this situation which is best described by Boss as an 'existential disability' in the sense of a dis-equilibrium. Therapeutic intervention addresses this constraint**.** Boss comments:

> "Therapy" is the name given to a particular kind of human activity, . . . commonly understood as that concerned with treating illnesses. Because only people have the capacity to act, all genuine actions including therapeutic procedures are the prerogative of human beings. (p.249)

The suggestion here is that therapy is a kind of action.

However, physicians are trained to assume that they are the lead, if not the sole actor, in the drama that is the physician - patient encounter. This is a direct result of modern medicine's currency which are facts, specifically facts based on calculations and measurement. But Boss goes on to note that such action is limited . . . "to responses to what has *already been perceived* in its context of meaning and reference." (p.249, *Italics* added) This limitation is actually due to a limitation of perception, i.e. the person as a physical object which is a pre-requisite of the natural scientific research method - a method which enjoys not only 'success' but also prestige, both of which are due to its explanatory power. The paradox is that success and prestige co-mingle with limitation. Boss engages this limitation.

C. The dynamic of the clinical encounter:

In addressing medicine as a practice Boss notes that the physician - patient encounter has three parts: i.) those acted upon, i.e. the patient ii.) the locus of the therapeutic action, and iii.) those who are therapeutically active. (p.249) He considers each part separately in the sequence noted. [3] What follows here is a brief consideration of this encounter

with an adaptation of this sequence. As for content what is presented will consider how one may view the parts and how they operate in the framing of medicine.

1. The locus of action:

This departure from the sequence put forward by Boss is based on the fact that the locus of action is common ground, i.e. shared ground, of the participants, and, therefore, merits consideration at the outset. The physician - patient encounter, the *sine qua non* of medicine as a practice, is the locus of action. Three aspects of this 'locus' are noted: the physician, the patient, and the encounter which is the 'in-between' the two participants. Thus, the 'locus' is the relationship which is outside of the participants and yet, necessarily includes the participants for without them there can be no relationship.

However, while the locus of action is common ground, the participants do not occupy identical space of this shared ground. In the context of disease there is a twofold imbalance between the physician and patient. One aspect is the imbalance of power and knowledge grounded in science and technology. The other is an 'existential imbalance' grounded in the patient's vulnerability for in every disease there is a vulnerable patient. This twofold imbalance favours the physician. This imbalance generates two elements which are the twin pillars of the medical profession: trust and personal disinterestedness. The former comes from the patient; the latter from the physician

Since vulnerability accompanies disease, trust comes not by way of patient choice but rather by way of necessity. However, disinterestedness, the purview of the physician, is not generated out of weakness but out of strength, i.e. knowledge. While having knowledge is a necessity, how it is exercised is a choice. The emergence of managed medical care (MMC) presented in Chapter 1 is an example of the erosion of this disinterestedness whereby interests other than the patient's interest were not only given standing but at times were given priority.

Boss notes that the nature of the physician - patient relationship largely determines the efficacy of therapy. Yalom

concurs noting that the relationship does the healing.[4] Efficacy requires a recognition of this . . . "and *learning* how to use it properly." (p.257, *Italics* added) This learning pertains to both physician and patient but in different ways. For the clinician it means being . . . "free from all intention, of all therapeutic, educational, and scientific ambition." (p.259) A physician's disinterest, then, is widespread. This relates to being focused entirely and solely on the interests of the patient.

From the outset the focus is primarily on the relationship and only secondarily on the 'actors'. It is then that the physician can turn to what Boss calls . . .

> (t)he true art of therapy (which) lies in paying attention to 'what' the patient visualizes and 'how' . . . (the patient) conducts himself in relation to it. (p.259)

Two aspects are noteworthy here. First 'therapy' is considered an art and not merely the application of scientific knowledge. Second it is the patient who is at the centre of the encounter. Thus, while the imbalances noted above are present, they do not determine the encounter. The locus of action, then, resides not with the physician and / or the patient but with the encounter understood as the relationship itself. This is Yalom's 'centre of the therapeutic arena'. (p.174) But this relationship is inherently dynamic. This dynamism is the river of life noted by Heraclitus some 25 centuries past. Also of note is that the power paradigm is part of his encounter.(See Table 6.1.)

2. Those who are active and
   those who are acted upon:

This, too, is a departure from the sequence put forward by Boss for it includes both patient and physician. It is this way for the art of therapy includes both. The reason for putting both together is that each participant is active and acted upon but not at the same time nor in the same way. This can be framed as subject (those active) and object (those acted upon). This is illustrated in the twin realties of disease and illness wherein the roles of each participant, i.e. active and acted upon, not only differ but reverse. The 'learning' that goes on in the locus of action, i.e. the 'in between' physician and patient, operates

differently in disease than it does in illness.

In the disease realm the physician has the knowledge and the patient needs to learn what the physician knows. This has been named herein as the 'experimental text'. In the illness realm the patient has the knowledge and the physician needs to learn what the patient knows. This is Leder's 'experiential text'. This is the patient as teacher. In the disease realm the knowledge is numeracy grounded in deductive reasoning. In the illness realm the knowledge is literacy grounded in inductive reasoning. These are two ways of reasoning which can also be understood as two ways of 'thinking' which provide two kinds of knowledge. In this exchange, i.e. encounter, each person's knowledge grows.

Through deductive reasoning science arrives at numerical conclusions which provides answers to the '*Why?*' question, understood as 'how' what is came to be. This is 'knowledge of ' something with that 'something' being disease. Since every experience speaks to us, every experience produces a text. This is literacy. The experience of illness produces an experiential text via inductive reasoning. The knowledge emanating from this reasoning is knowing something with that 'something' being the person with the illness. In a sense, our understanding of disease, grounded deductive reasoning, is a monoculture. On the other hand, while illness is situated within the context of disease, it also includes inductive reasoning, thereby making illness a hybrid culture. Both exist in and belong to the clinical encounter. This pertains to Leder's 'distressed body'. But what of the distressed psyche?

3. The distressed psyche:

The distressed psyche as a primary injury does not fit either model precisely. And yet, the psyche rightfully belongs to the locus of action. And so, to know that it is at the bedside is crucial to the therapeutic efficacy of the clinical encounter and to the art of medicine. The twin pillars, noted by McHugh and Yalom, '*what*' does psychiatry know and '*how*' does it know it' are sentinel guideposts to the psyche's presence at the bedside. The source of this knowledge is the patient. And so, the patient is the '*how*' of knowing. The '*what*' of knowing

emerges from this '*how*' in the here-and-now. Note that in Freudian psychoanalysis it was memory that was at the centre of the therapeutic encounter.

The knowledge regarding a distressed psyche comes through inductive reasoning. While some in the psychiatric community may claim otherwise, the role of science, e.g. neuroscience, in psychiatric practice is secondary. In brief, psychiatry is not and cannot be science of causation. It is this way for the psyche does not reveal a pathway, i.e. mechanism of injury. And so, inductive reasoning operates independently from deductive reasoning in a psyche primarily distressed. This differs from both disease and illness and yet, also belongs to both as being integral to medicine. It is unlike the former in that it is informed by inductive reasoning and unlike the latter in that it is not a hybrid culture.

The knowledge emanating from this reasoning is knowing something with that 'something' being the 'self'. This aligns with knowing the illness, i.e. the person who lives with the disease, and resonates with a distressed psyche as a primary event where it is the sole focus. Knowing the self is self - knowledge. This knowledge is what has been named here the 'existential text' of which the patient is the sole author and, therefore, has the copyright. This is the ultimate text. It is the patient's text for it is her / his existence which is being questioned internally. These questions are the existential concerns noted by Yalom. The Existentials of Boss give a direction as to how these concerns might be to addressed.

In the existential realm the roles of the active and acted upon are present but not scripted, thereby making the dynamic not only internal but balanced. This is the perception mode of the Existentials that is central to understanding the clinical encounter and essential to realizing its therapeutic potential. But the physician is not entirely passive in this creative activity. The role of the physician as 'actor', i.e. agent, is not a role of interpretation of the text for that belongs to the patient. Rather the physician's role is that of active listening in order to facilitate the patient's creativity in weaving (*texere*) the existential narrative. The Choy and TED Drama Triangles speak to this knowledge of self in terms of ownership and creativity. (Table 6.1.) This existential narrative resonates

with Charon's 'narrative competence' (Figure 5.4); however, the 'competence' as used here belongs to the patient.

Knowledge in the existential realm has moved on from 'knowing of ' disease, i.e. that which a person has, and from 'knowing' illness, i.e. what a person lives with, to 'knowing' the self. This is a migration from knowing a patient to knowing the person. This is an existential journey - an ultimate journey. Yalom's 'existential concerns' speak of this journey and the Existentials of Boss speak to this journey. This provides not only a reason for the presence of the psyche at the bedside but also how its place there may be filled.

This answers the '*Why?*' question understood as what is the purpose as in meaning of what is. But it also expands the first two pillars noted above from '*what*' and '*how*' psychiatry knows to '*why*' psychiatry knows what it knows. Knowing the self is the '*why*' of the *étrange dynamique* first noted in the Conclusion of Chapter 4. It is in knowing this '*why*', i.e. knowing the patient, that psychiatry comes to know where it belongs.

V. Explanatory power in medicine:

A. Text and context:

The approach toward the patient that physicians are trained to adopt is treatment of the disease. But for every disease there is an illness. Boss notes that every illness reduces a patient's option as . . . "certain of the patient's potentialities for relating himself to what is encountered become less available." (p.251) Therapies aim . . . "to cast aside the pathological obstructions to the free carrying out of all possible ways of relatedness" (p.255) that are necessary to own illness. This ownership is what McHugh refers to as mastery. This is lost in the education and practice of physicians today because medical education does not know how to ground the craft of medicine in any way other than in the natural scientific method with its inherent limitation due to an exclusive focus on disease and *ratio* as measurement. It is not that deductive reasoning is not effective but that it is insufficient. Modern day physicians being immersed in numeracy of the scientific

research method *vis-à-vis* disease lack the requisite tools to address a patient's illness. One such tool is literacy which is learned by listening to the patient's existential text.

In order to understand explanatory power in medicine it is helpful to consider medicine as it is practiced. Three contexts, each having a text, speak to this practice. This is presented in the following image:

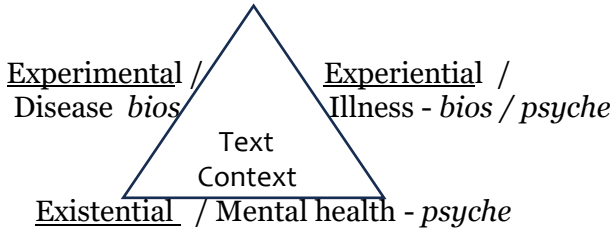

Figure 8.1 Text and Context

One context is scientific which concerns itself with disease. The text arising from this approach is the experimental text. Another context is illness considered in the realm of *bios* from which comes the experiential text. A third context is the *psyche* from which comes the existential text. Every disease / illness / distressed psyche brings the reality of finitude to the surface. Each context engages this finitude in its own way for each context is different.

The scientific method addresses the finitude through the lens of human biology. Its goal is to provide a way forward either by mitigating or removing the threat of finitude that a patient encounters. This approach when successful bestows enormous explanatory power in science. Three consequences follow from this success. First is that that human biology, understood in its narrow physical sense, defines the human condition. Second is that this condition is defined in terms of function which is also limited to the physical. In modern times science and technology is bestowed reverential status. And so, when science explores a reality that is inexplicable, i.e. beyond the reach of current scientific knowledge, life is incoherent for it is deemed to have no meaning. Science, then, is aligned with meaning such that when science is deficient life is without meaning. This is the third consequence.

The experiential text deals with the same finitude but through the lens of the person with an illness. Since this person is a subject and a subject is one with agency, the person with an illness seeks a way to deal with this finitude. And so, while the disease is present and, hence, deductive reasoning is also present so, too, is inductive reasoning present as the patient lives with the illness.

Questions of finitude also surface in existential psychotherapy. Yalom names these the 'existential concerns'. Of note is that the language Yalom uses to describe power in existential therapy is similar to the language of the scientific method. It is beneficial for understanding both contexts to consider this language. Yalom notes that prior to the reality of finitude surfacing to one's consciousness, patients often have a pattern of acting counter to their best interests. (p.76) The goal of therapy, then, is to change their focus such that they act in their best interests. This change in focus requires that one determine what those 'best interests' are.

Recall the traditional ethos of medicine requires that its practitioners to act exclusively in the patient's interests. What is encouraged in a distressed psyche is to have the patient learn to act in their own best interests. Yalom notes that . . .

> (e)xplanation provides a system by which we can *order the events* in our lives into some *coherent* and predictable pattern. To *name something*, to place it into a logical . . . *causal* sequence, is to experience it as being under our control. No longer is . . . our internal experience frightening, inchoate, out of control. (p.78, *Italics* added)

The 'causal sequence' is what the scientific method seeks to control. To the extent that science is successful, the internal experience is less frightening. But the coherence noted above differs from the coherence of science for it speaks to the patient and not to the disease. This is brought to the surface by noting that explanation . . .

> offers us freedom and effectance. As we move from . . . being motivated by unknown forces to . . . identifying and controlling these forces, we

> move from a passive, reactive posture to an active, acting, changing posture. (p.78)

This movement from passive to active resonates with Marcel's 'immobilization' and 'mobilization'. (Chapter 2 Philosophy in Medicine). It also resonates with the 'Power Paradigm' (Figure 6.1) whereby the non-use of power is addressed.

In the existential context the sense of 'finitude' of being is engaged such that its controlling power has been named if not yet neutralized. Naming this finitude brings it to the surface. This is the 'consciousness' element of Yalom's 'existential position'. And so, the controlling force of finitude is no longer unopposed. That, in itself, makes it less frightening. The ensuing movement from passive to active is the beginning of finding a new found freedom whereby choice is no longer controlled by the 'dread of a terrifying freedom'. One, then, can begin to consider options that are not counter to one's best interests.

The 'basic premise' of psychotherapy is that . . . "explanation . . . is to provide the patient with a sense of *personal mastery*." (p.78, *Italics* added) It is this mastery which is the measure of explanatory power for where there is no power or where power is 'non-used' there can be no personal mastery. For 'personal' one reads mastery of the person as in ownership of the person which is <u>acted out</u> in agency. This differs from the person as object to be <u>acted upon</u>. The distressed psyche is an illustration of a person being acted upon either via others or via disease. But the mastery sought by science is physical mastery which is of a different kind than personal mastery. Since 'mastery' is of two kinds, further explication is required.

Yalom continues on the same trajectory in the following:

> To the extent that it (explanation) offers a *sense of potency*, a *causal* explanation is valid, correct, or 'true' . Such a definition of truth is completely *relativistic* and *pragmatic*. It argues that no explanatory system has *hegemony* or exclusive rights that no system is the correct one. (p.78, *Italics* added)

But this 'causal explanation' speaks not only to the existential

but also to the explanatory power of the scientific method. The key terms are 'pragmatic', 'relativistic', and 'hegemony' for they place the causal explanation in perspective.

Yalom's existential psychotherapy is 'pragmatic' because it is patient - centered in that knowledge derives from and, therefore, resonates with the patient. Since each patient is unique, so, too, is every narrative. Thus, it is 'relativistic' in that everything hinges on the patient's narrative. By the same token 'hegemony' is not possible. However, while these features of Yalom's existential practice are noteworthy in themselves, they are also noteworthy in comparison to the natural scientific research method.

The basic premise of the scientific method is that objects have a finite set of properties which are norms. Pathology is defined as being outside of those norms. However, since these norms pertain to physical parameters, if they are allowed to determine the human condition the transfer to the non-physical becomes problematic. And so, while pragmatism may describe the scientific method, it is limited to the *bios*phere. Given the reverential status of science in medicine of our time, the relativism noted in the existential explanatory power is replaced with the hegemony of science. Thus, on all three counts - pragmatism, relativism, and hegemony - Yalom's approach challenges the dominant mode of explanation in medicine of our time.

Of further note is Yalom's mention of 'potency'. This can be seen in the context of what the patient has, i.e. disease or in the context of the patient and person. In the former the there is hegemony via the experimental text. Relativism and pragmatism via the experiential and existential texts are present in the latter.

B. Existential power:

While Yalom uses language which is familiar with the scientific method, e.g. 'control', 'cause' and 'explanatory power', his use of the terms differs such that the 'meaning' of the words is not interchangeable. The experimental text of science gives rise to numeracy whereas the patient's existential text is 'written' in literacy. A feature which distinguishes the

two texts is that while numeracy provides veracity, literacy provides authenticity. The presence of both texts accounts for relativism and, therefore, removes the possibility of hegemony.

As for being pragmatic both have this feature but in different ways. The dynamic of the existential text is that the effect of the explanation on the patient's mastery of his / her situation determines the power of the explanation. And so, the explanatory power is not determined by some outside force or theory such as the experimental text but rather by the person-as-patient which is the manifestation of the patient's agency. In brief, this construct is not deterministic. This is a further distinguishing feature.

The genesis of Yalom's construct is twofold. It comes from the patient via the locus of action, i.e. the therapist / physician - patient encounter. This is the narrative and is dependent on the patient for its 'data'. This makes it a process of inductive reasoning. The second source comes from Yalom's reading of philosophy, notably Heidegger. [5] Yalom notes *Da-sein* ('being there') as in being present to what is presented to us. It is this presence which is observed which is the nidus of inductive reasoning. This is developed further where it is noted that . . . "(e)ach *dasein* . . . constitutes its own world". (p.181) However, . . .

> to study all beings with some *standard instrument* as though they inhabited the same objective world is to *introduce monumental error* into one's observation. (p.181, *Italics* added)

With respect to the 'standard instrument' two points are noteworthy. First since each *Da-sein* 'constitutes its own world' and since each person's 'world' is unique, no person's *Da-sein* can be transported to another. Thus, in the existential realm, there is no, nor can there be, a standard instrument. For 'standard instrument' read the natural scientific research method. Moreover, *Da-sein* situates the patient in a world beyond the reach of science. While the explanatory power of science is real, it is limited for it cannot go beyond the depth of the *bios* sphere. This 'beyond' is below the subject-object cleavage noted by Rollo May. This limitation is significant since not all reality can be measured. And so, what is

immeasurable is beyond the reach of science.

The natural scientific research method is the standard for all disciplines be they physical, social, economics for science pertains to exploring the natural world and how it is organized with the goal of mastering that world. While this method may be appropriate for quantification of properties that lie within the physical sphere, its utility is limited to that sphere in spite of efforts by behavioural science and social science to claim relevance and competence. The 'standard instrument', then, cannot account for the patient's entire reality. Any effort to do so is imposed from the outside of the patient's world. This generates the 'error' noted by Yalom.

