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The Project of the Physician: An Inquiry into the Nature of Medicine

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Introduction

In philosophy, there are generally two ways in which a project can seem ridiculous at its outset. There are certain philosophical inquiries that initially seem laughable in the *complexity* of their telos – Hegel's *Phenomenology of Geist*, towards 'Absolute Knowing,' serves as a good example. But on the other hand, there are also philosophical inquiries that initially seem laughable in the *simplicity* of their telos – texts that seek to define a concept that seems so near to us, so seemingly obvious, that any inquiry whatsoever into that concept's nature seems gratuitous. The initial inquiries into the nature of language, for instance, must have appeared to be ludicrous at first – language is one of those things that most people assume to just *know*.

This project is one of the latter types of inquiries – it seeks to ask a question that very few people ever think to ask: what, exactly, is a doctor? Even within the field of the philosophy of medicine, this question is almost never raised – thinkers are too tied up with ethical dilemmas and questions about the nature of scientific evidence to ask the glaring question at hand. I haven't been able to find a reason *why* this question is never addressed. It certainly seems to me like an extraordinarily important issue – and hopefully, at the end of this discussion, the reader will agree. It seems that the physician, or anyone at that, must fully understand his project in order to carry it out effectively.

Hence, the telos of this project is twofold – in Part I, I will attempt to solidify the goal of the physician in medical practice, and in Part II, I will examine the specific ways by which the doctor can actualize that goal. In other words, the central questions are: 1) What is the goal of the physician? and 2) How is the physician to accomplish or

actualize that goal? At first glance, the project seems incredibly simple – the doctor is supposed to make you healthy, and he is to accomplish this through medicine. It seems that all people have an inherent understanding of health – that health should be a simple concept that we just know. However, this is certainly not the case.

But rather than try to complicate the seemingly simple nature of the discussion before it starts, the movement of this project seeks to embrace it. That is, the organization of the paper is based around deep explorations of the natural assumptions about medicine. Hence, the discussion of health will be used as a jumping-off point, as it were, for the examination of the goal of the physician in medicine – health is what the physician *seems* to strive towards. In Section 1, five different preexisting notions of health will be explored, in order to orient us in our project. In Section 2, the underlying philosophical issues of Section 1 will be explicated, bringing us to a fuller, more theoretically grounded notion of what the physician is, or should be, striving towards in the practice of medicine.

Once we have a firm grasp on the goal of the physician, we will move into the second part of the project, exploring how the physician is supposed to move towards this newly-understood goal. The obvious movement here is to suggest that the doctor will achieve his goal through medicine. Again, we will allow what seems apparent and natural to guide our discussion. Section 3, then, will examine the two most common medical paradigms in an attempt to explore how systematized medicine can serve as a way for the physician to accomplish his goal. And finally, Section 4 will attempt to elaborate upon, or specify, the way the doctor is to accomplish his goal by examining the specific clinical interaction. At the conclusion of these four sections, the hope is that a clear notion of the physician's project – both what it is and how it is to be

accomplished – will be derived.

I also want to note that it was originally my intention to clearly explain the importance of this analysis of medicine, but I believe it will hold more weight to the reader if he or she comes to see this importance for his or her self, by means of the movement through the sections. I *will* note, however, that it is a secondary goal of this project to illuminate how incredibly important it is to examine medicine philosophically. I will not say more, and I will not give a blatant reason as to why, but I do want the reader to be aware of this as he or she moves through each section.

Part I: Establishing the Goal of the Physician

Section 1: The Common Notions of Health

Although it seems natural to assume that establishing health in the patient is the ultimate goal of the physician, a complete idea of health is not so easily defined. Without an in-depth analysis, it seems that health is a simple concept that is easily understood in a descriptive way. Because so many specific maladies of the human body are named, isolated, and spoken about so plainly and clearly in the context of health, most people in contemporary American society have become accustomed to defining health *against* a malady or negative bodily condition. That is, because it has become the norm in our culture to seek medical counsel only (for the most part) in the event that we have a specific plight or complaint, we have come to understand the concepts of health and disease in an antonymous way. For most Americans, health is the opposite of, or more specifically the *absence* of, disease - health is generally viewed as our baseline state of being, and disease is understood as a specific imposition upon that state. Even the Webster definition supports this assertion - with regard to the human body, health is simply defined as 'the condition of being well or free from disease.'

But when the question of the notion of health is addressed more directly and explicitly, it becomes exceedingly complicated. Health reveals itself as a concept that is open for very extensive debate, giving rise to a plentitude of analyses and assertions about a correct understanding. The latter quarter of the twentieth century has given rise to an extremely intense discussion regarding the nature of health and its meaning amongst philosophers and medical professionals alike, resulting in a compilation of

several very specific definitions. Although the scope of this project will not allow me to address all of these specific claims, I do hope to arrive at a definition of health that is useful for the sake of examining the interaction between the physician and patient. What we hope to do here is establish a practical basis for the understanding of the telos of medical practice, upon which we can build the rest of the discussion.

This does not mean that a specific definition needs to be realized, but rather, that the practical implications of health, in terms of medicine, need to be explored. It is because of this that I choose to organize the discussion according to what I perceive to be five definitions of health that are linguistically non-philosophical - 'layman's' definitions of health, so to speak. They will however, move from one end of the philosophical spectrum to the other, for the most part - from the philosophically descriptivist, almost entirely biomedical understanding of health on one hand to the very philosophically normative, highly holistic understanding of health on the other end - but this simple terminology will hopefully keep the definitions grounded in the practical reality that relates to my overall project. The five definitions are:

1. Health is the lack of disease or sickness.
2. Health is the state of being within biostatistical norms.
3. Health is the state in which an organism is able to properly function.
3. Health is a state in which one is able to properly function in the world.
4. Health is a state in which one is able to achieve vital goals in their life.

Once the preexisting theories have been explored, I will attempt to establish my own concept of health that will be the most useful for the sake of the doctor/patient

relationship. It may be noted here that it is possible to discuss the concept of health in many different contexts, and theories of health are often postulated for many different reasons. Some of the theories that I will discuss are exploring health as a project in ontology, searching only for a theoretical notion of a concept, while others attempt to draw distinctions and lines of demarcation for the sake of practical implications in fields such as medical insurance or law. I therefore find it necessary to stress the point that this exploration of the concept of health, as well as the entire first part of this project, will move forward in the context of the pure interaction between doctor and patient. I am searching for a notion of health that will serve as a desired teleological outcome in the project of the physician - not as a legal stipulation or a purely theoretical notion.

Health as the lack of disease

The question of the nature of health almost always accompanies an inquiry into the nature of disease. As discussed previously, it has become a subconscious assumption, at least in our own culture, that health and disease are inherently related. And even in philosophical writing, there is almost never a discussion of health without a discussion of disease - we have come to use the terms 'sick' (or 'ill') and 'healthy' as the two opposite poles of our state of being. And because the term 'disease' is the most common term for the cause of a 'sick' or 'ill' state, the concept of the disease has become the evil entity that opposes and impedes upon our normal state – one of health.

Even in contemporary medical education, the concept of diagnosis is central to an understanding of proper practice - a doctor is not trained to look for health. Rather,

they are trained to isolate and identify different diseases (Scadding). Because there can be so many different kinds of disease - so many maladies with clear, objective, easily stated criteria - it is very easy to define the concept of disease simply as a set, or group, of all of these specific instances of disease. That is, the whole concept of disease itself is easily defined as a summation of all the individual diseases. Disease becomes tangible and isolatable - one can easily point to a thing and label it as 'disease' - while health remains entirely abstract. There are no named, isolatable 'instances' of health. This conceptualization of medicine as diagnosing malady tends to lead patients and doctors alike to the natural assumption that disease is a deviation from the normal state, leaving health simply as a lack.

Furthermore, some thinkers have come to conceptualize disease as prior, in some way, to health. The 'reverse theory of health,' described by K. W. M. Fulford, is based upon the notion that disease must be given an epistemic priority over health in our natural experience of the world. The argument is fairly simple - because we don't actively experience health until we experience disease, it is really disease that gives rise to health (experientially), and not vice versa. That is, if a person were healthy for all of their life, they would never recognize the notion of health. Interestingly, disease would then not be considered a deviation from health, but rather, an experience in and of itself. It would only be once that disease passed that the person would experience health, rendering disease the truly powerful and unavoidable state of our being (Fulford). With this reading, it would no longer be useful or desirable to discuss health without disease. Rather, it would be *impossible* to discuss health without disease.

So, it seems that from an experiential perspective, it is clear that one should consider health to be the opposite of disease. It is true that from an epistemic

perspective, we only actively experience health in relation to some other state, which is most commonly one of disease. Growing up, many of us think of health as the end goal of 'getting better' after a malady - it is experienced as a state of recovery. But I think this assertion of disease's priority is quickly eliminated when one looks at the reality of every day life. If we are speaking experientially, how could one make the argument that one does not *feel* better or worse on one day than they did on another? Even without the presence of disease, the way in which we experience the world, and experience the body, is constantly in flux. It is not necessary for a biomedically recognized malady to be introduced to our bodies in order for us to recognize positivity in our state of being. (This will be greatly elaborated upon in the following chapter.)

But regardless of the question of epistemic priority, the entire notion that recovering from disease leads to health – or even the idea that acquiring a disease leads to a lack of health – is created largely by our understanding of reason. Sadegh-Zadeh points out a clear fact about our perception of health and disease - our natural reasoning is entirely Aristotelian when it comes to the distinction between the two. This leads us to assume a few things about the two concepts. We assume that a person is either healthy or not healthy, but not at the same time, and we assume that an individual is ill[1] or not ill, but not both at the same time. And as described above, our epistemic experience of the world has led us to believe that these two concepts are in strict opposition to one another. We have therefore come to understand each concept as the lack of the other – 'not ill' is synonymous with 'healthy' and 'not healthy' is

[1] 'Ill' here refers to a state of disease - the distinction between illness and disease is a question of medical demarcation and is really unnecessary for this discussion - when I refer to disease or illness, I refer to an isolatable, named malady that a doctor would diagnose.

synonymous with 'ill.'

It seems that this is an intuitive reality - that it is an unavoidable truth that an unhealthy person is not a healthy person, and because of our perceived definition of the way the two concepts work, that the person must be ill. But in examining the diagnostic process, we see that this view might be problematic. When the doctor is examining the patient, he or she, as Scadding points out, is *searching* for malfunctioning of some kind. If this malfunctioning is discovered and the cause is isolated, this experience of causal malfunctioning (the combination of cause and effect) will likely be dubbed a disease (or illness or syndrome) and named - strep throat, for example. I think Scadding makes an unwarranted jump at this point - he would then say that the patient is in a state of disease, and hence is *not* in a state of health. There are two problems with this.

One is highlighted by Sadegh-Zadeh - the fact that a person is ill does not necessarily mean that they are not also healthy. This is an assumption based on our innate understanding of reason in a basic Aristotelian way, and it is very possible that this is a totally flawed assumption. That is, linguistically, and logically, any state cannot both *be* and *not be* at the same time. When we use the phrase "The sky is blue," it naturally seems to follow that we also mean "The sky is not not blue." This is obviously made clear in symbolic logic by the rules of negation – we draw the assumption that there can be blue, and there can be not blue, but not both in the same thing at the same time.

And yet, we see these types of things every day – things that are both blue and not blue. In some of his dialogues, Plato even addresses this issue in the Republic, for instance, during his discussion of Being, he notes that any quality that exists in a thing

also does *not* exist in that thing. He uses the famous example of the beautiful – anything that is beautiful is also in some way *not* beautiful. It is not at all difficult to see how this would apply to health. There are always ways in which we would call ourselves healthy, but could we not, realistically, always find something about our state that is *wrong* in some way? It seems that we can always find something that we would want 'fixed' by the doctor. And yet, we go on considering ourselves healthy. Clearly, we can – and are – always both healthy and not healthy. And as soon as we can isolate that thing that is not 'good' about our state, it becomes a disease, by our previous definition. Hence, it is nearly always the case that health and disease exist in us simultaneously. The simple fact that a person is ill does not mean that they are not healthy. It seems that our experiential way of understanding health and disease does not hold.

The other problem with Scadding's assertion follows from this realization, and pertains to the distinction between 'having a disease' and 'being in a state of disease.' It does not necessarily follow that the whole person has somehow 'lost' their health just because a single system within their body is not functioning properly. Even if health *were* to be understood as the lack of disease, it would not necessarily follow that the person is in an overall state of disease because of a single malfunction.

But despite all that has been said, even if we were to accept the fact that health is the lack of disease, isolating a specific disease is not always as easy as isolating a strand of bacteria. That is, even if health were simply the opposite of disease, how would one universally set the distinction between disease and health? Consider the case of high cholesterol – it is considered to be a disease, but what is it that denotes its presence? There is no pathogen that has invaded the body of the patient; no observable lack of

ability that is clearly causally attributed to the condition. It seems that there are many diseases that are not as easy to isolate and identify as Scadding assumes. This problem, in addition to the previously mentioned issues, suggests that there needs to be more specific criteria that denotes health, and a lack thereof. Through this discussion, it has been realized that the 'everyday,' natural, experiential way of looking at health and disease as opposites leaves us with a very undeveloped notion. If health and disease are to be understood in opposition to one another, there needs to be a clearer, technical way of doing so.

