Preface

THE TEST OF a system of medicine should be its adequacy in the face of suffering; this book starts from the premise that modern medicine fails that test. In fact, the central assumptions on which twentieth-century medicine is founded provide no basis for an understanding of suffering. For pain, difficulty in breathing, or other afflictions of the body, superbly yes; for suffering, no. Suffering must inevitably involve the person—bodies do not suffer, persons suffer. You may read this as merely another way of saying that modern medicine is too devoted to its science and technology and has lost touch with the personal side of sickness. The argument of this book is that such criticism, as correct as it may seem, does not get at the root of the difficulty and is consequently inadequate.

The difficulty is not with medical science or technology *per se*. No solutions to important problems can be based on a return to innocence, even if that were possible. Neither do the troubles arise because the wrong students are chosen—for decades medicine has had the best and the brightest the country has to offer. Nor is it money, power, or status. The problems were present when there was plenty of all three and they are there now when all are diminished. Finally, I believe the high cost of medical care and the malpractice crisis are more likely derivative than causative.

For more than two generations remedies for medicine's dehumanization and impersonality have been a failure. Great teachers have tried, wonderful books have been written, innovative medical school courses and curricula have been established, and even new medical schools have been founded on ideas believed to offer solutions. For the most part, all these attempts, large and small, have been disappointments. Over these decades there have been many great teachers, more wonderful physicians, and nothing less than superb medical care to be found. But these islands of excellence remain just that, islands separated from the mainland.

The problem does not lie with the general diagnosis of medicine's ill. The widespread perception, growing since the 1920s, is correct that what is lacking in twentieth-century medicine is an adequate consideration of the place of the person of the patient. The common belief that medicine is mired in this fault, however, is in error. In fact, as I will discuss in detail throughout there *is* change taking place. The sick person has been coming to the fore as the focus of medical care and the disease is gradually taking second place. Why is this not better known, and why is it taking so long to become medicine's dominant idea? As with the beginnings of all elemental social change, dissatisfaction with the existing order is more evident than willingness to accept new ideas and give up old ways of doing things. The solid intellectual foundation has not yet been constructed, the ideas on which the change is based have only been articulated by a minority, and the lessons that must be learned before the transformation is routinized have not yet been taught.

How is medicine to deal with suffering that arises in the person of the sick when even the word person is problematic. Despite all these decades of concern, there is little agreement about exactly what defines a person (except that each of us knows we are persons). Further, doctors do things. If they are to act specifically on the sick *person*, then they must know what that means, what they are to do, and how and what measures there are of the consequences of their actions. And they must acquire this knowledge in a systematic way, which means that it must be taught. Without system and training, being responsive in the face of suffering remains the attribute of individual physicians who have come to this mastery alone or gained it from a few inspirational teachers—which is where we are today.

To say that the focus of medical care is the sick person (rather than the disease) is a statement of a theory of medicine—a *different* theory from when the disease is the primary concern of doctors. New theories do not arise from the genie's lamp; they have an historical genesis. In addition, theories, new and old, have not only antecedents, but consequences. For example, if the focus is on the *sick* person, what made the person sick? If the disease made the person sick, are we not back where we started? Because of these questions the journey through this book starts not with a discussion of the nature of suffering, but with the history of theories of medicine. The task of Chapter 1 is to demonstrate how important theory is to medicine (indeed, to all endeavors) and to show how the weaknesses of the theory that is being superseded—disease theory (when people are sick, it is because they have diseases)—have contributed to its obsolescence. Medicine is so bound up with society that it probably will not be a surprise to see that current concerns about the environment arising as part of the ecology movement are intellectual trends related to the changes in the focus of medicine. Similarly, the increasing importance of ethics in medicine reflects changing cultural conceptions of the nature of persons.

The hallmark of modern medicine is its dependence on science and technology, and understanding the relationship of the two is fundamental to understanding medicine's problem with suffering. Whenever I use the word science

I am referring to its more restricted, modern usage as a branch of study that relates to the phenomena of the material universe and their laws. In this usage medical science is concerned with the phenomena and laws of normal and abnormal human biology. I do *not* use it in its older, more colloquial meaning of a particular branch of study, a trained skill, or reliable knowledge. I must make it clear at this point, as I noted above and will restate throughout, that nothing I say should be seen as anti-science or against technology. They are not, in themselves, the basic problem and there is no going back, thank heavens. It is inevitable, however, that difficulties raised by science and technology will become predicaments for medicine. One of the reasons for this is that medicine is practiced by doctors and what creates dilemmas for doctors as they attempt to care for the sick creates quandaries for medicine. Theories of medicine are exemplified in the actions of doctors. (In this book the words doctor and physician are employed interchangeably.) In fact, as Chapter 2 discusses, what any era considers the ideal physician reflects an amalgam of the demands made by the reigning theory of medicine, the social forces acting specifically on doctors and sick persons, and the general social attitudes toward persons and their relations with each other. Since all of these have been changing during this century, and more rapidly since World War II, it is not surprising that the concept of the ideal physician has also been transformed. The failure of medicine to meet the test put by suffering, which is really the failure of physicians to deal adequately with the suffering of their patients, only comes to be considered a failure because of personal and social expectations that are only recently emerging.

The nature of suffering is the topic of Chapters 3 and 4 and you might wish to start the book with them.