The existential engages reality where science cannot go and science does what the existential cannot do. Thus, each instrument has its limits but the limits differ. The 'standard instrument' sees pathology as disease understood as something the patient has. *Da-sein* sees pathology as a deficit, i.e. an illness with which the patient lives. The crucial point is to see 'instruments' as methods in the context of the patient's reality. While both disease and illness are real for the patient and for the clinician, the fertile ground is not the disease but the illness. The idea of explanatory power operates differently in disease than it does in illness. But the psyche is also fertile ground and explanatory, i.e. existential, power operates there also.

C. Existential power and the distressed psyche:

The current basis of knowledge in modern medicine is largely derived from and dependent upon the scientific research method. However, while the 'empirical approach' may provide measurement of physical elements, it cannot be of assistance in existential concerns. Two points clarify this. First since meaning is never caused, it can never be obtained from a study of component parts. Since it is parts which are the subject of scientific natural research, this approach cannot give meaning. Second Yalom's 'existential position' of consciousness, participation, and construction provides the framework in which existential therapy occurs. (Figure 6.3) This is the activity that takes place in what Boss calls the 'locus

of action'. This 'construction' is a culture and every culture is essentially creative for no culture is a given. In the context of medicine this creativity is the patient's existential text with its own inherent power. This is not limited to the physical changes of causality but extends to a place and complexity where science cannot go. This challenges the Cartesian view, a view which has given rise to the scientific method of research of a world full of objects and subjects who perceive those objects.

Since the empirical, i.e. scientific method, is insufficient, alternative methods of knowing . . . "the inner world of another individual" (p.181) are required. On this Yalom notes that . . .

> (t)he proper method of understanding the inner world of another individual is . . . to encounter the other without '*standardized* ' *instruments* and *presuppositions*." (p.181, *Italics* added)

By 'other' I take Yalom to mean the patient. While these 'instruments' may be referring to the physical domain, they also resonate with McHugh 's critique of psychiatry and his comment regarding 'predisposition bias ' noted earlier. Of note is that the patient is not subjected to instruments or to presuppositions. Thus, the therapist does not lead but follows by inviting, i.e. by being open to, the patient's lead. In brief, the patient finds the new focus on the existential interests. An encounter which is not encumbered by instruments and presuppositions allows for the patient's existential text to be written such that it (the text) is plausible and meaningful to the patient. In this way the 'text' carries explanatory power which is the first step to mastery - a mastery which those who suffer a distressed psyche are in need of most. This 'mastery' is McHugh's 'ownership'.

In existential psychotherapy it is this mastery which is the criterion of explanatory power. However, mastery is best understood in its wider sense as mastery over a reality, i.e. a situation, and not in the narrow sense of causality, i.e. control over the cause of a reality. While in a distressed body control over the cause, i.e. disease, may be possible for there is a mechanism of injury, no such control is possible in a distressed psyche. In existential psychotherapy one identifies

the effect and learns or does not learn how to navigate the 'pathway' that life presents. While the clinician plays a crucial role in each of these modes, the roles differ. In existential psychotherapy Yalom describes the therapist's role as one which attends carefully . . .

> to these vital concerns and to the therapeutic transactions that occur on the *periphery* of formal therapy, and to place them where the belong - in the *center* of the therapeutic arena. (p.174, *Italics* added)

It is in this migration from the periphery to the centre that existential therapy promotes. This is putting the patient-as-person back in the centre.

The focus is not the concerns noted in the formal therapy which can be understood in the sense of 'chief complaint' as in the *bios* of disease but rather to see the therapeutic centerpiece of the clinical encounter. The word that Yalom uses to best describe this centerpiece is 'dread' - the dread of choice, dread of the terrifying freedom of adulthood, of isolation and, hence, meaninglessness. This is allowed to surface in the patient's consciousness in the service of constructing an existential response which is actualized in living one's humanness. The Existentials of Boss speak to this humanness.

VI. Conclusion:

The division which is a feature of modern medicine can be viewed in many ways. It is most clearly seen through the lens of somatic - psychic relationship for this manifests many aspects of the division. Moreover, the somatic - psychic division speaks directly to medicine as a practice. The '*how*' and the '*what*' of knowing function differently in the somatic and psychic realms. But both coalesce in the '*why*' of knowing. It is this way because while there is a somatic and psychic component there is only one patient. And so, the somatic and the psychic are one. This illustrates the problem which is the first step to a solution with the solution being making whole that which is divided. It also highlights why a solution is necessary.

Living our humanness is the process to wholeness which closes the divide. It has been suggested that this comes about through an existential approach. But while this existentialism is bringing philosophy to the bedside, it respects the fact that philosophy is not a practice but tills the soil. However, this activity serves medicine as a practice. Both Yalom and Boss explore how existentialism can be situated in practice. Living our humanness is existentialism *in vivo*.

Three texts and contexts of medicine have been noted in living our humanness. Each (text and context) offers what an other does not. These are neither opposites by way of contrariety nor are they polar opposite as distinct and separate such that nothing holds them together. It is the patient who holds them together. But not only do they belong together, each also has found where it belongs, i.e. the place it can call its own. Thus, there is rightful place for disease, i.e. the *bios*, a rightful place for illness, and a rightful place for the *psyche*, i.e. mental health.

Each produces a text which contributes to our understanding of medicine as a practice and informs medicine's craft. In addition, each contributes to the fundamental goals of medicine which are to know '*why*', understood both as 'how' what is and the purpose (meaning) of what is that came to be. Thus, the power of medicine is not thereby limited to explanation of the *bios* but expands to meaning and purpose. It is here that the patient is a person. This is how psychiatry frames mental health and thereby cements its (psychiatry's) rightful place at the bedside. Living Our Humanness frames medicine the same way as psychiatry frames mental health. And so, this re-framing of medicine presented in the Figure below is indebted to re-thinking psychiatry.

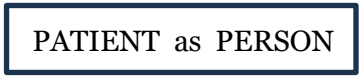

Figure 8.2 Re-framing Medicine

But this is not the first time that 'patient as person' has been used. The American Medical Association invited the philosopher Abraham Heschel (1907-1972) to address its

annual convention 1964. 'The Patient as a Person' was the subject topic Heshel was asked to address. While Heschel complied, his introductory comments indicated that he felt more comfortable with a modification. He noted: "I wish I could extend the theme of this session to . . . and speak about person as a patient". [6] This was based on the fact that . . . "(w)e are all patients. We all have suffering in common." (p.24) This is Dubos' innate vulnerability. This address is philosophy knowing of medicine rather than physicians knowing of philosophy as Paracelsus would have it.

Heschel notes that animals live by instinct. However, man is a different kind of animal. A human is more than a fact but a category of value. (p.24,26) But in medicine of our time the facts of science carry value such that what science cannot address is not valued. But in 1964 Heschel commented that "being human cannot be validated within scientific empiricism." (p.26)

In contrast to being a mere animal. Heschel comments that . . . "Perhaps the most amazing aspect about man is what is latent in him." (p.25) He continues: "(T)he essence of being human is not what he is but in what he is able to be." (p.26) For Heschel the fundamental feature of personhood is not satisfying our instinctive needs as animals do but a concern for others. (p.26) On this personhood he notes that . . "the secret of existence *appreciation*, its significance is revealed in *reciprocity*." (*Italics* added, p.26) Two points are noteworthy here.

First 'appreciation' resonates with Hillman's understanding of the Greek '*kosmos*'. (See Figure 5.8.) Second is the reference to 'reciprocity'. Relevant to this Heschel comments: "We cannot speak about the patient as person unless we also probe the meaning of the doctor as a person. You can only sense a person if you are a person." (p.27) And so, framing medicine 'patient a person' also places 'physician as person' in the frame. It is this is reciprocity that gives significance to appreciation.

This concludes the centerpiece of this work and at the same is a preparation for closing section which follows.

Chapter 9

Wholeness as Healing

The Art of Healing in a Scientific Age [1]

I. Introduction:

The original '*Apologia for the Art of Healing'* was a treatise from the Sophist School of philosophy in Ancient Greece regarding medicine as it was practised at that time. [2] In The Enigma of Health, the sub-title of which is 'The Art of Healing in a Scientific Age', Hans Gadamer (1900-2002) writes an 'Apologia for the Art of Healing'. This draws on the original 'Apologia' in order to understand medicine in the late 20th century - a span of 25 centuries.

In contrast to 'apology' whereby one expresses regret for some action / expression / inaction, the term '*apologia*' carries the sense of a defence of a theory or action. Thus, an 'apologia for the art of healing' would be expected to present a defence of this 'art' in the sense of its *raison d'être*. But Gadamer expands on this in noting that . . .

> (a)n apologia for the art of healing is more than a defence of a particular profession or a special art . . . . (I)t also represents a kind of *self-examination* and self-defence on the part of the physician which belongs to the peculiar character of the *medical skill* itself. (p.33, *Italics* added)

Thus, Gadamer's use of 'apologia' does not rationalize a profession nor does it defend a practitioner. Rather it is an openness to exploring the nature of the 'medical skill'. This skill is always in the process of being learned one patient-at-a-time for a physician's education continues as long as patients are in one's care. It is this which merits exploration.

But Gadamer notes that . . . "(p)hysicians can no more prove the worth of their art to themselves than they can to others." (p.31) And so, the matter for exploration is not a proof

of value but has an objective of understanding the art of medicine, i.e. of medicine as a practice and, hence, medicine as a profession.

II. Greek origins:

More than two millennia separate our times from Ancient Greek thought. The world of modern medicine is vastly different today and yet, Greek thought has something to contribute to understanding our time. Gadamer notes: "(W)e possess a treatise from the age of the Greek Sophists where . . . the art of medicine (is) defended against its detractors." (p.31) It is to this document via Gadamer's essay that one looks back not simply to return to the past but in order to shed light on the present.

A. *Techne*:

Several features of Ancient Greek culture are noted: the spirit of *logos* (word) and history, free-thinking inquiry, and the search for explanatory growth of all that we hold to be true. To this Gadamer adds *techne* as a unique creation of Greek culture. (p.31) It is *techne* which Gadamer finds was relevant then and is relevant now. In the Greek sense of the term *techne* . . .

> does not signify the practical application of theoretical knowing, but rather a special form of practical knowing. *Techne* is that knowledge which constitutes a tried and specific ability in the context of producing things. (p.32, Underline added)

Thus, *techne* as knowledge differs from mere application of theory in that it is knowledge which emerges from application. In brief, it is practical knowledge. But this knowledge is more than knowledge that goes into practice. It is knowledge which emerges from practice. And so, in medicine as a practice this knowledge comes from the clinical encounter, i.e. the 'bedside'. This is the foundation of the principle that it is the patient who makes one a physician. This is both an on-going praxis and an on-going learning. It is this way for it is in practising a craft

that the craft is learned. This is the difference between 'knowing of ', e.g. theory, and 'knowing' the craft. Knowledge, then, is grounded in praxis and not in theory since *techne* is ordered to the production of things.

An illustration may make the point. A blacksmith forges horseshoes out of a furnace. In earlier times the heat of the furnace was not measured by the temperature but by observation of the colour of the flame and heated metal. And so, the 'smithy' would know by observation when the iron was hot enough to form the desired product. Each step was practical knowledge which existed outside of theory. Moreover, each product is unique to the situation, e.g. no two sets of horseshoes are identical. After years of apprenticeship the blacksmith would be a master of the craft.

This captures the Greek understanding of *techne* expressed by Gadamer as . . .

> a unique ability to produce, . . . which knows what it is doing, and knows on the basis of grounds. . . . something independent is actually produced . . . (and) given over for the use of others. (p.32)

Three features of *techne* are noted: practical knowledge, production, and given to others. Practical knowledge, then, is knowledge which arises from a practice. Each *techne* is a form of practical knowledge. Medicine's *techne*, i.e. practice, is ordered to the health of the patient. It is this practical knowledge which separates medicine from philosophy. [3]

B. Science:

But theoretical knowledge was not unheard of in Ancient Greek philosophy. Gadamer notes that . . .

> (t)he . . . concept of *techne* and its application to medicine marked a <u>first decisive commitment</u> towards everything that essentially <u>characterizes</u> <u>western civilization</u>. (p.31, <u>Underline</u> added)

Noteworthy here is the significance of the convergence of techne and medicine as a marker of Western civilization. This 'decisive commitment' is attributed to Aristotle (384-322 BCE).

Gadamer states:

> Aristotle *specifically* uses medicine as his standard example for the transformation of the purely practical accumulation of skill and knowledge into a genuine *science*. (p.31, *Italics* added)

While this suggests a movement from practice to knowledge, it is a movement to organize practice and knowledge into a unified system. Thus, the practical became organized into a system, i.e. science, as a method of gaining that practical knowledge. This was no arbitrary decision but one 'specifically' taken.

But Aristotle was predated by Democritus (ca.460-370 BCE) who, Boss has noted, is credited as the father of science. It was Democritus who gave voice to the view that cause and effect and man's innate desire to dominate nature was paramount. Science has expanded its knowledge and role since Democritus and Aristotle.

C. The art of healing as *techne*:

Gadamer notes that the 'art of healing' is problematic today and was also in Ancient Greece at a time when science and medicine were in the early stages of a relationship. The principle issue was that the art of healing produced no product. Gadamer puts this as follows:

> (T)here is no 'work' produced by art, and no '*artificial*' product. . . . (W)e cannot speak of a material which is already given . . . by nature, and from which something new emerges by . . . an artfully conceived form. On the contrary, it belongs to the essence of the art of healing that its ability to produce is an ability to *re-produce* and *re-establish* something. (p.32, *Italics* added)

A key term is 'artificial' indicating something that is made by human hands rather than something naturally given. This questions what is it that medicine did in ancient times. If medicine did not produce anything, it cannot be considered a *techne* in the strict sense of the term.

Gadamer continues noting that medicine . . .

> involves the *restoration* of the health of the sick person. . . . (But) whether this is . . . the result of medical knowledge and ability cannot be directly observed. . . .Thus, it must always remain an open question just *how much* . . . the restoration . . . (is due) to . . . the *treatment of the physician* and *how much nature* itself has assisted in the process. (p.32-3, *Italics* added)

This sets the stage for Gadamer's 'apologia', not as a self - defence of the profession but as a self-examination by the profession itself.

The cornerstone of this examination is to consider *techne* in the context of nature because it was <u>within</u> nature that . . . "(a)ll ancient thought conceived the domain of what can be skillfully produced by human art." (p.33, <u>Underline</u> added) And so, . . .

> (i)f *techne* . . . (is) understood as the <u>imitation</u> of nature then . . . the artful capacity of human beings . . . fills out the <u>open realm of possibilities</u>. (p.33, <u>Underline</u> added)

Two points are noteworthy here. *Techne* is considered as residing <u>within</u> nature. This carries a stance of openness to possibilities which are innate in the natural. Boss has noted that 'openness' is a central aspect of being human.

Second medicine concerns itself with nature for its sole pre-occupation is the health of the person. Medicine, as it was known in Ancient Greece, is . . .

> a particular kind of doing and making which produces nothing of its own and has no material to produce something from. The expert practice of this art inserts itself *entirely within the process of nature* in so far as it seeks to *restore* this process when it is *disturbed*, and to do so in such a way that the art can allow itself to disappear once the *natural equilibrium* of health has returned. (p.34, *Italics* added)

Medicine, then, resides entirely within nature but a nature which is disturbed and when equilibrium is re-established. medicine need no longer be present.

But if medicine produces nothing, how can it be considered a *techne*? And if not a *techne*, one cannot speak of the 'art of healing'. Gadamer seems to have argued himself out of an 'apologia for the art of healing'. And yet, by introducing the notion of equilibrium he, in fact, opens the discourse to a way of understanding this art as a healing art. This is the self-examination of the art of medicine. It is this self-examination which reflects Gadamer's understanding of the term 'apologia'.

III. Equilibrium:

A. Introduction

Equilibrium introduces the notion of balance. It is common to think of balance as a state of inertia. However, while balance may imply a lack of movement, it is actually a dynamic state with numerous forces interacting. And so, the homeostasis we observe or participate in is an equilibrium between various forces of energy acting internally. Gadamer draws on the poetry of Rainer Maria Rilke (1875-1926) to illustrate this. He refers to Rilke's acrobatic artist noting that . . . "when the act works, *suddenly* everything *seems* to happen spontaneously, lightly, and effortlessly." (p.37, *Italics* added) The point of note is that 'balance' seems to lack effort and arrives suddenly. But this is only in appearance. What appears on the outside belies what is within.

Equilibrium pertains not only to medicine but also to the whole of nature. Gadamer notes that . . .

> (t)he notion of equilibrium also readily offers itself for our understanding of nature in general. The Greek concept of nature consisted in the discovery that the totality is an *ordered structure* which allows all the processes of nature to repeat themselves. . . . (T)he *whole harmonious balance* of interacting events determines all things as a form of *natural justice*. (p.36, *Italics* added)

A point merits attention. There is a confluence of 'whole', 'balance', and 'justice' such that there is a unity since all forces are in right relationship. Simone Weil has noted that the

Hebrew sense of justice is 'right relationship'. [4]

The experience of being a patient is an experience of an existential threat. This is Yalom's 'apprehension of finiteness'. While the details of this threat may not be fully grasped in our consciousness at the outset, the threat, i.e. Marcel's 'uneasiness', is no less real and arrives with the first suggestion that things are not what they formerly were. It is this which disturbs the equilibrium. Medicine is an attempt to address this dis-equilibrium But there is no new equilibrium *de novo* produced by medicine. Rather an equilibrium is 're-produced'. This difference is noted in the following:

> (M)edical practice is *not concerned* with . . . producing equilibrium . . . with building up a *new state* of equilibrium from nothing but rather . . . *arresting and assisting* the *fluctuating* equilibrium of health. (p.37, *Italics* added)

Thus, equilibrium as balance is a dynamic always under the influence of internal forces and potentially leading to clinical symptoms and signs when imbalance breaks through. Medicine aids in the re-balancing. And so, dis-equilibrium and equilibrium are always in tension and the change from one state to the other is a sudden transition. Gadamer notes:

> (w)e encounter the recovery of equilibrium in . . . the same way that we encounter . . . (its) loss, as a kind of 'sudden' reversal. . . . (T)here is no continuous and perceptible transition from one to the other but a *sudden change of state*. (p.36, *Italics* added)

This 'reversal' of dis-equilibrium and the consequent restoration of equilibrium is not merely a return to the same equilibrium. A 'restored' equilibrium cannot be identical to a previous state for equilibrium of the person is not generic since it is grounded in the experience of life's circumstances. This reversed equilibrium is not a repeat or restoration of the old but is a growth of what was present before. It is best understood as 're-newed' in the sense of the temporality Existential of Boss in which the expansiveness of time as *kairos* was noted. This reversal of equilibrium, then, is an expansion of the equilibrium which is innate to human nature.

