Prologue

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This book about the care of patients is centered on sick persons and their inability to live their chosen lives. Here, the interest of clinicians includes diseases but goes beyond to focus on patients' themselves, their purposes and goals and the impairments of functions from the molecular to the spiritual that interfere with their achievement. Directly obtaining information from and knowing about patients is central.

This prologue comes before anything else because it is about appreciating and keeping in awareness two basic and automatic influences on thought—**meaning** and the role of **science** in clinical medicine— that get in the way of understanding the ideas here as well as the accurate assessment and appreciation of patients.

The assignment of meaning to percepts is a cognitive function that is virtually instantaneous, invisible, precise, accurate, fundamental—and *individual*. Look into the woods and you see a bunch of trees. Yes and no. You actually see a bunch of colors and shapes but the meaning, *trees, leaves, (and etc)* immediately comes to mind. In the clinic you see an old man with yellow skin and sclera and a big abdomen. In a flash you register a jaundiced old man with ascites (probably). The assignment of meaning even made a probabilistic statement in the same instant. For trees as well as the jaundiced man, although we assign the same label, you and I mean something different because our experiences that shape the labels we assign have been necessarily different. Maybe just a tiny bit different or perhaps even greatly dissimilar. Unless we sit together to study the issue (very unlikely) we will not know our differences of meaning.

If meaning was only the assignment of labels with various complexities of content it would merely be an admirable (and very helpful) function of thought. Meaning is much more than that. Because the word itself has many meanings, let me clarify what I am talking about. The identification and labeling of perceptions is an assigning of meaning. We look out and see an angry appearing bunch of people coming and we say "that is an angry mob." We have assigned a meaning to what we see. This is the most common kind of meaning because it is the *labeling of experience.* The two examples that I gave—the trees and the jaundiced old man—are that kind of meaning. Labeling experience is a judgment in that it could, after all, be wrong. That labeling experience is a judgment also implies that two people may assign different **meanings** to the same experience. They can both be correct because the same experience

may have different **meanings** for different persons—sufficiently unlike to require different labeling. Or one can be correct and the other incorrect, yet they will have been exposed to the same external experience. We would expect that in the two examples given people would agree, but that is not necessarily true. You look out and see trees; I see the same scene and say, "Isn't Spring wonderful." I look at the jaundiced old man and I say, "Look at that abdomen. He probably has a belly full of tumor."

The opposite face of the labeling of experience is the one most commonly associated with the idea of meaning, the meaning of words and symbols. The dictionary definition of, for example trees, uses other words to define the symbol. More important in everyday life, however is the connotation of a word. The connotation of a word is the sum of the properties, attributes, or implications of the word apart from its strict definition. In everyday speech, those attributes of words—their emotional loadings and other **meanings,** as in a house is a home with all the ideas associated with home—are why language can be used to communicate so much. Of course, strictly speaking, the attributes are not of the word, but of what the word symbolizes. Much of the impact of the word on the person comes from its connotation. I have previously shown[1] that the many attributes of meaning include virtually every level of the human condition. There is, of course, the cognitive content; the stuff we use when we reason from one idea to the next. And images, where the word brings to mind what something looks like. This is why we can label visual experience. And the sound of things to allow the labeling of auditory experience—in fact, all the senses, major and minor that track both the outside world and inside the body from joints to viscera. Perhaps you think I have gone too far, included too much as part of meaning. But if not, how will you label the experience of certain foods and beverages and the pleasurable feel of them going down? Or label the feeling that foretells the onset of diarrhea (the cramps).

Experiences evoke feelings—emotions—from love and ecstasy to despair and rage and so also do the words that label those feelings—these feelings are part of the meaning. Feelings are not just things that happen in your head, they have effects on the body. Think of the physical feelings that are part of love, sorrow, joy, anger, amusement. Notice that I said, 'are part of,' the emotions. The emotions *do not cause* the physical reaction; the physical reaction is *part of the meaning.* The smile is a constituent of amusement, the heavy feeling in

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[1] See Chapter 13 in *The Nature of Suffering.* 2nd Ed. New York; Oxford University Press.

the chest is a part of sorrow, and scared feelings are an aspect of fear, and so on. We know the flow of catecholamine, hormones, endorphins, and so on accompany these physical sensations; these are also part of the meaning.

There is ample evidence that some aspects of meaning are hidden from conscious recall or awareness because of their association with painful or even forbidden (usually childhood) memories. As a consequence, the experience that is labeled by a word or phrase, may includes not only cognitive content, but body sensations, images, sensory information, and emotions whose origins are inaccessible to consciousness. It is also clear that the assignment of meaning, manipulation of the content included in meaning, and thought employing meaning can operate out of awareness. Sometimes it stays behind your eyes, so to speak, and at other times presents it conclusions to consciousness. However and wherever, meaning is part of the processes of thought. [2]