Health as a biostatistical norm

Clearly, the previous discussion gives rise to a very important question regarding health and disease - even if health *were* the absence of disease, what then, exactly, would designate the difference? In this section, we will explore the way in which most scientists answer this question. To clarify, it is not the goal of this section to determine an overall understanding of the concept of a disease. Rather, the point of this section is to rethink the possibility of dividing the two concepts.

In the previous section, it became clear that the concept of disease could simply be understood as the set of all diseases. Furthermore, it was determined that lines of demarcation between biological conditions that are and are not diseases are not so easily drawn. It is the object of this section to further clarify the difference between the two - health and disease - in order to illuminate what exactly the doctor is trying to move towards, and what the doctor is trying to move away from, in terms of the state of his or her patient.

In the previous section, diseases were roughly conceptualized as the named maladies that negatively affect a biological system in a person - essentially, as the isolated examples of perceived ill-health. Obviously, this is inherently problematic for most philosophers of medicine, for a number of reasons. But the primary issue with this understanding lies with the question of inclusion and exclusion in the categories. In conceptualizing health and disease as opposites, which biological conditions qualify as a disease, and which qualify as health? That is, when a physician finds a new condition of the body that has not been observed before clinically, what is it about that condition that leads the scientist to deem it as a disease? Saying that it negatively affects health would obviously be circular for the sake of our argument - so there needs to be something else that qualifies these conditions as 'disease' or 'lack of health' in order to ground and solidify the 'opposite of disease theory' of health, or what we will come to describe as the descriptivist theory.

Christopher Boorse (1977) is the leading thinker in this camp, having published multiple books and articles that have been extremely widely cited by other philosophers of health. His theory is considered the biostatistical theory of health (BST), and from a philosophical perspective, is highly descriptive - his argument rests on the assertion that health is an empirical, objective, value free concept. In short, he draws the distinction between the two objective concepts of health and disease by considering the statistical norms of a reference class. Boorse's concept of health simply refers to normal functioning, while the concept of disease refers to abnormal functioning. Because of this, health becomes completely objective and only discoverable by natural science - any evaluation or judgment by a subjective observer is completely irrelevant.

According to BST, health is a statistically typical contribution of all processes

and components of a person towards the overall goal of the person - survival and reproduction. The term 'statistically typical' refers to the statistical norm *within a reference group*, and is not necessarily representative of the entire population of humans - obviously, the statistical norms of a twenty-year-old male are not the same as those of a ninety-year-old woman. The point of Boorse's theory is that health is a clear-cut notion. It is not tied up with any sort of subjective value, in that its end or goal is determined biologically. Similarly, the concept of disease is simply a biostatistically determined lack of such functioning. It would seem that this notion put forward by Boorse is quite simple and easily acceptable - if each system in a person's body is functioning in a way that is objectively determined to be biologically normal, it would seem that they must be in good health.

But once again, some major problems arise, both in terms of his formulation of the specifics of the theory and with the question of the basis of the theory as a whole. Within the theory, the description and formulation of the reference class is quite problematic (Kingma). Boorse himself describes the idea of a reference class as a group that has the same functional design, by nature (Boorse, 1977, p. 562). Clearly, this leaves a lot up for interpretation. The theory makes sense when one conceptualizes the reference class simply by age and gender, but how do other natural characteristics of a person come into play? Things like religion and environment are clearly intentionally excluded by his definition, in an attempt to universalize the concept. But consider the instance of a reference class such as 'twenty year old males who are blind.' They all have the same functional design, by nature. So, if each individual in the set has similarly functioning biological systems – regardless of the fact that they are blind – then they are all in a state of health, according to Boorse, despite the fact that blindness

is commonly considered to be a state of disease in other reference classes. Now, it would make sense for one to say that a reference class cannot be based on something that is a disease, but obviously, this would be a circular argument (Kingma). This ambiguity muddles the objectivity of his theory - and there are certainly other examples that would be equally problematic.

The other major issue with the BST as a whole also arises out of the specific example given above. From Boorse's perspective, the twenty year old blind male who is biologically functioning completely normally would still *seem* like he *should be* in a state of disease, given the fact that blindness is a biologically abnormal and detrimental condition in many other reference classes. Hence, if one removed the stipulation of blindness from the reference class, that same twenty year old male would never be able to be in a state of health. That person could live to the age of 105, have three children and lead a completely happy life, but Boorse would still argue that he lived a life laden by disease, never achieving health.

To use another example, how would Boorse view a person living with an obscure allergy or a person with a transplanted heart? They are biostatistical outliers, but are they really in an eternal state of disease? Furthermore, what would Boorse say about a twenty year old male who is utterly miserable, but biostatistically normal? Because we are examining health in the context of the doctor and patient, these questions must be raised.

Boorse recognizes these problems with his theory, and in response, draws another distinction between theoretical health (what was just discussed) and practical health. He defines practical health as the opposite of *illness*, which he defines as an 'undesirable' disease (Boorse, 1976, p. 68). In order to keep his theory grounded in

objectivity, he adds that the lack of desirability must have some link to the design of the species - that a disease must be undesirable because it is impeding upon some biological process. In his attempt to explain the clinical setting, and open a more realistic understanding of health, he moves from a descriptivist, objective understanding of health to a very undeveloped normative one (Fedoryka). Regardless of how Boorse presents it, there is clearly an evaluation that must take place in the clinical setting in order to determine practical health. The question of 'conformity to species design' is vague and unhelpful, especially from a clinical perspective. It pushes the realm of medicine into one that is no longer rooted in objective science, but rather rooted in a specific doctor's *understanding* of objective science. As Fedoryka points out, this movement towards practical health is really just a shift towards an undeveloped normative theory.

By arriving at this practical notion, we are confronted by a fundamental reality of clinical health - it seems that it is almost unavoidable to incorporate at least some normativity in a useful definition. This is not to say that the BST cannot be useful, but it seems that it is not enough to encompass what a proper notion of health is in a clinical setting. That is, it does not do us any good in our project of defining the goal of the physician. From this analysis, it seems that health is something inherently tied to one's ability to function in the world, but that this idea needs much more clarification and explanation.

Health as the state in which an organism is able to properly function[2]

Moving towards a normative conception of health gives rise to a plethora of different nuanced theories about the notion of health. The obvious problem with a movement into the realm of normativity is that any objective, universally applicable understanding of health that is strived for by the descriptivist seems to be lost. It is because of this issue that many thinkers try to come up with a way of utilizing a normative description in a somewhat objective way[3]. For example, in her article "Health as a Normative Concept: Towards a New Conceptual Framework," Kateryna Fedoryka makes the claim that health is, 'a dimension of the good of a being which is a direct function of the nature of that being' (p. 155) and 'a dimension of the individual in which a certain unfolding of being happens in virtue of the natural structure of that being' (p. 155). In this definition, it is acknowledged that health is a movement towards a goal - natural actualization - and this goal is the reference point to which functions are considered to be good. There is clearly a normative element, in that the function is labeled as good, but by considering the goal 'natural actualization,' Fedoryka avoids the subject's influence on the definition. Natural actualization is something determined by

[2] At this point in the discussion, with the movement from descriptivism to normativism, explicit discussion of the concept of disease is largely abandoned – it no longer serves as a useful concept in establishing the goal of the physician. As will become clear, an objective understanding of the exclusion/inclusion criteria for disease will not be particularly important to the physician's project, nor to this project.

[3] It seems that many philosophers of medicine are tied up with the idea that a 'universal' definition of health has to be solidified, so that the project of medicine can transcend the boundaries of culture, religion, etc. It seems that they are seeking justification for the imposition of 'medical care' on any and all populations, and this could be for a wide variety of reasons – legal, economic, even ethical. But as it will be seen, this drive towards a universally understood definition of 'health' is both unnecessary and unnatural.

biology. It is a state generated by the structure of the organism itself – a state in which the systems of an organism would be functioning in a way that would actualize the organism, given that there is no negative outside influence from the will. In "Health as an Objective Value," Lennox argues that health is necessarily normative in a similar way - that the concept of health refers to a state in which all of an organisms goal-oriented biological systems are contributing to the overall goal of life. The fact that the goal of an organism is to sustain life should, according to Lennox, be implicitly understood.

Both of these theories claiming to be based on 'objective value' seem to be attempts to rework the ideas of Boorse in order to fix the 'practical health' issue. They seem to be attempts at bridging his two notions in order to establish one that is as objective as the theoretical while acknowledging the inherent normativity of the practical. But it is important to understand and acknowledge the fact that in drawing the distinction between the two, Boorse was not only acknowledging that health has a normative dimension in addition to the descriptivist dimension. I think, judging even by the names 'theoretical' and 'practical,' that Boorse was also acknowledging the fact that his theoretical concept could only be applicable *in theory* - and the 'objective value' approach suffers from the same shortcoming.

By shifting to the practical, Boorse was certainly acknowledging the inherent need for a normative influence, but what gives rise to this inherent normativity is the fact that all instances of health are *already in the world*, to use Heidegger's terminology. Both Lennox and Fedoryka claim that health is a state in which an organism can accomplish the goal of life - the state in which it can successfully actualize itself naturally. But both have similarly ignored the fact that the environment in which

an organism lives is never constant, and is very influential on an organism's ability to actualize itself. This idea solves many of the problems that arise in the discussion of biostatistics, but completely ignores the practical reality of health.

In the attempt to make health objective and only value-laden in so far as biology dictates a goal (avoiding true worldliness in the definition), Lennox and Fedoryka have ignored the fundamental fact that the biological systems are always functioning, or actualizing, *in the world*. Once a person is in the world, a reciprocal relationship emerges immediately. The person is no longer able to be viewed in and of itself – it must be recognized that the person can affect the world, and that the world can affect that person. The best way to discuss worldliness in practical, non-Heideggerian terms is to view the duality as a relationship between a willing subject and an external environment.

Health as the state in which one is able to properly function in the world

Because all biological systems are already in the world, all of these systems are open to, and influenced by, the environment and the will. It is impossible to isolate the activity of any biological system in a realistic sense - the human body is not self-perpetuating. The metabolism cannot properly function without the intake of food, for example. And this intake of food can only happen if the person wills to eat the food, and receives the food from his or her environment.

The will and the environment then *necessarily* become a part of these seemingly isolated biological systems. Even on a medical or scientific level, it is impossible to isolate and evaluate the efficacy of the human body in and of itself - all biological

systems need something from the outside world, whether that be oxygen, water, glucose, a certain protein or vitamin, etc. It is not like trying to evaluate the state of a car without a driver or gasoline – it is impossible, and useless, to evaluate a person's body while ignoring their mind and environment. In the diagnostic process of a mechanic, he can easily make a statement like, "*This car just needs a different driver*" or "*You have to use different oil, a higher quality of gas and stop driving it off road.*" In the case of a human, this is not so simple. The doctor can't simply proclaim, "Your body is fine, you just need different desires, passions and tendencies," and think that the problem is solved. Similarly, the doctor cannot make the claim that a patient simply needs to move to a different area of the world and adopt an entirely new way of life – at least in a realistic and useful sense. It is therefore useless – and arguably impossible – to discuss an organism while disregarding its environment and will.

If the environment and the will are taken into account, the conception of health changes significantly. Health becomes the state in which an organism has an active and successful *relationship with the environment*. Conceptualized in these terms, health is both a state and an order - as a state, health is the body's ability to handle the difficulties imposed upon it by the environment, and as an order, it is the body's ability to expand and actualize its possibilities (Mordacci, 487). Clearly, the necessary imposition of the environment and the will upon health significantly reduces the amount of clarity that the definition has.

The idea that health is the ability to adapt to and thrive in an environment is much more vague and ambiguous than the previously discussed definitions - in accepting that the notion of health is now opened to the environment, it must be recognized that it is opened to the *totality* of an environment, or in other words, a

world. This does not only include the physical environment, but also the social, political, and moral environment (Kovacs). And in opening health to the influence of the will, we are confronted with the question of how subjective intentions and evaluations will affect the notion.

Through this movement, the idea that health is an organism's ability to 'function in the world' has been greatly expanded. By 'function in the world,' we no longer mean exist as an isolated organism that can actualize some biological processes in order to sustain life. The phrase now implies that an organism must be able to actively and successfully *participate with* its world. Naturally, a number of questions arise here. How far can the domain of health be expanded into the involvement with the world? How *exactly* are we to understand this notion?

Before moving forward, let us revert to the original intention of this project - to identify health as the teleological goal of the doctor/patient interaction. It may seem that the notion of health that we've arrived at is leaving the realm of medicine, but this is not the case. What seems to be happening, rather, is that the notion of health, and therefore the project of the doctor, is expanding out from the realm of biology. With this expanding view of health, the project of the doctor is expanding beyond the concept of a 'biological human technician.' It may be useful here to ground the movement in an example.

