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THE CONFLICT BETWEEN THE DESIRE TO KNOW AND THE NEED TO CARE FOR THE PATIENT

There was a symposium about the moratorium on recombinant DNA research. Someone said that the research would start up again, that it had to. Hans Jonas asked the simple question – "why?". A scientist answered that if we did not do it, someone else would. Therefore we had to. Again Hans Jonas asked "why?". Others may move you to examine your dearest unquestioned assumptions by the persuasiveness and complexity of their reasoning; but such is the force of Hans Jonas' intellect and moral authority that his simple question – "why?" can be more provoking of reflection and inner questioning than longer and more complicated arguments. Certainly, he has had this effect on me and this essay is a small acknowledgement of what I have learned from him. I would not think as I do were it not for him.

In the art of medicine, knowledge about the body is used in the service of the sick. That knowledge varies from a vast theoretical structure of human biology through ever more practical and less generalizable facts used in the care of the ill. The profession of medicine would appear at times to love its knowledge more than its practice. Thus, the modern ideal of medicine is the research center not the clinic, and young physicians are more often taught by researchers than practitioners. (Although that is less true of surgeons.) Yet, doctors are, ultimately, the caretakers of the sick and their knowledge is meant to be used for the good of their patients. It seems to me, therefore, that medicine and physicians may be in relation to their patients as science and scientists are in relation to nature – if Hans Jonas is correct, that man is caretaker of his world. I believe he is correct and that therefore the relation of the doctor to knowledge in medicine provides an opportunity to explore the problem of the double agent – caretaker versus knower.

In an attempt to explore this conflict in medicine, it seems helpful to describe a case that lends itself to an examination of the dilemma. A thirty-three years old woman who had always been healthy was finishing her doctoral dissertation in sociology, when a nagging pain in the upper right side of her abdomen forced her to see her doctor. The pain, after coming on suddenly, became progressively worse for two weeks. In addition, she was aware of loss of appetite, weight loss and weakness. Her lack of desire to do anything distressed her greatly, because it prevented her from working, despite the

S. F. Spicker (ed.), Organism, Medicine, and Metaphysics, 57–72.

approaching deadline. Finally, she developed a fever. She was obviously ill when her doctor examined her. The abdomen in the region of the liver was quite tender. The doctor explained that the story of the illness, the examination and office laboratory tests all seemed to indicate that she had had an attack of gall bladder disease with gallstones. He told her that she had probably developed an inflammation or infection of the bile ducts of the liver (cholangitis). She was advised to enter the hospital where tests could be done which should prove the diagnosis.

Within the first few days, the blood tests and X-rays suggested by the diagnosis had been done. They had caused the young woman some, but not much, discomfort. The tests were, however, all normal. There was no apparent gall-bladder disease and the blood tests showed no evidence of liver infection. Although she was aware of the possibility that the diagnosis would not be substantiated, she was disconsolate because her weakness and fever persisted, and she continued to lose weight. The pain and tenderness over her liver were less, but still distressing. Other tests, although not pointing to a diagnosis, continued to show that her illness was serious.

The doctors' (for by now interns and residents were active in her care) concern for her future heightened. Increasingly, it was suggested (although not to her) that malignant disease, probably lymphoma, was the cause of her illness. The pressure to make a diagnosis increased as the days passed and illness deepened. Although apparently obvious, it seems reasonable to inquire into the source of the pressure.

The case was mystifying. There could be no question of the seriousness of the illness. To doctors that means an active disease process which threatens death or which would significantly impair or interfere with normal life; a situation in which the disease or its effects dominate the patient's life. It is in the nature of the physician–patient relationship that what threatens the life of the patient in some sense threatens the physician. It seems reasonable that the threat to the physician inherent in the threat to the patient, is one source of the sense of responsibility the physician feels for the patient.[1] The responsibility of the doctor for the patient is central to the conflict between the desire to know and the need to care for the patient.

The evidence in the case suggested infection except for one small but important test which was normal (white blood count). But infection of what? The pain and tenderness in the upper right side of the abdomen pointed to an infection of the liver or something near the liver. The adjacent kidney was normal and no abscess could be found (negative scans and sonogram). The very absence of any concrete evidence for a specific disease entity in this sick

young woman did not calm the physicians' fears, but rather increased them.

