

Spring 2014

# The suffering body: an introduction to current issues in the care of the sick and the role of uncertainty in medicine

Emily Dohm

*University of Colorado Boulder*

Follow this and additional works at: [https://scholar.colorado.edu/honr\\_theses](https://scholar.colorado.edu/honr_theses)

---

## Recommended Citation

Dohm, Emily, "The suffering body: an introduction to current issues in the care of the sick and the role of uncertainty in medicine" (2014). *Undergraduate Honors Theses*. 76.

[https://scholar.colorado.edu/honr\\_theses/76](https://scholar.colorado.edu/honr_theses/76)

This Thesis is brought to you for free and open access by Honors Program at CU Scholar. It has been accepted for inclusion in Undergraduate Honors Theses by an authorized administrator of CU Scholar. For more information, please contact [cuscholaradmin@colorado.edu](mailto:cuscholaradmin@colorado.edu).

The suffering body: an introduction to current issues in the care of the sick and the  
role of uncertainty in medicine

By Emily Dohm

Department of Humanities Honors Thesis  
University of Colorado at Boulder

7 April 2014

*Thesis Advisor*

Anthony Abiragi, Department of Humanities

*Committee Member*

Joaquin Espinosa, Department of MCD Biology

*Honors Council Representative*

Paul Gordon, Department of Humanities

**Abstract**

The relationship between science and medicine, while having generated some of the greatest advancements of the 20<sup>th</sup> century and thus having provided us with innumerable benefits, has been detrimental to the ability of the physician to not simply treat the disease but to truly care for the patient. This “biologizing” of the patient often, ironically, interferes with the ability of the physician to treat the patient’s suffering. The alleviation of suffering can be considered to be the end goal of medicine. But suffering, by nature, is a multifaceted and complex condition. To better understand suffering, one must first better understand the person or, even, what is meant by “person.” A growing movement in the past two decades amongst physicians and philosophers has been to use a phenomenological approach, or simply an understanding of experience through a first-person account, to better understand the clinical encounter, the effects of pain and illness on the body, and the nature of suffering. This approach is used here to introduce aspects of a larger problem within medicine and our culture in general—and that is our tendency to seek a cure before we have understood the problem. We make tremendous efforts to protect and preserve our lives—in good health, from death—but we rarely stop to wonder what we are preserving them *for*. This paper serves as an introduction to larger problems both within and outside of medicine, to the phenomenological approach, and to the many aspects of the clinical encounter.

“Now we feel profoundly the limitation of our being, and there is something in us which gladly holds onto these chains—for if the divine in us was not limited by any resistance, we would know nothing outside of ourselves, and so also nothing of ourselves.” (Holderlin, *Hyperion*)

## Introduction

### *The Birth of the Clinic and the Flexner Report*

Major advancements in science and technology over the past two centuries have armed medicine with the capacities to mediate many of the imbalances and disruptions that throw the human body into illness. As the modern clinic developed in late 18<sup>th</sup> and early 19<sup>th</sup> century France, the incorporation of scientific *positivism* (the view that the world operates according to general laws and that truth can only be determined from empirical evidence) enabled physicians to actually *see* what was going on inside a sick body, not simply to resign to inference: “Open up a few corpses: you will dissipate at once the darkness that observation alone could not dissipate” (Foucault 146). The emergence of this method of *seeing*, where the gaze of the knowing physician quietly and freely meets its object in the body of the patient or in the diseased organs of the corpse, marked a fundamental shift in Western medicine from the traditions of the preceding 2,000 years to the modern medicine practiced today.

In the United States, this scientific foundation in medicine was not firmly established until the early 20<sup>th</sup> century. Up to this point, American medical schools lacked support, legitimacy, and quality teaching and were failing in comparison to their European counterparts

(Germany in particular, which followed a “hyper-rational system of science”). In 1910, set with the task of reforming medical education in the United States and the financial backing of the Rockefellers, Abraham Flexner produced a 300 page-long report evaluating the condition and effectiveness of medical schools across the U.S. His report suggested, most prominently, that medical education be science-based and that the advancement of scientific knowledge be the “defining ethos of the modern physician.” This established the “biomedical model as the gold standard of medical training” (Duffy 1). The value this gave to medicine in the 20<sup>th</sup> century cannot be understated: “The Flexner Report set American medicine on a course that was fueled by the energy of scientific discovery. Those discoveries have immeasurably improved the lives of all human beings, and it is difficult to cavil in the face of such accomplishments” (10).

But these advances in the *science* of medicine detracted from the simultaneous development in the so-called *art* of medicine; it was not long after the “Flexner Report” was released that older physicians, like Francis Peabody (1881-1927), began to notice that younger students were learning “a great deal about the mechanism of disease, but very little about the practice of medicine—or, to put it more bluntly, they are too ‘scientific’ and do not know how to take care of patients” (“The Care of the Patient”).

### ***Current affairs in medicine***

The current climate of medicine in the U.S. is messy to say the least. The issues that

plague medicine and impede the ability of physicians and other health care workers to deliver quality care to their patients are many: costs are excessive and spiraling out of control; much of clinical care is fragmented and spread amongst subspecialties; litigation and increased scrutiny of medical records and decision making in the interest of insurance companies is impinging on the freedom of the physician; and lastly, patients tend to be “biologized,” or simply reduced to their diseases (Barondess 9). Of interest to this paper is this latter issue, which is rooted in the aforementioned integration of science and medicine in the early 19<sup>th</sup> and 20<sup>th</sup> centuries and which has permeated clinical practice and hindered the ability of the physician to actually *care* for the patient ever since.

Physicians writing today on this issue explain that it is not *science* that is the source of the problem—to say this would be to discount the significance of medical science—but rather, it is the relationship of one to the other that requires readjustment:

In the United States, the power of science and the science faculty rules the medical schools and determines much of their curriculum...unfortunately, certain fundamental ideas of science—such as valuing individually verifiable facts over systems, like whole persons; glorifying objectivity at the expense of disparaged subjectivity; and creating a duality that separates nature (including the body) from the person that mimics the old mind-body duality—help perpetuate impersonality in medicine. (Cassell xiii)

### ***The clinical encounter***

The emphasis of this paper will be on the clinical encounter—that is, on the interaction

between the physician (even though other health care professionals are increasingly engaged in similar relationships, for purposes of simplicity and of primary interest, largely only the *physician* will be referred to here) and his or her patient. The impetus for this focus comes from multiple sources, not least of which is the unique positioning of the clinical physician between the language and scope of medical science on the one hand and the realm of the humanities—the activities of the individual—on the other. Although greater forces (such as capitalism and biopolitics) are also at play and continue to shape medicine and the way we, as humans, view ourselves, this clinical encounter remains the crux of present medical practice: “Modern medical science and technology will change the nature of the medical meeting, but medical practice will, without doubt, at the same time...remain a meeting between persons” (Svenaesus 29).

### ***Defining an approach***

Phenomenology, most simply described as the study of experience from the first-person point of view, provides a means to overcome this “biologizing” issue in medicine. As Fredrick Svenaesus points out, “Even if the experienced practitioner knows that illness is not disease, but rather a life-form, and that medicine is not only science, but primarily dialogue and understanding, he presently lacks a language for articulating this knowledge in a systematical way” (5). Phenomenology, in its emphasis on the first-person experiences of individuals, can provide such a vocabulary. A growing body of literature and interest on the topic of

phenomenology and medicine has emerged over the last 20 years, and so the essential nature of this paper is to bring attention to a number of issues that surround and emerge out of the clinical encounter, while simply providing an *introduction* to the larger and more detailed discussions currently being had by physicians and philosophers alike.