'Innate' carries the sense of being inherent in that it is a given feature. Thus, equilibrium is inherent to our humanness such that it belongs there and, therefore, is what one seeks in order to live humanness. Innate, then, is open and dynamic and not closed and static. But how does 'this' equilibrium come about and what role does medicine have in its presence?

B. The genesis of equilibrium:

Gadamer notes that . . . " equilibrium is accomplished in medical practice at just that point where intervention is rendered superfluous and dispensable." (p.37) This is the 'suddenness' noted above indicating that it comes from within the patient and not from without via the clinician. The paradox is that the practitioner's contribution . . . "consummates itself by disappearing as soon as the equilibrium of health is restored." (p.37) But 'consummates' suggests an active participation and contribution.

The essential point is that medical intervention does not exist in a vacuum but in a context which, in Gadamer's view, in a process whereby an . . . "*inner* relationship . . . (with) nature itself comes into play." (p.37, *Italics* added) This is the 'locus of action' noted by Boss. This 'inner relationship' is the basis of the clinical encounter being primarily, i.e. first and foremost, an existential encounter. This inner aspect speaks to the view that balance is a dynamic reality which is rooted internally but exhibited externally. This internal - external balance is integration. This dynamic is what Gadamer saw in Rilke's poetry.

He goes on to note that . . .

> (i)n our experience of *balance* the *exertion* involved is paradoxically directed at somehow *loosening* its own *grip*, precisely in order to *allow equilibrium* itself to come into play. (p.37, *Italics* added)

Thus, there are different forces in play. It is only when the grip is loosened that the acrobat, i.e. patient, experiences restored equilibrium. Finally, it is by loosening the grip that one learns trust - to trust oneself. And so, one does not earn trust from another but rather one learns to trust the self. But this also

entails risk for only the patient can loosen the grip.

This speaks to the role of the practitioner which is described in the following:

> (A) doctor's intervention cannot properly be understood simply as making or effecting something but must rather principally be seen as supporting those *factors that help sustain* equilibrium. (p.37, *Italics* added)

The key point here is that rather than effecting something medicine allows something to happen. This 'something' is the patient's inclination to equilibrium which is a person's natural state. The physician's role, then, is supportive of nature and when equilibrium is 'renewed' the physician becomes superfluous.

But this may not be as easy as it sounds. Gadamer continues noting that . . .

> (m)edical intervention always stands under a *double sign*: the act of intervening either constitutes a *disturbing factor* itself or it introduces a specific healing effect into the *harmoniously interacting factors*. (p.37, *Italics* added)

To illustrate this disturbing - harmonious dyad Gadamer, drawing from the Greek 'Apologia', invokes the example of tree-sawing described as an . . .

> internally unified configuration in which the respective movements of the two tree-cutters fuse to become a single rhythmic flux of movement. . . .Yet if they employ violent force . . . they will fail utterly. (p.38)

This 'tree-cutting' is the active part of the locus of action. Equilibrium emerges in the balance or is avoided in the imbalance. But while balance may be innate, imbalance is not and neither is re-balancing. One must acquire the skill necessary to achieve re-balance out of imbalance.

Gadamer continues noting that the . . . "skilled hand of the master lets the deed appear effortless in just the place where the apprentice produces only a forced effort." (p.38) The acrobat in Rilke's image 'releasing the grip' speaks to effortless appearance in contrast to forced effort. The tree-

cutting image illustrates the same dynamic. And so, the 'experience of equilibrium', to use Gadamer's phrase, is a creative art form which implicates 'every practiced skill'.

But without being elitist, it is important to note that the practice of medicine is not tree-sawing, nor is it an acrobatic performance, nor is philosophy a practice. Medicine is a unique art in that . . . "it is *not* concerned . . . with the . . . mastery of a skill that is directly demonstrated by *an accomplished piece of work*." (p.38, *Italics* added) Again we see that medicine produces nothing, that is to say, nothing tangible. But this view is not consistent with medicine today for surgeons are skilled and do accomplish much as does science. And yet, Gadamer notes that skill is contextual which is described as follows:

> (T)he particular solicitude of the doctor . . . must continue to respect the equilibrium which persists despite . . . disturbance and . . . stay *attuned* to the natural process of that equilibrium. (p.38, *Italics* added)

In that respect the physician is not unlike the tree-cutter. Note that attunement was one of eight Existentials put forth by Boss.

In turning the page from ancient to modern medicine two points are noteworthy. Equilibrium persists in spite of its disturbance. Second equilibrium is a natural process meaning that equilibrium is our natural inclination. It is to this presence of equilibrium in spite of all appearances to the contrary *and* to this natural inclination that the skilled practitioner is to be attuned. For 'inclination' one reads 'disposition'.

IV. The art of healing and the art of rhetoric:

Gadamer's 'apologia' introduces another art form from Ancient Greece - 'the art of rhetoric.' It appears that he has left the clinic to enter the arena of public discourse. It was Socrates (470-399 BCE) who championed reason as a tool of persuasion in the public realm. An alternative school pre-dating Socrates was the Sophist school - the school which, as noted, produced the original 'Apologia for the Art of Healing'.

A 'sophist' is defined as 'one who argues cleverly but fallaciously or unnecessarily minutely' and 'sophism' as 'a false argument intentionally used to deceive'. (Funk & Wagnalls) Equating passive and active euthanasia as *per* Rachels is an example of false reasoning. (Chapter 1, Note 16) This raises concern that rhetoric may not be able to claim the same authority as reason.

But the art that Gadamer introduces here is grounded in 'rhetoric' as understood by Plato (ca.428-348 BCE) for whom rhetoric is not any 'arbitrary' discourse but 'the right kinds of discourse'. (p.41) He draws on Plato's *Phaedrus* . . . "since it illuminates the predicament of the physician who possesses this 'science' " (p.39) with 'science' being the technological construct of modern medicine. It is in *Phaedrus* that Plato speaks . . .

> about the *true* art of rhetoric and draws a parallel with the art of healing. For in both . . . it is a question of *understanding nature*, either the nature *of the soul* or *the nature of the body*. (p.39, *Italics* added)

'Nature', then, is implicated in both rhetoric and in healing.

Of 'nature' two aspects are named - 'soul' and 'body' where body is *soma* and soul is *psyche*. This relates to the classical understanding of human nature. However, as has been noted, this classical view is no longer prominent in modern discourse. But the somatic - psychic dynamic was central to von Uexküll's thought and is relevant to the great divide of modern medicine. And yet, psychiatry pertains to the psyche. How, then, may Plato's view resonate with psychiatry as a practice?

This is explored by entering the realm of the practical. Gadamer begins by noting that . . .

> (j)ust as we must know which remedies and what sustenance should be administered to the *body* if it is to become healthy and vigorous once again, *so too* we *must know* what laws and ordinances and which kinds of discourses should be introduced to the *soul*. (p.40, *Italics* added)

Here it is not body or soul but rather body and soul (*psyche*).

This 'and' becomes important in understanding the art of healing in our scientific age.

With this general introduction Gadamer continues by noting that . . .

> (t)he true art of healing . . . involves an *authentic* knowing and doing . . . . (This) requires the capacity to distinguish between the *particular constitution* of the organism and what is actually *compatible with that constitution*. (p.40, *Italics* added)

By 'constitution' he means body and soul. However, in the existential aspect presented earlier (Chapter 8 Living Our Humanness) the focus was not on what constitutes our humanness (Dailey's 'essentials') but rather how our humanness is lived (Dailey's 'existentialism'). This is the practical. And so, how does the practical of lived humanness resonate with what constitutes our humanness? In brief, how does philosophy relate to practice? A corollary to this is: ' How do the parts, (what constitutes our existence) relate to the whole (how that existence is lived)?' This is expressed, as in manifested, by the patient-as-person.

But this knowing and doing is not philosophy (knowing) dictating to practice (doing) such that the . . . "medical art (is) inspired by a specific philosophy of nature." (p.40) On the dynamic of the clinic (practice) and philosophy note the 'chauffeur' and 'back-seat driver' illustrating the different orientations between Yalom and Boss.(See p.209-10 above.) Rather Gadamer notes that a . . .

> a differentiating examination of the various manifestations of sickness with a view to grasping a specific *unified picture of sickness* in question which will then permit us to pursue an *integrated* course of treatment. (p.40, *Italics* added)

And so, there is no division between knowing (philosophy) and doing (practice) but rather a 'unified picture of sickness'. This unified picture leads to an integrated treatment. The knowing of our existence and the doing of that existence, then, . . . "does not imply the isolation of a particular part from the context of the whole." (p.41) On the contrary, it is integration

into the whole. This speaks to von Uexküll's somatic - psychic 'differentiation without division'.

Of the 'whole' Gadamer comments that . . . "(t)he nature of the whole includes and involves the *entire life situation* of the patient, and even of the physician." (p.41, *Italics* added) And so, this whole is something greater than the sum of the parts. Gadamer sees medicine as aligned . . . "with the true art of rhetoric which allows the *right kinds of discourse* to exercise an *effect on the soul* in the *right kinds of way*." (p.41, *Italics* added)

The link between the art of rhetoric and the art healing can be found in the notion of the 'common good'. In the former the common good is the societal well-being which is neither contrary to the individual's well-being nor a multiple thereof. The goal in medicine is the well-being of the patient which is the good that is held in common by the patient. This is the whole of the patient, i.e. the patient-as-person. This is presented in the following:

> The parallel . . . is also valid to the extent that the *constitution* of the body passes over into the *constitution* of the human being as a whole. The position of the human individual within the totality of being is a *balancing* position not merely in the sense of stably maintaining health but also in a much *more comprehensive sense*. (p.42, *Italics* added)

Two aspects are noted here – 'balance' and 'comprehensive'. Both relate to wholeness as a dynamic. This 'comprehensive sense' speaks to the triple exile Leder noted in his reading of *Philoctetes*. This pertains to the lived humanness of the patient-as -person in the context of an illness.

This brings us back to equilibrium. Gadamer continues noting that . . .

> sickness and loss of equilibrium do not merely represent a medical - biological state of affairs but also a life - historical and social process. . . .(T)he sick individual '*falls out*' of things, has already fallen out of their normal place in life. (p.42, *Italics* added)

This 'falling out' is a state of imbalance, of dis-equilibrium. Of

equilibrium there is only one. Gadamer concludes . . .

> there is only *one single great equilibrium* which sustains human life and which, though it sometimes wavers and flickers, fundamentally determines our very *state of being*. (p.42, *Italics* added)

And so, medicine like rhetoric, is to find the right discourse to effect the whole which is to restore, in the sense of renew, equilibrium to the person-as-patient in order to effect the patient-as-person. This speaks to ownership of the person where the person is the 'self '. This is wholeness.

V. Medicine as a practice in a scientific age:

A. Introduction:

A defining feature of medicine in Ancient Greece was its integration . . . "into the course of *nature* in such away that it can make its contribution *within* the *natural process* as a *whole*." (p.34, *Italics* added) There has been a transformation in the intervening 25 centuries such that what was central in the past is now either absent or, at best, marginalized. Nature, as understood in modern natural science, . . . " is not the nature into which the medical skills and . . . all skills of human art once felt themselves to be *integrated*." (p.35, *Italics* added) But is it nature that has changed or has medicine changed?

Gadamer notes that natural science in our time understands itself . . . "as a capacity to produce effects." (p.35) This is due to . . .

> (t)he mathematical - quantitative *isolation* of laws . . . in the natural order . . . directed to the *isolation* of *specific contexts* of cause and effect which allow human action various possibilities for intervention which can be *repeated* under *exact conditions*. (p.35, *Italics* added)

This fits the goal attributed to Democritus noted earlier. The notion of 'whole' in Ancient Greece noted above is now replaced by 'cause and effect' based on exploration of 'mathematical isolated laws' in specific conditions and 'repeated under exact conditions'. From this emerged the

notion of 'explanatory power'. The term 'numeracy' has been used to describe this development. To this one can add recent advances in technology and more recently in the post-Gadamer era the arrival of the cyber universe to the natural realm.

B. Transformation and integration:

It is this explanatory power which leads to the . . "capacity to produce desired effects (which) makes itself *independent* . . . . (permitting) the control of . . . physical processes." (p.35, *Italics* added) It is interesting to note that in antiquity the fact that medicine did not produce anything set it apart from *techne* understood in its narrow sense. However, in antiquity medicine had a role in 're-producing' equilibrium. In our time we see medicine as producing something through scientific and technological advances as noted by McGregor. (Chapter 1, Note 3) This makes modern medicine a '*techne*' in its narrow and concrete sense. But the process of this 'production' comes with it being 'independent' of the natural as understood Ancient Greece.

Gadamer does not critique these advances as such but rather how they are understood and operate within modern medicine. On this the following is noted:

> The *necessary integration* of a differentiated body of knowledge and skills into the *practical unity* of treatment and healing cannot emerge from that powerful force of knowing and acting that modern science *cultivates* in a methodologically precise manner. (p.35, *Italics* added)

The key point is that the 'practical unity' necessary for healing requires an integration. This integration process is aligned with cultivation, i.e. a culture, which in itself is a choice of how we understand and, thus, how we see ourselves and others. This is expressed in how we live our humanness. And so, in medicine there is a unity between practice and knowledge - a knowledge which is gained through practice.

However, in spite of the success of science and technology in medicine of our time, such unity is elusive since

'necessary integration' is not forthcoming. While modern science with its 'explanatory power' can accomplish much, it cannot accomplish this integration which the 'unified picture of sickness' requires. And so, as knowledge as 'know-how' increases, the more medicine can 'produce', the more necessary and more elusive integration becomes. And yet, the knowledge is placed at the service of humanity to serve the person as a whole. This lack of integration is in contrast to medicine in antiquity.

The result is that modern medicine, empowered with scientific prowess, now sees itself transforming nature rather than being open to what nature offers and integrating itself into that natural domain. This is consistent with the desire to master nature that motivated science as it emerged from adolescence in the 16th century. Gadamer notes that . . .

> technological application does not understand itself as. . . (occupying) the *open domain* yielded by nature or as something that must *integrate* itself into the . . . process of nature. (p.39, *Italics* added)

This 'open domain' aligns with 'openness' of the spatiality Existential as presented by Boss. (Chapter 7) However, Gadamer indicates that technology and nature do not co-exist but rather technology operates independently in a 'closed' space. Nature, as noted here, is not hostile to technology. However, it has its own autonomy in the sense that it is a 'given' to be respected - a respect which is honoured by 'integration'. However, it is not nature which is to be integrated into technology for technology is only a tool but rather science and technology which needs to be integrated into nature.

The alternative to integration is transformation. Technology that is transformative in how we see nature including ourselves is the continuation into the 21st century of the Cartesian construct that began centuries past. In terms of Tournier's automobile analogy modern science and technology in our time is a newer model. (Chapter 6, Note 1) The cyber universe is a further expression of the same construct.

But given its power and isolation, technology itself

risks becoming foreign. Gadamer notes that modern medicine, grounded as it is in science, is . . .

> a kind of knowledge that is guided by the idea of *transforming nature into a human world*, indeed almost of eliminating the natural dimension by means of rationally controlled projective 'construction'. (p.39, *Italics* added)

But is this transformed nature a 'human world' or merely a world that humans inhabit? Gadamer suggests an answer in the following:

> As science this knowledge allows us to <u>calculate</u> and to control natural processes to such an extent that it finally becomes capable of *replacing* <u>the natural</u> <u>with the artificial</u>. This . . . (is) the very essence of science. (p.39, *Italics* original, <u>Underline</u> added)

Artificial intelligence holds the potential, if not the promise, to further fulfill this replacement. Continuing on the same thought Gadamer comments:

> (T)he application of mathematics and quantitative methods . . . within the natural sciences is only possible because the knowledge involved is a form of construction. (p.39)

Note that 'construction' was part of Yalom's 'existential position'. (Figure 6.3) But Yalom's construction was more of an integration within the person rather than the transformation which science and technology promote. This 'replacement' of modern culture is in contrast to the 'renewal' / 'restoration' of equilibrium noted in the original Apologia.

And yet, man, as part of the natural world, is a given. But man's place in that world is not a given for it is determined by culture. The world has been re-structured, i.e. cultivated, in accordance with the explanatory power and numeracy of science and technology. The notion of 'quality-of-life' and accompanying QALYs embraced by modern day palliative care is a direct result of this cultivation. 'Death with Dignity' is another development that can be traced back to the same source.

This 'human world', then, risks becoming foreign if not hostile to humanity. More precisely, humanity becomes

foreign to this 'human world' which has been constructed. In brief, the world becomes less human. Thus, living our humanness faces challenges in this constructed world of modern medicine.

C. Wholeness as healing:

The traditional view is that man inhabits the natural world. The newly constructed world of our time is revealed most clearly in medicine. However, of this world Gadamer notes that . . .

> (a)mong all the sciences concerned with nature the science of medicine is the one that can never be understood entirely as a technology . . . because it invariably experiences its own abilities and skills as simply a *restoration* of *what belongs to nature*. (p.39, *Italics* added)

Noteworthy here is the notion of restoration. What is restored is that which rightfully belongs to nature. This is medicine's original *techne*. Thus, medicine, in its traditional role, cannot be reduced to or dominated by the sciences. [5] He continues:

> (M)edicine represents a . . . peculiar *unity* of theoretical knowledge and practical know-how *within* the domain of modern sciences, a unity . . which . . . cannot be understood as the application of science to the field of praxis. (p.39, *Italics* added)

Medicine, then, while being the application of theory, is more for it also generates practical knowledge which includes knowledge arising out of praxis.

This unity presupposes integration. But technology, being a tool which man applies, seems unable to integrate into a unity with nature. Since knowledge cannot lay dormant, technology comes with its own inherent power. However, while this power is exercised by humans and not by a machine, the 'human' is put aside, i.e. is displaced, by the machine. Gadamer concludes: "Medicine . . . (is) a . . . practical science for which modern thought no longer possesses an adequate concept." (p.39)

In the domain of the distressed body, medicine can

'produce' much more today than before such that our lived experience can continue where previously it could not have. But Gadamer notes that . . .