Consider the woman who comes into the doctor's office on a Monday afternoon for a check-up. During the physical examination, the doctor finds patterned bruising on her back, which is clearly the result of blunt trauma, but other than this, her biological systems seem to be functioning fine. The doctor also notices that she is tired and disheveled - her hair is matted and her eyes bloodshot. At the end of the exam, she

explicitly mentions to the doctor that she is in a violent relationship and that it she is worried that she may lose her job because of the toll it is taking on her. Considering this patient as an isolated organism, the doctor would deem her to be in a state of health - all biological systems are doing their job, and are even within biostatistical norms. Without considering her environment or will, the doctor's job would be done - according to the previous definitions of health, this woman is perfectly fine, and it would not be the doctor's job to impose on any activities or events in her life that are unrelated to her health.

On the other hand, if he expanded his understanding of health, he would view her violent relationship as an impediment on her health - he would acknowledge the fact that her environment was disallowing her from achieving health, and help her in any way he could to alter or overcome the plights in her environment that were harming her. When she thanked him, he would be able to rationalize his actions by explaining that it is his job as a doctor to make sure she is healthy. Clearly, environmental context has to be considered in the determination of overall health - it cannot just be an objective evaluation of all the isolated biological systems of a person.

But consider another more puzzling example. Consider a woman with the same conditions, but this time, place her in Country X. She is still disheveled and beaten by her husband, but in the culture, this is normal. By considering the totality of her environment, it would seem that she is in a state of health - she is functioning perfectly well for the cultural standards. But as a western observer, it still seems that this is in some way wrong - that her environment is detrimental to her health. It would seem that this is an example of how consideration of the overall environment can be harmful in the determination of health. This illuminates the problem with inclusion of all

environmental factors in a descriptivist theory - as an external observer, all one can do is consider this woman's ability to function in her environment - she either is able or she is not. Even as a physician, observation of this woman wouldn't enable one to say she is not in a state of health. The first woman was clearly not in a state of health because she was losing her job - it's clear that she was not properly functioning in her environment. But assuming that this woman is able to perform all of the tasks that she normally performs, despite being in a brutally abusive relationship, she is functioning perfectly well in the world, and hence, is in a state of health.

The above situation seems inherently problematic, and it is likely for two reasons. The first is that our evaluation of the above scenario is still descriptive - she either is or is not able to function in her environment. But this is not really the case in terms of functioning in the world. Functionality is not really a descriptivist notion - it is more of a normative one. We say that a person is functioning well or not functioning well. It is not a matter of true or false, it is a matter of evaluation - the question is not *if* a person is functioning, it is *how well* is a person functioning in their environment. So with the introduction of the environment, we also must introduce normativism.

The second reason the situation seems problematic is that we are not considering the question of the will. Does the second woman want to be in the position she is in? Is she there by force, or does she opt to stay? When discussing worldliness, the specific questions of the will seem to be of paramount importance. Regardless of the way the environment interacts with the subject, what ultimately matters for health in the worldly relationship is the subject's attitude towards their situation. The ability for one to function in the world cannot be something that is examined from the outside, even if worldliness is taken into account. What matters most about the practical reality

of health is that it *belongs to an individual.* Although an individual's environment in the world certainly *influences* his or her health, their subjective judgments and understandings are ultimately what will dictate the state of health.

Health as the state in which one is able to achieve vital goals in life

Upon introduction of the environment, the notion of health loses most, if not all, of its objective qualities, and becomes normative and evaluative - the prior definition ceases to work, and a level of positivity or negativity must be assigned to a person's level of functioning in their environment. Hence, there must be some evaluation of a person's functionality in the world - the idea must change from 'health is a state in which a person is able to function in the world' to 'health is a state in which a person is able to function *well* in the world.' From a theoretical standpoint, an evaluation of how well or not well a person is functioning in their environment would be done by society in a type of cultural process (Kovacs). The process of evaluation could never be viewed as objective in any sense, which is not a problem in itself. But a problem does arise when one considers that an individual's views may not match the views of their society or culture. To use the previous definition, if it is generally held by Country X's culture that the proper function of a woman in society is to be completely subordinate to her husband regardless of any violence or harm that he may cause her, and to do the duties that he commands her to do, then even if this woman was completely miserable, and in a state of suffering, the society of Country X would consider her to be doing quite well in terms of her function in the world, and hence, she would be in a state of health regardless of her will.

But if we have accepted the fact health is a matter of subjective evaluation, then it does not seem just for anyone but the individual subject who's health is being considered to evaluate their *own* state in the world. That is, if the wills of other subjects are being considered in order to determine general rules for the basis of health, it only makes sense for the individual subject in question to make the final decision on whether or not they are in a good state. To refer to the clinical setting, it seems clear that the patient's own understanding of their condition is more important than their *societies* understanding of a condition. The environment or society may very well influence the evaluation in some way, but ultimately, the will of that individual is paramount.

Nordenfeldt acknowledges this reality about the will of the individual in his conception of health, introducing the notion of goal achievement. In his theory, Nordenfeldt goes beyond the idea that health is a person's ability to function well, asserting that health is a state in which an individual can function well *according to his own will*. To use his words, "P is healthy, if and only if, given standard circumstances, P has the ability to realize his or her vital goals. P's vital goals constitute the set of those states of affairs which are necessary and together sufficient for P's minimal happiness" (Nordenfeldt, 1993, p. 8). Interestingly and controversially, Nordenfeldt bases his theory of health upon happiness, and not just a biological end like survival or reproduction. With this understanding of the idea alone, there are two apparent problems with Nordenfeldt's theory that pertain to this discussion, both pointed out by Schramme (2007).

The first objection raised by Schramme is that the theory includes far too much exclusion criteria by associating health directly with happiness. Schramme asserts that

there must be a more solidified scientific basis for what situations count as illness and which situations are just examples of failure or unhappiness. To illustrate this, he gives the example of an athlete, Lily, who cannot meet her goal of jumping two meters - an ambition she has had all her life. Lily has no biological abnormalities or diseases, but she cannot achieve this goal, no matter how hard she tries. Schramme claims that under Nordenfeldt's definition, Lily would be considered ill, despite the fact that she is clearly healthy, emphasizing a major inadequacy in Nordenfeldt's definition.

In response, Nordenfeldt first stresses the fact that health is not a descriptive concept - that there is a range of health from very high to very low, but he acknowledges the fact that Schramme would probably refuse to accept that her health is lowered in any way, and moves on to his next point. Nordenfeldt stresses the fact that a person's goals are a reflection of *mental* health - that if this athlete cannot achieve even minimal happiness without jumping two meters, that she certainly is not in a state of health. Hence, in this circumstance, the care would not be provided by a surgeon. Rather, it would be provided by a psychiatrist who would help her reassess her vital goals in life.

The second issue that Schramme raises is that Nordenfeldt's theory is entirely dictated by a subject's sensation and experience - he raises the question of dormant diseases that are asymptomatic. That is, he asks how, given Nordenfeldt's theory, a person could be considered medically abnormal (not in a state of health) if they do not *feel* badly. In reply, Nordenfeldt explains his analysis of the concept of disease - that a disease is a bodily or mental process that has, in past cases, produced suffering in some way (2007). Though not explicit in his reply to Schramme, I think Nordenfeldt's point is one we realized near the outset of this discussion - that a person can be both in a

state of health and in a state of disease - that these two concepts are not antonymous to one another. A person with dormant cancer, for instance, may have a disease, but also be in a state of health.

I find Nordenfeldt's formulation to be a very satisfying way of defining health in terms of a person's subjective understanding of their ability to interact with the world. However, as noted by George Khushf in his article, "An Agenda for Future Debate Regarding Health and Disease," Nordenfeldt seems to push a bit too far into the realm of the practical, without considering the theoretical notions upon which his ideas are built. That is, Nordenfeldt's definition of health establishes a teleological goal that medicine can strive towards, in a real and practical way, but it does not seem to be clear what the philosophical backing is behind this issue.

Clearly, according to our originally stated goal in this section, Nordenfeldt's definition *seems* to achieve the precise goal of the whole discussion. However, now that a holistic, practical medical telos has been realized (or seems to have been realized), it is necessary to examine what is going on behind these assertions. That is, we must engage in a deeper philosophical examination of the basis behind the movement we have just experienced. To clarify, Nordenfeldt's notion does seem useful, but in order to fully understand this practical idea, we must look deeper at the movement that resulted in our acceptance of it.

Section 2: Being as the Basis for Health

In the previous section, we have come to one clear realization, if none other: that the notion of health is exceedingly complicated and controversial. Clearly, there are a multitude of ways to define health, with different nuances and specificities. It seems that there has to be some underlying philosophical issue behind all of the debate – one that will help further illuminate what the true goal of the physician is. Although Nordenfeldt's definition does seem somewhat practically satisfying, one cannot help but inquire into the philosophical underpinnings of the entire debate. It seems that there is something lurking throughout the discussion, some reason that the debate even exists. It is the goal of this section to examine the previous movement, with hopes that a basis may be found for the confusion about health. Furthermore, from that basis, I hope to arrive at a philosophically sound way of thinking about health, and a clear telos for the project of medicine.

Thus, in this section, three major points will ultimately be realized. The first is that discussions of health must be understood as inherently human. The second is the fact that health is a human construct, and that this construct is based on a subjective notion of being, which is why the task of defining health has become so difficult. The third is that in western society, our notion of being is completely fragmented, and this leads to a massive amount of confusion about health and medicine[4]. Through the discussion of these issues, a useful theoretical notion behind the project of the physician will come to light.

[4] This notion is somewhat similar to Gadamer's discussion of health in *The Enigma of Health, The Art of Healing in a Scientific Age*.

The humanity of medicine

It seems that the most blatant realization made in the previous section is that any discussion of health in medicine must acknowledge the fact that it is addressing an issue that is inherently and intimately human in nature. Throughout the discussion, there is not only a movement from the philosophically descriptive to the philosophically normative – there is also a clear movement from the discussion of an object to the discussion of a subject. As the definition of health widens, what seems to be occurring is an incorporation of the things that make humans different than other organisms. A seemingly obvious fact starts to come to light – it seems that human health is completely different than any other kind of health, and it must be treated as such.

In the earlier definitions, the human is treated as a body that is subject to external imposition, a thing that can be statistically evaluated for normality from an external and objective perspective. This way of thinking about health may be useful in the examination of a plant, or even of an animal. But what seemed to be continually overlooked was that the entire notion of health – of normal functioning, of statistical norms of a lack of some pathogen – is an idea that is created by our own understanding of what it is to *be*.

We are tied up in a method of thinking by which we *assume* that we are functioning in a single metaphysical paradigm – the common assumption about the concept of human health is that it's generated by the way the natural world functions. The early concepts discuss the functioning of biological systems as if they are inherent to our own notion of what it is to be in a positive state. The descriptivist notions make

a blatant assumption that humans are simply organisms – that scientific observation and theories about the biosphere can be turned and applied to us, since we are biologically and physiologically similar to the rest of the living world.

Health as a human construct and a derivative of being

What these descriptivist theories are fundamentally misunderstanding is that the notion of health is one that can *only* exist if humanity exists. Health is not a concept that is derived from the observation of the way the external world functions – rather, it is the opposite. In reality, health is an externalization of our own understanding of being – it is a concept that we selfishly throw upon the world, due to the way we inherently think. It is clear that each specific notion of health is seeking to explain, in clear and objective terms, a single phenomenon – what it means to *be* a certain way:

-The 'lack of disease' theory strives to make the claim that a human is *being well* when they do not have a clear-cut malady that has been previously perceived in a negative way.

-Similarly, the 'functioning in the world' theory asserts that the human is *being well* when it can perform tasks that will result in its physical survival and longevity within its society.

-The statistical model is somewhat different, as it makes a strong attempt to remove the notion of health from any sort of normative notion at all – claiming that health simply describes normality. But I think its quite clear that this is really an attempt to describe some larger phenomenon in clearer and more precise terms – it is

an attempt to solidify both the 'normal functioning' and the 'lack of disease' models in clear, mathematical terms. For if health were nothing more than normality, the word 'health' and the notion of 'normal' would be no different than one another – what it is trying to do is explain the concept of the 'normal' as it relates to *being*[5].

-Nordenfeldt's notion of health can easily be seen as addressing the issue of being. By discussing 'vital goals,' Nordenfeldt is making a practical assertion (possibly too practical) about our deeper philosophical notions of what it means to be.