By better understanding the illness experiences of the patients they are treating, physicians can better *care* for patients as Peabody, back in 1927, urged them to do. Ultimately both those giving and seeking care must consider medicine is *for*. This is a discussion that could indeed fill volumes, but is worth mentioning here because, as it seems, unless a person truly understands what he or she is doing something *for*, unless an enterprise has an *end goal*—and one as enormous as medicine surely does—then it is easy to lose touch with the importance of the endeavor, with oversights and apathies as likely byproducts along the way. As we will see, a number of physicians have articulated the end goal of medicine most simply as the alleviation of *suffering*. Presupposing that this is indeed the goal of medicine, we would need both a better understanding of suffering and of *person*, for as we will see, suffering is an affliction of *persons* not simply of bodies (Cassell xii).

Current trends in medicine, such as the “biologizing” of the sick person, unfortunately have had the effect of undermining what medicine seeks to create: a state of health, free from suffering. In our very attempts to live more fulfilling lives, free of illness and suffering, we have

sought out better drugs, treatments, and cures, and science (biology) has delved further and further into our bodies and their smallest components. Driving these efforts are our hopes that the more that we can understand and the more that we can *cure*, the better, longer, and more meaningful lives we will have. As we will see, however, disease is only one source of suffering—and needless to say, its treatment is usually greatly beneficial. Yet while we are searching down the rabbit hole for the causes of and treatments for all our afflictions, we often forget about that which we are trying to protect—*our humanity*. The experience of illness has a particular effect on a person that, while limiting, impeding, or damaging, seems to stir the awareness of that person in a way that is not usually thought of as occurring *through* the body (rather, such effects are talked about in regards to the *mind*, the thoughts, emotions, etc). The same will be discussed in regards to death. Both illness and death are events or experiences that tend to instigate the search for meaning (and whatever that might mean) in a person’s life.

This paper hopes to introduce some of these ideas using a phenomenological, or experience-based, approach. The topics of the sick body, suffering, death, the clinical encounter, and the role of uncertainty science and medicine are all discussed, albeit briefly, in hopes to better elaborate on the aforementioned ideas.

### **“To biologize”**

Before delving into a discussion of phenomenology, let us pause to consider what

“biologizing” a person really means and how this might relate to the larger scope of this project.

We are all made of the same “stuff”—the 20,000 or so protein-coding genes that make up the human genome, the billions of cells that give rise to the many tissues, the signaling pathways that connect and control the organ systems, all covered in skin and filled with blood... We *are* biological beings. From the discovery of the structure of DNA in 1953 to the completion of a draft of the human genome in 2001, we have uncovered a tremendous amount about our biology, about how life works on a molecular level, in the last sixty years alone. The more that we know, however, the more we realize how truly complicated we are. The strict mind-body dualism that has dominated Western thought for centuries is slowly breaking down as we continue to uncover much about the relationship of our minds and bodies, about how our physiology affects our emotions and vice versa. Despite these growing understandings, however, and perhaps because of them, we continue to search for a biological basis to everything that we do and feel—from consciousness to love and so on.

But, surely we do not consider ourselves *just* to be our biology.

*Between the idea and the reality, between the motion and the act...the conception and the creation...the desire and the spasm...the potency and the existence...falls the Shadow...We are the hollow men, the stuffed men. (T.S. Eliot, *The Hollow Men*, 1925)*

The mysteries and paradoxes of the human being that we have wrestled with for the past few millennia, will these, too, one day be reduced to some biological explanation? Do we want them

to be? Again, we do so much to protect and preserve ourselves, to maintain our health so that, we often say, we can live more meaningful lives. What becomes of the meaning—where we will find it, how we will express it—when we have reduced ourselves down to the last atom? The things for which we care most, I.A. Richards says, are the in-betweens, the “vast *corpus*” between that which can be discussed as fact and that which is accepted by convention:

There are subjects—mathematics, physics, and the descriptive sciences supply some of them—which can be discussed in terms of verifiable facts and precise hypotheses. There are other subjects—the concrete affairs of commerce, law organisation and police work—which can be handled by rules of thumb and generally accepted conventions. But in between is the vast *corpus* of problems, assumptions, adumbrations, fictions, prejudices, tenets; the whole world, in brief, of abstract opinion and disputation about matters of feeling. *To this world belongs everything about which civilised man cares most.* I need only instance ethics, metaphysics, morals, religion, aesthetics, and the discussions surrounding liberty, nationality, justice, love, truth, faith and knowledge to make this plain. (Richards 7)

In medicine, “biologizing” the sick person has meant treating the disease as a set of biologic phenomena to the “neglect of associated, illness-related human needs” (Barondess 10). It has meant referring to a patient as her disease (e.g. “acute pancreatitis” in room 331) rather than the person’s name (e.g. “Ms. Dohm with acute pancreatitis” in room 331). And while this reduction has been necessary for the treatment of a number of diseases, the physician, whose subject *is* a person, cannot treat his or her patient the same as would a scientist an object of study in the laboratory:

Disease in man is never exactly the same as disease in an experimental animal, for in man the disease at once affects and is affected by what we call the emotional life. Thus, the physician who attempts to take care of a patient while he neglects this factor is as unscientific as the investigator who neglects to control all the conditions that may affect his experiment. (Peabody, “The Care of the Patient”)

A physician must consider—just as a patient must—that a *person* is the subject of medicine, and with this comes all the inconsistencies, struggles, depths, and uncertainties that make us *human*.

### **A phenomenological approach**

Although views and interests vary amongst various phenomenologists, one can discuss a “phenomenological approach” because of the commonalities that link the movement. Perhaps most distinctively is Edmund Husserl’s (1859-1938) notion that it is *to the things themselves* to which we should look—that instead of ignoring *everyday experience*, we should seek to better understand and reflect upon it (Aho and Aho, 2008; Toombs, 2001).

In the *Handbook of Phenomenology and Medicine*, S. Kay Toombs effectively summarizes the utility of a phenomenological approach to medicine and the discussion of suffering, “person,” and the clinical encounter. First, phenomenology seeks to articulate the distinction between the everyday experiences of life and the theoretical accounts of those experiences. This plays a role, for example, in recognizing the difference between a clinician’s theoretical understanding of a disease and a patient’s firsthand account of his or her experience

with an illness. Second, phenomenology opens up a means to actively reflect on one's experience, that is, to question assumed truths about the world as well as to develop an awareness of the "colorings" of our various experiences. A physician must be aware not only of the disease that afflicts a person but also—and sometimes more importantly—of the context in which that disease appears: what it is about this person's lifestyle, background, and so on that might change how the disease manifests and how treatment might then differ between patients with the same disease (Toombs 2; Cassell).

Third, through the motif "to the things themselves," phenomenology emphasizes the importance of firsthand experience, e.g. how it is that a person perceives and responds to their environment. As we will see, illness is a narrative, and the communication of this story by the patient to his or her physician has considerable practical value in the clinical experience. And lastly, many of the themes investigated by phenomenologists—such as the body, the nature of existence, temporality, and intersubjectivity—are relevant, perhaps more than anywhere else, to the field of clinical medicine (Toombs, 2001, 3).