> (t)his science goes beyond . . . a kind of mechanics: it is *mechane* . . . the artificial production of effects which would not (have) come about simply by themselves. (p.39, *Italics* original)

This '*mechane*' is a kind of ideology which, like all ideologies, exists not only to serve but to be served. And so, technology, enabled by science, enjoys an autonomy. In such circumstances medicine becomes . . . "not a matter of healing, but rather of effecting something and so of producing something." (p.35)

And yet, . . . "the art of healing remains . . . bound up with the presupposition . . . implied in the ancient concept of medicine." (p.39) The art of healing noted in Ancient Greece is a constant feature of medicine. And so, there is a lacuna between ancient and modern medicine - a lacuna described as follows:

> Modern natural science is *not* primarily a science of nature conceived as self-maintaining and *self-restoring*. Our science is based *not* on the *experience of life* but on . . . making and producing, *not* on the *experience of equilibrium* but on . . . projective construction. (p.38, *Italics* added)

This describes the 'predicament' of the 21st century clinician. But this does not belong to the clinician alone for it also implicates the patient. It is this way for both physician and patient inhabit the same world. The invitation is 'How to go forward?'

The 'art of healing' in our time is set apart from its companion 'art of rhetoric'. It is this rhetoric, as understood by Plato, which allows for the right kind of discourse. This discourse pertains to the psyche and, hence, is the domain of psychiatry. This is grounded not in deductive reasoning of the scientific method but in inductive reasoning emanating from the experience of lived humanness. It is here that equilibrium can be restored whereby the patient returns from exile and is

made whole.

It is this wholeness which lies outside of the reach of science and technology but which science and technology serve. And so, in the context of the 21st century, the goal of medicine is better expressed by 'wholeness' rather than 'healing'. This frames medicine consistent with its tradition. That frame is not 'person-as-patient' (Figure 5.9) but 'patient-as-person' as psychiatry would have it. (Figure 6.4) It is this re-thinking of psychiatry which contributes to medicine as a practice whereby the person becomes whole. (Figure 8.2) In this way wholeness is healing.

VI. Conclusion:

Two 'apologies for the art of healing', written in a span of more than 25 centuries, have been considered. Each has been written for its time. Humanity lives in time and place. As Boss has noted in his Existentials, time is 'temporality' and place is 'spatiality'. Each - time and space - can be 'closed' or 'open'. As closed time and place the 'Apologias' do not speak to each other; however, as open time and space they do. And so, as closed time and space one may be inclined to reject the old and accept the new or reject the new and accept the old. But each of these options dismisses what the other offers and, therefore, does not foster understanding. However, to engage the Sophist's 'Apologia' is not to return to the past and sacrifice the present. Rather it is to understand the present in the light of the past. This is Benjamin's 'backing into the future'. (Chapter 5, Note 10) Gadamer's 'Apologia for the Art of Healing in a Scientific Age' provides that understanding and thereby brings an understanding not only <u>of</u> but also <u>to</u> modern medicine.

Two key features of the Sophists' 'Apologia' are <u>equilibrium</u> and <u>integration</u>. These are equally crucial and mutually involved in nature for integration generates equilibrium and equilibrium when disturbed requires integration. However, there is a third feature given less attention but which is also crucial. Nature is an <u>open</u> domain. In his treatise on the existential foundations of medicine Boss gave major importance to openness as a fundamental

characteristic of being human. It is this openness which allows for growth of an organism which in medicine is the person-as-patient becoming a patient-as-person.

Since equilibrium is innate to being human, it is home for man as *anthrōpos*. And so, equilibrium is where man belongs and, thus, where man seeks to be. Illness is a dis-equilibrium, hence, the importance of integration in order to restore balance. In this process nature is open in two ways. It was open to be disturbed and is now open to integration. Integration is inherent to human existence for it is the key to wholeness and it is wholeness which addresses dis-equilibrium. However, science and technology understand nature as a closed entity to be mastered by human rationality. Out of this rationality has come innumerable and previously unimagined advances in diagnostic and therapeutic capability that not only inform but define modern medicine.

But of equal note is that science and technology come with an imperative, i.e. an internal drive, such that it cannot but be manifested. No development arising from science and technology remains on the shelf. Scientific and technological prowess comes with a constructive imperative which does not accommodate but rather assimilates nature such that nature is transformed. In this 'construct' nature is closed only to be opened by man's rational mind seeking to explain 'why' in the sense of how 'what is' came to be.

However, while the investigative and therapeutic advances do benefit the patient, this 'healing' is not integration but rather transformation of nature. This approach is especially noted in a distressed body for it is the *bios* which lends itself to exploration by science and technology. It also addresses, albeit indirectly, a distressed psyche that may accompany a distressed body. However, this approach is limited. Evidence for this comes from chronic illness whereby science and technology cannot transform nature. In this 'construct' of transformation what cannot be transformed cannot be integrated.

The closed stance toward nature has no potential for 'healing' understood as 'wholeness' for without integration there is no place for wholeness. But the psyche does not lend itself to the scientific method of explanation. From this two

conclusions follow. Transformation is not an option and, thus, cannot be a goal since psychiatry is not science. This opens the door to integration. This is done through the art of rhetoric whereby the right discourse is engaged. Although Gadamer does not say this, the right kind of discourse in his 'unified picture of sickness' is inductive reasoning. The psyche, in contrast to the scientific method which operates in deductive reasoning, lends itself to inductive reasoning. It is this which enables the psyche to be the seat of integration. This is the second point.

It was noted that the treatment of a fractured wrist required a reversal of the mechanism of the injury, i.e. the forces that caused the fracture. However, the actual healing, i.e. the wholeness, of the fracture is a natural process. The physician's role, then, is to facilitate the natural process. A distressed psyche is different but yet the same. The difference is that there is no mechanism of injury which can be reversed. But the making of wholeness out of a distressed psyche is a natural process. Here, too, the role of the clinician is to facilitate the natural process. Since nature's natural state is equilibrium, so, too, man's natural state is equilibrium.

This allows for and even requires a re-thinking about 'healing'. Leder has noted that 'healing' and 'wholeness' share a common etymological root. Integration is wholeness for it establishes equilibrium where dis-equilibrium once was. And so, one may speak of 'the art of wholeness' as being the 'art of healing'. This wholeness comes about by integration. This return to equilibrium has been described in terms of 'renewal', 'restoration', and 're-balancing' . While it is this, it is more than a return to a previous state.

The temporality Existential of Boss noted that time as *kairos* speaks to the past, present and future in such a way that the past is carried forward into the present and future but is now seen in a new light. This new light is an equilibrium which is a reality that while connected to the past is more than a return, a renewal, or a restoration of the past. It is a new - but not *de novo* - expression of man's innate equilibrium. This wholeness is the patient-as-person. This is Gadamer's 'unified picture of sickness'.

It is through this integration that psychiatry comes to

occupy its rightful place by re-framing mental health. Thus, it is via psychiatry that medicine is re-framed [PATIENT as PERSON] whereby the patient becomes whole again by being a person. This wholeness is man's natural state. This is the re-framing of medicine by re-thinking psychiatry. But how might this be follows in the closing Chapter - 'Putting the Person Back in the Centre'.

Chapter 10

Putting the Person Back in the Centre

How Might Psychiatry Save Medicine

I. Introduction:

Some 40 years past Toulmin penned '*How Medicine Saved the Life of Ethics*'. This was presented as a statement of fact. However, the culture of medicine has evolved since. A few decades later others posed the dynamic as a question in two forms: '*Did Ethics Really Save the Life of Medicine?* ' and '*Can Ethics Save the Life of Medicine?* ' Most notable in this evolution is that Medical Aid in Dying, established as a legal right, now has a presence at the bedside. Since the genesis of Medical Aid in Dying implicated many sectors of society, it is not only a medical reality but a paradigm of the 20th century.

What is proposed here is to bring Medical Aid in Living to the bedside as a paradigm for medicine of the 21st century. But this is not a pathway from Medical Aid in Dying but rather a pathway to Medical Aid in Living. But is this pathway realistic? The question is valid on two grounds. One is on the grounds of medicine in a scientific age; the other on the grounds of psychiatry itself. The sub-title carries two presuppositions. One is that there is something remiss in modern medicine that needs to be addressed. The second is that psychiatry is well-suited to address this issue. Both presuppositions merit consideration.

With respect to the former, it is noted that the hallmark of modern medicine is science and technology. Heschel (1964) noted: "Is dehumanization . . . the price that we (medicine) must pay for technical progress? . . . . (And if so) medicine must be concerned with its own health." [1] He concludes that . . . (m)edicine today is . . . itself in need of therapy. (p.35) This dehumanization gives rise to a division which is a prominent

feature of medicine today. Passing this reality through a prism reveals a spectrum of ways to characterize this division: deductive reasoning / inductive reasoning, object / subject, function / meaning (purpose), and disease / illness. For Heschel disease is common and illness is unique to the patient. (p.25) While all ways to view this division are relevant, there is only one division for there is only one patient. From the clinical perspective the somatic - psychic division captures this reality best. It also introduces the second pre-supposition, i.e. psychiatry. But psychiatry has its own internal problem and, therefore, also needs 'saving'. Both Kleinman's Rethinking Psychiatry and McHugh's question '*What's wrong with psychiatry?*' (Try to Remember) have brought this to the surface. In identifying the problem within psychiatry each, in his own way, opens a pathway to the larger problem of medicine's great divide.

The concerns that touch modern medicine were engaged through three principles. While each principle is important, none stands alone. The first principle '*identifies the problem as a first step to a solution*'. The second principle is the '*theory of opposites*' through which the relationship between the problem and solution can be evaluated. These principles have application in many circumstances but are applicable to modern medicine in a special way. The third principle '*the patient is the best teacher*' pertains to medicine specifically. These principles were placed in the context of knowledge which was considered in a threefold manner: *How* do we know, *What* do we know, and *Why* do we know it.

II. Philosophy in medicine re-visited:

Philosophy differs from medicine in that it is not a practice. And yet, several sources have noted its relevance to medicine. The basis of Toulmin's article was that moral philosophy, i.e. ethics, was the domain of philosophy relevant to medicine. But Toulmin's phrased this as more about medicine being relevant to ethics. The matter was framed this way for medicine was considered by the ethicists to be a moral encounter. Passing philosophy through a prism reveals the many aspects of philosophy which are pertinent to medicine.

This includes metaphysics and existentialism. Without discounting the former, what was presented here is that existentialism is the philosophy most relevant to medicine. It is this way because vulnerability is the universal feature of being a patient. It is this vulnerability which disturbs our 'existence'.

But this relevance is not limited to existentialism. The patient - physician encounter, then, is first and foremost, an existential encounter and only thereafter does it become a moral matter. An image of a tree captures this reality. The root below the ground is the source of what is manifested above the ground. In this way the two are related. The ethical is not replaced by the existential. Rather its position of primacy in medicine is displaced. This is understood in two ways. First its (ethics) self-proclaimed primacy is itself a displacement of its proper function in medicine. Second as the existential assumes its proper place as the central philosophical domain in medicine, it displaces ethics from its current position of primacy. It is not that ethics is to be suspended but that it is to assume its proper place.

A further illustration of this connection, noted previously, is found in the observation by Aquinas that the 'moral' effect of any action / words is on the agent, i.e. person-as-subject, and not on the person acted upon, i.e. the person-as-object. (Chapter 6, VIII) However, a corollary of this, although never expressed but no less relevant, is that the existence of the person-as-object, i.e. the one acted upon, is affected by the one who exercises this agency. This effect resides at the existential level. In brief, our existence, i.e. the root below the ground, is touched by what goes on above the ground, i.e. by what presents itself to us. But ethics and existentialism are not in themselves opposites by way of contrariety for each belongs to the person. However, while they can be contrary when two or more people are implicated based on the roles assumed, the contradiction is between the subject and the object.

Consistent with philosophy not being a practice Kolakowski has noted that philosophers only 'move the soil'. But tilling the soil is integral to cultivation. The patient is the soil of medicine. This shines a light on Frankl's observation

that patients present with philosophical issues. The following verse speaks to medicine as a practice and to philosophy:

- Food for thought -
Food nourishes the body;
And yes, one needs to eat in order to live.
Thought nourishes the mind;
And some think in order to live.
And this is so because thoughts
are connected to life.
And so, life informs our thinking.
One who thinks in order to live
we call a sage, that is to say wise.
This is so because life teaches thought;
And that is to say, thought is learned through life.
And so, thought occurs with life in mind.

But others live to think;
And so, the mind rules their life.
And yes, thought nourishes the mind;
But for one who lives to think, thought teaches life.
But this is absurd
because it is life which teaches thought.
And so, if one wishes to be taught,
one is best taught by life and not by thought.
And that is food for thought!

Medicine as a practice, then, is life teaching thought. It is here that medicine as a practice is learned. (Chapter 9, Note 3) It is this which makes the patient a physician's best teacher. This separates medicine from philosophy. And so, how does philosophy contribute to medicine as a practice? In Kolakowski's terms how does 'moving the soil' cultivate medicine as an art of wholeness? Existentialism as philosophy becomes relevant to medicine as a practice by exploring how a patient lives their humanness. Thus, existentialism understood this way is philosophy's presence at the bedside. It is for this reason that existentialism takes precedence, i.e. displacing but not replacing ethics.

III. Passing medicine as a practice through a prism:

A. Medicine in a scientific age:

Science and its companion technology are not new to medicine. However, due to the success of this approach science has become the defining feature of medicine as a practice in the 21st century. The scientific method seeks to determine a pathway of disease. Armed with this knowledge measures are taken to interrupt the pathway or mitigate its adverse trajectory. Moreover, science in our culture today also defines our humanity such that science heals what afflicts our body and what cannot be healed is framed in terms of QALYs (quality-of-life years), pointlessly living, MMC (managed medical care), and advance directives all of which contributed to the introduction / insertion of Medical Aid in Dying into medicine as a practice.

But science in framing medicine as [DISEASE] (Figure 5.1) carries an understanding of the person-as-object. It is this way for in exploring the disease pathway the person is seen objectively in the sense of an object to be acted upon and not a subject with agency. This is not to condemn science but to acknowledge that its success in medicine comes through this process. And so, while the contribution of science and technology is invaluable and necessary, it is at the same insufficient for medicine is more than science. Medicine is a practice and, therefore, must move beyond the experimental to the experiential while at the same time not abandoning the experimental.

Since the patient is relevant to both sides of the divide that characterizes medicine today, one can turn to the patient in order to identify both the problem and the solution. And so, the somatic - psychic divide identifies the problem and is the first step to a solution.

B. The distressed body:

The Greek tragedy ***Philoctetes*** considered the patient as subject. This provided the context for The Distressed Body where Leder saw the experience of illness - that which the

character Philoctetes lived with - as an experience of a threefold exile. This was presented here as intrapersonal, interpersonal, and supra-personal (cosmic). And so, the person-as-subject is central to the experience of a distressed body. Leder names the text of this exile the 'experiential text'. (Figure 5.7) While this incorporates the classical triad of patient's history (narrative text), physical examination (physical text) and laboratory data (instrumental text), the experiential text is unique for it is written by the patient. This sets it apart from the 'instrumental text which has been named here as the 'experimental text'. However, while the experiential text is written in the presence of the classical triad, it extends beyond that. A further distinguishing feature is that the experiential text is grounded in literacy and not numeracy.

A 'distressed body' concerns itself with a patient's experience of living with an illness. In this context medicine can be framed [PERSON as PATIENT]. (Figure 5.9) This is re-thinking disease. While inductive reasoning has a prominent role in living with an illness, in a distressed body this operates in the context of disease which is the realm of the deductive reasoning.

Leder has made significant contribution to our understanding of a distressed body. While he does not explicitly mention the psyche, its presence can be implied in his reference to distress . . . "in which one is pulled apart and pressed inward (*stressed*)." (Leder p.5, *Italics* original) However, while the distressed body implicates the psyche, the psyche is not a primary element in this setting. But the significance of the psyche requires that its place be given due consideration. The question is 'What may this place be?'

C. The distressed psyche:

Voices from within psychiatry, notably Kleinman and McHugh, have focused on this. Each in in his own way suggests that the place presently occupied by psychiatry is not the place where it belongs. To arrive where it belongs the point of departure must be the psyche itself. Fundamental to a psyche primarily distressed, i.e. a psyche that is directly injured, is that there is no universal pathway or mechanism of injury.

This feature sets the distressed psyche apart from the distressed body for if there is no mechanism / universal pathway of injury there can be no reversal. This excludes deductive reasoning, so useful in the application of the scientific method *vis-à-vis* a distressed body, from having a significant role in matters concerning a psyche primarily distressed. Psychiatry, then, is not science and any attempts to make it a science are misguided.

McHugh chronicled one such 'misdirection' whereby deductive reasoning was applied in Freud's approach to psychoanalysis. However, the foundational analytics were not a given but rather were a human construct. In brief, the proposed 'pathway' was not internal but rather imposed from without and, therefore, not inherent to the psyche. But this does not mean that science has no role in psychiatry. Cognitive neuroscience via imaging and biochemistry may provide physical markers of psychic events. However, they are 'after-the-fact' signals of those events. While they may serve 'therapeutic' purposes in that they may lead to interventions, they serve as antidotes to these effects. Antidotes are not reversal but rather are 'symptomatic' treatments. Trauma Care, as put forth here, illustrates this.

Since the psyche lacks a universal pathway and a mechanism of injury, an alternative approach to a distressed psyche is necessary. McHugh and Yalom have introduced the twin notions of '*<u>What</u> do we know and <u>How</u> do we know it?*' To this '*<u>Why</u> do we know what we know*?' was added here. Leder's reading of *<u>Philoctetes</u>* offers insight to the distressed body but just as there is a triple exile in that situation so, too, is there a similar exile in the distressed psyche. However, in the distressed psyche the 'intrapersonal' is disproportionally affected and is fundamental to the other 'exiles'. But this differs substantially from the 'intrapersonal' of a distressed body for it goes directly to the core of one's being.

The significance of this impact can be understood in the light of the views of Aquinas noted above that the 'moral' effect of an action / words is on the agent. However, the existential effect is on the object of that action, i.e. the person acted upon. This is the intrapersonal. While the injured psyche may be the result of how others see one's self, the injured psyche tends to

see the self the same way. And so, an injured psyche is first and foremost an existential concern. The existential domain, then, is where psychiatry belongs. And psychiatry's place in medicine also makes medicine as a practice an existential encounter. Understanding this dynamic is crucial for understanding the intrapersonal exile of an injured psyche.

