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THE SUBJECTIVE IN CLINICAL JUDGMENT*

INTRODUCTION

Someone telephones the doctor that he has had increasing dull pain in the right side of his abdomen and back for several hours. While not exactly nauseated, he is repelled by the thought of food. He thinks the pain is the same as that of his wife when she had her gallbladder attack. The patient's complaint is clearly subjective and of the type that most often initiates the medical act. Yet, in its subjectivity, the report lies in a domain of medical practice that is least understood, or more precisely that is least systematized. The deficiencies of medical practice in regard to the subjective are highlighted by the increasing use of the problem-oriented medical record as a tool of medical education. In *Medical Records, Medical Education, and Patient Care; The Problem-Oriented Record as a Basic Tool*, Lawrence Weed [4] points out the equal importance of patients' subjective experience with objective, measurable facts of medicine. Further, Dr. Weed gives excellent examples of the kind of profiles of patients' personal and social lives that should be included in any complete medical record.

It has been my experience, however, that the problem-oriented medical record *as actually used* by the medical students and house officers at the New York Hospital (many of whom trained at other schools) is a sterile instrument that rarely meets the goals set for it precisely because it is deficient in its recording of the subjective. It has also been my experience that many younger (and too many older) physicians distrust the patient's report of his own symptoms and experience.

One more comment seems necessary to document the problem of the subjective in medical practice. The social medicine movement of earlier decades succeeded in establishing the importance of the patient's social and personal history as part of any complete medical record. And yet, a generation later that aspect of a patient's history is usually confined to personal habits (tobacco, alcohol, etc.), job history and some marital and family facts. The movement was successful in getting some aspects of the patient as subject into his own care but in a fashion often uselessly sparse because only the objective facts of the patient's existence are recorded.

H. T. Engelhardt, Jr., S. F. Spicker and B. Towers (eds.), Clinical Judgment: A Critical Appraisal, 199–215.

THE SUBJECTIVE IN MEDICINE[1]

I believe the subjective involves four aspects: the sociologic person, the unconscious, experiencer, and assigner of understandings. The sociologic person includes the patient's past and present cultural set, his roles (attorney, mechanic, father, son, etc.), the unfolding story of his life and his important others. The subjective also includes the unconscious self, generally considered to be conflicts, repressed materials, drives and motivations – matters not volitionally available to the conscious mind. Then there are the things experienced by the body or person of the patient. These may be objectively non-confirmable as in the instance of abdominal pain or objectively confirmable as in the instance of fever. In all instances, after the experience has passed it is non-confirmable, although subsequent objective evidence may allow it to be inferred. Lastly the subjective includes the meanings assigned by the patient to the experience and events he reports. This includes feelings evoked, beliefs about the nature of disease or illness as well as its causes, and extends to feelings, perceptions and beliefs about physicians and the world of medicine.

Obviously these four aspects of the subjective in medicine are not truly separate and cannot be made to remain separate except for purposes of explication, as I am doing here, and except for action as when the physician asks questions. Together they are the subject *in* medicine and the subject *of* medicine. They are, in other words, the patient.

Indeed it would be difficult, for example, to distinguish that part of the patient that assigns meanings from, say, the unconscious, or even from the perceiving experiencer. But I hope to show that these domains of the subjective can be kept apart, if only in action, well enough to serve the physician as he makes his diagnosis and treats his patient.