In recognizing that the notion of being is at the center of all attempts to define health, it becomes quite clear that the entire notion of health is a construct of the human – it is a way of describing what it is to *be* well. This is, quite literally, the definition of health – 'holistic health' is often used as a synonym of the term 'well being.' When we define any other thing in the world as 'healthy,' we are making an assertion that is based on our *own* understanding of what it is to be. In saying that a tree is healthy, we are making a judgment about the being of that tree – we are imposing a definition of the tree's being, and then judging the tree based upon that definition. In other words, our assertion that the tree is healthy rests upon our own assertion that it is good for trees to continue to grow, sprout leaves, produce seeds, etc. We assume that this is a fundamental fact about the tree – but in reality, this is not necessarily the case. We have no idea what a tree is supposed to do – what a tree is supposed to be like. The only thing that we can do is make a judgment about how it is supposed to be. Hence, when we say it is healthy, we are making an unwarranted assumption about the tree. We assume that trees are supposed to grow and age

[5] The term 'being' here is not supposed to refer exclusively to any specific philosophical interpretation of it – it is intentionally left ontologically open.

because that is how we perceive our own being. And to apply that to the realm of all living organisms, our assertion that 'well functioning' is a state in which an organism is able to reproduce and thrive is equally unwarranted.

The fragmented western conception of being

The fact that health is a human construct wouldn't be at all problematic in medicine, if we had any clear notion of what it meant to be. But in modern western culture, we have an extremely complicated and confused idea. The purpose of our lives is not as clear-cut and teleological as it was in other time periods or in other parts of the world. In ancient Greece, for example, the notion of being was entirely holistic – the project of medicine was explicitly understood in terms of a 'harmony' between soul and body. In the *Phaedrus,* Plato writes, "medicine has to define the nature of the body and the rhetoric of the soul" (p. 9). And even in other parts of the world in modern times, being is understood entirely holistically. The Kogi people of Colombia, for example, conceptualize being as 'one with the entirety of the universe' – all ailments are understood as imbalance, or as having occurred due to deviation from the natural moral order (Riechel-Dolmatoff).

The problem, or condition, that currently exists in *our* world is due to the fact that the natural scientific paradigm has become overwhelmingly widely accepted over the course of the last century. Hence, our notion of what it is to be has become tied up, almost exclusively, in a biological or scientific notion, rather than any other philosophical one. In defining being in terms of science, we have put ourselves – the subjective selves – on the level of all other life forms. In one sense, being has become

nothing more than biological actualization, but at the same time, it still seems that there is so much more to it. This is why it is so difficult to define health in western culture – our world involves an inherent contradiction. Biology considers us a part of the animal kingdom, and yet, we still strive to separate ourselves as a single, unique entity that exists at a higher level than the rest of our animal peers. Our conception of what it means to be has been brutally fragmented by the developments in natural science, and we are having an extremely hard time putting the pieces back together.

It seems that there are three major positions that can be taken in the western world when it comes to being, and each of these paradigms would have a different understanding of the doctor and of medicine. These ideologies can be understood as positions on a spectrum[6]:

On one end of the spectrum is the hard scientist, who genuinely believes that the being of a human can be entirely understood and explained by mathematics and science. These people truly believe that the human is an animal – that the only thing separating us from the rest of the animal kingdom is evolutionary advancement. As far as health goes, they are likely to side with the biological functionalist – claiming that health is a state in which an organism can thrive in the physical environment in a way that is no different than an amoeba. Hence, they would probably claim that the doctor is just a bio-physiological specialist of the human body. In terms of the project of medicine, then, they would understand the doctor as nothing more than any other scientist. They would see the project of medicine as having a clear teleological outcome, either adopting a Boorsian, statistical understanding of what it means to be

[6] The 'ends of the spectrum' serve as archetypal – I am not making the claim that there are a large number of people who actually take these positions. Rather, I am using the positions as a way of illuminating the ideologies towards which people may tend.

healthy, or a biologically functional understanding.

On the other end of the spectrum is the person who denies that science has a major impact on what it means to be, and asserts that being is something much greater than scientific understanding. These people would reject the notion that science holds any primacy – and claim that assertions of the natural sciences are only grounded and important insofar as they influence some other worldview. Most of the *western* people of this group would be very religious. There's no doubt that there are other groups in the world that recognize some aspects of science, but see it as a secondary explanation of being. But in the western world, most of these groups would be religious groups with a clear understanding of what it is to be in the world – and hence, their notion of health would be quite clear. They would understand the physician as a person who could help them fix some parts of their being, but not all – the truly religious Christian, for example, would likely understand biological problems as fairly minute in the greater scheme of being. Nevertheless, this type of person would have a clear idea of what they wanted out of the project of medicine, based upon their clear understanding of being, whatever that may be.

If everyone embodied one of these two extreme archetypes, there wouldn't be much difficulty in defining the project of medicine. Both parties would come to the doctor with a clear understanding of what they expected. But of course, these archetypes are unrealistic. What is more common is the middle position – the position that most people occupy in the western world. These people would have a fragmented, unclear understanding of being, accepting most or all scientific assertions, but still retaining some assertion that there's 'something more' to being human. This group likely asserts that biological health – keeping their bodies well – is an integral part of

being as a whole, but that being involves more than this. The problem with this position is that they would not know how to reconcile, or explain, their dual view. It would be extremely difficult for these people to understand what they wanted out of medicine – if one doesn't understand their own being, then how can the doctor make it well?

This exhibits the challenge of the western doctor – he must reconcile a notion of being that has been shattered over the course of the last two centuries. He must navigate the intricate and nuanced interplay between unclear notions of what it is to be healthy. In doing so, he must treat the patient biologically, but also take into account the patient's personal understanding of what it is to be well in the world. This task is much more difficult than the task of another type of doctor – a shaman, for instance. The shaman has a clear idea of what it is to be healthy, and how the world works. His patients believe in him and his methods, his explanations are clear and encompass the patients whole being. When confronted with the ultimate challenge in medicine – the possibility on non-being, or death, the shaman can come up with clear answers, explanations, and decisions, since the paradigm of the shaman and his patient is whole and clear.

But when the western doctor is confronted with situations that involve death, or any major decision for that matter, a blatant mystery arises. Without a clear understanding of what it is to be, it is extremely difficult to make decisions that involve the possibility of non-being – it is difficult to make decisions at all, for that matter. Since being is so loosely defined, health is equally loosely defined – and it is open to each patient's interpretation. The major problem with this is that most patients – and many doctors – don't even realize that this is happening. The western patient believes

on a conscious level that he is only going to the doctor to fix his biological condition – but he still *expects* to be treated like a human. People tend to like doctors who are kind and warm, who treat them with compassion and empathy, who guide them through the process of treatment while taking into account all of the things that affect their lives. Although much of what the western doctor seeks to achieve is biological in nature, the overall notion of health must encompass more than just the body – it must address the hidden side of the patient's perceived notion of being, the other parts of this confused paradigm of the world.

The theoretical notion behind the physician's project

It seems that Nordenfeldt comes close to realizing the scope of what health really is, but pushes too far into the pragmatic with the idea of goal achievement. Nordenfeldt seems to have recognized the fact that health is really just well being, but his explanation of that concept is too practically oriented. In using the term 'achieving vital life goals,' Nordenfeldt really makes the suggestion that a person is healthy when they can go on living according to whatever they think living is supposed to look like – according to their own understanding of being. The narrowness and overly practical nature of his theory to criticisms such as the 'inadequate athlete' example – a measurement of how badly one wants to achieve a certain *specific* goal in the world should not yield a definition of health. Rather, an *overall* goal of life, which is derived by one's personal understanding of being, should yield a notion of health.

Clearly, when analyzing a person's health, there is much more than just a goal that must be understood and analyzed. But nonetheless, in western medicine, the

biological state of the patient is key to the patient's health, due to our complicated paradigm. So how is the doctor to understand the reconciliation of the two? How is it that the western doctor is to understand the complex interplay between overall well being and the biological, or scientific, side of being?

In order to answer these questions, let us revert to the original assertion about what happened to being upon the introduction of science to our world. I think it's important to understand that the common notion of being was not *split* after the introduction of natural science – rather, it was *fragmented*. This is why our common understanding of being is so complex – it is not the case that there are two notions of it, or even three. Rather, there are a plethora of different *instances* of beings.

And because we defined health as a positive state of overall being, we must also understand health in terms of this fragmentation. What seems to have happened, then, is that we went from an overall understanding of Health, as a unified idea of being well, to specific instances of health, or the specific ways in which we can be well. Health, as a unified concept, turned into the set of all 'healths,' as it were. Now, we use terms like 'spiritual health,' 'emotional health,' 'mental health,' etc. All of these constitute the fragmented parts of our overall notion of what makes up the holistic notion of Health, or overall well being.

With this conceptualization, the role of the physician becomes a lot more accessible, as do the previous assertions about health. The differences in a lot of the definitions constitute which 'healths' the doctor is supposed to address, and which he is not. I don't think that anyone would argue that emotional health does not exist – but I do think some thinkers would argue that it is not the role of the physician to address this component of overall Health. What does seem to be universally agreed upon is

that *biological health* is very important to the project of medicine. Every one of the definitions that we discussed in the previous section addressed medical health as biological in some way. What *changed* was how the health was treated, or understood, beyond the biological context.

I think this is the key to understanding the project of the western doctor, as well as the notion of health. It seems that it is the goal of any doctor, regardless of culture or time period, to move his patient towards a notion of Health in some way. Over time and throughout the world, some kinds of doctors may specialize, or may have specialized, in different kinds of health (or, in other cases, they may have been able to address Health as a whole), but all of these doctors have certainly been trying to bring their patients towards overall Health. Even within our own culture, we can see other health-specialists, such as marriage counselors, who seek to bring a person towards overall Health by improving the health of their relationship. The western medical doctor, then, is to be seen as the 'biological health specialist.'

But if this were the simple goal of the physician, it seems that we could have stopped the discussion a long time ago. This idea of a 'human technician' seems to be what we have been moving away from – the previous movements have been towards a humanization of medicine, not a re-emphasis on the biological.

But what has been realized is that the doctor must move towards biological health *only insofar as it improves a person's overall Health*. That is, it is absolutely imperative to recognize the limits of the scope of western medicine, and the way it is supposed to fit into a person's attempt to establish Health. As previously noted, each individual patient will have a totally different way of reconciling the two concepts – biological health and Health as a whole. Some people will value their own biological

health more than others. Clearly, there is a subjective, individualistic element to the relationship between Health and biological health – and the physician *must* recognize this in order to accomplish the overall goal of establishing Health.

This leads to a quite clear and satisfying answer to our original question. The role of the physician is to be conceptualized as twofold. On one hand, the physician must come to understand the complicated interplay between biological health and overall Health in each one of his patients, in order to understand how decisions are to be made in each specific medical context. He must recognize and respect each subjective understanding of what it means to be, and be in Health, and base his decisions upon the patient's notion, and not his own. On the other hand, he must actually improve upon the biological health of the patient, carrying out what we consider 'medical procedures'. Furthermore, although it is the doctor's specific goal to establish biological health, it is not to be forgotten that it is his overall project to establish complete Health. Hence, he is to do whatever he feels is within his power to accomplish this. The doctor is to realize and remember the limitations of his *training* and not the limitations of his *project*. Therefore, if a patient complains of issues that seem non-biological, but still effect Health, he is to do everything in his power to address those issues – likely referring the patient, caringly, to another specialist.

Before moving on, let us first address an issue that may arise at first glance – it seems that making a claim about 'biological health' re-raises the problem that was being worked through in the previous section, sending us back to square one, with different terminology – 'biological health' is still undefined. However, if we look at the context in which the term is used, it is not at all problematic. That is, the term is simply used as a vague notion of things that are generally considered to affect a person's

experience of the world from a biological perspective. In other words, biological issues are the ones the western medical doctor is *trained* to deal with.

We do not need specific inclusion or exclusion criteria for two reasons. The first reason is that we have clearly stated that the *overall* project of the physician is to establish holistic Health in the patient, although he is a biological health *specialist*. With this understanding, a physician could never make the claim that a certain borderline-biological issue is 'outside of his jurisdiction.' The physician must do everything in his power to address *any* issue that may be considered biological. His training is what will dictate what he can address. Furthermore, the second reason the lack of a clear definition will not be a problem is that the patient's subjective understanding of holistic Health is what is used to make decisions about medicine. This eliminates the doctor's ability to *force* a procedure upon a patient in the name of health. All decisions will be an agreement between physician and patient[7].

So to clarify, the two major aspects of the physician's role are 1) to come to a specific understanding of the way each patient conceptualizes the interplay between biological health and overall Health (or in other words, attempt to understand the patient's overall conception of being), and 2) to improve upon the biological health of their patient. In addition, the physician is to remember that his ultimate goal is to establish overall Health, and he is to do whatever he can to accomplish that goal. The question that now needs to be asked is: how, exactly, is the western doctor supposed to achieve this goal?

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[7] It is recognized here that this may cause a dilemma in certain circumstances, in which the individual cannot make decisions for him/her self (ie. infants, the mentally insane, the unconscious). This certainly needs to be addressed, but it does not fall within our scope. The inquiry here seeks to address the common, every day clinical interaction.