The patient is the source of knowledge of a distressed psyche. The patient, then, is '*how*' psychiatry knows from which comes '*what*' psychiatry knows. This knowledge comes through inductive reasoning whereby the patient comes to know and, thus, reveals how the injured psyche has touched her / his existence, i.e. what it says to and about the 'self'. This revelation is the 'existential text'. Unlike the 'experimental text' which is written in numeric language, the 'existential text', like the 'experiential text' is a literary text.

While the 'experiential text' of illness is also a literary text, the 'existential text' differs in that it is not a hybrid of deductive and inductive reasoning but rather grounded in inductive reasoning alone. And so, the focus is not on the 'person-as-patient' but rather on the 'patient-as-person'. It is this which sets the existential apart. It also places psychiatry where it belongs, i.e. in inductive reasoning. This frames mental health [PATIENT as PERSON]. (Figure 6.4) One's identity, i.e. how one sees oneself, then, is no longer as a patient but as a person. It is in framing mental health patient-as-person that the psyche finds its rightful place and thereby closes the somatic - psychic divide which is the hallmark of medicine of our time. And so, medicine via psychiatry can be re-framed [PATIENT as PERSON]. (Figure 8.2) It is in this re-framing that psychiatry might save medicine.

IV. How might psychiatry save medicine:

A. Putting the person back in the centre:

Moving from 'patienthood' to personhood is an existential journey for it is a movement from 'healing' to 'wholeness'. Ownership, a prominent theme in McHugh's understanding of psychiatry, speaks to this. Ownership may be considered as aligned with mastery which can be understood

as a response to being overmastered by the injury or disease. This is a reaction to the event such that the event owns the patient. This is the sphere of healing which operates in the person-as-patient mode.

But there is another way so consider ownership and mastering. Ownership can also be understood as owning the person. Here mastery is not owning the event in response to the event overmastering the patient but rather owning the self with the 'self ' being most important person of all. This places the person in the sphere of wholeness which is the realm of patient-as-person. This is more than a restoration of the old and more than a renewal for it is something new built on the old.

This is the how Gadamer understands the 'Apologia for the Art of Healing' that dates back to the Sophist School in Ancient Greece. The equilibrium of the Art of Healing in Greek medicine was 'wholeness' - although this term was never used - whereby the equilibrium innate to nature, having become a dis-equilibrium, is 'restored'. In brief, this wholeness is forever new and yet also forever old for the 'new' builds on the 'old'. This, in essence, is the sense of that other source from Ancient Greece who noted that 'You cannot step into the same water twice'. (Heraclitus - 6th-5th century BCE) A note of interest is that Heraclitus is one of two pillars Heidegger used to re-construct metaphysics. (Chapter 2, II B 3)

And yet, one is always stepping into the water of life. And so, this newness is wholeness - but a wholeness which was never experienced before and, yet, not isolated from what was before. In brief, this wholeness is dynamic - a dynamic which is ever-present. This is also consistent with the threefold past, present and future aspect of the temporality Existential of Boss where time as *kairos* was described as expansion. And so, owning the self is also owning the event. But there is a fundamental difference between owning the event and owning the injury.

Owning the self can be understood as taking responsibility for the self. But in Frankl's understanding one is not responsible <u>for</u> life but rather <u>to</u> life. And so, ownership of the self is being responsible to the self, i.e. a response to what is presented to the self. This resonates with the

Existentials presented by Boss. Yalom's existential position (Figure 6.3) also speaks to ownership. In addition, Charon's narrative competence and honouring its meaning relates to ownership for in owning the self one is being responsible to the self which is to honour the self. In addition, 'honouring' relates to the 'appreciation' which was a central feature of the Greek *kosmos* as presented by Hillman. (Figure 5.8) While this includes owning the event, one is not responsible *for* the injury for that responsibility lies elsewhere. Owning the event is owning one's vulnerability. While this is being responsible *to* the self (Frankl), it also includes exercising the power which is innate in our humanness (Dubos). Ownership, then, is wholeness by which the patient-as-person is put back in the centre.

This addresses *une étrange dynamique* introduced in Conclusion - Chapter 4 whereby the patient is not only the '*how*' and the '*what*' of knowing but also the '*why*'. The patient as person is knowing the self. It is this knowing which begets ownership and ownership begets wholeness. And so, wholeness is the '*why*' of medicine. Each framing of medicine has a '*why*'. The '*why*' of the scientific framing is [DISEASE] The '*why*' of illness is the [PERSON as PATIENT]. But the ultimate '*why*' is the [PATIENT as PERSON]. It is ultimate in that the '*why*' *vis-à-vis* disease and illness are at the service of the person. This is what makes the patient-as-person the ultimate '*why*' of knowing. In knowing the self *une étrange dynamique* is no longer strange for the patient is made whole. It is no longer strange since the patient was a person before becoming a patient. This is putting the person back in the centre. This is re-thinking psychiatry and is how psychiatry might save medicine.

But medicine of the 21st century with its primary focus on the *bios* sphere foregoes engagement of this wholeness as ownership of the self. Much of medicine in a scientific age consists of exploring ways to own the event. And when the event cannot be 'owned', i.e. mastered by science, ownership of the self is deemed beyond reach. Angell expressed this as 'meaningless suffering' in the opening citation of this work. However, this view indicates that in the presence of injury as engaged by deductive reasoning the sole focus is on healing.

And so, if healing is not possible wholeness is ruled out. Thus, without healing there is no meaning. Meaning, then, is aligned with function such that when function is compromised so, too, is meaning. The 'Death with Dignity' movement which had a central presence in the public discourse in the genesis of Medical Aid in Dying is best understood in this way.

B. Psychiatry as an existential practice:

Psychiatry operates in the realm of inductive reasoning. It is from this that understanding rather than explanation is pursued for in the absence of a mechanism explanation is not possible. However, understanding is always possible for it is never complete. Existentialism, not as a philosophy but as practice, is ordered to the pursuit of this understanding, specifically understanding of the 'self ' with the self being the 'patient-as-person'. This understanding opens onto ownership of the self which in turns opens onto wholeness. This wholeness is putting the person back in the centre.

The insights of Yalom and Boss help inform psychiatry as an 'existential practice'. But this practice can also be informed by views of psychiatry as expressed by Kleinman and McHugh. In fact, all four speak to each other. What has been presented here is not a complete review of these sources from the psychiatric community for such a review is beyond the competence of this writer. Rather it serves as an introduction to their thought and an invitation to the psychiatric community to take this further. This introduction to Kleinman, McHugh, and others can open onto a pathway of understanding the patient as a person. A hallmark of this pathway is a psychosynthesis *of* and *by* the patient. This is what Boss refers to as being 'therapeutically active' which pertains to both clinician *and* patient. It is through this psychosynthesis that the person can find wholeness and thereby return from exile. It is 'existential psychosynthesis' grounded in the experience of a distressed psyche which defines psychiatry as a practice.

V. Conclusion:

In modern medicine, dominated as it is by science, value is measured by function. What is real is circumscribed by its measure; however, what cannot be measured is deemed not to be real. But a person is immeasurable and, yet, is real In this calculus the person is marginalized. But the person is put back in the centre by facilitating the wholeness of the patient. The role of the clinician is to facilitate this migration from patient to person. This was the role of medicine in Ancient Greece and remains the role today. Psychiatry, then, offers medicine a pathway to Medical Aid in Living. But, as Kleinman and McHugh have noted, psychiatry also has to save itself for mental health needs to be addressed.

Wholeness is not determined by function for it belongs to another genre. Function is situated in the domain of ethics, i.e. 'what one does', whereas wholeness resides in the domain of 'who one is'. This places wholeness in the existential realm and existentialism at the centre of medicine. In the 16th century Paracelsus referred to the need for physicians to know of philosophy. In the 21st century this philosophy is existentialism. To paraphrase Platt, 'ethics is uncomfortable in the presence of existentialism'. (Chapter 2, Note 27) However, existentialism is where psychiatry belongs, and so, too, does medicine. Thus, psychiatry is well situated to enable medicine to accompany patients on the return from exile to wholeness.

Gadamer's 'Art of Healing in the Scientific Age' also included Plato's 'Art of Rhetoric'. This art is the art of having the 'right' discourse. This discourse grounded in inductive reasoning. In passing the art of rhetoric through a prism of medicine three 'rights' of medical discourse are unveiled: i.) the '*right* reason', ii.) the '*right* way to do the right thing' and iii.) the *right* thing to do'. These 'rights' are presented in in the following image:

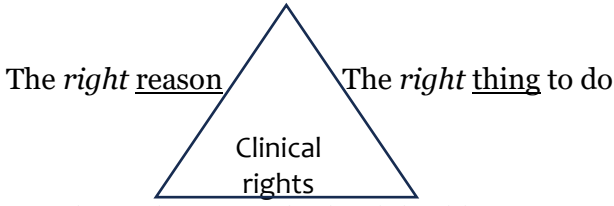

Figure 10.1 The Triangle of Clinical Rights

These can be considered not as legal rights to be claimed by the many but rather as 'clinical rights' given to the few in the service of the many.

Seen through the optics of 'power', the 'rights ' are exercising one's power in serving others. However, properly understood, they are not simply physician's rights but specific duties in the service of the most vulnerable among us. These rights have been part of medicine from its beginning and, therefore, are its foundation. Learning these rights through practice is to know the art of medicine for every art is learned through practice.

Medical aid in living is always the *right* reason. Deductive and inductive reasoning is the '*right* way to do the right thing. At times deductive reasoning will be the *right* way and at other times the *right* way will be inductive reasoning. Out of this reasoning will come the *right* thing to do. Medicine as a practice, then, is a three step process from A → B → C. But in the practice of medicine missteps can and do occur. Medical Aid in Dying is one such misstep. And so, one returns to the clinical rights and comes to understand that Medical Aid in Living is the *right* reason (A) for medicine as a practice. In the realm of the psyche inductive reasoning is the *right* way (B) to finding the *right* thing to do (C). It is through this 'pathway' that the clinician can facilitate putting the patient back in the centre.

A prism reveals the various aspects of whatever passes through it. This allows for an analysis of that reality. But a prism also allows for synthesis of what has been revealed. This synthesis is making a whole of the parts that make up reality such that the parts fit together in their proper place. This is what makes wholeness. Psychiatry when occupying its proper place frames mental health [PATIENT as PERSON]. This is putting the person back in the centre. This framing is a psychosynthesis whereby the synthesis done by the patient, facilitated by the clinician, a distressed psyche is made whole again. This is a re-balancing in which equilibrium is restored to the patient.

The centerpiece of Gadamer's thought - 'unified picture of sickness' - is noteworthy. He presents two analogies

to illustrate this unified picture - one from the original 'Apologia', the other is original to his 'Apologia'. The image of tree-cutting comes from Ancient Greece; the image of an acrobat comes from Rilke's poetry. Both images are dynamic for in each there are opposing forces present. However, these forces act in harmony in order to effect a desired outcome. This harmony is grounded in the reality that each force knows its rightful place. But its rightful place is not permanent as in a fixed closed space but rather is dynamic which is an openness to reality. It is through this openness that the rightful place of one allows for the rightful place of the other. And so, these 'forces' are opposites not by way of 'contrariety' as science of physics might have it but by way of polarity understood as 'distinct *but not* separate'. It is this way because the rightful place for one force complements the rightful place of the other force. It is from this rightful place where each is present in the right way that a 'unified picture of sickness' emerges. This unified picture is wholeness.

But the image of tree-cutting from ancient Greece also has relevance to our time in a unique and real way. Tree-cutting today is not by opposing forces guided by two people working in concert but rather by a cutting tool operated by one person. This is technology whereby the saw may be the tool but the person is the instrument. This is not an image but a reality which illustrates in a simple way the dynamic of medicine of our time. And yet, the tree-cutting image speaks to the somatic-psychic divide in medicine today and does so in two ways. It speaks to how the divide came about and to how the divide may be closed - the latter by being open to what presents itself to us. But this openness is not an openness to anything that fills Hillman's 'empty envelope' of our 'universe'. Rather it is an openness to wholeness of the person.

Re-framing medicine [PATIENT as PERSON] is how psychiatry 'might' save medicine for that is how the somatic - psychic divide, characteristic of modern medicine, can be closed and the patient becomes whole. This is putting the person back in the centre. Heschel concludes: "The achievement of personhood, being human, is as important to health as all medical interventions put together." [2]

Afterword

A Paradigm for the 21st Century

Nature and Culture

It is commonly held that nothing occurs in a vacuum. However, this is only a half truth for while it may be true in the world of physics, it is not true in the world of culture for there a vacuum is an opportunity for something to fill the space vacated. Medical Aid in Dying filled the vacuum created when medicine as a profession vacated its traditional ethos of a physician's fiduciary responsibility to the patient's vulnerability. The genesis of Medical Aid in Dying is multifactorial in that several sub-cultures within a larger culture made a contribution. Moreover, each was indispensable for each provided something that another sector could not. And so, while medicine contributed to this genesis, the reality is that Medical Aid in Dying did not come *from* medicine alone but rather came *to* medicine. For this reason Medical Aid in Dying is better understood not only as a paradigm of medicine of our time but also as a paradigm of the 20th century.

Accompanying the ascent of science in the 16th and 17th centuries was a corresponding descent of philosophy. In a sense this, too, was a vacuum which was filled by science. But there never is a vacuum in philosophy for every epoch and every culture embraces a philosophy. And so, the issue becomes what philosophy. Paracelsus lived in the early years of this dual migration. His advice for physicians to 'know of ' philosophy was prescient for much has changed in both medicine and philosophy in the ensuing decades and centuries. Since both science and philosophy have a place in medicine as a practice, a physician's role today is more complex for one must 'know of ' both the ascent of science and the descent of philosophy. Paradoxically, this makes Paracelsus more not

less relevant and does so on two counts. First in 'knowing of' philosophy one will come to know thought before and after the transition of science into adulthood. In addition, one will also come to know the departure from earlier times that science and technology represent and its effect on how we understand our world and ourselves today which in turn impacts on how medicine is practised.

What has been presented in the opening Chapter reflects the culture at large which includes the medical culture. It is this way for while medicine is a culture, it is also situated in a context of a wider culture. What was written in the Chapters that followed was not an argument against Medical Aid in Dying but rather an attempt at illuminating the vacuum and how it might be filled in ways other than Medical Aid in Dying. While the focus was on illuminating medicine as a practice, the light also shone on the wider culture as well for medicine is situated within a greater whole.

The media, another of society's sub-cultures, has the greatest influence on the public's consciousness. It is common for the media to frame public discourse in binary terms of A vs B, right vs wrong, positive vs negative. However, this discourse is often one-sided whereby one view is condemned and the other is deemed righteous. This approach has two inherent problems. One is that the discourse is skewed in the direction that the media outlet prefers. Second philosophy cannot prove the negative.

The condemnation, directly or indirectly, then, of one view is a moral judgment which once made cannot be unproven. Therefore, the judgment remains standing not necessarily on its own merit but on the authority of the media. Ethics, not being a practice and, thus, lacking accountability, operates in a similar fashion. However, what was presented here was not a binary dynamic of arguing against Medical Aid in Dying and thereby by default 'approve' of Medical Aid in Living but rather to understand both phenomena each on its own merit.

A binary dynamic presupposes that one view is enlightened and the other is in the dark. The goal of illumination is to become enlightened. To this end three principles guided what has been presented in pursuit not of

explanation but of understanding. The first principle identifies the problem not as a moral stance, as a binary construct would have it, but as a first step toward a solution. The reason why a binary construct is avoided is that things can be opposite in a variety of ways. And so, while position A may implicitly or explicitly condemn position B, in the light of the second principle, i.e. the theory of opposites, they may not be incompatible but rather different aspects which belong to a singular reality. Illumination, then, brings clarity when one enters the realm of the practical for it is there that the light shines brightest even in the dark. In medicine as a practice it is the patient who lights up the clinical encounter, thereby illustrating the third principle - the patient as the physician's best teacher. This theme of illumination is also relevant to the matter at hand for what was presented was intended to illuminate Medical Aid in Living.

There are several tools of enlightenment. One is the microscope by which the core of nature is unearthed and brought to light. Another is the telescope through which the universe above becomes known. But there is another tool which explores neither what is above nor what is below but rather what presents itself to us in the here-and-now. The goal is neither function nor explanation but rather understanding and purpose of a lived reality. This tool is the prism.

The full colours of the spectrum are revealed in passing white light through a solid glass prism. The universal experience of this phenomenon is the presence of a rainbow when sunlight passes through a drop of rainwater. A prism, then, unveils reality and thereby illuminates what is. This is enlightenment. In brief, a prism expands our awareness of reality. It was in passing culture through a prism that unveiled the spectrum of cultures which contributed to Medical Aid in Dying as a paradigm of the 20th century. But a prism also has a role in our understanding of Medical Aid in Living.

A prism, then, opens our mind to a greater understanding and appreciation of that reality and allows us to find our place in the world. Thus, it is not about explaining that space as a microscope may do or measuring a space as a telescope may do but rather of knowing and occupying our place. In brief, it is not about numeracy but about literacy. This

place is a world not of the whole as the sum of the parts but rather a world where the whole is greater than sum of the parts and where each part is placed in the whole in its rightful place, i.e. the place where it belongs.

Passing modern culture through a prism reveals that science and technology are the dominant features of our time. This is the world of the microscope and telescope to which one can now add the computer. This has been in the process of development for centuries and is presently being accelerated with the unfolding of the cyber universe. There may be no better example of this dominance than in medicine in the 21st century. It is, therefore, worth our while to consider the place of science and of technology in modern culture in order to understand medicine's place in that culture.

In this regard Nisbet's comments on the presence of technology in our time are informative. He notes that . . . "technology, like any other force, has moral consequences only when it becomes part of the . . . *normative environment*." [1] (*Italics* added) In modern culture technology has become normative for that is how we are defined. Medicine today is an example of this for science frames medicine as [DISEASE]. Furthermore, . . . "(o)nly when technology becomes *institutionalized* . . . (and) becomes a social system can we discover its impact on ethical decisions." (p.9, *Italics* added) This, too, speaks to medicine of our time for the opening Chapter noted the role of technology and bioethics in medicine and in the genesis of Medical Aid in Dying.

While technology has been with humanity for millennia, it is only in the 20th century that it has become institutionalized such that as Nisbet notes . . .

> the ends of technology are sufficient and autonomous . . . . (Thus), technology is today an *autonomous pattern* of *ends*, *functions*, *authorities*, and *allegiances*. (p.10-11, *Italics* added)

These features form a 'pattern' which defines a paradigm. This is a whole which, having reached 'reverential' status, is an ideology of our culture. The clinical relevance of this autonomous pattern is noted by Langer (1948) cited by Nisbet:

> The mind . . . can draw its sustenance only from

> the surrounding world; our . . . symbols must spring from reality. . . . (This) requires time, habit, tradition, and an intimate knowledge of a way of life. (p.16)

In brief, this means culture. Langer's point speaks to the importance of passing culture through a prism.