It is prudent to note here, however, a criticism of phenomenology, articulated by Arthur Kleinman, psychiatrist and medical anthropologist: "The chief problem with phenomenological theory is that it has over time become a special language whose conventions, accepted by initiates, are opaque to general readers. The neologisms invented by Edmund Husserl, Martin

Heidegger...and others obscure more than they illuminate about the felt quality of the flow of experience” (1995, 276). Kleinman recognizes and lauds phenomenological theory for its opening up of means to talk about and understand human suffering, but he also criticizes its “predilection for an esoteric terminology,” which has in turn prevented its insights from reaching a larger population (Svenaeus, 48).

Despite recognition of these limitations, the ideas, perspectives, and conversations offered by a phenomenological approach are of primal interest to this discussion of suffering and personhood. Because the amount that has been written about these theories in the context of medicine—and even more specifically on medicine’s address of suffering—in the last two decades is immense, this paper is by no means a comprehensive look at phenomenological theory. Instead, this is an introduction to an approach that serves as an appropriate vehicle to better understand what it means to be human in this world and thus what is meant by human suffering. Some of these insights, which are more or less intuitive but that oftentimes go unarticulated, will be discussed here.

### **The world**

As described by John Russon in *Human Experience*, the phenomenological approach has in part been to challenge us to be wary of traditional views of the world. Rather than understanding ourselves to be “on one side and the world on the other...as discrete agents facing

a world about which we must make choices,” we might better understand this relationship as far more interconnected, as a sort of dialogue (9-10). Martin Heidegger (1889-1976), one of the first to articulate this framework of inquiry, describes all experience as “hermeneutic,” that is, as a relationship or interaction, one that involves an interpretative act, between subject and object (Aho and Aho 11). As we will see, the clinical encounter is particularly illustrative of this hermeneutic relationship. The objects and people that surround us, making up our world, place a demand on us, just as we do them. In a sense, the “I” is derived from the world just as “natural laws” or “human nature” are really no more than products of history and culture, according to this phenomenological perspective (11-12).

One traditional view is that the universe precedes human understanding and that matter, nature, the laws of physics, and reality are objective and can be separated from human-derived influences, e.g. culture, politics, etc. Another view, however, contests that the universe only exists because we perceive it (part of the thoughts surrounding the Anthropic Principle), and thus it would follow that reality is a subjective matter. In either case, however, nature, whether objective or subjective, must be *translated* by human understanding to become substantial to us. Science, in a sense, is a translation of the unknown to the known in means that we, as humans, can understand. If this is what science is, then it cannot remain unaffected by our limitations. And as such, it cannot remain unmolded by culture. To become aware of these *prejudices* by

means of reflection is essentially what it means to adopt a “phenomenological attitude.”

We exist insofar as we are situated in the world. A person grows to learn *how* the world is, but she does not learn *that* the world is (Russon, “On Human Identity,” 308). The world already *is*; the way we interact with the world is precisely that which makes the world *how* it is *to us*. In other words, we are born into an already existing world, with already established rules. And it is the objects and people that we are surrounded by, both voluntarily and involuntarily, that dictate our experiences—our family, for example, is how we become “socialized” in the world, and we look to those closest to us for a sense of shared meaning and purpose. The world itself is a shared space, that is, it would not be “the world” were it solely *my own*. It is precisely because the world is *shared* that it *is* something (Russon, *Human Experience*). We differ in how we appear to the world, and because of this our experience in the world differs. Each person’s interaction is “colored” by an infinitely varying combination of factors—education, geography, race, interests, needs, and so on.

### **The body**

Needless to say, our body is the vehicle through which we participate in the world: “The world that is for me is beyond me—it is a reality with which I can engage only by means of real bodily interaction” (Russon, “On Human Identity,” 308). In this sense, the human body is a fragile, finite interface, precariously maintained between two infinite universes, that without and

that within—“a cosmos within a cosmos” (308). To be *embodied*, this “is the very matrix of all our experience, all our engagement with significance” (Russon, *Human Experience*, 23).

How we think about our bodies, then, influences how we think about our world and our relationship to it. Toombs quotes philosopher David Abram to elucidate one aspect of this embodiment: “We may think of the sensory body as a kind of circuit that completes itself only in things, and in the world...it is primarily through my engagement with what is *not* me that I effect the integration of my senses, and thereby experience my *own* unity and coherence” (Toombs 6).

While much has been—and can be—said about the body, it is of use to consider another major goal of phenomenology: to disrupt the mind-body dualism that, though birthed in early Western philosophical thought, was popularized by Rene Descartes (1596-1650) in the 17<sup>th</sup> century. Most simply, this Cartesian dualism considers the thinking mind to be separate from the material body. Critics of the tendency of physicians to “biologize” the sick person cite this separation as central to the problem:

If health care practitioners focus their attention almost exclusively on the body/object as a malfunctioning anatomico-physiological entity and ignore (or de-emphasize) the patient’s *lived experience* of bodily disturbance, then important factors of illness (such as interpretations, emotions, desires, worldly involvements, cultural background, and so forth) are ignored—despite the fact that such factors play a crucial role in the course of disease and in therapeutic effectiveness. (Toombs 8)

The Cartesian dualism is disrupted when we consider the body as the nucleus of our

experience in the world, as the material through which all thoughts, emotions, and gestures are generated. As Drew Leder, physician and phenomenologist whose *The Absent Body* delves deeply into the felt-ness of the body, points out: “If the body as a lived structure is a locus of experience, then one need not ascribe this capability to a decorporealized mind. The self is viewed as an integrated being” (5).

Probably most apparent to us is that the body we experience is not the same as the body that is observed by the medical gaze. That is, we think of our body as the *lived body*, the one felt and understood as *ours* on a daily basis; we do not typically consider the *physiological body*, the actual matter, cells, and organs that can be observed, measured, and manipulated. The German words *Leib* (the *self*, the body as we experience it) and *Korper* (the body as matter, as a complexity of processes and functions) are often used to describe this distinction (Aho and Aho; Leder; Toombs).

Leder warns, however, of the overemphasis of this distinction (of the use by phenomenologists of *Leib* and *Korper*), with the possibility that such a “partialized conception” of the lived body might simply generate a new dualism. To avoid this, he points out first that, intrinsically, the lived body is *both* subject *and* an object observed and interacted with by others, not solely a first-person entity. And that “to be a lived body is always also to be a physical body with bones and tendons, nerves and sinews, all of which can be scientifically characterized.

These are not two different bodies. *Korper* is itself an aspect of *Leib*, one manner in which the lived body shows itself” (6).

### **The paradox of the body**

A notable aspect of the lived body is its paradoxical nature. Often we do not think about our bodies until they are hurting or functioning differently. The body is both that which is most self and most other (i.e. something that is separate from or different than *me*; to be “an other” is to be something outside of my reach or beyond my full comprehension). Take, for example, the process of digestion: A man feels hungry, so he finds something, say, a sandwich, to eat. His bodily hunger drives him to take action to satisfy it. Perhaps he develops feelings of anger or agitation until these needs are met. Either way, what he feels is that “*I’m hungry.*” Once the food is eaten, however, it undergoes the process of digestion. This is not a conscious process; the man is not directing the actions of his organs. The peristaltic contraction of the muscles along his digestive tract, the secretion of enzymes from his pancreas, or the movement of sugars and other molecules into his bloodstream—these are all being done without the awareness of the man (Leder 37-39).

Once the man’s hunger is relieved, his body is no longer central to his focus—that is, until he later feels the need to find a restroom, or perhaps the sandwich did not “sit well,” and he feels a discomfort in his “stomach” for the rest of the day (37-39). The process of digestion takes

place largely without the man's knowing or control of it, and yet it *is* taking place in *his* body.