Part II: Actualizing the Goal of the Physician

Section 3: The Major Paradigms of Medicine

In light of the holistic, philosophically grounded notion of the project of the physician, we can now begin to look into the way by which the physician is to achieve his goal. In order to do so, it seems natural to start with a discussion of the two major 'paradigms of medicine' – patient centered medicine (PCM) and evidence-based medicine (EBM). The two approaches will be explicated and explored in light of the overall philosophical goal of the physician in order to determine which of the two, if either, is a more effective route to accomplishing the overall project of the physician.

In light of our twofold goal of the physician, the hope is that we will be able to come to find a way these two paradigms accomplish each of the two goals – both the goal of establishing the patient's understanding of the relationship between biological health and holistic Health, and the goal of improving upon the notion of biological health. Simply based off of the names, it seems that EBM may accomplish the first, while PCM may accomplish the second – but that is left to be explored.

Evidence Based Medicine

Evidence based medicine is, in short, the process of gathering, appraising, and utilizing relevant research findings in order to make decisions in the clinical setting. It is based nearly exclusively upon a set of quantified data, and seeks to avoid the 'subjective' influence of the clinician in order to base decisions and actions in fact.

From a practical perspective, EBM is based on four separate, yet equally important, elements or steps[8]. These steps are used to ensure that the best medical treatment is being used in any given scenario. The first step to EBM is the formulation of a question according to the patient's condition. This step involves a clarification and quantification, to some extent, of the symptoms and signs. It is noted that they should be as specific as possible, include a specific 'type' of patient (a classification according to different characteristics), as well as a style of clinical intervention and the 'clinical outcome of interest.' In their article 'Evidence based medicine: an approach to problem solving,' Rosenberg and Donald use the following example of an appropriate question in two parts: "How great is the annual risk of embolic stroke in a 77 year old woman with non-rheumatic atrial fibrillation, hypertension, and moderate left ventricular enlargement if she is not given anticoagulants?" (p. 1123) and "What is the risk of reduction for stroke from warfarin therapy in such a patient, and what is the risk of harming her with this therapy?" (p.1123).

Once the question is formed, the clinician must find the best available evidence, based on what is available in literature databases. Large online data sets have been in the process of assembly over the last several years, and are constantly being updated. With some fairly elementary search skills, a clinician can find meta-analyses and other articles that address prognosis and treatment of the condition, with reported data of outcomes. With proper search technique in the right database, a large array of information should be available.

Following the gathering of data, the clinician must appraise the evidence. This

[8] This explanation of the steps of EBM is based largely upon the article 'Evidence based medicine: an approach to clinical problem solving' by Rosenberg and Donald – they give a clear and concise explanation of how, exactly, EBM works.

part is slightly more complicated – it involves the interpretation of clinical studies with regard to the specific patient. In this step, the clinician decides whether or not an article is useful in terms of guiding the treatment. Although some clinicians are not formally trained in research methodology and analysis, a method called 'clinical appraisal' has become popular, in which a team of trained scientists answer a series of standardized questions about published articles, and offer this appraisal along with the research findings. This almost serves as an instructions manual for the research.

After the research has been appraised and it has been deemed that the article will be relevant to the current state of the patient, the evidence must be acted upon. In this stage, the clinician must isolate the useful components of the evidence that directly relate to their own patient, and apply those same methods on the patient in hope that it will have a similarly beneficial outcome.

In terms of our overall notion of the project of medicine, EBM seems to deal exclusively with biological health. There does not seem to be explicit 'room,' so to speak, for the doctor to attempt to understand the patient's personal understanding of being. That is, it seems that EBM only addresses one of the two major roles of the overall project – the establishing and improving upon biological health. There is a rather clear conceptual framework for this medical paradigm, and there is never any explicit mention of the patient's subjective influence. This is likely a major reason why so many modern thinkers are tending away from the model – it seems to view health as strictly biological.

But with our clear understanding of the physician's goal, this does not pose a problem. It seems completely legitimate to consider the possibility that EBM, as a system of practicing medicine, could constitute one part of the overall medical

paradigm. It could serve as the basis for the development of biological health, while some other ideology or system could serve as the basis for establishing an overall understanding of holistic Health in the patient. That is, EBM could be the way by which physicians actualize a preconceived decision with regards to health. The fact that these decisions need to be made through some other method does not pose much of a problem – another paradigm can be used to accomplish this task. So as long as the doctor understands and accepts the limitations of EBM, and is not viewed as the *only* paradigm of medicine, it seems that it may be quite beneficial.

Furthermore, from a practical biological perspective, it is not hard to see why so many scientists appreciate and support EBM – it seems to generate clinical decisions with a very high level of factual backing, and it eliminates a good amount of uncertainty about those decisions. However, even from a practical view, many other scientists and physicians see some major issues with the approach. The main issues arise when one examines the process of data appraisal and evidence application – neither is as objective and factual as it originally seemed.

The general explanation of EBM and how it works ignores some fundamental difficulties that arise in the practice, a major one being the process of appraising evidence. Even if relevant data can be located on a given topic, the evaluation of the efficacy of that data in the treatment of a specific condition is never as clear-cut (Haynes *et al.*). There are several guides available that inform clinicians of how to appraise data to determine its efficacy in different circumstances – guides that tell the clinician when or why to use specific treatments covered in articles. Essentially, the primary research articles require a further level of review before they become effective in a lot of circumstances. As mentioned before, the practice of 'clinical appraisal' has

also become popular, in which another level of uncertainty is added to already uncertain data. The existence of these 'middle men' in data interpretation and appraisal muddles the scientific rigor that may exist in the quantitative evidence. Essentially, the practice of interpreting a quantitative data set for its application to a qualitative, ever-changing scenario (as is the nature of the human body) is one that can never be completely uninfluenced by some subjective ideology, no matter how science-based it may seem.

Furthermore, the complexity of a lot of therapeutic strategy is commonly overlooked, and this results in articles simply being appraised as relevant without further analysis into the nuances of the procedure. That is, even if an article is appraised to be effective in a given circumstance, there are a plethora of nuanced elements of medical procedures that may be overlooked or understated, either from the perspective of the researcher or the practicing clinician (Naylor). When clinical strategies are developed, there are usually several different technologies or techniques involved. It is impossible to analyze each of these nuances individually – generally; articles just give an overview of a clinical strategy without explaining the specific type of technology, timing, sequence, etc. In other words, there are a huge number of variables that cannot practically be controlled, especially when dealing with a human subject. So even if an article is deemed as 'effective' for a certain situation, the actualization of that treatment may not be in accordance with the original study's protocol, which may cause a different outcome.

Furthermore, the fact that a human being is the subject of the procedure makes scientific rigor very difficult to uphold. There will not only be inevitable variables in the way in which the procedure is carried out – there are also inevitable variables within

the patient. There is no way, even conceptually, to control every bodily system in a patient. When an original clinical study is carried out, the investigators can only control for so much – age, gender, race and things of the like, along with certain exclusion criteria. But those exclusion criteria are nothing more than an informed guess about what may or may not get in the way of the therapy they are testing. A study may proclaim, for instance, that a certain procedure on the lung is successful as long as a patient does not have a certain type of heart condition. But what if certain liver conditions also affect the efficacy of the procedure? If none of the patients in the study had these liver conditions, the researchers would never know that there would be an affect on the lung procedure. The point here is that the human body is extraordinarily complex – quantifying it in any way is a very daunting task.

Clearly, there are some major problems with EBM, even when viewed from a strictly scientific paradigm. But nonetheless, it does seem to have the potential to become very effective if the level of scientific rigor in the medical community is increased. If studies become clearer and protocols more exact, it should become the ultimate way to practice biological medicine. But is this really so? The soundness of the philosophical basis for the model is still left to be explored.

The notion of 'evidence' is one that has been somewhat unclear in the philosophy of science during the twentieth century. In her article "On evidence and evidence-based medicine: Lessons from the philosophy of science," Maya Goldenberg argues that the notion of evidence as 'fact' is an antiquated belief of the positivist empiricist, and that this misunderstanding stands at the root of the inefficacy of EBM. It does not occur to many people to question this issue – it seems, especially in modern western culture – that a stronger correlation to 'the evidence' yields increasing

certainty. In an age in which paradigmatic notions of the world are so unclear and different, adhering to 'evidence' seems to serve as a universal notion that clarifies between the correct and the incorrect with regard to all claims – referring to evidence seems to be the way in which the scientific paradigm has come to permeate all aspects of life. It seems, at least in the scientific community, that evidence serves as a god in a godless world – it judges, it controls, it can be found in and through all things. In the process of scientific inquiry, evidence is the judge of the good and the bad, the fact and the rubbish. But is evidence really this all-powerful entity that it seems to be?

There are two major objections to the idea that evidence is effective as the basis of scientific methodology. The first claim, held by both Kuhn and by Hanson, involves the assertion that all observations, especially those made in a scientific context, are inherently connected to an already-existing theory. It seems that much of the empiricist epistemology of the early modern to modern era assumes that there is a stable and unchanging relation between the external world and the perceiving subject. Thinkers like Hume have made the assertion that the simple ideas that we hold in our minds are 'copies' of the real things in the world – that they are accurate and clear representations of them. But when we introduce the concept of naming, or language, it becomes more difficult to clarify what the implications of this are. Wittgenstein's duck-rabbit serves as a useful example. Even if we see the image of the creature, and our idea of that the creature really is a 'copy' of it, the way we name it, or conceptualize it, is going to be muddled by something else – whether that is our own mind or some other influence from the external world is not important. The point is that the route from an image in the world to our verbal assertion about that image is not clear and direct. There is plenty of room for error or some kind of influence – it doesn't matter if one

deems this subjective interpretation or something else. The point is clearly illustrated by the duck-rabbit – one person might call it a duck, another will call it a rabbit. Hence, two different observers may describe even a simple piece of evidence differently.

And furthermore, scientific data interpretation is obviously never as simple as naming a duck or a rabbit. The impressions (to use Hume's terminology) that are received in scientific inquiry are extremely complex – even Hume would agree that they require a massive degree of mental synthesis, on behalf of the imagination, before one could actually say anything about the impression. Obviously, this is a major problem when it comes to a researcher's assertion about evidence – using scientific terminology, the relationship between quantitative data and an actual assertion about evidence is a very complex one. The arguments made by Kuhn and Hanson assume that this is due to a theoretical backing in the observer – they argue that it is a difference in the perception of the subject. Again using Wittgenstein's image, a scientist who studies ducks will probably call the image a duck, while a scientist who studies rabbits will deem it a rabbit. But regardless of the philosophical question about the root of the distinction between the asserted ideas/evidence, there is no doubt that some confusion exists.

The second major objection against evidence as the unquestionable root of science is an elaboration on the previous idea, in a way. Both Duhem and Quine make the claim that the connection between data and theory is always somehow interrupted by an unwarranted subjective influence. That is, theory is not only derived directly from data. It points to the fact that a single body of evidence can be used to suggest multiple different scientific theories, depending on how it is interpreted by the

researcher. It is noted that often times, scientists are left in a position where they have to adopt one theory over another – this actually happens quite often in science. The mere fact that one theory can be 'believed' by a scientist completely destroys the idea that scientific theories can be utilized as factual. The adoption of any theory, especially theories of medicine, is always predetermined by subjective biases. Hence, all scientific studies involve subjective choices on behalf of the researchers. In the process of interpreting the data, the investigator must make subjective judgments about the data in order to turn it into evidence – no theory is solely based upon the external world.

To put succinctly, the first plight raises an issue with the connection between phenomena in the world and our assertions about what those phenomena are. That is, it raises an issue with the derivation of evidence from observation. The second plight raises a further issue, claiming that theories are almost never sufficiently determined by data, and that the decision to adopt one theory over another is usually a matter of subjective choice. These two major issues exhibit the philosophical basis for the previously discussed practical problems in EBM. It seemed at the outset that the problem with evidence appraisal, application of theory and the complexity of the human subject were problems that arose due to a lack of scientific rigor – that they could be eliminated with stricter protocols and better methodology. But as it turns out, there are inherent philosophical problems at their root. It seems that the conceptualization of evidence as a representation of factual reality is misleading for several reasons – the entire concept of basing medical practice solely on evidence is flawed from the outset. But if we cannot use science alone to solve a scientific problem, then what is to be done?

To recap, it was established that EBM is the type of medicine that is to be used to

solve entirely biological problems – the type of medicine that increases the functionality of the body alone, without treating the subject as whole. As stated, it would seem that adhering to evidential findings would be the best approach to addressing these types of issues. All other fields of science seem to use quantitative research and statistical data analysis to derive evidence that will then be used to carry on with a theory. But there is a fundamental difference between medical science and all other types of science – in medical science, the end result is the sustenance of a human life. The stakes are much higher in medicine.