Nisbet makes two final points relevant to culture. He notes that technology . . .

> will significantly affect human behaviour . . . as it ceases to be something external and becomes *internalized in a culture*, a recognized part of norms and institutions. (p.16, *Italics* added)

'Internalized' resonates with 'institutionalized' and 'normative'. These coalesce into an 'autonomous pattern' which not only forms a culture but defines that culture. Science is a part of this for science and technology are companions. While this is a cultural phenomenon in the larger sense of culture, it is exemplified in a particular way in the medical culture of our time.

A further point is the issue of 'conflict' which Nisbet notes is . . .

> the *essence* of social change. . . . *(E)thical conflicts* are themselves manifestations of institutional struggle for functional dominance and superiority. (p.16, *Italics* added)

Several key points are noteworthy here. First is the presence of institutional struggle for dominance. The success of science and technology carries an imperative, i.e. a stimulus, of 'social change'. The power paradigm speaks to this. (Figure 6.1) The guiding principle of 'identifying the problem' resonates with this 'social change'. How this conflict is presented has a great influence in how it is understood. The 'theory of opposites' contributes to this understanding. The media have the greatest influence in how a society understands an issue. But the media operate in a binary mode of A vs B and not within a framework of 'opposites' as presented here. Of further note is that this 'struggle for dominance' is functional, i.e. pragmatic, and not theoretical or abstract.

Conflict implicates ethics which is aligned with the

institutional. The triangle of Figure 4.2 relates to this. Noteworthy is that ethics is the branch of philosophy that not only occupies the central place in medicine of our time but does so at the exclusion of other parts of the philosophical spectrum. This is a monoculture whereby ethics fills the space vacated by other branches of philosophy. Thus, ethics will have a major presence in how this 'dominance and superiority' will unfold. This presence was noted in Chapter 1

Glock has written about cultural deprivation. While this has been in the context of the 'origin and evolution of religious groups', it pertains to science and technology in two ways. First 'religion' (*re ligare*), in the objective sense of the term, carries a meaning of 'to be bound to'. Nisbet's understanding of technology indicates that technology and science is what we are bound to today. This accounts for the reverential status given to science and technology.

Glock's comments merit consideration in this light. He lists five 'deprivations': social, economic, ethical, organismic, and psychic. Organismic deprivation . . .

> refers to the fact that some individuals are deprived, relative to others, of good mental or physical health. . . . (such as) persons suffering from neuroses and psychoses, the blind, the deaf, the crippled, and the chronically ill. [2]

Organismic deprivation, then, aligns with function. This resonates with science and with palliative care's use of QALY's in clinical assessment. Glock continues in noting that economic, social, and organismic deprivation . . . "share the characteristic that the individual does not measure up to society's standards." (p.28) While the economic factor may be individual, it is also relevant to society at large in the light of the increased cost of technology, the demographic changes, and utilitarian ethics noted in the genesis of Medical Aid in Dying.

In a third relevant comment Glock states that in . . . "ethical and psychological deprivation . . . the individual feels that he is not living up to his own standards." (p.28) And so, falling below society's standards coincides with falling below personal standards. This is more than a coincidence for the two are aligned in that the individual, i.e. personal, and the

societal, i.e. the group, are in step. This relates to the subject - object and function - purpose divide which marks modern culture including the medical culture.

It is in the ethical and psychic realms that Glock's views take on increased significance. He notes that . . .

> (*e*)*thical deprivation* exists when . . . (one) comes to feel that the dominant values of the society *no longer* provide . . . a *meaningful* way of organizing (one's)life. . . . (This) deprivation is, in part, philosophical. (p.28, *Italics* original)

Two points are noteworthy here. First there is an incoherence in that society does not speak, i.e. relate, to the person in a 'meaningful way'. Second Glock indicates that the matter is philosophical. This resonates with von Uexküll's 'philosophical dilemma' noted earlier. It also resonates with Paracelsus' comment and with Frankl's view that patients present with philosophical concerns albeit not articulated. In addition, it relates not only to the wider culture but also to medicine of our time. Naming the deprivation as 'ethical' suggests that the philosophy implicated is ethics. This implies that since the deprivation is ethical, the correction comes from ethics.

The point of note here is that ethical deprivation gives rise to 'meaninglessness' – a term used by Angell in the citation which opened Chapter 1 and is manifested in the palliative care language of 'pointlessly living' prominent in the 1990s and into the 21st century. Glock links this meaninglessness grounded in ethical deprivation to psychic deprivation which he sees as . . .

> akin to ethical deprivation . . . (in that) there is a concern with philosophical meaning . . . but sought for its own sake rather than a source of *ethical prescriptions*. (p.28, *Italics* added)

This links to and expands on the previous citation in two ways. It links the psychic and the ethical. But in doing so it indicates that the role of ethics being prescriptive is limited. And so, while philosophy is relevant to psychic deprivation, it is a philosophy which differs from the prescriptive content that is characteristic of ethics. The philosophy sought, while not named, can be understood as existential which was presented here as a philosophy relevant to re-thinking psychiatry and

thereby to the practice of medicine.

> Glock continues noting that psychic deprivation is . . . primarily a consequence of severe and unresolved social deprivation. The individual . . . (may not be) missing the material advantages of life but has been denied its psychic rewards. (p.29)

It is this social deprivation, even when material needs are met, that remains unresolved which makes life meaningless. And so, in ethical and psychic deprivation, there is a loss of meaning - a loss of coherence between the personal and the social. This is beyond the material which in medicine can be understood as beyond the physical, i.e. *bios*, and therefore, beyond disease. This is Leder's 'cosmic' exile in that one's place in the world is left vacant. Ethics is a prescriptive response to this lack of coherence.

While written in the 1960s, the views of Nisbet and Glock are no less relevant today. Nisbet's understanding of technology places vulnerability in a larger context which itself increases this vulnerability. Glock's contribution names this vulnerability in terms of deprivation. In fact, as science and technology have advanced over the late decades of the 20th century and into the early decades of the 21st century these views are more relevant. The reverential status given science and technology informs who we are and, therefore, how we see ourselves and others and how others see us.

In a culture dominated by science and technology function is the measure of all reality including the person for only function has value. The 'Death with Dignity' movement aligns dignity with attributes such that a loss of attributes means a deficit in one 's dignity. Thus, by aligning dignity with function one also aligns 'dys-function' with a loss of dignity. This loss of coherence in one's existence nurtures a sense of life not worth living. It is this deprivation aligned with and related to technology which is prominent in modern culture including medicine.

And so, Nisbet and Glock, each in their own way, engage the internal and the external and in doing so name the divide that marks our culture and medicine of the 21st century. Both contribute to our understanding of the scientific

age. This is of importance for two related reasons. It describes the cultural context out of which Medical Aid in Dying emerged. It also informs the task that faces medicine today.

But there is another voice pre-dating Nisbet and Glock which also speaks to us today. The American psychiatrist Leo Alexander (1905-1985) wrote of the early years post-WW II from that perspective and experience. While the context differs greatly from our time, there were seeds planted in medicine then which would be harvested later. In the context of the geo-political reality of Europe in the 1940s, Alexander notes that at the same time there was a shift in American medicine which began with 'small beginnings'. He comments:

> The beginnings . . . were merely a *subtle shift* in emphasis in the basic attitude of the physicians. It started with the acceptance of the attitude, basic in the *euthanasia movement*, that there is such a thing as a life not worthy to be lived. [3] (*Italics* added)

From this 'subtle shift' a dynamic emerged such that the 'euthanasia movement' expanded to encompass a wider population. 'Dignity' is part of this dynamic.

But Alexander also refers to another change from that same era:

> (W)ith . . . increased efficiency based on scientific development went a *subtle change* in attitude. Physicians have become . . . close to being mere *technicians of rehabilitation*. This essentially rational Hegelian attitude has led them to make certain *distinctions* in handling acute and chronic cases. (p.45, *Italics* added)

While not using the term, Alexander is speaking of 'function' as the goal of medicine and the standard of its success. The 'scientific development' noted in the 1940s has expanded markedly since then. On 'distinctions' Alexander notes that . . . "(r)esources for the so-called incurable patient have recently become practically unavailable." (p.45) This is the seed of a utilitarian ethic. A final point of note is the importance of cultivating the 'lay opinion' in promoting a public policy. (p.39) This speaks to the role of the media in the genesis of Medical Aid in Dying noted in Chapter 1.

While Alexander's comments were focused on the European context of that time, their content is not irrelevant to medicine in America at that same time. Thus, some, perhaps many, may discard the latter in the light of the former, the reality of which is so extreme so as to be seen as a 'one-of' phenomenon. However, it is important not to misinterpret or dismiss Alexander for to discard his concerns of medicine in America at that time is to misread medicine in our time. The 'subtle changes' identified are seeds planted in American medicine of the 1940s which have germinated, taken root, and are harvested in Canadian medicine of the 1990s and into the 21st century. The genesis of Medical Aid in Dying presented in Chapter 1 speaks to this.

Although medicine had a role in the genesis of Medical Aid in Dying, the genesis originated for the most part in the 'triangle' occupied by those who write policies and laws but have no responsibility to provide care to the vulnerable and, therefore, no accountability. This speaks to '*How medicine got to where it is*'. However, those in the 'rectangle' are fully occupied caring for the vulnerable. This speaks to where medicine '*needs to be*'. (For triangle and rectangle see Figure 4.2.) Thus, as has been noted, to a large extent Medical Aid in Dying came not <u>from</u> medicine but <u>to</u> medicine.

The great divide of medicine of our time presented here has been characterized in several ways: deductive reasoning / inductive reasoning, disease / illness, function / purpose (meaning), and the existential /ethical. To these explanation / understanding and transformation / integration can be added. In a sense science occupies the chair of explanation and function but the chair of purpose and understanding remains empty. In the context of medicine the somatic-psychic feature encompasses everything with somatic aligned with the first entry of every division and the psychic with the second.

The mind operates in two modes: explanation and understanding The explanation pertains to science and technology whereby the somatic is transformed such that the somatic viewed in terms of function only. Understanding comes through inductive reasoning which aligns with the psychic. This allows for integration of the somatic and psychic whereby the division is bridged and wholeness achieved. Two

examples illuminate these aspects of the mind.

The emergence of 'artificial intelligence' is noteworthy. AI is pure calculation of data which are fed into a machine and, therefore, requires no reasoning. While AI may explain many things for which an explanation is available, it cannot reason. And so, while AI relates to explanation, it cannot relate to understanding for it cannot reason.

The role of science and technology in this division is illustrated by the term 'text'. In the cyber universe 'text' is instantaneous messaging through technology. But in the clinical world 'text' expresses the reality of a lived experience of our existence written internally and over time. The former is mechanical; the latter creative. It was noted that Latin t*exere* carries the sense of 'to weave' and that it is the etymological root of 'text'. Several texts relevant to medicine were presented.

In our scientific age the gold standard of medical knowledge derives from deductive reasoning and puts forth what is described as the 'experimental text'. This frames medicine as [DISEASE]. However, in the context of anatomical disease (the distressed body), a patient writes a text of the experience of illness. This 'experiential text' frames medicine [PERSON as PATIENT]. But in the context of a distressed psyche not aligned with a distressed body a patient writes a text of this experience which relates directly to her / his experience. This is an 'existential text' which frames medicine [PATIENT as PERSON]. Weaving' the texts is a creative activity leading to ownership which is owning the person. These frames are presented in the closing image as follows:

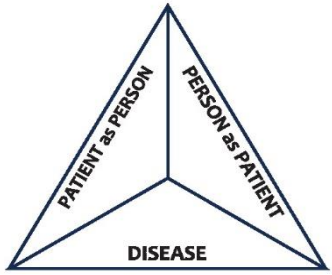

Figure 11.1 Framing Medical Aid in Living

The image here is identical on the cover. While the overall structure is triangular, both are presented in a three dimensional frame. The image is that of a pyramid. This is intended to give focus on the content of the image and not only to the frame. Thus, it is substance within the triangle that is to be noted. This substance is threefold: disease, person-as-patient, and patient-as-person. While the goal is to put the person back in the centre, there is no hierarchy for each is indispensable and makes a unique contribution to that goal. The pyramid is the image that best frames Medical Aid in Living for a Scientific Age.

Throughout this document multiple triangular images have been presented each relevant to medicine as a practice. While these were presented as two dimensional images, they, too, can be visualized with the mind's eye as three dimensional for each has substance and, therefore, is full and not empty.

Bandura's social cognition of moral disengagement (Figure 1.1) speaks to the pyramid for its substance is social cognition. So, also, do the Triangles of 'Philosophy' (Figure 2.1), 'Practical reasoning' (Figure 3.1), 'Knowledge pathways' (Figure 4.1), and 'Principles' (Figure 4.3) have substance. But the other triangles also carry content of a pyramid and in a more direct way to medicine as a practice. Noteworthy in this regard are the 'models of medicine (Figures 5.2, 5.3, and 5.5) including Charon's 'rectangle of competence' (Figure 5.4). Of particular note are Leder's Triangles of 'Exile' (Figure 5.6) and 'Experiential text (Figure 5.7) and Hillman's 'cultural triangles' (Figure.5.8).

Of additional importance are the 'existential' triangles', i.e. those that pertain directly to the core of our existence, and, therefore, implicate the psyche. In this regard the Power Paradigm (Figure 6.1) is central for our innate vulnerability (Dubos) which is susceptible to the misuse of power by others. Aligned with this vulnerability is Karpman's Drama Triangle (Figure 6.2) and the other 'drama triangles' noted in Table 6.1. The final triangle in this group is Yalom's 'existential position'. (Figure 6.3) But added to this is another triangle applicable directly to the clinical but in the service of the patient. This is the Triangle of Clinical Rights where the 'right' discourse is engaged. (Figure10.1) It is in this way that the clinician serves

the patient's interests which is the cornerstone of medicine.

The triangles, then, can be understood as pyramids But these pyramids are not empty but full of substance that pertain to medicine. In fact, one can visualize medicine as one large pyramid. Passing a light through this collective pyramid reveals the many parts of medicine. Knowing where the parts belong and putting them in their rightful place is to know the art of medicine. But every art is known only though practice. It is from the patient that one learns the art of medicine. It is this way for the goal of medicine is to place the patient as person back in the centre. This is Medical Aid in Living. It is re-thinking psychiatry which re-frames medicine this way. But this is more than putting the person back in the centre of medicine. It is putting the person back in the centre of life for the patient was a person before becoming a patient

The pyramid, then, can be seen in the light of a prism. The opening verse speaks to this:

- A prism -

Passing white light through a solid glass prism
unveils all the colours of the spectrum.
What was concealed is now revealed.
This is called enlightenment.

Passing medicine through a prism
reveals the parts of the whole.
One comes to know the rightful place
where each part belongs.

For the patient-as-person that rightful place
is at the centre of life.
This is called living with enlightenment.

Nature and Culture:

This work opened with a focus on culture. It is fitting that it should close with the same theme. Nature is what is given; culture is what man as *anthrōpos* does with what is given. As the summit of nature man has the authority and responsibility to form a culture. This nature - culture dynamic

is a constant throughout history with each epoch of history making its imprint. Every culture is an expression of how it understands humanity. Science emerged in a culture dominated by philosophy and theology. It has now matured such that that it and its companion technology dominate modern culture.

This culture considers man through the lens of function. The great divide of our culture *au sens large* is manifested in medicine. This has function and discovery on one side of the divide and purpose as meaning and revelation on the other. The difference between discovery and revelation is that discovery comes from humanity and revelation comes to humanity. Function and discovery align with deductive reasoning. This is the domain of explanation. Purpose and revelation align with inductive reasoning. This is the domain of understanding.

But since culture is not a given, it does not need to be the way it is. In brief, nature can be cultivated in another way. In fact, every encounter *interhomines* cultivates. And so, medicine, being such an encounter is where patient and clinician are cultivators. Medical Aid in Dying is now part of that culture. Moreover, as a legal right it is now embedded in the larger culture. And so, Medical Aid in Dying is a paradigm not only of medicine of our time but also of the 20th century.

What has been presented here is illumination of both Medical Aid in Dying and Medical Aid in Living. At the core of this illumination is man (as *anthrōpos*), specifically how medicine as a profession and we as a people understand the patient-as-person. In brief, this is not about ethics as some, perhaps many, would have it but rather is about man, i.e. anthropology. And so, what is at stake in both Medical Aid in Dying and in Medical Aid in Living is *anthrōpos,* i.e. how we see ourselves and others and how others see us. Psychiatry, in fulfilling its proper role, places the person in the centre. This is significant in two ways. The centre is where the person belongs and where the person seeks to be. For one with a distressed body or psyche this place may be hard to find; however, it is medicine's role to facilitate the patient in seeking this equilibrium – an equilibrium which is innate to our human nature. This is wholeness which if not sought will not be

found.

However, while the anticipated expansion of Medical Aid in Dying to the mentally ill scheduled to begin in March 2024 has been delayed, the expansion has not been cancelled. Medical Aid in Dying precludes a journey to wholeness. And so, this is not simply an expansion but an extension to an entirely new sphere which will leave no person-as-patient untouched. Medical Aid in Dying will then know no boundaries. This confronts medicine as a culture but also our culture at large for medicine is a culture which subsists in and speaks to a wider culture.

It was noted that *Salus populi suprema lex* (health of the people is the supreme law), where '*populi*' carries the sense of the commonweal, is the guiding principle of the State in fulfilling its proper function. (Chapter 1) While medicine shares this guiding principle, it operates one-patient-at-a-time. And so, just as it is not for medicine to dictate how the State should conduct its affairs, neither is it for the State to dictate how medicine is to be practised. And yet Medical Aid in Dying has become part of both medicine and the State.

Medicine is framed in three ways: [DISEASE], [PERSON as PATIENT], and [PATIENT as PERSON] . Each is a culture for each represents an understanding of man as *anthrōpos*. Each has a place in medicine but [PATIENT as PERSON] is the ultimate goal for that places the person back in the centre which is where the patient came from and where the patient longs to be.

Medical Aid in Dying presents an existential challenge to medicine as a profession and as a practice. But as part of our culture it is also an existential challenge However, the discourse that gave rise to Medical Aid in Dying largely, but not but entirely, took place outside of medicine. And so, Medical Aid in Dying and Medical Aid in Living is a debate that never was but a debate that needs to be. Therein lies an opportunity to meet the challenge facing medicine and society today. Re-framing Medicine by Re-thinking Psychiatry gives voice to this debate. In meeting this challenge Medical Aid in Living for a Scientific Age might become a paradigm of medicine of the 21st century. This, too, is cultivation.