Another element of the meaning of experiences (and their descriptive vocabulary) is importance. The importance of something is always importance to someone. To say something is more or less important is another way of saying that it has greater or lesser value to that person. In ordinary conversation adjectives and adverbs modify nouns and verbs so as to make their meaning more explicit. They also, however, intensify or diminish the meanings of the words that are modified. As in a beautiful, lovely, nice-looking, ordinary, spavined, or useless horse. Or, for a person, as elated, happy, even-tempered, angry, sad, or depressed. Someone runs speedily, swiftly, or clumsily. By so modifying they add a dimension of value or importance to the nouns or verbs. Feelings, as we have seen, are an element in meaning. They can be of variable intensity. The word *cancer* can strike terror into the heart of one person, merely frighten another, or arouse interest in someone else (the oncologist). The emotional response to the sensory component of meaning may also be variable, thus introducing a variable element of importance. In general terms, therefore, we can say that there is always an importance or value aspect of meaning, which is contributed by all of its components.[3]

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[2] For a more complete description of the phenomenon of meaning, see *The Nature of Suffering*. New York: Oxford University Press. 2nd ed 2004. Chapter 13

[3] *Ibid* p.239

The complexity of meaning, its individuality as well as commonality, and especially its widespread—but virtually invisible—effects on the person emphasize why I have put this description in the front of the book. A physician seeing a patient, hearing about an illness, or examining the patient is having experiences that evoke meanings that may be all right for the task of disease-hunting, but might bring up, though out of awareness, impersonal or even negative responses to the patient. These reactions where the clinician's task is healing and the relationship to the patient is most important might not be helpful (or worse). The solution is straight forward but difficult. From the first contact with the patient, the healer has to be consciously and actively aware of the response the patient is evoking so that it is under the clinician's control. This means thinking about the patient *and* thinking about what you are thinking about the patient. Not simple. Especially difficult since clinical thinking is in part very sophisticated pattern recognition. When a pattern is grasped, the next step is assigning a label which puts the clinician back into the problem of meanings which may begin invisibly to guide thought. A patient who has lived much longer than expected and who cries as she talks about it may make the label, "Survivor guilt," come to mind. The next thought should be, "What do I actually know about survivor guilt?" The answer should be, very little. This again opens the clinician to careful thought about what the patient is saying.

The place of **science** in clinical medicine must also be clarified before starting out. The promise of science when it entered medicine in force before the Second World War was that medicine would be based solely on scientific fact. The statistical methods that have been so crucial in the development of new medical knowledge have smoothed out the differences between individual rather than emphasizing them. Scientific medicine, then, would be freed of the problems raised by individuality, subjectivity, opinion, and the weight of authority. This is the way people speak of evidence based medicine now. One hears this currently in the often expressed belief that the only evidence that is valuable is objective evidence and only that which can be measured truly meets the standard. This means that patient reports of their illnesses and their symptoms, which can only be subjective, and the reactions in thought and throughout the clinician in response to the patient which are also necessarily subjective will always be suspect and can never be granted full citizenship in scientific medicine. The specter of failing the test of scientific adequacy seems always to be present. In this book and the definition of sickness on which it is based, subjective reports from patients about their goals and purposes and the functions required for their achievement can never be scientific, yet they are

essential. In fact, the sick-person-in-full who is our major concern (each of whom is distinctively particular) is not and cannot be an object of science. This is neither bad nor good, it simply is. On the other hand, many aspects of sickness, particularly those in body parts, can fit within the canons of science and should be held to such rules.

Persons' meanings, whose cardinal importance I just discussed, *cannot* ever be anything except subjective. What of other dimensions of sickness? What of goals and purposes, or desires and concerns, or affective responses to illness, or pain, dyspnea, or other symptoms? For that matter what of utterances and opinions and anything else about sickness including prognostic statements by physicians? None of these is measurable but that does not mean the information cannot be accurate. The information can be exact, precise, and replicable when obtained with care. It can also be valid, correct, and point to the truth. Bemoaning the subjective nature of all these things or complaining about the lack of science when it comes to meaning and what patients say is like deploring the fact that patients are human.

The problem is not that so many aspects of clinical medicine cannot be dealt with scientifically. Rather, the romantic but *impossible* idea that science was going to create a clinical medicine from which subjectivity, opinion, and the greater inherent authority of some than others would be banished is not now and never was helpful. Look at what did happen, however, in these seventy or so years. The contemporary quality of scientific evidence is one of the great advances of medicine, scientific ideals permeate aspects of medicine where they are appropriate, and there have been untold achievements in knowledge and technology all of which are a consequence of science. The central fact of the science of medicine is that it achieves it goals because the goals have been made small enough to accomplish with the scientific method. This is called reductionism. What price has medicine and the society paid for the reductionism necessary to make medicine's leaps forward? We have lost our appreciation of wholes—whole persons, whole societies, and even the country as a whole. True also for readers in countries other than the United States. Now the task is to accept the undeniable fact that all persons (patients) are wholes in themselves and each different than another. Then to include the flood of subjective information that is obtained from patients systematically with rigor and discipline so that we meet the ideal laid down by Alvan Feinstein for a science (in the original sense of knowing through study and mastery of knowledge) of patient care where N=1. (Feinstein, Alvan. *Clinical Judgment.*) Keeping in mind, while doing that, that it is whole

persons we are caring for—kept as wholes in our thoughts because it is their ability to pursue their purposes and achieve their goals that is the North Star that guides our actions.