Doctors do not deal with suffering in the abstract—they treat persons who are afflicted by something that leads to the suffering. The separation of the disease that underlies the suffering from both the person and the suffering itself, as though the scientific entity of disease is more real and more important than the person and the suffering, is one of the strange intellectual paradoxes of our times. In Chapters 3 and 4 we begin to illuminate not only what suffering is, but, because the two are inseparable, what a person is. And what it is about being a person alone and among others in a culture that leads to suffering. These chapters should also make clear that the reduction of sick persons to their physical, psychological, or social dimensions is both artificial and leads away from the relief of their suffering. We are of a piece; virtually nothing happens to one part that does not affect the others.

In addition to the intellectual and social bases of medicine and their exemplification in physicians, there is a third dimension without which any understanding of medicine and its approach to suffering will be incomplete—the relationship between patient and doctor. This mysterious relationship through which *all* medical care flows of *any* type and in *any* setting (even when there seems to be none) is the subject of Chapter 5. The relationship is mysterious if only because it is the foundation of the phenomenon of healing, itself obscure. It seems mysterious also because it points to aspects of the connections between

individuals which in a rational, essentially non-spiritual culture like ours are little known and less understood. An appreciation of these connections and their disruption is required for a comprehension of suffering itself. Our expectations of physicians, sadness when they fail us, and their moral demands on themselves also arise from the nature of the doctor–patient relationship.

Because consideration of medicine, sickness, or suffering is impossible without manifest or latent notions of disease, Chapter 6 examines what it means to say that someone has a disease. Using cancer of the breast, pneumonia, and coronary heart disease as examples, it becomes apparent that while many think of diseases in their classic form, recent decades have seen profound changes in this concept.

Throughout the remainder of the book, the idea of person is heightened. Ensuing chapters discuss the work of doctors in their four fundamental tasks: finding out what is the matter (diagnosis), finding how it happened (cause), deciding what to do (treatment) and its interdependent partner, predicting the outcome (prognosis). As strange as it may seem, throughout much of the history of medicine, and certainly in the modern era, the idea has taken hold that the disease can be discovered, its cause uncovered, treatment accomplished, and predictions about its outcome made apart from the particular sick *person*. Put another way, many doctors—perhaps most people—still believe that different persons with the same disease will have the same sickness. By the end of Chapter 9 (and probably sooner) the illusion—for it is no less than an illusion—will be permanently dispelled. Once we understand the nature of suffering, we can discuss the changes in medicine necessary for its relief; this is the topic of the last three chapters and the epilogue.

To be successful in treating the sick and alleviating suffering, doctors must know more about the sick person and the illness than just the name of the disease and the science that explains it. What can be known about the sick *person* seems to make up the deficiency. To meet this requirement we want the doctor to know as much about the sick person as about the disease. On the face of it, this seems impossible—the individual is unknowable, an ancient saying goes. While this is true, Chapter 10 shows that the extent that we *do* know each other through shared ideas, beliefs, culture, and language is remarkable. With skill and training even more of the person can be known, particularly when the knowledge is focused on the task of caring for the sick. Prior to the nineteenth century, the body was largely a mystery. In the last century and in ours the wonders of the body have been revealed to the gaze of medicine with results that have reached far beyond medicial science. Just as privacy about the body held back knowledge in the past, reticence about revealing ourselves presently retards learning about persons. Nonetheless our era has seen the beginnings. The job of the twenty-first century is the discovery of the person—finding the sources of illness and suffering within the person, and with that knowledge developing methods for their relief, while at the same time revealing the power within the person as the nineteenth and twentieth centuries have revealed the power of the body.

The dominance and success of science in our time has led to the widely

held and crippling prejudice that no knowledge is *real* unless it is scientific—objective and measurable. From this perspective suffering and its dominion in the sick person are themselves unreal. This is simply an unacceptable conclusion. Chapter 11 examines the kinds of information necessary to know about persons. Our perceptions of other persons are not based on elemental facts alone but also on values and aesthetic criteria. The way we think in terms of values is explored to show that along with brute facts, values are not mere prejudices but a kind of information that can be consistently and reliably employed in our knowledge of persons. Were it not so there would be no stability in our personal or social lives. Aesthetic criteria, which at first might seem foreign to medicine, are also essential for knowing whole persons within space and across time. Values and aesthetics raise the specter of subjectivity, so worrisome to medicine and medical science. In response to that problem we see further how the person of the doctor, first discussed in the relationship with the patient and interspersed in succeeding chapters, enters into the equation of medical care.

Since antiquity there has been a prejudice in favor of reason and against experiential knowledge. The long-standing dichotomy of medicine into its science and art is a medical expression of this bias. Knowledge, however, whether of medical science or the art of medicine, does not take care of sick persons or relieve their suffering; clinicians do in whom these kinds of knowledge are integrated. Chapter 12 deals with the nature of experience in general and the clinician's experience specifically. At first it appears that the problem to be solved is the relationship of knowledge to experience. In practice the more central issue turns out to be the relationship of the subject to experience. The patient and the illness are not merely experienced, they are experienced by this particular physician. The problem is that experiential knowledge is tinged with emotion and passion—it cannot be otherwise. Centuries of trying to disengage the person from knowledge born of experience through science or other means have not been successful. The solution to the problem lies in remembering that only another person can empathetically experience the experience of a person. In medicine the triad is inseparable—patient, experience, physician. It must finally be accepted that there can be no substitute for the physician as a person. The moral compulsion of their responsibilities exposes physicians to the peril of unavoidable uncertainty and overwhelming subjectivity created by serious illness and suffering. It can only be through education and method that these dangers are converted into therapeutic power. It follows that medicine needs a systematic and disciplined approach to the knowledge that arises from the clinician's experience rather than artificial divisions of medical knowledge into science and art.

The timeless goal of the relief of suffering remains the challenge to change and the enduring test of medicine's success.

New York E.J.C.
October 1990