The most obvious reason for pressing on toward the diagnosis – the medical equivalent of knowledge – was to make the patient better. In fact, however, as the diagnosis became more and more obscure, the probability diminished that a treatable disease would ever be found. Instead, experience suggests that such patients usually either get well without specific treatment or are ultimately found to have a malignancy. But further, the need (in terms of the patient's physical well being) to press for a diagnosis recedes, because the necessity for *urgent* treatment becomes extremely unlikely. In terms simply of the patient's body, it could be argued that the best course might be to wait and allow further events to unfold. In other words, to allow the diagnosis or lack of necessity for it, the patient having become well, to express itself through time.

I. THE PATIENT'S NEED TO KNOW

Such a course seemed most difficult for both the patient and her doctors. The young woman had a need to know what was the matter with her. But what is the nature of the knowledge that the patient desired? Clearly, it is not abstract but rather very concrete. The focus of her desire to know is primarily the patient herself rather than that which is making her sick. What the illness is doing to her is her concern. The young woman's knowledge of her disease is experiental and whatever she knows of patients in similar positions is regarded in relation to her own situation. It is, if you will, a kind of "I" knowledge, a knowing in which the central position from which perception will come can only be herself, her well-being, pain or suffering. The label that will ultimately be attached to her illness will be (to her) symbolic of her suffering rather than of the thing apart from her. And so it must be of all knowledge to the degree that the knowing of anything has an experiential component. But where others can to one degree or another move their knowledge and manipulate it as a thing apart from both themselves and their experience of it, such ability to abstract is denied the sick. So the limits on this young woman's desire to know are set by the price in pain and suffering that further knowledge may cost. She has competing needs. She is caretaker of her body and must protect its integrity and her dignity not only from the disease and from her doctors but from her own desire to know.

In fact, however, the patient did know *what* was the matter: she had pain, weakness, no appetite, and she knew these things better than anyone. But what she did not know was why. The symptoms were events that had

occurred in her body and she could not put them from her mind. Generally, it seems impossible for anyone to perceive an event without pursuing cause. An example is the lengths to which someone will go to identify the source of a strange sound: as long as the sound is present, it cannot be put from mind. A story of Sholom Aleichem makes the point. A man has lost his money, and disconsolate, asks everyone whether they have found it. Several days later, his friend finds him cheerful again and asks whether he is happy because he found the money. "No," says the man, "but I found the hole in my pocket." The desire to know (desire seems too small a word, perhaps drive would be better) is not merely to know what, but to know why. More than this is involved.

When the desire to know is stimulated by the occurrence of an event, learning what and why does not put the mind to rest; also required is some idea of what will happen. Further, it seems to me that events are always perceived as occurring, because of the operation of something. Some object, whether it be government, a tin whistle or a disease is thought to be present and actively operating. Thus, the why, or antecedent conditions, and that which will be, or consequences (as we understand them), are always connected to our conception of an object. For the young woman of our case to know what is the matter, it is not sufficient (in this era) for her to know simply that she has fever, pain, lassitude and so on. Because although each of these is also a thing in itself, she will perceive them as characteristics of some, more inclusive, object. To know the more inclusive object is also to know causes and outcomes. It would seem, then, that to perceive an event is to desire to know the object of which the event is a characteristic. And to know the object is to have some idea of its origins and its functions or outcome. The conception of an object in this view is a dynamic thing. It always comes from something and it always does something. Remember, in this regard, the toy of a few years back that was a small black box with randomly flashing lights. The humor was in the fact that the box *did* nothing. So it is that our patient needs to know what is the matter and she has the expectation that what is the matter is an objectified process. And the process has a name – the diagnosis. Clearly, however, the names serve purposes even when the knower of the name does not thus also possess a clear knowledge of the cause and outcome. Much medical humor comes from the lack of content of some medical terms. A man has pain in the tailbone and is satisfied to hear the doctor say he has coccyalgia or coccydynia – both of which merely mean painful tailbone. The name itself has some power.