For people whose body is functioning *normally*, its demands are not consciously placed at the center of their focus (Cassell). Again, it is not usually until something is *wrong* that we pay attention to and wonder at this *other*: "My body is '*mine* most of all, yet [it is also] *other* most of all'... Indeed the very times when it is most other than me are precisely the moments when I experience it as most truly my own. This aching knee...the knee of which I was earlier entirely oblivious, is *my* aching knee; this back pain *my own*; this headache *mine*" (Aho and Aho 19).

There is an "uncanniness" of this sensing of the body as *other than me*: "When the body is rendered opaque through loss of function, we become aware of its alien presence" (Toombs 7; Leder 82). We realize that much of what happens *to* or *in* our bodies is beyond our control—something that can cause distress, worry, and even total helplessness. Sickness and injury heighten this awareness.

### **The sick body**

Often when we are sick, our bodies are all that we can think about. In sickness, the boundaries of our world collapse in around us—the world shrinks (Aho and Aho; Leder). Pain plays a role in this shrinkage: the *cramping* of the stomach, the *tightening* of the neck, and the *contraction, contortion, pinching* of the muscles (Aho and Aho 116). More aware of our own body, its pain and discomfort, we therefore become less aware of anything outside of our body;

we experience a cessation in our relationship with others and our habituated environment (Russon, “On Human Identity”). Not only physically—a person is *contained* in the intensive care unit (ICU) or in his or her bed at home—but also emotionally, the sick body *separates*: “the inability to feel into the world forecloses any possibility of emotional connection to others” (Aho and Aho 119). It can be seen, then, why a person with a chronic illness often becomes accustomed to loneliness—not only because the sick body retreats from the world, but also because others, even close family and friends, cannot truly comprehend the illness experience of that person (Toombs 388).

A body that begins to fail or that can no longer do what it used to undoubtedly changes a person’s relationship to the world: “As the means by which one interacts with the world, the lived body makes possible the existential projects that are expressive of one’s personhood. Consequently, the disruption of bodily capacities has a significance that far exceeds that of simple mechanical dysfunction” (Toombs 7). Take professional basketball player Steve Nash as an example. He has spent the last 18 years of his life playing in the NBA. Surely, as a professional athlete, the functioning of his body is the center of his focus—a clear example of how a person’s body defines and determines his or her world. At forty years old, however, he has reached a point where his body is being riddled with injuries that have significantly limited the number of games he has played in his last two years with the L.A. Lakers. Nash now finds

himself confronted with the reality of these limitations: “I feel like there’s something that I can’t quite put my finger on...it feels like it’s blocking me, like this kind of dark presence. I’ve started to wonder if that feeling again...is it the truth, that I am done?” (*The Finish Line*).

The world of a professional athlete is conspicuously constructed around his or her body—what it can do, how it functions and moves in space dictates the athlete’s place in the world. As soon as the athlete’s body begins to fail, he or she no longer belongs to the world of his or her sport and must begin to re-familiarize with another part of his or her life. The body-world interaction of the athlete is visible to us. And while in some ways it might seem that the condition of an athlete no longer able to keep playing his or her sport is trivial compared to the condition of a person, say, diagnosed with a brain tumor, whose entire life is subsequently upended, to a degree, these cases are not so different. As Nash explains, “Every athlete, when they lose their skills, they lose a big part of themselves, a part that they built their life around. You know, it’s been a huge part of their purpose, self-esteem, identity, so when the skill or ability goes, it’s like there’s been a death. It’ll never be the same again” (*The Finish Line*).

### **Suffering**

Now to better understand *suffering*, let us first consider that “suffering is an affliction of the *person*, not of the body” (Cassell xii). Although a person *is* an effect of his or her physical properties—from the atoms and molecules to the cells and tissues to the greater systems and

physiological processes—a person is by no means *just* his or her biology. We experience the world *through* our bodies, but when asked in earnest *who we are*, we will not typically respond with a simple description of our biology or bodily constitution: “A person is an embodied, purposeful, thinking, feeling, emotional, reflective, relational human individual existing through time in a narrative sense” (Cassell and Rich, “Intractable End-of-Life Suffering”).

A phenomenological account is one of first-person experience—how *I* experience the world, how *I* interact with others, how *I* look for meaning. But the legitimacy of our subjectivity is not undermined by the fact (and thus should not exclude) that we are also objects that can be observed by others, scientifically characterized, and so on. As Leder emphasizes, “*Korper* is itself an aspect of *Leib*” (6). The physical body is a part of the lived body that we experience as our personhood. This personhood, as we understand from our discussion on “the world,” is not separable from the world, or in other words, we exist or are *who we are* because of our interactions in the world and with others. And so when thinking about a person, we cannot ignore his or her context, just as the practitioner of medicine cannot ignore the person when thinking about the disease: “Persons do not exist except as imbedded in the matrix of their society...thinking about or trying to understand the word ‘person’ separate from his or her society is like thinking about or trying to understand the word ‘person’ apart from language in general and the fact that language is a human capacity that presupposes that humans live in

groups” (Cassell 150).

While Steve Nash may or may not consider himself to be suffering, what he describes—*losing a big part of oneself, there being a sort of death, things never being the same*—is something experienced by many people (most, if not all, actually) at some point in their lives.

This sense of loss, death, and irreversible change beyond the control of the individual, accompanied by fear or anxiety, forms the basis of human suffering. Eric Cassell, retired internal medicine physician and author of *The Nature of Suffering and the Goals of Medicine*, considers what it is that makes suffering an affliction of persons (as opposed to bodies): “Most generally, suffering can be defined as the state of severe distress associated with events that threaten the intactness of the person” (32).

The complexity of the history, implications, and various interpretations of suffering cannot be understated—it *is* inextricable from the “human condition.” In the words of C.S. Lewis, “Try to exclude the possibility of suffering which the order of nature and the existence of free-wills involve, and you find that you have excluded life itself” (*The Problem of Pain*).

One society that dealt readily with suffering was that of the ancient Greeks. In a manner that might seem strange today, the ancient Greeks celebrated suffering as part of life. At festivals dedicated to Dionysus, the god of wine and fertility, they would gather to watch and perform the tragedies of playwrights Sophocles and Aeschylus while also imbibing in wine and reveling in

song and dance. The ancient Greeks saw that in order to live fully, one must embrace all aspects of life—its joys as well as sorrows, the possibilities of greatness as well as the limitations of mortality.

This acceptance of suffering, however, did not mean that the ancient Greeks did not seek to alleviate it. In a century of much growth, change, and turmoil (the Peloponnesian Wars, the teachings of Socrates, etc), Hippocrates (ca. 460-370 BCE), from the island of Kos, laid the foundations of modern medicine. Recognizing that “health is the greatest of all human blessings,” Hippocratic medicine sought to restore balance to the body and to care for and reduce the suffering of the sick—“this too is part of the physician’s art: to do away with that which causes pain, and by taking away the cause of his suffering to make him sound” (*Volume IV*, trans. 1931).

If the goal of medicine is indeed to treat suffering, Cassell’s definition of it as “the distress of whole persons whose intactness is threatened or disintegrating” demands that physicians better understand the person and not simply that which can be known about the person’s body by gazing upon it through the eyes of the clinician (or the hands of the surgeon, the images of the MRI machine, or the computer screen of the geneticist). What Cassell describes has more or less become the *accepted* definition of suffering amongst those writing on this topic today, e.g. a number of phenomenologists and physicians (Aho and Aho; Svenaeus;

Toombs).