To use an example, if a pharmaceutical company is investigating the efficacy of an antibiotic for deadly bacteria, and their studies show that 90% of bacteria die when treated with this agent, the drug is deemed effective. The 10% that lived are simply deemed as outliers, and are never analyzed specifically. When that drug goes into practice, if 90% of the people treated are cured, it is similarly considered successful in the scientific community. But those 10% of people who were not cured cannot be pushed aside as outliers like in the case of the bacteria. It is not only morally corrupt, but impractical to quantify human life in the form of a statistic. Those unsuccessful cases need to be examined thoroughly to investigate why and how the antibiotic didn't work – what it was about their body, specifically, that disallowed the efficacy of the drug. For unlike the bacteria, each of those unsuccessful patient cases is just that – a case. Each patient is viewed as an individual project, as a whole person, rather than an insignificant component of a study. When a patient dies, there is a 100% failure – blaming 'uncontrolled variables' for that failure is not acceptable. Those variables need to be explored and discovered in order for a study to be deemed effective.

Clearly, the use of statistical data in medicine is far less useful than it would

seem. Medicine requires much more than the application of faulty evidence proven by questionable studies. The central problem with EBM is that it ignores the uniqueness of the medical situation and the specific patient, even on the bodily level. Although evidence may be used as a guiding element in practice, the idea that protocols can be systematized and applied to people is impossible from a practical and philosophical perspective. The answer to the problem, as I see it, lies in the recognition of the individual body and the individual care provider. That is to say, the efficacy of medicine does not only lie in the systematic approach – it really lies more in the individual physician.

This is clearly exhibited in the field of surgery. In surgery, there are clear protocols, evidentially supported methods, and physical skills that require fine-tuning. A surgeon can be trained by the best educators and have impeccable skill with his hands, while following a strongly evidentially supported procedure, and still make a fatal mistake. But how can this happen? The answer, as I see it, lies in the 'intangible' element of medicine that is commonly overlooked due to its lack of scientific rigor – intuition.

By intuition, I refer to the ability of an individual doctor to make decisions without synthesizing sequential and clearly stated reasons. This may at first seem like the opposite of what a good doctor does, but I argue that the concept is rooted in two main things – the physician's ability to think well, and the physician's experience. The ability to 'think well' is a term that I use instead of 'decision making ability' because I think that the concept should be understood in a broader sense. What I mean by this is that the thought processes behind the actual moment at which the decision is made in the clinical setting should be acknowledged and emphasized. That is, it is not only the

faculty of the mind that one would use in the event of a bleeding artery – the part of the mind that would be presented with options and choose one – that makes a doctor effective. It is more than this – the effective physician has very good memory and forethought, among other things, so that each of his minute decisions can be precise and thought-out. Furthermore, the effective physician will be able to focus on a task, while still considering the totality of his situation. Hence, the mind must be strong in its totality in order to deal with the specific nuances that will inevitably arise.

But in addition to a strong mind, the physician must also have extensive experience to draw upon. Experience serves as the uncategorized knowledge base of the physician that will contribute to his overall intuition – although he may not be able to relate a decision to a specific study, the experienced physician will usually be able to explain another nuanced case he saw that he finds similar and relevant. Although any doctor can follow a large-scale procedure, only the one with a strong intuition will be able to tackle the specific, nuanced problems or challenges that inevitably arise in the practice of medicine. The intuitive physician is the one who will know how to deal with an unusually formed physiological structure, or what to do when vitals change in certain strange situations.

It's important to note here that the philosophical objections to evidence also apply to the experience of the doctor – all of his experiences are still subject to his own interpretation. This is an inevitable fact in the world – all observations are subject to some interpretation. However, what makes the use of ones *own* experience markedly different than the use of another's is the fact that it's consistent. The central claim made by Hanson and Kuhn is that all perceptions are affected by preexisting beliefs in the subject, and hence, when a study is conducted and published, the way the scientist

subjectively interprets the data is always swayed by his prior experience. The problem that then results is that *other* doctors make further assumptions about the study, and the way it was interpreted, and utilize it incorrectly – differently than the original investigator intended it to be used. If the doctor relies most heavily upon his own direct experience, there will always be a level of consistency with which he views medical practice.

Similarly, if we emphasize the fact that the doctor is to rely more heavily upon his own experience, the second issue starts to disappear as well. As long as the doctor understands that he inevitably has a tendency in his analysis of different published studies, he will not come to rely too heavily upon them – he will understand the fact that his own experience is paramount to the experiences described by others. Hence, the benefit of the individual's application of his own experience is that it eliminates a lot of steps in which the reality of the relevant experience can be lost. That is, the steps involved in scientific procedure – or any conveyance of information, at that – are always vulnerable to a loss of reality. Less subjective input will naturally yield a clearer idea.

Nonetheless, no doctor can ever encounter every problem in every situation – an evidence-backed basis for medicine does seem to be a useful piece to the overall approach to care, as long as the doctor understands the limitations of evidence, and the plethora of ways it can be obscured. However, we must not forget how important the individual experience is – that in each specific case, it is the individual doctor who will be addressing the individual patient. Hence, in the case of biological health, objectivity can only really be approached when the inherent subjectivity of the situation is embraced, rather than shunned.

Alone, EBM is clearly not a sufficient paradigmatic approach to address biological health. Surprisingly, even in addressing the strictly bodily, biological side of health, it is still imperative to understand the individual body – and the individual doctor – *as individual*. The influence of the subject, and the influence of individual, cannot be avoided in medicine.

Before moving on, there are several conclusions that can be drawn from this discussion. The first is that EBM has weak/flawed philosophical backing – it is a systematic approach based on flawed steps. The second realization is that the patient is an individual, and is unique in any and every circumstance. The patient cannot be grouped with others or quantified if care is expected to be effective. A third realization is that medicine cannot be systematized from the perspective of the provider – quality and efficacy of care is always inherently related to the individual doctor.

So is everything about EBM complete nonsense? I would say no. The concept of evidence can be used as a *basis* for an approach to the achievement of biological health, but an overreliance or overconfidence in evidence is not only ineffective, but potentially harmful to the patient. Systematizing/quantifying care according to set protocols is based on an entirely flawed ideology. To clarify, research can be used to point providers in the right direction, but it should never be used as the sole reason for a clinical decision. While research does have the potential to suggest certain things about a procedure, those suggestions should not be directly applied to the decision making process. Telling someone that 'this is what we do in this situation. Its protocol – it has the highest success rate of all available procedures' is unacceptable and useless.

I also think it's important to note here that this is the part of medicine that rests entirely upon the doctor – the part of the project that is undertaken after other

philosophical decisions have been made about treatment. This will be addressed in the future section on autonomy in the doctor/patient relationship – only the doctor should make decisions of this kind. If a patient comes in and claims that they have 'read about a procedure' and that they want it done, they are basing their decision on an entirely flawed ideology. The doctor is the sole person who can make the types of decisions that aim to achieve a predetermined goal, as he is the only one who has the relevant experience to do so.

Patient Centered Medicine

In the previous discussion, one side of the project of medicine was explored – the attempt to improve upon biological health. In the opening remarks, it was noted that this side of health seeks to actualize a predetermined goal – to achieve an outcome that has already been set. In accordance with our understanding of the project of the physician, the determination of this outcome relates to the attempt to arrive at an understanding of the relationship between overall Health and biological health. Clearly, the EBM paradigm did not address this issue at all. The hope, therefore, is that an exploration of this other major paradigm – PCM – will accomplish that goal. It seems, according to the name, that patient centered medicine would explain the way in which the subjective patient is incorporated and focused upon in medical practice.

However, defining the term 'patient centered medicine' actually turns out to be an extremely difficult task – certainly more complicated and unclear than the defining of EBM. In the literature about EBM, there is a clear, accurate and easily understood definition. EBM truly is a way of practicing medicine in the western context, which

strives to accomplish a clear-cut biological outcome. Although it is clearly flawed and incomplete as a whole approach to medicine, there is a clear and well-understood idea amongst doctors and philosophers of medicine alike of what it *is*, namely a strategic approach to improving upon a person's biological state through certain means.

The literature on PCM is quite different than the literature on EBM – there is a significant amount of confusion regarding what the term actually refers to. Almost all of the articles written on the subject define it in terms of what it is *not*, rather than what it is. In most discussions, it is contrasted with disease-centered medicine or doctor-centered medicine, but it is rarely fully explained in and of itself. Jozien Bensing presents a clear example of this tendency in his article, "Bridging the gap. The separate worlds of evidence-based medicine and patient-centered medicine." In defining PCM, Bensing explicitly states that, "an illuminating way of [defining PCM] is by contrasting the concept with its opposite" (p. 21), and then goes on to state that it can be defined as the opposite of disease centered or the opposite of doctor centered. Even most physicians adopt this method of defining PCM in terms of what it is not. In his article in the New England Journal of Medicine, which is explicitly titled, "Defining 'Patient-Centered Medicine,'" Dr. Charles Bardes states that PCM strives to move away from the purely biotechnical medical model, and also strives to establish a more 'equal' relationship between the doctor and the patient – but neither of these ideas are explicated. Rather, they are simply stated. Clearly, the general understanding of what PCM actually refers to is usually quite vague.

However, it was possible to find one article that gave a fairly substantial *explanation* of PCM, though I wouldn't call it a definition. Dr. Moira Stewart gives five criteria that describe the concept. The claim is that PCM does the following: "a)

explores the patients' main reason for the visit, concerns, and need for information; b) seeks an integrated understanding of the patient's world – that is, their whole person, emotional needs, and life issues; c) finds common ground on what the problem is and mutually agrees on management; d) enhances prevention and health promotion; and e) enhances the continuing relationship between the patient and the doctor" (p. 445).

In reviewing both descriptions of PCM – both Stewart's description and the opposite-oriented description of Bardes and Bensing – these concepts seem quite familiar. It becomes clear that PCM simply describes a way of thinking about medicine itself – a way that was just described in its totality. All of these attitudes about medicine seem to be practical implications of our conception of the actual project of medicine. Essentially, the term 'patient centered medicine' just *describes* the kind of medicine that would be practiced by our ideal doctor. Unlike EBM, a doctor can't really practice PCM – they can agree with it or adopt the ideas of it, but as stated, it is really more of an attitude about medicine than an approach to practicing medicine. While discussions surrounding PCM do contain some useful ideas about health and medicine, none of them explicitly address *how* the doctor is to actualize these goals, or what the ideas really mean.

So, where does this leave us in the greater scheme of the project? If PCM doesn't serve as a way for the doctor to reconcile biological health with overall Health in the patient, then where are we to turn?

It seems that a reexamination of the ways PCM is described may shed some light on the issue. As stated, PCM is always characterized in terms of holistic health and a more patient-controlled clinical setting. Obviously, the first of these two issues has been extensively explored. But the second has not – the question of the relationship.

In searching for a practical way to determine each individual's conception of being, it was misguided to look at a medical paradigm in order to derive how to do so. In reality, it is the subject-subject interaction between the patient and doctor that must be examined in order to explore the way by which the doctor can explore the patient's notions of biological health and overall Health.

And this does seem to make sense, in light of the discussion of EBM. It became quite clear that the individuality of each clinical encounter is something that cannot be systematized or fully explained by a single paradigm. Rather, each clinical interaction needs to be examined individually. For the sake of improving biological health, this individuality is important insofar as it recognizes the uniqueness of each patient's body. In order to embrace individuality from this perspective, the important thing was to understand the fact that each patient has a different biological/physiological structure. But in order to embrace the individuality of the patient in an attempt to establish a notion of overall Health, and to make biological decisions in light of that, it only makes sense that the doctor patient interaction is examined beyond the physical level.

Hence, the assumption that EBM and PCM were going to be two components of medicine that are to coincide in order to achieve full and effective medicine was wrong. Rather, one component of medicine is based on biological manipulation, which is to be achieved through the means discussed in the section on EBM, which strives to improve the biological side of a person's being. The other side is entirely based on the relationship – a systematic approach or 'paradigm' cannot achieve something so specific and individualistic. In order to realize a person's notion of being, a one-on-one interaction between two people must take place. And that is what will be examined in the following section.

Section 4: Models for the Clinical Interaction

Through most of the previous discussion, it has become clear that the project of the physician, as a whole, can only be understood in terms of each individual clinical interaction between the doctor and the patient. Furthermore, it has become clear that any attempt to objectively systematize medicine is not only ineffective, but also dangerous, as seen in the case of the pure evidence based medical paradigm. Even from a biological perspective, the individuality of the patient's situation always has to be taken into account – every medical decision must occur by means of a specific analysis of the unique case at hand. That is, cases are not to be thought of or described as *a* case *of* x or y, but rather *the* case. So, prior to any assertions about subjectivity or the actual relationship, the specific clinical encounter is still to be valued in terms of absolute importance in the project of medicine. As we have come to see, it really is impossible, or at lease useless, to discuss medicine without discussing the specific clinical interaction.

In this section, the specific nature of that clinical interaction will be explored in light of the previous discussion on health and being, in order to determine the nature of the most effective clinical interaction. Referring to the previously proposed model of overall health, we will attempt to isolate and identify a specific kind of clinical interaction in which the patient's own notion of holistic Health can be most readily and effectively brought to light, so that decisions about biological health can be made effectively.