THE SOCIOLOGIC PERSON

Two domains of the subjectivity of the patient have received the most attention in medicine: the sociologic person and the unconscious. There is ample evidence that the sociologic person is important in medicine. Diseases as disparate as tuberculosis and coronary heart disease are influenced in their occurrence by the life history of the person who has them. The malnourished black child from a large ghetto family has a much higher probability of acquiring tuberculosis than the white suburban child of a Bell Telephone supervisor, especially if there is an old person with tuberculosis in the crowded ghetto apartment. And the Bell Telephone supervisor has a greater

probability of dying of a myocardial infarction than the unemployed father of the black child, especially if the supervisor smokes cigarettes, is sedentary and has a family history of coronary heart disease. Modern medicine has made much of the contribution of sociological variables to disease production (although even Virchow was politically radicalized by his awareness of the contribution of social factors to typhus prevalence in Silesia). But while probabilities may be crucial to directing the diagnostic thinking of a physician, probabilities are often not as necessary in making a diagnosis as what the sick person *says*. More important, however, is that probabilities are objective parameters of the sociologic person, not subjective. The probabilistic person is seen as propelled towards his expected pattern of disease by facts of his existence which he (usually) did not create and over which he (often) has no control. In other words it is not that the sociologic person cannot be construed as a part of the subjective domain of medicine – part of the domain of the consciousness of the patient, but rather that its current use by medicine is primarily in the objective domain: measurable or at least objectively confirmable personal facts linked to confirmable facts about the lungs or the coronary arteries. Even Weed's use of the subjective in the profiles of patient examples is aimed towards useful objective information. This kind of information might help in the interpretation of other diagnostic information (in the sense that "divorced women with young children are often . . ." and so on). But such data, while undoubtedly helpful and even often vital in clinical decision making, are part of the subjective of the physician more than of the patient. Sociologic parameters do not tell us about *this* divorced woman, but rather about the class of divorced women. In a sense the use of these facts to speak for the person so much occupies the physician's head (not to say his or her preconceptions) that they prevent the physician from hearing what *this* divorced woman has to say.

THE UNCONSCIOUS

The other aspect of the subjective that has received widespread attention in medical practice is the unconscious. It is fair to say that one of Freud's major contributions to medical practice was to put the person as subject back into medicine. It is not necessary to detail the evidence to support the belief that there are unconscious determinants of symptoms and disease. The widespread acceptance of psychosomatic medicine is an acceptance of the influence of the mind on the body. Oddly, it is conceived of as the influence of the *unconscious* mind on the body: a mind not available to the volition of the

person and almost always conceived of as causing illness or symptoms. It is somewhat interesting, if only historically, that this view maintains the Cartesian duality but gives the (separate) mind some control over the body. This view of the duality is not nearly as meaningful or useful as the view of mind and body as a polar duality discussed by Guttentag [1]. Much as North and South cannot exist without each other and mutually influence each other, so also do mind and body. Of more immediate importance to our discussion is that the way the unconscious domain of the subjective is most often used in medical practice excludes the subject. That is to say, the patient is seen as not knowing what his unconscious contains or is doing. It is not under the patient's control and even the patient's words are an untrustworthy guide to its contents and its actions. We, the physicians, take it that we know better than the patient what are the unconscious determinants of his symptoms or his disease. While that may well be the case, it is an uncharitable view of the patient since that view bypasses the consciousness of the patient just as effectively as does the dominant view of the sociological person.

To view the unconscious as solely an inaccessible domain with only negative effects on the body is also, I believe, an uncharitable view of the unconscious. This is not the place (nor am I the person) to attempt a summary of the various views of unconscious process. Nonetheless, it seems important to point out that any such summary would have to include the understanding that the patient's unconscious is part of his subjective aspect that is able to communicate to another person. And, the unconscious and its communication are legitimate expressions of that person. Unconscious communications are not merely unsuspected leaks of inadequately repressed material but purposeful expressions. As the unconscious can speak, it can also be spoken to [2]. Finally, and of more direct importance to medicine, the unconscious appears able to communicate with the body. These phenomena which can be glimpsed in biofeedback techniques, hypnosis and certain yoga feats suggest a relationship of the subjective person to the body that is at present minimally understood.

Thus, just as the sociologic person is often used and viewed in medicine as an objective thing apart from the consciousness of the patients, so too is the unconscious used and viewed. For both sociologic person and unconscious, such understandings tend to diminish the potential importance to medicine of those aspects as factors of subjectivity.