As a resident at Bellevue, I had a patient who was persistently dissatisfied

with our lengthy explanations of his condition. My intern satisfied this patient by telling him that his problem was that he had a gastric stomach. Why was the patient now satisfied? He could not have been relieved, because in knowing the name he knew the cause, characteristics and outcome. The humor (for the intern) derived from the fact that the patient was happy knowing that he had a "stomach" stomach. If he knew that to have a gastric stomach was simply to have a stomach stomach, we cannot conceive of his being satisfied, but rather insulted. What function, then, did the name serve for that patient? For one thing, he now knew that his physicians knew the name of the disease and thus all that is implied in the conception for which the name is label. As the doctor may be perceived (for some patients and in some situations) as the instrumental arm of the patient, if the doctor knows, the patient is provided the same comfort as if he knows himself. But more, the very fact of a name signifies that the thing is known. Labelling in itself signifies the move from unknown to known, providing all the comfort and reduction of uncertainty that goes with a known object. Further, the label or signifier can then be manipulated as though the object itself was being manipulated but without concern for the actual content of the conception so signified. As evidence for this, think of the many meaningless or at best imprecise signifying words that function well, precisely because we do not look too closely at their content. As we shall see, the fact that physicians can name something may also imply they can do something. To name the beasts of the field implies the power to dominate them.

In any case, we know that the sick young woman wants to know what is the matter as well as causes and outcomes. And that she, with the rest of us, views causes in terms of processes or objects whose characteristics are signified by the name.

She also needs to know the diagnosis, the name of the thing that is making her sick, for social reasons. She has to tell her mother and the rest of the family why she is in the hospital. Not to be able to say what is wrong would cast doubt on the quality of her medical care, the competence of her physicians and the excellence of the hospital. For her mother, as for others, the absence of a name allows worry to seek its own name. Her parents have to tell others and it is not sufficient to say that their daughter has fever, weight loss and abdominal pain. Those informed would only half believe that the doctors did not know. They would also wonder whether someone was not telling the whole truth, and in avoiding the name was concealing a more terrible truth as in newspaper obituaries that say, "he died after a long illness." If the facts are being concealed, those being told might wonder who is

doing the hiding, the mother, the daughter or the doctors? It does not overdo things to point out how much interpersonal relationships depend on the sharing of knowledge and how much meaning is read into the absence of a name. The patient also needs to know, so that she can tell her employer why she cannot work and why her dissertation will not be finished when anticipated. She needs the diagnosis to justify her hospitalization and even her assumptions of the sick role. The name avoids ambiguity in such situations. But here, the important content of the conception labelled by the disease name deals with such things as length of hospitalization, post-hospital convalescence, ultimate health, and ability to function. In other words, the content of the conception labelled by the same name may or probably will be very different depending on the function of the knowledge represented in the conception.

II. THE PHYSICIANS' NEED TO KNOW

The physicians also have a pressing need to know what is the matter. Their need stems from their relationship to the patient, from matters of influence and authority, from social or institutional pressures as well as from an intellectual desire for true knowledge.

As mentioned earlier, the threat to the patient from her illness is to some degree felt by the physician as a threat to him. As she is not whole without a diagnosis, neither is he. In part, this is because he cannot know what his attitude is to be towards the patient and her disease. If it is curable, then the connection between them may need to be strengthened to help make her better. If it is fatal, then preparation must be made for separation or at least handling those special aspects of the dying. That such changes in attitude may not be conscious does not diminish their reality. Of more concern here is that the physician will, in learning about the disease, be acquiring experiental as well as abstract knowledge. Further, as he experiences some threat to himself in the danger to her – and it is not cynical to realize that some of that threat is to his reputation, as well as arising from a vital if poorly defined human bond – then some of the knowledge must be, in common with the patient's personal knowledge, focused upon himself and related to himself. But unlike the patient, we expect him to be able to de-center and to abstract his information into true knowledge. The fact that abstraction is not always possible, or even that it is not always desirable in medicine, is beside the point. It remains true that the knowledge that he brings to the patient is tested by his personal need to make her better. And perhaps equally by his need to test the know-

ledge itself. Thus, not only does the patient need him, and he the patient, but his knowledge needs the patient in order to be tested, to become "real" and thus to become part of him. In this latter regard, we understand the constant desire of medical students to take responsibility for the care of patients. Until their knowledge of medicine is thus applied, they are not a part of medicine and medicine is not truly a part of them.