Before starting the discussion, I find it important to clarify the use of the term 'relationship.' Soon after considering the clinical interaction, it seems to become

imperative to discuss the *relationship* between the doctor and patient. But this is not necessarily the best way to understand the interaction. The term 'relationship' already implies a certain *kind* of interaction between doctor and patient. And although our previous discussion of health, and the nature of health and being, would suggest that the interaction must develop into a relationship, it is not the case that all ways of conceptualizing the clinical interaction involve a relationship in the full sense of the word. Using the term relationship implies that there is a meaningful connection between two people, but in some ways of conceptualizing the clinical setting, this meaningful connection does not come to exist.

At the outset of the discussion, we are left with a major question that must be addressed before we can start – how are we to *classify* different kinds of medical interactions? With some thought, one issue emerges as the preeminent feature used to classify many interpersonal interactions, especially ones that center around a decision making process involving two individuals – the issue of power. And because of the specific aforementioned nature of the clinical interaction, namely that it inherently involves a decision making process, the question of power can be considered synonymous with the more specific question of autonomy.

Autonomy really is the central feature of any interaction that involves a mutual decision between two people – the interaction cannot be thought of without it, and it is the ultimate feature that will decide how decisions are made. The importance of autonomy in any interaction is elucidated when one considers government – all governments are classified according to the level of autonomy amongst the ruling versus the ruled. It makes sense that the clinical interaction is almost always conceptualized and organized in the literature according to this concept of autonomy.

Hence, an examination of autonomy in the relationship will serve as the first step towards identifying the nature of the most effective clinical interaction, and as a way of organizing or dividing clinical interactions into kinds.

It is also important to note that each of these models results in a different notion of health, by its nature. That is, as autonomy changes, so does the functional notion of health. This movement will not be linear through the discussion. Rather, the health conceptualization will be more objective and biologically-rooted in the models where autonomy is one-sided (the first and last model), and will be more subjective and holistic where the autonomy is shared. This will turn out to be a major factor in determining which model is most effective.

In order to explore this concept of autonomy in the interaction, we will explore five different ideal models of the clinical setting. In the discussion, we will move from a model in which the physician dominates the autonomy towards one in which the patient is mainly autonomous. It is to be noted that these models may have different names in the literature, or may be described slightly differently by different authors, but there are commonly four major models that describe the main categories for kinds of autonomous medical interactions. I've decided to include an extra, less common model because it serves as a useful middle ground between the two sides (patient-controlled and doctor controlled). The five models, moving from doctor as autonomous to patient as autonomous, are[9]:

[9] Emanuel and Emanuel provide a very clear and concise explanation of the models of the relationship – this is the model that the discussion will largely be based off of, as it has been widely accepted in the medical community as a valid representation of the clinical interaction. Childress and Siegler also provide some useful insight as to how these models can be understood.

1. The paternalistic/parental/priestly model
2. The deliberative/friendship model
3. The negotiation model
4. The interpretive/partnership model
5. The informative/engineering model

The Paternalistic Model

The paternalistic model of medicine, also called parental or priestly, is the classic way of conceptualizing the interaction between doctor and patient. Although the name seems to suggest that this model is inherently based on a relationship, this is ironically one of the interaction models that I find very non-relationship based. In this classic model, the doctor serves as the absolute controller of the decision making process – the physician, as expert, makes decisions according to an objective set of medical values, and the patient is to respect those decisions and follow the doctor's orders. It is expected that the patient will consent to "the physician's determination of what's best" (Emanuel and Emanuel, p. 2221). Because health value is seen as objective and absolute, it is only the physician who can make the best decisions regarding health – he is to use his expertise and training in order to isolate a problem and come up with the best solution. Clearly, this model does not rely on much patient input at all. The patient's only job in the interaction is to objectively inform the physician of his symptoms. Decisions about treatment are made without any subjective influence from the patient – the patient's role is simply to carry out the doctor's instructions as precisely as possible.

Under the paternalistic model, the interaction between doctor and patient does not leave room for the generation of a meaningful relationship. But if the interaction were to be conceptualized in terms of a relationship, I think the model of the father or priest with son or worshipper is misguided to describe it. The interaction does seem to be paternal or priestly in that the patient must have absolute trust and reverence towards the physician, as in the case of the father or priest, but the suggesting of a father/child relationship implies more than just one of reverence and order following. The so-called paternalistic model of the interaction does not entail the nuances of the relationship between a father and his child. There is no implication of mutual care or empathy, nor is there any sort of meaningful communication that takes place. Hence, I think it would be more useful to think of this type of interaction as the kind between a soldier and his commanding officer. The soldier respects the knowledge and capability of his commanding officer, and takes orders from him without inputting any subjective influence. This seems to be more representative of the way the patient and doctor interact in the paternalistic model – it is cold and objective, and does not rely on a close relationship in the full sense.

The Deliberative Model

The movement from the paternalistic model to the deliberative model constitutes a large shift in the way the interaction works. The patient's influence is introduced in this model, but the doctor still retains a good share of autonomy in the relationship. In the deliberative model, the doctor informs the patient of the totality of their clinical situation, and seeks to persuade the patient to make decisions that he (the

physician) deems best. In order to do so, the physician must fully explain the situation to the patient, taking into account all of the subjective criteria that may be at stake. The doctor must have an informed conversation with the patient in order to identify what goals would seem best in this specific instance for this specific patient.

This model of the interaction acknowledges the fact that health is not an objective, universally understood issue. A conception of health is explored, given the situation, according to the specific ongoing in a patient's life. However, in the deliberative interaction, the doctor ultimately seeks to make a final decision on what he thinks is the right option in terms of decision making. Although he does take the subject into account in the process of deciding, the doctor will ultimately try to persuade the patient to make one decision over another – this model seems to open health to *some* subjectivity, but it still holds on to the objective health value of the paternalistic model. It is often noted that decisions ultimately belong to the patient, and that coercion is to be avoided, but the doctor still makes a clear and strong effort to inform the patient of what to do – the doctor seems to have an attitude that he knows the true objective nature of health, but that he doesn't have the *right* to impose that notion on the patient.

In the deliberative model, there is definitely a strong relationship developed between physician and patient. Although that relationship is often characterized as friendship, I think it is more useful to characterize *this* model as paternalistic – or maybe motherly – but between a parent and an *adult* offspring. The relationship here is very intense, and extensive communication takes place in the interaction, leading to the development of a strong relationship. But what makes it parental, to me, is the fact that the doctor still believes that he 'knows best' for the patient, just as the parent

always thinks that he or she knows what is best for the child. Illuminating the model in this way seems to make it a bit less mutual, at least ideologically. Even though the patient has the final say on what he or she is to do with his or her health, the attempt by the physician to tell him or her what he should do seems to be an imposition, similar to the way the mother and father seem to impose on the decision making process of their adult child. Just as the child of the parent will assert that he is an adult, and that he knows what is best for his own life, it seems that the patient would, or should, do the same. This will be discussed in more depth in the discussion.

The Negotiation Model

The negotiation model is rather uncommon and unorthodox – it is put forth by Childress and Siegler as a way of 'leveling the playing field,' as it were, between the physician and patient. That is, it seeks to generate a model of medicine in which neither doctor nor patient is autonomous. In this model, it is assumed that the doctor and patient may both have their own individual interests – just as a patient may have a presupposed notion of health, the doctor may have one as well. In these circumstances, according to the negotiation model, neither party has to submit to the assertions of the other. Rather, the two should have a conversation in which they both put forward their view, and come to a mutual decision on a hybrid version of the overall decision. Hence, this model acknowledges the subjectivity involved in any understanding of health, but does not seek to put either the doctor or the patient in the right.

In order to come to a mutually agreeable decision, the doctor and patient would

both be required to put forth the entirety of their idea of health, and propose an argument for their understanding of the current situation. Interestingly, Childress and Sielger believe this to be especially effective because it allows for notions of health to change and evolve over time. It seems that this model is an attempt to acknowledge how unique each clinical interaction is – rather than setting a standard way of viewing autonomy, it is proposed that the autonomy can and should shift according to the specific situation. In other words, the relationship between the doctor and patient can be controlled by the doctor in some instances, and by the patient in others. It is a model that does not tie autonomy to either party, but rather conceptualizes the relationship in terms of a constant flux of autonomy from one interaction to another. By acknowledging this movement from interaction to interaction, the negotiation model seems to bridge the gap between the two parties. But whether or not this model is effectively useful will be discussed in more detail later in the discussion.

The Interpretive Model

The interpretive model, as I see it, seems to be a slightly more patient-controlled version of the deliberative model. In the interpretive model, the physician still seeks to help the patient identify a specific notion of health within the context of the situation at hand, and help the patient come to a decision regarding these matters. It is the job of the physician, according to this model, to elucidate the medical issues clearly, so that the patient can fully understand the situation, and to engage in a conversation with the patient in order to bring the patient's own understanding of the issue to light. Similarly, the physician will seek to identify a set of goals with regard to any given

condition, taking the subjective will of the patient into account. Unlike the deliberative physician, however, the interpretive physician stops there – there is no attempt to persuade the patient to make one decision over another, regardless of the physician's own inclinations or beliefs.

Clearly, the interpretive physician realizes the subjective nature of health. But unlike the deliberative physician, the interpretive physician does not believe that he is to impose on an understanding of health. That is, the interpretive physician views health as an entirely subjective notion, while the deliberative physician views health as somewhat subjective, but still retaining some form of objective value. Because of this belief, the interpretive physician will only seek to elucidate a notion of health within the patient – it is accepted that often times, health is not a clear cut issue, and it requires a fair amount of clarification and discussion before one can arrive at an absolute understanding of what one thinks is best with regards to health decisions.

The interpretive model of the interaction is, like the deliberative, inherently based on a relationship – it is only through intimate conversation that the physician can help the patient arrive at a full and acceptable notion of health. To me, *this* model is the one that should be characterized by friendship, although Emanuel and Emanuel characterize it as a partnership or a relationship between advisor and advisee. The two thinkers take the physician's lack of effort to input his own subjective belief as a lack of care on behalf of the physician, in that one may conceptualize the physician as 'allowing the patient to make a bad decision.' But I think this is very misguided – with a more full understanding of health, it is clearly acknowledged that subjectivity in these decisions must be embraced in their entirety, though this will be discussed later in detail. In my view, the interpretive model is more representative of a friendship than

any other model – it stresses mutual respect and mutual care. According to Childress and Siegler's account, the friendship model is similar to the deliberative model, but it is different in that it "stresses the intensity of the *relationship*" (p.21). The doctor shows respect for the patient's autonomy, while the patient shows respect for the doctor's ability to describe the situation and help them arrive at a notion of being, even though the patient has the ultimate say on the course of his or her treatment.

The Informative Model

In terms of autonomy, the informative model represents the opposite of the paternalistic model – it is a conception of the interaction that gives the patient absolute autonomy in the decision making process, severely limiting the role of the physician. Other ways of describing this model are as technician or engineer's model, viewing the physician as an expert in human biological systems. In the informative model, the physician simply analyzes the patient and gives him or her information regarding the situation at hand – the patient then makes decisions according to the objective criteria put forth by the physician. In no way does the physician have any influence in the decisions that are made – the job of the physician is simply to inform the patient what the situation is, and what possible treatments there are. As stated by Emanuel and Emanuel, "There is no role for the physician's values, the physician's understanding of the patient's values, or his or her worth of the patient's values" (p.2221).

The model adopts an interesting, yet somewhat confusing, notion of health. In one sense, the physician is understood as a biological expert, and nothing more. That is, the physician is nothing more than a textbook – simply explaining certain biological

conditions, options for procedures, and statistical outcomes. In this sense, health seems entirely objective and biological. But on the other hand, the patient is the one who ultimately decides what to do. This seems to go against the objective notion of health – understanding health as biological and objective, it would seem that the patient would rely on the doctor to choose the best procedure. The fact that the patient ultimately decides on what to be done seems to suggest that health is more subjective, but that the physician is not to be involved in the generation of health itself.

It is unclear what notion of health is adopted here. On one hand, it seems that health is to be understood as objective, but that the patient is making the assertion that he or she is just as competent as the physician in the process of identifying effective procedures to achieve that objective goal. But on the other hand, it seems that the patient may be asserting that the physician is not to be involved in the notion of health – that health is entirely subjective, and that it is only the doctor's job to give information about a person's biology, not to help them develop health in any way but a physical one. The first of these two possibilities seems to be misinformed and somewhat silly – there is no way that a patient could make decisions about their objective biological condition more effectively than someone who does it for a living. And the second possibility seems to make sense, but to be somewhat overconfident in its ideology. That is, it is possible for someone to think that they don't need the doctor's input in the attempt to identify health values in given situations. If this were the case, it seems that this model diminishes the conceived role of the physician, but does not move toward an objective notion of health.

Regardless, conceptualizing the interaction in these terms clearly leads to a situation that is as sterile and cold, if not more sterile and cold, than the one generated

in the paternalistic model. There seems to be no relationship here at all – this notion of the physician is no different than a computer. The patient retains all autonomy – there is none to be shared.