Addendum

Advance Directives Re-visited

I. Background:

Advance Directives were a key development in medicine which became commonplace in palliative care in the 1980s and in medicine as a practice in general in the 1990s. Noteworthy in the latter was the direct role of ethics and funding from the Canadian health insurance industry in the evolution of Advance Directives. (Chapter 1,Note 7) In addition 'managed medical care' (MMC) emerged in the 1990s and gained prominence in the decades that followed. These factors, along with contribution from other sources, contributed to the genesis of Medical Aid in Dying as a legal right in Canada. This was presented in Chapter 1.

This legal right was initially limited to those with terminal illness and, therefore, was based on scientific findings. However, rights understood in a legal setting cannot be offered to some and not to others. Although legal rights may be contextual in that in the Courts they apply to a particular setting, rights that carry a legal *imprimatur* are not contextual. Thus, there is an inherent imperative to expand Medical Aid in Dying. The first expansion legislated by the State is to those who are mentally ill. However, as a practice the this has been put on 'pause' twice with the latest pause extended to 2027. The significance of this expansion is that there is no and can be no requirement for scientific findings. It is this way for psychiatry operates not by deductive reasoning but rather by inductive reasoning. In brief, psychiatry is not a science. However, psychiatry in medicine in our scientific age has yet to find its rightful place, i.e. the place where it belongs.

Not long after the legal right of Medical Aid in Dying was established mention was made in public discourse of

expansion to Advance Directives. More recently this has re-surfaced in the context of patients who develop dementia such that an Advance Directive written before the onset of dementia would 'qualify' one for Medical Aid in Dying. However, given the inherent imperative of legal rights further expansion can be anticipated. This gives increased relevance to Advance Directives.

II. Safeguards:

Some voices from within psychiatry have expressed concern about the expansion of Medical Aid in Dying to the mentally ill. [1] While these voices support Medical Aid in Dying in patients with terminal illness, they seek 'safeguards' for those with mental illness. The difficulty here is that while psychiatrists may act as consultants in the former situation, they would be the attending physician in the latter. It is unclear what would be the basis 'safeguards'. It may be grounded on the professional vulnerability as the role of the psychiatrist changes from consultant to attending physician. Alternatively, it may be on the basis that psychiatry is not a science for that would argue against expansion to the mentally ill. However, many, perhaps even most, psychiatrists may view their discipline as being within the scientific realm in spite of the fact that psychiatry does not operate by deductive reasoning.

An Editorial in the Canadian Medical Association Journal also calls for safeguards. This is stated as follows:

> *If* access to MAiD is expanded, new *safeguards*, specifically tailored to each new indication for MAiD, should be put in place. Then, we must once more proceed with caution, *measure* carefully and reassess.[2] (*Italics* added)

Noteworthy here is the call for measurement which is associated with safeguards such that the two features in combination will allow or not allow further expansion. But what will be measured, how, and by whom? An example will exhibit the soft underbelly of what this 'measurement' may be. Palliative care providers refer to QALYs (Quality Life

Years) which is a product of quality of life x years of life expectancy. But this is not a 'measurement', it is an evaluation.

Perhaps the 'measure' the Editorial considers refers to an article by Downar *et al* in the same issue of the CMAJ which presents results of a cohort study on the practice of Medical Aid in Dying in Ontario. [3] Sources cited expressed concern about potential barriers to MAiD. One source implored . . . "Canadian healthcare professionals, policy makers and legislators to consider MAiD as a viable EOCL option for *all* Canadians." [4] (*Italics* added) For EOCL read 'end of life care'. Palliative care in the Dame Cecily Saunders era understood this as '*end-of-life* care' whereby patients would receive care until the end of their natural life. In the current era, influenced by managed medical care, i.e. resource allocation, utilitarian bioethics, and third party interests, EOCL has come to be understood by the euthanasia movement as '*end of* life-care'. This distinction is not semantics but substantive.

A further point of note comes from the United Nations Declaration of Human Rights - a document coinciding with the Nuremberg Trials. The Declaration opens by stating that dignity is inherent in our humanness. However, the Canadian Parliament in embracing the 'right to die' also embraced the opinions of Death with Dignity, a movement which holds the view that 'dignity' is not inherent in our humanity but rather dependent on our attributes understood as function. Singer endorsed this view. (Chapter 1, Note 14) But this position is at odds with the U. N. Declaration.

The issue of safeguards raised by psychiatrists and the CMAJ merits further comment. 'Safeguards' are also of concern to advocates of Medical Aid in Dying. However, the 'safeguards' sought by the euthanasia movement are in the context of human rights. This position is grounded in the view that 'rights' cannot belong to some and denied to others. Since Medical Aid in Dying is a legal right, it must be available to all. Thus, 'safeguards' must be in place to ensure that there is no infringement on the 'right to die'. This puts the 'if ' noted above in the CMAJ Editorial in perspective. For the euthanasia movement there is no 'if ' of expansion only a 'when'. In every expansion of Medical Aid in Dying there is the removal of a previous limitation. Given that there is an inherent

momentum in legal rights to encompass all members of society irrespective of 'qualifying' circumstances, safeguards to place boundaries on Medical Aid in Dying will not go unchallenged.

In brief, while safeguards may be a concern for several spokespersons, 'safeguards' are understood differently such that there will never be any agreement among all participants. In such a climate the relevant discourse comes not from within medicine but from beyond its borders, i.e. legal, political, academia and media, all of which were instrumental in the genesis of Medical Aid in Dying. This is the triangle of Figure 4.2.

And so, safeguards cannot come from beyond the bedside. Nor can they come from the bedside for the conscience rights of the care provider were given no legal standing and, in fact, were denied in the law governing Medical Aid in Dying. But there is one safeguard that is ultimate for it cannot be overridden by the Court, by Parliament, by an institution, or by a health care provider. This safeguard lies with the patient. Just as Advance Directives had a role in the genesis of Medical Aid in Dying so, too, Advance Directives can have a role in safeguards limiting Medical Aid in Dying.

However, in the light of the current climate Velleman's comment from three decades past is prescient for our time. He noted that once . . .

> a person is given the choice between life and death, he will be . . . perceived as the agent of his own survival. . . . Hence if people ever come to regard you as existing by choice, they may expect you to justify your continued existence. [5]

III. Advance Directives:

A. Introduction

An Advance Directive is a text. But every text is written in a context. In an Advance Directive this context is twofold - personal and communal. The personal is the lived experience of the patient-as-person. From this comes the text of the Advance Directive. The communal aspect is the larger context

in which one is situated. Since this context has an influence - direct or indirect - on how one understands a lived experience, the communal context needs to be named in order to insure the patient's wishes are not unduly influenced by outside factors.

B. The communal context:

The following points are presented:

- Nature and culture in medicine in the 21st century:

Nature is a given; culture is cultivated for it is what we do with what is given. Illness is something that happens in nature; culture is how medicine deals with it. Medicine as a practice is an interpersonal encounter between a care giver and the patient in which both are participants. This encounter is first and foremost existential and only then is it ethical.

- A rectangle and a triangle: (See Figure 4.2)

The dynamic of the clinical encounter is horizontal. A rectangle captures this reality. However, there are elements outside of the clinical encounter which impact on that encounter. These elements occupy a triangle which sits above the rectangle. Occupants of the triangle are not participants in the clinical encounter but rather observers with no direct responsibility or accountability for patient care.

This describes the role of an ethicist. And yet, resource allocation is a core part of the curriculum in the education of an ethicist. Moreover, hospital-based ethicists are employees of the institution. In practical terms the triangle places pressure on the rectangle to conform to the priorities of the internal dynamic of the triangle.

- Hallmarks of the culture of our time:

The hallmark of modern culture including medicine's culture is science and its companion technology. This has brought many advantages to medicine. However, the focus is on function to the extent that function is the measure of value. Thus, loss of function carries a sense of devaluation. 'Quality-of-life' and 'Death with Dignity' reflect this devaluation.

Conclusion:

All aspects of the communal context are captured by the nature - culture dynamic. This applies to medicine in a particular way via a rectangle and triangle. In addition, the dominance of science and technology means that value is measured by function. All of these factors marginalize one who lives with an illness beyond the reach of science.

C. The personal context:

While the bureaucracy (triangle) may wish to influence the bedside (rectangle), the responsibility and the authority of an Advance Directive rests with the patient. The following points are presented:

- Power of Attorney as decision:

As a Power of Attorney for Personal Care an Advance Directive is seen a legal document. Typically, it is understood as one being given legal authority which goes by the phrase '*surrogate decision-maker*' whereby one acts '*in place of* ' another.

While this gives authority to another, it also comes with a burden. This burden increases in a medical culture where Medical Aid in Dying is offered - or even recommended - as an option to a patient whose Power of Attorney is burdened with the authority and responsibility to decide.

- Power of Attorney as discernment:

An alternative understanding of '*surrogate decision-make*r' is to consider the surrogate as an '*agent of discernment*' whereby one discerns what another would do in the presenting circumstances. This carries the sense of judgment '*on behalf of* ' another in the given circumstances.

The legal sense is thereby muted by a judgmental sense understood as practical reasoning. This brings the 'natural' aspect back into focus.

- Dignity:

In a culture dominated by science everything is evaluated by function. Dignity, then, is understood as attributes such that a lack of attributes, i.e. function, carries a loss of dignity.

But in the realm of nature, dignity is a given such that it is inherent in our being. (U.N. Universal Declaration of Human Rights 1948) Thus, irrespective of our external attributes and in spite of dys-function human dignity remains intact.

Conclusion:

The personal context is the context of the patient. It is only in knowing the patient's context that a healthcare provider can understand and interpret the 'text' of an Advance Directive.

The surrogacy may be one of 'decision' or of 'discernment'. The former carries a 'legal' responsibility and authority; the latter carries the wisdom and moral authority of prudential judgment. One carries a sense of '*in place of*'; the other '*on behalf of*'. These distinctions between 'decision' and 'discernment' are substantive. Of additional importance is the patient's understanding of ' dignity'.

And so, one can describe in the Advance Directive that the surrogate has been assigned the role of discerning what 'the' patient would do or would have done given the circumstances. The burden, then, is not on the surrogate to decide but rather is on the caregiver to respect the patient's wishes as discerned through a duly appointed surrogate. In this way an Advance Directive becomes a safeguard from a healthcare provider promoting the legal right to Medical Aid in Dying.

C. Power of Attorney for Personal Care *

I [insert name] duly appoint [insert name(s)] as my Power(s) of Attorney for Personal Care. This appointment is not a power to decide *in my place* but rather authority to discern *on my behalf* what I would do given the present circumstances. Moreover, this discernment is to be done free of pressure from caregivers and employees of any institution.

'Medical Aid in Dying is a legal right recommended by the Court and enacted by the State. But Medical Aid in Dying is more for it is a medical procedure and, as such, is a part of the medical culture of our time. But Medical Aid in Dying is also a stance one can have toward oneself and toward others. I do not embrace this stance and I expect my caregivers not to adopt that stance toward me. Frequently accompanying this positive stance toward Medical Aid in Dying is a view that life encumbered by illness is lacking dignity. This is a view that I do not hold for myself or for others.

The primary moral effect of any action is on the agent of that action. And so, the moral effect of Medical Aid in Dying is on the one who performs the act. The same holds for Medical Aid in Living. 'Medical Aid in Dying' has no place at my bedside; 'Medical Aid in Living' does. ** If the care givers and / or institution where I am situated cannot respect my views then I should be transferred to those who do.

While medical aid in dying may be a right authorized by the State, so, too, is medical aid in living a right, albeit one not recognized by the State and thereby not enshrined in law. However, medical aid in living comes from within and, therefore, has greater authority than that of the State, the Court, the institution and its representatives, and caregivers.

Francis B. Kelly

* This is presented as a sample of an Advance Directive. It is a description in general terms and not as a prescription in specific terms.

** 'The Genesis of Medical Aid in Dying' (Chapter 1) and 'Advance Directives Re-visited' (Addendum) from Medical Aid in Living: Re-framing Medicine by Re-thinking Psychiatry are to be attached to my medical file along with my Advance Directive.

List of Figures

Different geometric images are presented throughout the text, the most common being a triangle. Except for the Drama Triangle (Karpman) where the focus is on the three points of the triangle, the triangular image is to be understood as a three-sided structure whereby each side represents one of the three aspects relevant to that image. The image is to be understood as three dimensional indicating a pyramid with that named sides filling the triangle. The closing image (Figure 11.1) and the cover image express this.

A rectangle is another image presented here: Figures 5.1, 5.4, 5.9, 6.4, and 8.1. The rectangular image is self explanatory. Figure 4.2 has both a triangle and rectangle and as such carries a unique interpretation.

6.1 The Power Paradigm p.164
Serve others / Exploit others - serve self / Non-use

6.2 Karpman's Drama Triangle * p.165
Victim (V) / Perpetrator (P) / Rescuer (R)
* See also Table 6.1 p.166

6.3 Yalom's Existential Triangle p.169
Consciousness / Construction / Participation

6.4 Re-framing Mental Health p.174 PATIENT as PERSON

8.1 Text and Context p.230
Texts: Experimental / Experiential / Existential
Contexts: Disease - science / Illness - *bios* / Mental health - *psyche*

8.2 Re-framing Medicine p.238 PATIENT as PERSON

10.1 The Triangle of Clinical Rights * p.274
The *right* reason / The *right* thing to do / The *right* way to do the right thing
*Adapted from the right discourse of Plato's Art of Rhetoric

11.1 Afterword:
Framing Medical Aid in Living p.287
DISEASE / PERSON as PATIENT / PATIENT as PERSON

Notes

Chapter 1 The Genesis of Medical Aid in Dying

1. M. Angell. Euthanasia. The New England Journal of Medicine, Vol. 319, No.19, Nov.17,1988. p.1348.
2. M. Boss. Existential Foundations of Medicine & Psychology. London, Jason Aronson, 1983. p.119-22.
3. M. McGregor, Technology and Allocation of Resources. New England Journal of Medicine, Vol. 320, Jan.12,1989. p.118-120. Note that McGregor's comments in the NEJM followed those of Angell, the editor of NEJM by 2 months. One closed 1988, the other opened 1989.
4. Canada's Medicare is cost-shared between the Federal and Provincial Governments. Originating in the 1960s the cost-sharing formula was 50-50 with no ceiling. In the 1970s the Federal Government imposed a ceiling, thereby ending the open-ended formula. The Canada Health Act (1984) added further changes such that Provinces would be penalized dollar for dollar if physicians were allowed to 'extra-bill', i.e. bill beyond the fee schedule. 'Extra-billing' had been a common practice among physicians for the fee schedule negotiated was based on 85% of billings prior to Medicare. The 15% being an estimate that physician would not be paid by patients.
5. At the 1994 CMA Leadership Conference the keynote speaker, a sitting Premier, told the audience that 'their patients are not patients but consumers of government services'. This remark is not part of the official record. Its source is an attendee at the Conference.
6. As part of its teaching mandate Departments in teaching hospitals present topics to the entire medical staff including physicians-in-training. At one such venue a senior physician in Palliative Care presented the subject of 'pointlessly living' - a concept first championed by palliative care physicians in Liverpool. In another session a visiting Professor spoke about

how physicians-in-training were being taught to have a conversation with patients about death,

7. B.P. Squires, Editorial: Award to ethicist Peter Singer, Canadian Medical Association Journal, Vol.143, No. 10, 1990. p.991.

8. E. Pellegrino. The Medical Profession as a Moral Community, Bulletin of the New York Academy of Medicine, Vol.66, No.3, May - June,1990. p.221-232. As a point of interest a Dean of Medicine at the University of Toronto spent a sabbatical year with Pellegrino in 1988 following his tenure as Dean and became the founder and first director of the University Centre for Bioethics and later the inaugural Director of the Joint Centre for Bioethics.

9. A leading voice in this development was Peter Ubel, M.D. who advocated bringing rationing of healthcare to the bedside. His major work is Pricing Life: Why It's Time For Health Care Rationing, MIT Press, 2000. Ubel is a physician - behavioural scientist who uses psychology and behavioural economics in health care decision - making at the bedside and to policy. 'Behavioural economics' means understanding behaviour as an economic calculation. It has been described as the application of reason to self-interest where the 'self ' may be a corporation, an institution such as a health care facility or bureaucracy. For further comments on behaviour and economics see closing comments see Schwartz citing Becker and Edgeworth Chapter 3, Section IV. B. 'Economics and human nature' also cited in Chapter 5, Note 9.

10. H. McGurrin. Impact of Palliative Care Consultations. Reported in VISTAS, Oct. 2015. p.7. (VISTAS is a community newspaper of the Alta Vista Community, Ottawa, Canada.) The study referred to [Impact of Palliative Care Consultations on Resource Utilization in the Final 48 to 72 Hours of Life at an Acute Care Hospital in Ontario, Canada) was led by the Ottawa Hospital Director of Clinical and Organizational Ethics and published in the Journal of Palliative Care, Vol.31, No.3, 2015. p.76-88.

11. J.A. Oesterle, Logic: The Art of Defining and Reasoning, Prentice-Hall Inc., Englewood Cliffs, California, 1963. p.253.
12. D. Leder. The Distressed Body. Chicago, The University of Chicago Press, 2016. p.21.
13. M. Rosenberg. Getting Past the Pain Between Us. Encinitas, California, Puddle Dancer Press, 2005. p.9. Rosenberg goes on to note that empathy as being present is . . . "trying to hear what's alive (in the other) right now". (p.8) Empathy is being present in the present. This presence is not an intellectual activity (p.8) / process but an existential moment.
14. P. Singer. Advance Directives in Palliative Care. Journal of Palliative Care, Vol.10, No.3, 1994. p.111.
15. V. Solovyov. The Justification of the Good: An Essay on Moral Philosophy. Grand Rapids, Michigan, Wm. B. Eerdmans Pub. Co., 2005. p.229.
16. J. Rachels. 'Passive and Active Euthanasia' in The End of Life. Oxford, Oxford University Press, 1986. p.106-17.
17. In personal communication with a leading academic in law and bioethics I was reminded and advised that the adjectives 'passive' and 'active' - adjectives which I was using - no longer belong in the debate.
18. Euthanasia Prevention Coalition [EPC] Newsletter, enclosure, No.171, Dec.2015
19. Sébastien Grammond. Globe and Mail, June 30,2016.
20. On 'conscience rights' see open parliament.ca Vote #72, May 30, 2016. Bill C-14 An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)
Motion:

> (7.1) It is recognized that the medical practitioner, nurse practitioner, pharmacist or other health care institution care provider, or any such institution, is free to refuse to provide direct or indirect medical assistance in dying.
> (7.2) No medical practitioner, nurse practitioner, pharmacist or other healthcare institution care provider, or any such institution, shall be deprived of any benefit,

or be subject to any obligation or sanction, under any law of the Parliament of Canada solely by reason of their exercise, in respect of medical assistance in dying, of the freedom of conscience and religion guaranteed under the Canadian Charter of Rights and Freedoms or the expression of their beliefs in respect of medical assistance in dying based on that guaranteed freedom.