Simply refining one's understanding of suffering does not lead to its melioration—if anything, all that is realized is how complex this task is. But if one is going to successfully contribute to the reduction of another's suffering, it will be by taking into consideration all that that person is and thus all that might contribute to their suffering. As we will see, however, this expanded understanding of suffering might simply make one aware of the possibility that it is never fully eliminated, at least, that it is never fully within the scope of the physician to achieve this.

The “intactness” of a person summarizes a state of synchrony between the many pieces that constitute a person (“I am large; I contain multitudes.”-Walt Whitman). Needless to say, that which affects one piece will affect the whole. Suffering can arise when a person is no longer able to be in the world in a familiar way, or when his or her “face to the world” is no longer the same (Cassell 274). For the professional athlete who is forced to retire because of injury or a mother who is going to lose her only child to leukemia, the distresses and fears surrounding these events may be more of a burden than the initial injury or diagnosis itself: “What is threatened or injured is the integrity or intactness of the person as a person. The injury to the person and the distress of suffering become more important—loom larger than the actual physical symptom, disease, or life situation that produced the suffering” (274).

A physician cannot see this when his or her sole focus is on the disease or dysfunctional part, or when he or she fails to listen to the narrative of the patient, of which symptoms and habits are only a part. The overlooking of these elements, in turn, has the potential to do more harm to the patient than the disease itself (which seemingly contradicts the purpose of the treatment and fails to adhere to the vow of doctors per the Hippocratic Oath to “do no harm”). In his 1927 Harvard address, Peabody gives the following example, where in a not uncommon case, a patient is treated as his disease (in this case, mitral stenosis) and not as a sick *man*:

The disease is treated, but Henry Jones, lying awake nights while he worries about his wife and children, represents a problem that is much more complex than the pathologic physiology of mitral stenosis, and he is apt to improve very slowly unless a discerning intern happens to discover why it is that even large doses of digitalis fail to slow his heart rate. Henry happens to have heart disease, but he is not disturbed so much by dyspnea as he is by anxiety for the future, and a talk with an understanding physician who tries to make the situation clear to him, and then gets the social service worker to find a suitable occupation, does more to straighten him out than a book full of drugs and diets. (“The Care of the Patient”)

Not all suffering is caused by disease, and not all who are ill or in pain, severe as their condition may seem to others, are suffering. Suffering occurs *through* the body, yet there are many sources of suffering. Often we distinguish existential suffering from physical suffering. But, and as Cassell would remind, regardless of the source, once the *thing*—the severe pain, the fear, sense of loss, distress, etc—imbeds itself deep enough, reaches a point where it arrests,

suffocates, dissolves a person's sense of self or self-control, the suffering is indistinguishable.

Perhaps a young man is *existentially* suffering because he, on daily basis, begins to think about his own smallness in the universe, his inability to connect with those around him, or the certainty that he will indeed die one day. These ideas wear him down so much that he begins to feel disconnected even from himself, and, recognizing this, falls into a dark depression. Although the causes of suffering differ from person to person, the feeling of loss or separation or disintegration of personhood is more or less consistent.

### **Pain**

We often use pain and suffering interchangeably—"the pain and suffering that she felt...that he endured"—and not without reason, as these two are certainly related and often indistinguishable. The temporal aspect of pain—how long it must be endured—as well as not knowing what is causing the pain are both important factors that contribute to the emergence of suffering from such pain sensations: "People in pain frequently report suffering from pain when they feel out of control, when the pain is overwhelming, when the source of pain is unknown, when the meaning of the pain is dire, or when the pain is apparently without end. In these situations persons perceive pain as a threat to their continued existence—not merely to their lives but their integrity as a person" (Cassell 35).

Whereas suffering is an affliction of persons, pain is of the body—or rather, pain is felt *in*

the body; it can be pinpointed, ascribed to a particular location in the body. Suffering, too, may have bodily symptoms, where the feelings of fear, of anxiety, of panic have a direct physiologic effect, e.g. the tightness in her chest, his raised blood pressure, the nausea in her stomach. But pain *can* be experimentally investigated and interrupted, and thus pain is relatively well understood on a molecular, cellular, and physiological level. A biologist's definition of pain might have something to do with pain receptors called nociceptors, a signaling network called the anterolateral system, and the different locations in the brain where this information is received and processed.

Yet while much is known, the subject of pain remains a perplexing and actively studied area of research. Not least in its complexity is the *subjectivity* of pain (and this is where we approach the limits of what science can really *know* about a person's experience, where the realms of the purely subjective and the purely objective clash). We know that different people have different tolerances to pain, and in various situations and cultures, responses to and conceptions of pain vary greatly. Neuroscientists recognize that the "perception of pain is subject to central modulation... (and) that such 'psychological' effects are as real and important as any other neural phenomenon" (*Neuroscience* 223). A Cartesian model of mind/body starts to break down with this notion that "pain is in the brain."

A phenomenological understanding of pain considers how pain alters our relationship to

our bodies: “No event more radically and inescapably reminds us of our bodily presence” (Leder 76). At the same time, as noted before, “pain effects a certain alienation” and makes our bodies feel foreign or separate—the pain is an “it” rather than an “I” (76). Leder points out that this distancing can have a relieving or protective element to it; by experiencing the painful body as an “it,” this threat or disruption is separated or distant from the “essential self.” And so while the gaze of the physician tends to objectify the body, scrutinizing and probing its parts and pieces, we begin to do this with our own pain experiences, before we even visit the physician at the clinic (77).

While the distinction may not always be clear, and while we tend to group the two together, as they are often inextricable, pain and suffering are not the same. To summarize, pain can usually be traced to the body, whereas suffering is an affliction of the person (Cassell). Not all who experience pain suffer, and not all who suffer, suffer because of pain. Most simply, the relationship of pain and suffering is that of a stimulus (pain) eliciting a sensory response (nociceptive pathway) that then is incorporated into a person’s experience (the self body and the scope of one’s awareness). This incorporation makes the pain available for the “assignation of meaning”—and it is thus through giving meaning to this pain that suffering arises (Braude, “Affecting the body and transforming desire”).

## **Death**

*“Woe, destruction, ruin, and decay; the worst is death, and death will have his day”*

(Shakespeare, *Richard II*, Act 3.2, line 102). Although some people see death as a welcome freedom from the toils, struggles, and abuses they experience in life, and others, as the promise of an eternal life or as the release of their soul from an imprisoning body, death, by definition, is the ultimate threat to a person’s intactness. For many people, the idea of death, and the correlative limitations of a mortal life, is a profound source of fear and anxiety, of suffering—“the self-apprehension of mortal life”...or simply that one, and everything that one knows, will cease to exist (Schmidt 134). Seemingly, each injury and sickness is a reminder of this: “As the sensation of pain is the harbinger of illness, and as illness foretells the coming of death, so the alien presence of the body expands until it can threaten the entirety of one’s world” (Leder 83).

The loss of a person’s identity or familiar relationship to the world, such as is experienced in illness, as Leder points out, simply serves as a reminder of the fate that all of us eventually face. Consider Steve Nash once more. As he becomes aware that he no longer fits into the world of the NBA and that it will continue on without him, he also begins to gain this sense of closeness to death, though he cannot quite articulate or grasp what it is: “I can see it out the corner of my mind’s eye. It’s like this dark presence. And I don’t want to sound mystical, but I feel this sense of something, you know, blocking me, or slowing me down, or troubling me” (*The Finish Line*).