Discussion

In light of our previous discussion on health, the efficacy of some of these models is fairly easy to judge. The paternalistic model, to start with, is clearly ineffective in achieving a whole notion of health. It completely disregards the idea that the patient has to realize his or her own notion of Health and being before any medical decision can be made, drawing on the false assumption that Health, as a whole, is strictly biological. The paternalistic model seems to be the one used by physicians who rely solely on EBM, viewing conclusions drawn from research and statistical observations as dogmatic ways of representing how to achieve health. It is this model that much of the 'PCM' movement is rallying against – many view this model as an unacknowledged infringement on patient rights, and assert that overly aggressive assertion by the doctor is unethical (Goodyear-Smith and Buetow).

The informative model is also quite troubling, though for a different reason. The interpretive model completely skews the conception of medicine that we've been working toward. The model relies on a very unclear idea of health, and completely devalues the importance of the physician's role in medicine. Furthermore, it ignores the fact that the physician is the only one who can most effectively make decisions regarding biological health. That is, even if a person came in with a clear and well-thought out understanding of their life and what it is to be in good Health, there is no

way that the patient would be able to effectively align that notion with a medical procedure (at least in many circumstances). That is, even if someone comes in without a doubt in their mind as to what their own subjective notion of Health is, if he or she is confronted with the decision to choose between complex procedures. There will still be a *necessary* conversation that would occur between the doctor and patient with regards to the alignment of that notion with the outcomes of the procedures.

In other words, there is no way that a patient could immediately learn everything about a single procedure based on objective information. Medical procedures are extremely complicated and nuanced – the doctor's input is absolutely necessary in the attempt to clarify and elucidate the way in which outcomes will affect each individual. Hence, it is not realistic to call the model 'purely informative' – there may be cases in which an interaction can be informative (you have an infection – you can take antibiotic A or B), but any complex clinical situation necessarily requires a more detailed and nuanced conversation. That is, even the patient who 'believes in' the informative model will enter the realm of the interpretive model in a more complex situation.

The deliberative model seems to be quite close to an effective way of actualizing our notion of health. Many scholars, including Emanuel and Emanuel, support this model as one that embraces mutual autonomy most effectively. The model has been conceptualized as a way to give the patient their fair share of control in the interaction, while still retaining the understanding that the physician is ultimately the professional (Chin). In keeping the 'benefits' of paternalism – namely, an assertion that health goals should entail some 'objectivity' – the 'integrity' of medicine stays in tact. But in the acknowledgment of the individuality of the patient, the specific case is examined,

taking the whole situation of the subject into account. In this sense, the deliberative model seems to expand a notion of health, while holding on to some objective basis.

Although I think the deliberative model is a movement in the right direction, as it were, I don't think it does so in a particularly useful way. It seems that this model acknowledges that there is some sort of duality that goes on in our conception of medicine, but does not do enough to elucidate just what that duality is. That is, the deliberative model seems to lack philosophical basis. It ignores the necessity to examine the nature of that confusing fragmentation in our overall understanding of Health, and because of this, the solution is not very well thought out – it seems that the assertion is simply that there should be something objective, at least in some way, about health, but that it is also subjective, in some other way. The way the deliberative model goes about reconciling this confusion is by simply addressing the ideas of physician and patient as different in some way, assuming that the physician knows the objective side of health while the patient knows the subjective side. Clearly, as discussed in the section on health, the distinction is not so simple.

The interpretive model seems to make the same mistake, though I believe this model comes closest to addressing health as we have conceived it. The interpretive model stresses the importance of a realization of the notion of health by the patient, and also stresses the importance of the physician in accomplishing this. At first glance, it seems that the interpretive physician does exactly what we've asserted the physician is supposed to do – elucidate a personal notion of Health – and this is true. But once again, the lack of a clear definition of health leads to a shortcoming. Although the physician can effectively arrive at a notion of Health through this model, it is not so clear that he can actually improve the biological side of health through this model. The

way it is described by Emanuel and Emanuel, the informative model leaves the physician in a place where he has almost *no* say in the deliberation process. That is, although the informative physician will do an admirable job of allowing his patient to come to their own subjective understanding of biological health and overall Health, he also allows them total license in choosing a medical procedure – he has no input at all. This does not seem right, given the previous discussion of EBM – the doctor must have input in choosing the actual course of action, while *basing* this off of the patient's conception of Health.

This central flaw (the lack of doctor autonomy in choosing actual medical procedures) can be viewed, in a way, as the other side of the deliberative model's central flaw. It seems that the deliberative model wants to suggest that the physician is the only one who knows best in terms of the improvement of biological health, but that it ignores the fact that the patient's notions are central – not the physician's. Speaking of our preconceived notion of health, it seems that the deliberative model is able to improve upon biological health most effectively, but that the informative model is able to generate more useful medical decisions based on a whole conception of Health.

There must be some way to reconcile these two models, drawing the beneficial parts from each. And in order to do so, we have to return to the central notion of autonomy. It seems to me that a fundamental flaw in the analysis or description of these models in the literature is that it ignores the fact that there are different *parts* to the clinical interaction. Once this is understood, one doesn't have to label the overall interaction in terms of autonomy, but rather, parts of the interaction. It seems that the negotiation model made a good move in attempting to assert that each individual interaction must vary, even between the same physician and patient – but I seek to take

this one step further, and assert that each part of the interaction must vary in terms of autonomy.

I think the nature of decision-making needs to be more closely examined in order to elucidate these different parts. Every decision involves two fundamental steps. The first step is the realization of a desired outcome, and the second is an action that strives to achieve that outcome. In terms of medicine, the realization of the desired outcome is obviously the process by which one comes to understand their own notion of Health, and hence their notion of biological health. The action that strives to achieve that notion of health is the actual medical procedure. Understanding the decision making process in this way, it becomes clear that the patient holds the autonomy in the process of defining their notion of Health, but that the physician holds autonomy in deciding on *how to achieve that goal*, or in other words, the physician should have the final say on the actual medical procedure. Hence, the deliberative model is flawed in its assertion that the doctor should influence the patient's actual understanding of health, but the interpretive model is flawed in its assertion that the physician shouldn't have autonomy in the process of choosing a procedure.

Now, this is not to say that the autonomy is to be held in full in each of the respective parts of the decision making process. There obviously can, and will, be ways in which the doctor is involved in the derivation of the notion of being, and similarly ways in which the patient is involved in the choosing of a procedure. But this cross-involvement should be limited, and should respect the autonomy of the other. For instance, the doctor may prod or ask questions in order to elucidate a notion of being, and at the same time, a patient can voice concerns about different procedures for different reasons. But in each of these cases, it should be done with a level of respect

for the other – the doctor must acknowledge that the patient is an expert on his or her life, and at the same time, the patient must acknowledge that the doctor is an expert on medical practice. To clarify, it should never be the case that the doctor makes a blatant assertion about what the patient should want. And similarly, the patient should never tell the doctor which procedure is best for their desired outcome.

It is this model that serves as the most effective – one that acknowledges the dual nature of the decision-making process, and does not try to attribute all autonomy in the interaction to one party. Clearly, the patient and the doctor are both experts, albeit on very different topics. The two must recognize and respect their positions in the interaction, and respect each other's level of expertise. Through this understanding of the clinical interaction, the doctor will ultimately be ale to achieve the goal – by effectively communicating with each patient on an individual basis, while maintaining this firm understanding of the way the autonomy is to be distributed in the interaction, the doctor will be able to make confident medical decisions that are soundly rooted in the individual patient's own understanding of Health.

Conclusion

Arriving at the end of the Section 4, it seems that both major goals of this project have finally been realized. It is hopefully clear by now that Part I was successful in defining the telos of the physician in medical practice. To clarify one last time, it was decided that the two major aspects of the physician's role are 1) to come to a specific understanding of the way each patient conceptualizes the interplay between biological health and overall Health (or in other words, attempt to understand the patient's overall conception of being), and 2) to improve upon the biological health of their patient. In addition, the physician is to remember that his ultimate goal is to establish overall Health, and he is to do whatever he can to accomplish that goal.

Part II was also rather successful in establishing the answer to the 'how' question. It was concluded that in order to most effectively realize a subjective notion of Health in the patient, the doctor must address each patient as a free-thinking subject, while keeping a clear understanding of the way the relationship and decision making process is supposed to work. Furthermore, in order to improve upon biological health in the patient, it was made clear that the doctor must always remember the individuality of his patient, must rely on his own intuition above all else, and must never blindly adhere to a systematic approach to medicine.

According to the outline of the paper in the introduction, the project was definitely successful – a description of medicine's telos, as well as a description of the way the doctor is to actualize that goal, has been formulated. Clearly, this *was* the goal of the paper. But looking back, if we delve beyond the *content* of the text, and towards

the actual *movement* that was made in order to come to these assertions, an even more interesting conclusion comes to light.

At the outset, we began by examining several preexisting notions of what it means to be healthy. We delved into the assertions of different scientists and philosophers, referencing different books and articles, in an attempt to learn from others. We gathered as much knowledge about health as we could, in an attempt to come to know what medicine is. Different assertions were made about the ideas – we agreed with some, disagreed with others. But regardless, the object of the first section was to establish a knowledge base upon which we could build the rest of our project.

In the second section, we reexamined that entire knowledge base – the assertions made in the previous section were scrutinized and analyzed. We grappled with the different concepts that we had just learned about in an attempt to make our own idea – to come to understand what was really going on beyond the academic debate. Despite all we learned, we made a strong attempt to come to our own understanding, thinking *beyond* what had already been stated.

In the third section, we began our search for the correct way to practice – the best system of medicine. But in each of the two, we found some fatal flaws. It seemed that there was no way to accept a single, structured paradigm. Clearly, systematized medical practice was detrimental and useless. Nonetheless, we learned a good amount from the flaws of the ideology before moving away from the systematic and towards the individualistic.

Within the analysis of the clinical setting, it quickly became clear that a positive relationship between doctor and patient was absolutely paramount to good medical practice. Although we came to understand the general attitude that the doctor must

have in the clinical setting, the nuanced skills – the ways by which the doctor can actualize his goal – are still left to be explored. This part of the 'how' question seems impossible to answer in full – there can always be another way for the doctor to do his job better, both in terms of biological health and in terms of his generating a notion of holistic Health.

Clearly, this was originally intended to be an external philosophical analysis of the way medicine works. But looking back upon the project, it seems that it became *more* than just an external inquiry – it seems to have become a kind of phenomenological experience. That is, the education that *we* received in the movement through this paper can be seen as a direct analogue to the way a *reflective doctor* should move through his education and career.

The first section can be seen as analogous to the physician's experience in medical school, starting from scratch, examining the theories of others in order to build up a knowledge base, which could be used for the rest of his project in medicine.

The second section can be seen as the physician's attempt to sort through the different theories and notions that he learned in school in order to come up with his own conception of what medicine really is. In this stage of his career, the physician seeks to establish a true basis of his project, based on all of the knowledge acquired in school, just as we attempted to find greater meaning in these preexisting notions of health.

The third section can be seen as the physician's experience in residency – the physician enters the practical realm, and into a structured system of medicine that relies upon hierarchy and protocol, just as we entered the realm of medical paradigms which were similarly structured. Just as we did in the discussion, the reflective

physician will ultimately realize the inadequacy of the system. Through his experience, the physician will come to realize the importance of the individual clinical interaction.

Section four can be seen as the physician's movement away from the systematization of the residency experience and towards a more individualistic kind of clinical medicine. As we did in the movement through this section, the physician will ultimately come to realize the best way to interact with his patients. Furthermore, he will come to realize that he can always improve upon his project, just as we realize that we can always expand upon this paper.

The reason why this parallelism is so important is because it shows just how much philosophical thought the field of medicine demands of the physician. In order to be a truly adequate physician, one must never stop examining his situation, never stop questioning his teachings, and never stop asking which elements about his practice are good, and which are bad. Only the reflective physician can be a decent physician, regardless of technical skill or training. The ability to think deeply and reflectively is a *fundamental* attribute of any good physician – and it is a quality that the physician must never lose. Regardless of technological advancement, we cannot forget that the field of medicine deals with the fundamental element of humanity – being. The physician truly is an ontologist, and he must recognize himself as such.

In conclusion, if nothing else is taken away from this project, it is my hope that the reader has realized one fundamental reality: we *must* think philosophically about medicine. Throughout this project, it has not been my intention to lead the western world to an enlightened understanding of the entire field of medicine, nor has it been my goal to make a groundbreaking assertion about ontology or intersubjectivity. The content of the paper is certainly important, in that it raises questions and concerns, and

makes a few suggestions about medicine. But even if the reader disagrees with every claim I've made in the text, I hope that he or she will still recognize – by the simple process of reading through this paper – that medicine is *necessarily* more than just science or technology, and demands an *immense* amount of thought, both from the behalf of the physician *and* the patient. In dealing with the lives – the Being – of individuals, the project of medicine must be thoughtfully reflected upon *incessantly*.

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