Vote: Yes 97 / No 222

2I. W. May. Beleaguered Rulers: The Public Obligation of the Professional. London, Westminster John Knox Press, 2001. p.201.

22. Idem, p.201-2. See May's reference to E.J. Epstein, The News from Nowhere, Part 1. New York, Random House. 1973.

23. J. Simpson. Assisted suicide - the issue we can't ignore. Globe and Mail, April 19, 2014.

24. T. Koch. Living versus Dying "With dignity": A New Perspective on the Euthanasia Debate. Cambridge Quarterly of Healthcare Ethics, Vol.5. 1996. p.50-61

25. 'The hand that rocks the cradle rules the world' is variously attributed to Shakespeare (1602) and William Ross Wallace (1819-1881). Although the language is outdated the sentiment that there are controlling forces which have input to our consciousness remains unchanged throughout history. In today's world that role is owned by the media.

26. For more on social platforms see Franklin Foer. World Without Mind: The Existential Threat of Big Tech. New York. Penguin Press, 2017.

27. Danielle Ofri. Book review Victoria Sweet's God's Hotel, San Francisco Chronicle April 22, 2012. Figure 4.2 below speaks to this.

28. CBC.ca Ottawa regional report. Early Sept.2016

29. P. Kalanithi. When Breath Becomes Air. London, The Bodley Head, 2016. p.68

30. A. Schweitzer. The Philosophy of Civilization. Amherst, N.Y., Prometheus Books, 1987. p. xi

31. Idem, p xvii.
32. See Wiley on line library: Moral Disengagement, Bandura.
33. Craig Haney, On Structural Evil: Disengaging From Our Moral Selves accessed on Internet. A review of Moral Disengagement, Worth Publishers New York, N.Y. 2016.
34. R.A. Nisbet. The Impact of Technology on Ethical Decision-Making, Religion and Social Conflict, eds. R. Lee and M.E. Marty. Vol. 43, Issue 2, 1964. p.21. The lessons of the 20th century bears this out. Nisbet cites Rosenberg (Commentary, November 1961) regarding the trial of a collaborator of the Holocaust whose lawyer presented the view that his client was acting in accordance with the laws of the State.

Chapter 2 Philosophy in Medicine

1. Viktor Frankl. The Doctor and the Soul. New York, Bantam Books. 1965. p. 245.
2. L. Kolakowski. Why Is There Something Rather Than Nothing: 23 Questions from Great Philosophers. New York, Basic Books, 2007. A collection of 23 essays, each of which is written by Kolakowski, about great philosophers throughout history. Thirty essays were presented in the original Polish edition. Philosophers left out of the English edition include Aristotle, Meister Eckhardt, Nicolas of Cusa, Hobbes, Heidegger, Jaspers and Plotinus. No reason is given.
3. J. Schwenkler. Moving the Soil, Book Review: Why Is There something Rather Than Nothing?, Commonweal, Vol. CXXXV, No.8, April 25, 2008. p.33.
4. Ibidem.
5. Ibidem.
6. Viktor Frankl. Op .Cit., p. 9.
7. Idem, p.90.
8. V. Frankl. Man's Search for Meaning. New York, Washington Square Press, 1963. p. xiv.
9. Idem, p.9.

10. M. Boss .Op. Cit., p.19.
11. S. Toulmin. How Medicine Saved the Life of Ethics, Perspectives in Biology and Medicine, Vol.25, No.4, 1982. p.736-50.
12. A. Neumann. The Patient Body: How Ethics Saved the Life of Medicine, The Revealer, posted on Aug.26, 2015.
13. Ibidem. Neuman cites Caplan from 'Done Good'.
14. A. Caplan. Done Good, Journal of Medical Ethics.Vol.41, 2015. p.26.
15. S. Toulmin. Op. Cit. p.749-50.
16. A. Badiou. Ethics: An Essay on the Understanding of Evil. London, Verso, 2012. p.5.
17. Ibidem.
18. Idem, p.6.
19. E. Pellegrino cited from memory.
20. E. Cassell. The Nature of Suffering and the Goals of Medicine . New York, Oxford University Press, 1991. p.28.
21. L. Kolakowski. Why Is There something Rather Than Nothing?, New York, Basic Books, 2007. p.5. [On Socrates] *Truth and the Good: Why do we do evil?*
22. Idem, p.176. [On Schopenhauer] *World, Will, and Sex: Should we commit suicide?*
23. Idem, p. 192-201. [On Neitzsche] *The Will to Power: Is there good and evil?*
24. Idem, p.202-212. [On Bergson. *Consciousness and Evolution: What is the human spirit?*
25. I. Thomson. Heidegger on Ontotheology: Technology and the Politics of Education. Cambridge, Cambridge University Press, 2005. p.8. Page references in this document refer to this text.
26. A.C. Grayling. The Frontiers of Knowledge. Dublin, Penguin Random House, 2021. p.59. See also Louis Dupré. Passage to Modernity: An Essay in the Hermeneutics of Nature and Culture. New Haven, Yale University Press, 1993.p.66.
27. T. Platt. Medicine, Metaphysics and Morals, p.1, PAIDEIA [ΠΑΙΔΕΙΑ] 20th World Conference of Philosophy: Bioethics

and Medical Ethics, Boston, 1998. www.bu.edu/wcp/MainBioe.htm
28. G. Marcel. Problematic Man. New York, Herder and Herder, 1967. p. 35-6.
29. G. Maté. The Myth of Normal. Knopf Canada. 2022. Introductory citation.
30.See M. Pawliszyn. Suspension of Ethics, *Studia Moralia*, Vol.51, No.1, 2013. p.153-73. This is based on the thought of the Russian philosopher Lev Shestov (1866-1938).
31. T. Platt. Op Cit., as per note 27.
32. M. Heidegger. The Question Concerning Technology and Other Essays. New York, Harper Perennial, 1977. p.8. Translated by William Lovitt.

Chapter 3 Re-thinking Human Nature

1. Noteworthy is that 'pneumonia', an infection of the body's organ of breathing has its etymological root in *pneuma*.
2. S. Brock. The Luminous Eye: The Spiritual World of Saint Ephrem the Syrian. Kalamazoo, Michigan, Cistercian Publications, 1985. p.153.
3. P. von Tongeren. Moral Philosophy as a Hermeneutics of Moral Experience. International Philosophical Quarterly, Vol. XXXIV, No.2, Issue No. 134, June 1994. p.207.
4 .L. Dupré. Op. Cit., Chapter 3 The Emergence of Objectivity p.65-90 of his Passage to Modernity: An Essay in the Hermeneutics of Nature and Culture.
5. J. Hillman. A Blue Fire. A Blue Fire: Selected writings by James Hillman. ed. Thomas More. New York, Harper - Perennial, 1989. p.293.
6. The root of phronesis is *phrené* (φρενη) from which the phrenic nerve takes it name. This nerve stimulates the diaphragm, the most powerful muscle of respiration, which moves the *pneuma* (spirit) into the lungs. This resonates with Note 1 above.

7.J. Bishop. Transhumanism, Metaphysics, and the Posthuman God. Journal of Medicine and Philosophy, Vol. 35, 2010. p.716.
8. A. Kleinman. Rethinking Psychiatry: From Cultural Category to Personal Experience. New York, The Free Press, 1988. p.92.
9. B. Schwartz. The Battle for Human Nature: Science, Morality and Modern Life. New York. W.W. Norton & Co., 1986. p.17.
10. D. Leder. Op. Cit., p.72.
11. M. Boss. Op. Cit., p.21.

Chapter 4 How We Know What We Know and Why We Know It

1. The title of this Chapter is adapted from McHugh and Yalom, the adaptation being the sequence and the addition of 'Why'.
2. P. Tournier. The Whole Person in a Broken World. London, Harper & Row, 1964. p.40-41. First published in 1947.
3. A career in its popular sense is a vertical movement. This occurs in the triangle where each 'station' is a rung on a ladder of upward mobility. I observed that a 'clinical career' operates in the horizontal for that is where medicine is practised. In the vertical domain one advances by attending to the person above. In the horizontal one's career is grounded in taking care of the vulnerable.
4. W. May. Op. Cit., p.8.
5. The membership of this Panel and its recommendations are in the public domain.
6. The Provincial and Territorial Expert Advisory Group on Physician -Assisted Dying played a central role in the political discourse on Medical Aid in Dying. By its very title the *raison d'être* of an ' advisory group' is to provide advice. This in itself carries a prescriptive and imperative sense. Noteworthy is that

Parliament's rejection conscience rights aligned with the recommendation of the Advisory Group.
7. The term 'existential' is used here to indicate that the psyche engages the lived experience at the core of one's existence. This is developed in Chapter -The Distressed Psyche - Part I.

Chapter 5 The Distressed Body

1. The title is borrowed from D. Leder. Op. Cit., p.13. The Distressed Body: Rethinking Illness, Imprisonment, and Healing.
2. R. Munson. Why Medicine Cannot Be a Science, The Journal of Medicine and Philosophy. 6, 1981. p.183-208.
3. E. Cassell. Op. Cit., p.6-7.
4. G. Engel The Need for a New Medical Model: A Challenge for Biomedicine, Science, Vol.196, No.4286, Apr. 8, 1977. p.130.
5. R. Charon. Narrative Medicine A Model for Empathy, Reflection, Profession, and Trust. Journal of the American Medical Association, Oct.17, 2001, Vol.286, No.15. p.1897.
6. F.R. George. The Cognitive Neurosceince of Narcissism. 2017 Science journal open access. p.6. Center For Cognitive & Behavioral Wellness; Email: frank.george@cfcbw.org
7. C. Fine. A Mind of its Own: How Your Brain Distorts and Deceives. London, Icon Books, 2007. p.12 and p.14. The first study 'Motivated changes in the self-concept', Journal of Experimental Social Psychology, 25:272-85. The second study 'Motivated inference: self-serving genrration and causal theories' , Journal of Personality and Social Psyvchology, 53: 636-47. Fine's book with 252 references of text from the behavioral scientific literature in 211 pages is well researched in itself.
8. M. Boss. Op. Cit., p. 25-6.
9. In closing Chapter 3 Section IV- B above two sources from Schwartz relevant to behaviour are cited. These are repeated here: Becker: "I have come to believe that the *economic approach* is a comprehensive one that is applicable *to all*

human behaviour, be it . . . patients or therapists." (*Italics* added) Edgeworth "The first principle of economics is that every agent is actuated *only by self -interest.*" (*Italics* added) See also Chapter 1, Note 9.
10. For more see R. Barglow, Tikkun Magazine, Nov.1998.
11. D. Leder. Op. Cit., p.13.
12. C. Sedergreen. BMJ 324, 1533 Rapid Response., Oct.29, 2011.Also internet access Harvey Cushing quotes.
13. On Heidegger's thought re *da-sein* ('being there') see Boss, Op. Cit., p.161-64 and Thomson, Op. Cit., 141-70. See also Chapter 8, Note 5.
14. J. Hillman. Op. Cit., p.293. Hillman's understanding of *kosmos* was introduced in Chapter 3, Note 5. It is developed more fully here.

Chapter 6 The Distressed Psyche - Part I

1. P. Tournier. Op. Cit., p.37.
2. P. McHugh. Try to Remember: Psychiatry's Clash over Meaning, Memory, and Mind. New York, Dana Press, 2008. p.1.
3. P. McHugh *et al*. Mental Illness - Comprehensive Evaluation or Checklist. New England Journal of Medicine, Vol. 366, May 17, 2012. p.1853-5.
4. S. Arabi. Becoming the Narcissist's Nightmare: How to Devalue and Discard the Narcissist while Supplying Yourself. New York, SCW Archer Publishing, 2016. Also Christine Louis de Canonville. The Three Faces of Evil: Unmasking the Full Spectrum of Narcissistic Abuse. Stouffville, Ontario, Black Card Books, 2015.
5. R.A. Friedman, Grief, Depression, and DSM -V. New England Journal of Medicine, Vol. 366, May17, 2012. p.1855-57.
6. A further item of relevance is presented by Elliott who in commenting on Continuing Medical Education (CME) and the pharmaceutical industry noted that . . . " (s)pecialty groups like

the American Psychiatric Association and the American Academy of Family Physicians are heavily dependent on industry funds." C. Elliott. Pharma Goes to the Laundry, Hastings Center Report, Vol. 34, No. 5, Sept. - Oct. 2004. p.21.
7. Other sectors of medicine produce textbooks such as Harrison's Textbook of Medicine, Schwartz re surgery, Robbins' re Pathology, and Goodman & Gilman re pharmacology all of which are anchors to their specialty.
8. B. van der Kolk. The Body Keeps The Score: Brain, Mind, and Body in the Healing of Trauma. New York, Penguin Books, 2015.
9. M. Boss. Op. Cit., p.29.
10. The dictionary (Funk &Wagnalls) defines empiricism in terms of 'observation' and 'experience'. Both McHugh and Yalom use the term 'empirical'; however, it seems that their understanding differs. For McHugh 'empirical' means 'experience'. This resonates with Leder's 'experiential text'. For Yalom 'empirical' means 'experimental'. This resonates with what I have named the 'experimental text' in referring to the scientific method applied to human biology.
11. R. Dubos. Man, Medicine, and Environment. New York, A Mentor Book,1968. Citation from back cover.
12. I. Yalom. The Yalom Reader. New York, Basic Books, 1998. p. x.

Chapter 7 The Distressed Psyche - Part II

1. The sub-title comes from M. Boss, Existential Foundations of Medicine and Psychology.
2. Idem, p .xii.
3. Note the 'something rather than nothing' identifies with the title of Kolakowski's book: Why Is There Something Rather Than Nothing .
4. *Da-sein* carries the sense of 'being there' as in presence. See Chapter 5, Note 13 and Chapter 8, Note 5.

Chapter 8 Living Our Humanness

1. M. Boss. Op. Cit., p.31.
2. T.F. Dailey *et al*. Do you mind? The Anthropological Question Underlying Bioethical Discussions. Ultimate Reality & Meaning, Vol.29, Issue 1-2, March -June, 2006. p.112.
3. M. Boss. Op. Cit., p.249-283, (Chapters 15-17).
4. Idem, p.257.The physician - patient encounter is a way of being - together, i.e. living our humanness. Yalom has a chapter (p. 5 - 42) on therapeutic factors that heal.
5. See Chapter 5, Note 13. On Heidegger's thought re *da-sein* see also Boss, Op. Cit., p.161-64 and Thomson, Op. Cit., 141-70.
6. A. Heschel. The Insecurity of Freedom. Toronto, Ambassador Books, 1966. p.24.

Chapter 9 Wholeness as Healing

1. Hans-Georg Gadamer. The Enigma of Health -The Art of Healing in a Scientific Age. Cambridge, Polity Press, 2004. This is collection of 13 essays or lectures from 1963 to 1990 presented mainly in German. See p. ix-x. The title of this chapter is from the sub-title of The Enigma of Health initially from x to y first published in German (1993) and in English (1996). Gadamer's 'Apologia for the Art of Healing' is Chapter 2 of this publication which first appeared in 1965. p. ix .
2. Idem, p. 43. The original 'Apologia', translated into German in 1890, is the basis of an essay of the same title by the German philosopher Hans-Georg Gadamer's (1900-2002) first published in German in 1965.
3. The 'practical knowledge' resonates with Aristotle's 'prudential judgment' cited by Dupré. It is also noted that prudence carries the sense of 'practical wisdom' which aligns with prudential judgment. (See Chapter 3, Section III text and Figure 3.1.) In the light of this The Center for Practical Wisdom (University of Chicago) and The Center for Studies

of Practical Knowledge (Södertörn University -Stockholm) seems to be misplaced for one gains practical knowledge and, hence, wisdom by doing rather than by thinking.
4. Simone Weil (1909-1943) cited from memory.
5. This concurs with E. Cassell. Op. Cit., p.28 cited here in Chapter 5**,** II, p.124. Munson makes the same point. See Chapter 5, Note 2.

Chapter 10 Putting the Person Back in the Centre

1. A. Heschel. Op. Cit., p.35.
2. Idem, p.37.

Afterword: A Paradigm for the 21st Century

1. R.A. Nisbet. Op. Cit., p.9.
2. C.Y. Glock. The Role of Deprivation in the Origin and Evolution of Religious Groups, Religion and Social Conflict, eds. R. Lee and M. E. Marty. Vol. 43, Issue 2, 1964. p.28.
3. Leo Alexander. Medical Science Under Dictatorship. New England Journal of Medicine. Vol. 241, No.2, July 14, 1949. p.44. While this article is grounded in Alexander's experience at the Nuremberg Trials which pertains to events of the 1940s and earlier, it also speaks of the medical culture in America of that time. It is the latter which relates to us today. A further note of relevance is that Alexander's views come from his clinical role as a psychiatrist.

Addendum Advance Directives Re-visited

1. Personal communication.
2. A. Laupacis. Canada's Federal government should continue to proceed with caution on MAID policy. CMAJ, Vol.192, Issue 8, Feb.24, 2020. p.189.
3. J. Downar. *et al*. Early experience with medical assistance in dying in Ontario, Canada: a cohort study. Canadian Medical

Association Journal, Vol.192, Issue 8, Feb.24, 2020. p.173-81. The lead author has advocated for MAiD through association with Death with Dignity. He has also promoted a MAiD curriculum with American private sector interests. A co-author (J. Gibson) was co-chair of the Provincial - Territorial Expert Advisory Group on Physician - Assisted Dying (2015) which advocated for Medical Aid Dying and against conscience rights of health care providers. See Chapter 4 Note 6.

4. A. Wright *et al*. The spectrum of and of life care: an argument for access to medical assistance in dying for vulnerable populations. Medicine, Health Care and Philosophy. Vol.22, 2019. p.211-19.

5. J.D. Velleman. Against the right to die. The Journal of Medicine and Philosophy, Vol.17, 1992. p. 673-4.

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