The certainty of death, however, is precisely that which gives life meaning; it illuminates the dimensions of our life that are obscured by the distractions of living. Our bodies, for example, are built in such a way that the very parts keeping us alive—our hearts, brains, livers, and, even more seemingly remote our cells, proteins, and DNA—are hidden from view: “Life itself is allied to a certain concealment, a withdrawal and protection of its vital center” (Leder 45). Unless we are severely injured, with, say, our guts hanging out of our stomach, our vital forces are kept out of sight. So paradoxically, while life conceals itself, death acts as the magician pulling the rabbit from the depths of his top hat—it reveals.

The anatomists of the late 18<sup>th</sup> and early 19<sup>th</sup> centuries, Foucault describes, found that only by “opening up a few corpses” could the nature of a disease and the machinery of the body be truthfully understood: “Knowledge of life finds its origin in the destruction of life and in its extreme opposite; it is at death that disease and life speak their truth: a specific, irreducible truth, protected from all assimilations to the inorganic by the circle of death that designates them for what they are” (145). Our nature is to survive and to persist—even with all the advanced technologies we have today, allowing us peer inside our bodies while we are still alive, our inclination to deny and avoid death stifles any such revealing powers until death itself demands our acute attention.

While the foregoing describes our understanding of the organic body (the *Körper*), this is

also true for the lived body (the *Leib*): our lives become precious, meaningful, something to be protected or preserved, only because of death. As Dr. Rita Charon, internist and professor of narrative medicine, explains, “Those things that give us meaning...are only available through the presence of death” (“Honoring the stories of illness”). While we are consumed in the day-to-day concerns of living, we are not usually reflecting upon who we actually are—we just *are*. It is not until we take a moment of pause from our daily routines, prompted by an event such as death of a friend, natural disaster, or illness, that we, even momentarily, develop a sense of what gives our lives meaning, i.e. what they are *for*.

As long as we are in denial of death, or are afraid to acknowledge, accept, and confront it, we remain handicapped from truly developing a sense of meaning or seeing what it is that makes our lives something worth caring for and preserving. To know what we are, we must consider what we are *not*. And we must be able to fully accept death in order to truly gain our sense of being alive—“For whoever wants to save his life will lose it” (Matthew 16:25).

Many physicians, like Charon and Cassell, see patients suffering from illnesses such as cancer, where prognoses are not often positive (though these days are increasingly becoming so) and where the fear of death is palpable. These physicians recognize the space that is opened by the presence of death: “The physical suffering simply exposes an underlying suffering that is present all the time...that I think many of us, many of my patients, don’t recognize until they’re

facing death. And then it becomes a terror, and it becomes part of my job as a doctor to be able to recognize *with* them all the elements of their suffering” (Charon).

### **The clinical encounter**

As we have seen, pain and illness affect not just our flesh and our blood, but our entire experience of being-in-the-world. Our relationships with others and even with our own body are altered by these physical perturbations. Illness *exposes* us, explains Charon: “You’re down to the floor of who you are in the presence of illness” (“Honoring the stories of illness”). The clinical encounter thus places the physician in a unique position of *close contact* with a patient—that is, there is little separating a physician from a patient who has been stripped bare by illness and seeks a return to health (to wholeness, to a familiar sense of being in the world). Charon talks of the contact that she has made with her patients “through the glare of death.” Such intimacy is not often experienced between two persons on a daily basis:

The *goal* of the medical meeting is that which separates it from most other kinds of meetings, other ways of being-together-in-the-world...The patient, who comes looking for help, is distressed, suffering and often afraid because of what is happening to him. The dialogue and examination will have to deal with intimate parts of life, parts which one would normally only share with someone one knew very well, or perhaps with no one at all...Deep trust, despite estrangement and asymmetry, is therefore a necessary feature of the medical meeting. (Svenaesus 147)

In *The Hermeneutics of Medicine and the Phenomenology of Health*, Fredrik Svenaesus

delves into the topic of the clinical encounter and the use of 1) phenomenology to better understand health and illness and 2) hermeneutics to better make sense of the “interpretive meeting” that is the clinical encounter. While much is to be said on the topic of hermeneutics—a theory of interpretation—and clinical medicine, that is mostly outside the present scope of this paper. Svenaeus’ work, however, is worth mentioning here because of his relevant ideas on the clinical encounter, most notably, and put most simply, that the practice of clinical medicine “can be best understood as an *interpretive* meeting between health-care personnel and patient” (2).

Different from the interpretive act that takes place with the close reading of a text, this interpretive meeting is one between two subjects, both with the aim of healing the sick patient. Although the physician and the patient engage in this meeting with different points of view—“the doctor’s world...is primarily one of disease, while the patient’s world is one of lived illness”—both necessarily contribute to the *end goal* of the encounter: “the patient and not the doctor experiences this unhomelikeness (basic to the illness experience) in his being-in-the-world, and this unhomelikeness is also the matter of the meeting...(while) the doctor’s expertise and mission (is) to help in matters concerning health and disease, which is not present in the horizon of the patient” (153-154).

To recall the problem of “biologizing,” the physician’s focus on the disease has become an issue when his or her *sole focus* is on the disease, rather than engaging in this dialogue with

the patient in order to better understand the illness experience of the patient. The deficiency of medicine to treat the patient and not simply the disease results in part because of the “asymmetric” nature of the doctor-patient relationship—the patient is in a position of weakness, seeking the help of the physician, and lacks the knowledge about his or her prevailing condition that the physician or health care worker can provide (153). This imbalance of power (between the two subjects; harkens back to Foucault) makes it easier for the perspective, focus, or *language* of the dominant party (the physician) to supersede the narrative of the often relegated *lived body* experience of the deferential party (the patient).

### **Role of the physician**

The physician is trained to see the disease, perturbation, or imbalance in the body of the patient. This is the physician’s expertise—and a complex and difficult one to gain at that, for the knowledge we now have about the biology, physiology, and pathology of the human body is substantial and only continues to grow. With the development and use of increasingly sophisticated technologies, however, the physician is simultaneously able to see more while doing less in a number of specialties. At the same time, the need for and prevalence of subspecialists (and fewer generalists) has grown substantially with these new technologies. The establishment of science and technology as the base of clinical practice has been so successful and so widely applicable that “we have come to largely consider science and technology to *be*

medicine, a stance that underlies some of our problems, including the dismay of some physicians and many of our patients” (Barondess 8).

But as we have seen repeatedly, medical practice cannot be treated the same as medical science. The privilege and the burden of the practitioner of medicine is the centrality of the patient. The experience of the *person* and his or her “illness-related human needs,” in addition to the disease itself, demands the attention and expertise of the physician (8). As indicated before, the same disease will manifest differently in different people, and thus the required or best-deemed treatment will also vary. The challenge of the practitioner of medicine, of the clinician, then, is to balance a hefty corpus of scientific knowledge with an intricate understanding of and care for humanity. To recall Peabody’s famous words, “One of the essential qualities of the clinician is interest in humanity, for the secret of the care of the patient is in caring for the patient” (“The Care of the Patient,” 1927).

This essential aspect of clinical medicine is by no means easy to achieve or uphold, and there are times when the focus of a particular physician does not call for it: 1) certain specialists, such as a pathologist or surgeon, spend much less time, and some might have little to no time, interacting with patients; 2) the ability to take the *time* to engage in a meaningful dialogue, in which a patient is able to tell his or her story, is not always realistic, especially in a busy clinic or fast-paced hospital; and 3) the current climate of health care, with increased scrutiny and tedious

paperwork from insurance companies as well as other costs, etc, makes it especially difficult to remain dedicated to the *care of the patient* (Barondess 7). Having acknowledged these challenges, the physician *still* must be dedicated to the ultimate goal of medicine—the restoration of health and the alleviation of suffering—even if that requires extra work in today’s climate.

Some are critical of the role of the physician to help the patient restore his or her relationship to the world through such a dialogical interaction (as called for by Svenaeus). In his lecture on the treatment of suffering in medicine, for example, Dr. Hillel Braude, physician and professor of clinical ethics, cites psychologist and philosopher Karl Jaspers’ criticism of the role of the physician to treat meaning (“Affecting the body and transforming desire”). However, as Dr. Charon says, her role as a physician is one of both expert and companion: “What medicine is for is to donate expertise...to give someone company, and to form staunch, sturdy affiliations...so no one has to be in the glare of sickness, of death, alone” (“Honoring the stories of illness”).

This partnership is also one in which the physician helps the patient not only to recognize the elements of his or her illness and/or suffering, but also to *adapt* to his or her prevailing condition, to work *with* the physician (or other medical practitioner) to once again find a state of health. A 2009 editorial in *The Lancet* references Georges Canguilhem (1904-1995), French philosopher and physician, who believed that health is defined by the person and not the doctor,

according to his or her needs: “The role of the doctor is to help the individual adapt to their unique prevailing conditions. This should be the meaning of ‘personalized medicine’” (“What is health?”).

### **Agency of the patient**

As discussed, illness interrupts a person’s usual relationship with the world—our familiar “being-in-the-world” is thrown askew by the disruptive nature of pain or disease (Aho and Aho; Leder; Toombs). At times, the illness or pain can be all-encompassing, where the world is so blocked out, the awareness so restricted to the ailing body, that the sufferer cannot *see* or even think about anything but the thralls of his or her condition. But even for a person in this state, this illness-entrapment, there most likely will be a moment, however brief or fleeting, when he or she pauses or reflects upon his or her condition. It most likely is not a profound “Aha!” moment (though it certainly could be); it may simply be a thought of sadness or of longing to be rid of *this illness*, to return once more to a state of health, not only to be able to do the activities that have been suspended but also to address facets of his or her life that had been previously neglected...perhaps this illness has awoken the person to the brevity of life. It is precisely in this simple and brief moment that that person, longing for a state of health, becomes *aware* of his or her life in a way that he or she most likely was *not aware* of before. As with death, illness heightens our sensibility of the things in our lives that matter most to us—it opens up a space or

separation, even if momentarily, where the once invisible, or hidden from view, becomes visible to us (Leder; Foucault).

Illness makes us conscious of that which was unconscious to us our whole lives—our self in relationship to the world. This aspect of illness, its disruption and separation and the longing for health that follows, places a demand on the person to respond: answer to these changes (*adapt*, as Canguilhem says) or remain in this state of suffering. Canguilhem’s definition of health, “as the ability to adapt to one’s environment,” puts the onus not on the physician but on the patient to conduct a response to his or her illness (or pain, etc): “It puts the individual patient, not the doctor, in a position of self-determining authority to define his or her health needs. The doctor becomes a partner in delivering those needs” (“What is health?”).

In addition to this, we can also consider that implicit in the nature of suffering is the reality that we can never fully understand another’s suffering. Suffering is ultimately a personal affliction, i.e. those things that threaten one person’s sense of intactness differ in someone else, and to truly know another’s suffering we would need to truly *know* that person:

To know in what way others are suffering demands an exhaustive understanding of what makes them the individuals they are—when they feel themselves whole, threatened, or disintegrated as well as their view of the future, the past, others, the environment, and their aims and purposes. Given its almost infinite complexity, this may appear impossible; after all, we usually do not even know these things about ourselves. (Cassell 198)

This task, though perhaps inherently incomplete (that is, that suffering can not be wholly eliminated), need not be rendered impossible. It requires, as we have seen, not just the action or the direction of the physician (and the passive submission of the patient), but also (and no less importantly) the *active* participation of the patient. In order to address a person's suffering, that person must be able to acknowledge what it is that is causing the distress or uncontrollable fear that is so threatening—simultaneously recognizing that which is meaningful in that person's life (Cassell).

It is important to note also, though, that many people are of course limited by a number of different factors in their abilities not only to cogently and effectively express their experiences to a physician but also to gain access to healthcare *at all*: mental disability, history of abuse, language barriers, socioeconomic status, lack of education, geography, and so on. Even in the seemingly most unfair or uncontrollable situations, however, a person (a patient, a sick person, a dying person) *still* has some degree of agency, however tiny and undetectable, to *choose* how to respond or to adapt to his or her prevailing condition.

### **Our expectations**

Understanding the complexity and many sources of suffering, then, we must remember, as Svenaeus points out, that medicine can deal with suffering and the perceived threats to a person's integrity only so far as they are related to illnesses of these people—"Happiness and

integrity in general cannot be the goals of medicine, since this would expand the activities of the clinic in an absurd and even threatening way” (121). We often *expect* that the happiness and freedom from pain take care of themselves when we visit a physician or seek medical intervention. This is hardly ever the case. One source of the suffering might be eliminated, and we might feel considerably happier, e.g. back pain that was the root of one man’s anguish for years is gone after surgery or a series of steroid injections. (And perhaps having these basic expectations of happiness and comfort as the *normal* state, and our sometimes-entitled sense to have this normality restored, is a problem that needs addressing in its own right.)

But in the sense that we *expect* there to be a medical solution to every discomfort we might feel throughout our lives, we risk two things: 1) that by continuously medicating ourselves, by perpetually *numbing* or seeking to numb ourselves from every natural pain of life, we risk not allowing ourselves those moments of pause or separation from our lives that often can only be experienced *through* illness and pain (not to say the latter experiences are *good*, but rather that without some sort of struggle or reflection or search for meaning, we *do* reduce ourselves to little more than our biology). And 2) we risk conditioning ourselves with the expectation that there is or will be a cure for everything. Maybe it will be possible to cure most, if not all, diseases sometime in the future—the advancements made in medical science in the past decade alone suggest that this can be achieved. But, again, this sets up an expectant mindset that

we can “cure” everything—the “quick fix” mindset, which threatens to prevent us from developing, ironically, our *humanness*.

To a degree, however, some of these expectations must face the realities that the very same science is showing us: “given that we now know the important influence of the human genome in disease, even the most optimistic health advocate surely has to accept the impossibility of risk-free wellbeing” (“What is health?”). Additionally, because we can now better see how central the *person* is to medicine, and how *uncertainty* inherently accompanies “person,” we must reincorporate and become more comfortable with the concept of uncertainty: “A medicine focused on the sick or well person is a medicine that would once again be plagued by an irreducible element of uncertainty that cannot be dismissed, and for which there is no technical fix” (Cassell xiii).

### **Uncertainty and the nature of science**

The greatest scientific minds have acknowledged that we can never be fully certain about anything—or rather, that there is always the possibility that a theory is wrong, e.g. it only takes one black swan to dismantle the premise that all swans are white (Karl Popper). The field of quantum physics tells us that, on a fundamental level, nothing is known with absolute certainty, e.g. the Heisenberg uncertainty principle states that the more precisely the position of some particle is determined, the less precisely its momentum can be known, and vice versa. Some

things can be known with *more* certainty than others, and it becomes a matter of determining what these things are. But in the clinic, laboratory, or operating room, uncertainty is always present. A scientist or a surgeon knows that anything they do or think they know can be easily disproved, or rather that something else can be found to be *more true*. A surgeon well attuned to his craft will articulate the risks and limitations of a particular surgery to a particular patient (e.g. a woman who is 87 will not have the same chances of recovery as a woman of 63 from the same hip replacement surgery).

Although questioning and uncertainty have been foundational for the progress of science, the great successes, the number of things science or medicine *has* been fairly certain about—and that are currently accepted as “fact”—tend to outweigh or outlast the thousands of other things science thought certain that were proved otherwise or claimed right and proved wrong. Thus the role of uncertainty in science is not well translated to those outside of science. The “combination of ambiguity and authority (is) implicit in science;” the issue has been, however, in conveying this to the public, in making it *okay* that something is not known (Mnookin 159).

The constant verifying of facts, the act striving to know something with as much certainty as possible, the over-glorification of objectivity—these aspects of science are what have dominated and “helped perpetuate impersonality in medicine” (Cassell xiii). The uncertainty implicit in the nature and process of science, on the other hand, has not translated in this same

way. And this assumption of certainty has contributed both to the expectations of people demanding help in their state of suffering (or simply discomfort or illness or pain) and the desperation of people looking for answers without really grasping the problem.

## **Conclusion**

In attempts to maintain and preserve ourselves, we have undoubtedly contributed to the *dismantling* and *deconstruction* of that vital center we thought we were protecting: our *humanness*. While many physicians are aware of the need to be more compassionate, empathetic, and engaged with their patients, many lack the necessary “language for articulating this knowledge in a systematical way” (Svenaeus 5). Phenomenologists have, for some time now, been developing a vocabulary that would be useful to physicians to improve these relationships.

One step towards a solution to this problem of the “biologizing” of the sick person and the subsequent lack of empathy for that person’s suffering, would be the incorporation of this “language of phenomenology” into medical practice. Kleinman’s problem with phenomenology is its “predilection for an esoteric terminology,” its inability to be understood, not necessarily because of content (*it is* dealing with first-person experience after all) but because of its language. Such inaccessibility has long plagued medicine and other such fields, as Foucault points what out happened with medical knowledge in the 18/19<sup>th</sup> centuries:

Before it became a corpus of knowledge (*un savior*), the clinic was a universal

relationship of mankind with itself: the age of absolute happiness for medicine. And the decline began when writing and secrecy were introduced, that is, the concentration of this knowledge in a privileged group...what was known was no longer communicated to others and put to practical use once it had passed through the esotericism of knowledge. (55)

A number of medical schools *are* developing “courses in patient communication, medical ethics, and medical humanities...(and) departments of medical education are now part of medical faculties that train their members to incorporate these ideals into their courses” (Thomas 10). A shift is slowly being made in medical education to further merge the knowledge of the physiologic body with the lived body—a move that perhaps one day can translate to the wider public, to the people most affected by their fear of death, most absorbed in the task of living, and least aware of their sources of meaning.

While the nineteenth and twentieth centuries saw great advances in medicine by cutting open the body, an act that both revealed and “demonstrated the miraculous complexities of human biology,” Cassell believes that the focus needs to be on the *person* in the century to come: “A central task for the twenty-first century is the discovery of the person—finding the sources of illness within the person, generating methods for the relief of illness from that knowledge and revealing the power within the person as the nineteenth and twentieth centuries have revealed the power of the body” (163).

Although there is room for improvement, science and medicine *do* play a role in the

alleviation of suffering as it relates to illness—the rest, though, is left up to some other discipline and, *ultimately*, to the individual. When a body is sick, a person's relationship to and in the world changes. In this separation or pause that illness creates, there is an opening up of space for a person to better *see* aspects of his or her life, otherwise hidden, as when faced with death.

Indeed, each of us is threatened by death every day, but it is not usually until we are directly confronted by it, through illness or loss, that we feel its true weight and can, in turn, directly confront *it*. It is in this recognition of death, and the comfort and relief that we all, on some level, require, that the physician can then play a role in helping the patient to realize what it is that is causing his or her suffering. And in recognizing *this*, a person subsequently recognizes what it is that he or she finds meaningful—for the suffering reveals the aspects of a person that are held closest, the most fragile.

When we reach the point when all we can realize is that we know so little, becoming fully aware of our “mortal life,” we can in turn find a means to see that to which we are bound and that for which we strive...for if we did not have these limitations, “we would know nothing outside of ourselves, and so also nothing of ourselves” (Holderlin, *Hyperion*).

**Works Cited**

- Aho, James and Kevin Aho. *Body Matters*. Lanham: Lexington Books, 2008.
- Barondess, Jeremiah. "The care of the patient." *The Pharos*. 74.3 (2011): 7-10.
- Braude, Hille. "Affecting the body and transforming desire: the treatment of suffering as the end of medicine." Pain and Suffering Project Workshop. 2009.
- Cassell, Eric J. *The Nature of Suffering and the Goals of Medicine*. 2<sup>nd</sup> ed. New York: Oxford University Press, 2004.
- Cassell, Eric J. and Ben A. Rich. "Intractable End-of-Life Suffering and the Ethics of Palliative Sedation." *Pain Medicine*. 11.3 (2010): 435-438.
- Charon, Rita. "Honoring the stories of illness." TEDxAtlanta. 2011.
- Duffy, Thomas P. "The Flexner Report—100 Years Later." *Yale J Biol Med*. 84.3 (Sept. 2011): 269–276.
- Foucault, Michel. *The Birth of the Clinic*. Trans. A.M. Sheridan Smith. New York: Vintage-Random House, 1994.
- Hippocrates. *Volume IV: Heracleitus On The Universe*. Trans. W.H.S. Jones. London: Loeb, 1931.
- Holderlin, Friedrich. *Hyperion*. The Metric Version. Cited in: Schmidt, Dennis J. *On Germans and Other Greeks: Tragedy and Ethical Life*. Bloomington, IN: Indiana University Press, 2001.
- Kleinman, Arthur. *Writing at the Margin*. Berkeley: University of California Press, 1995.
- Leder, Drew. *The Absent Body*. Chicago: University of Chicago Press, 1990.
- Lewis, C.S. *The Problem of Pain*. New York: HarperCollins, 1940.

Mnookin, Seth. *The Panic Virus*. New York: Simon and Schuster, 2011.

Peabody, Francis. "The Care of the Patient." *JAMA*. Vol. 88 (1927): 877-882.

Purves, Dale et al. *Neuroscience*. Ed. Dale Purves. 5<sup>th</sup> ed. Sinauer Assoc., 2012.

Richards, I.A. *Practical Criticism*. New York: Harcourt Brace & Co, 1929.

Rose, Nikolas. *The Politics of Life Itself*. Princeton: Princeton UP, 2007.

Russon, John. *Human Experience: Philosophy, Neurosis, and the Elements of Everyday Life*. Albany: State University of New York Press, 2003.

Russon, John. "On Human Identity: The Intersubjective Path from Body to Mind." *Dialogue*. XLV (2006): 307-314.

Schmidt, Dennis J. *On Germans and Other Greeks: Tragedy and Ethical Life*. Bloomington, IN: Indiana University Press, 2001.

Svenaesus, Fredrik. *The Hermeneutics of Medicine and the Phenomenology of Health*. Dordrecht, the Netherlands: Kluwer, 2000.

*The Finish Line*. Dir. Ezra Holland. Hock Films, 2014.

Toombs, S. Kay, ed. *Handbook of Phenomenology and Medicine*. Dordrecht, the Netherlands: Kluwer, 2001.

"What is health? The ability to adapt." *The Lancet*. 373.9666 (2009): 781.

Whitman, Walt. "Song of myself." *Leaves of Grass*. New York: Penguin, 2013.