III. KNOWLEDGE AS POWER

The doctors have a need to know based on the desire for influence and authority. There are those who believe the physician maintains his control and power over the patient by controlling the knowledge and its communication. But further, status is conferred on the physician who makes the diagnosis in difficult cases. Especially for the younger physician, a demonstration of knowledge is seen as the sceptre that confers power and authority. This function of knowledge is often emphasized in the academic setting of the university medical center, where the faculty member with the greatest store of esoteric disease information seems to be most admired. It is not uncommon for physicians in training to try and upstage one another by quoting the latest medical journal. Somewhat more pernicious is the attempt to be the first to record the correct diagnosis on the chart of a patient with an obscure disease, even though such mention may bend the rules of etiquette.

Because the young woman's illness continued unabated and still undiagnosed, her physician called a respected and experienced senior associate in consultation. On the telephone to the consultant, her doctor described the case in detail. Overhearing the conversation, the consultant's younger but very knowledgeable associate was struck by the similarity to a case he had recently seen in which the diagnosis had turned out to be Fitzhugh–Curtis Syndrome (an inflammation around the liver (perihepatitis) occurring in the course of gonorrheal infection of female pelvic organs (salpingitis)). Passing the hospital floor on which the patient was situated, the younger associate mentioned the diagnosis to the resident. When the specialist arrived to make his consultation, he found that the resident had already written a note on the chart suggesting the diagnosis and crediting it to the young associate. The specialist examined her and her records in his usual careful manner and then wrote his opinion which concurred in the suggested diagnosis and recommended treatment.

There was no evidence that the young woman had gonorrhea (such overt evidence may be lacking in Fitzhugh–Curtis Syndrome), but the diagnosis

offered the chance to act. Increasingly the sciences of medicine have become interventionist sciences. Pedro Lain Entralgo relates that 100 years ago, the great Austrian physician Joseph Skoda gave a brilliant lecture at the bedside on the nature and origin of a patient's disease. When his assistant asked what should be done for the patient, the question was brushed aside as of no interest. The object was not to do, but to know. It was believed that only such a view of its role could elevate medicine. Now, however, knowledge has become the power to act in medicine as in the other sciences. We are all aware of the evolution of man's relationship to nature that has occurred hand in hand with the belief that knowledge provides the power to act against nature. It may be well to stand in humble tranquility before nature's majesty revealed in the distant stars, but it is humiliating helplessness to stand before the same nature revealed as the inexorable progress of a disease. Thus, for her doctors to know the young woman's disease was to have the power to act. It is true that physicians have always done things to their patients. What distinguishes the present era is that so much action is not only based in theory, but is also effective. Theory has always been present, but effectiveness is recent.

In the case of the young woman, cause being discovered, action soon followed and she was started on high doses of intravenous antibiotics. Everybody was relieved at the lifting of ambiguity. Attributing the illness to gonorrhea created certain strains for the patient, but such negative aspects would be a small price to pay for a cure.

IV. INSTITUTIONAL PRESSURE FOR KNOWLEDGE

Having a diagnosis relieved other institutional pressures on her doctors. It is not an exaggeration to say that the entire institution of medicine revolves around the system of diagnostic categorization we call disease. Although a detailed discussion of institutional pressures is not pertinent to this essay, any analysis of the physician's need to know what is the matter cannot entirely neglect these pressures. Indeed they are so prominent that one could be led to believe that institutional forces are primary in the push towards diagnosis. Institutional in the narrower view; all insurance forms, requests for X-rays and laboratory tests, hospital admission forms and virtually all the other bureaucratic paraphernalia of medicine require diagnostic entries. Institutional in the wider view; diagnosis and diagnostic categories provide the basis of conversation among physicians and other staff members about patients or about their work. In other words, the group structure of medicine and the system of individual interactions revolve around disease categories. I do not

believe institutional pressures are primary, but rather, that they are derivative from the other forces being described. It cannot be denied that institutional forces are both stabilizing and essentially conservative, holding the profession within the view of the world based on disease categories long after new concepts have emerged that will provide the basis for the institutional pressures of the future.

In the light of all these pressures, it is not surprising that everybody was pleased that the diagnosis was made. Unfortunately, several days of intravenous antibiotics produced no improvement in the woman's condition. The bacterial cultures that might have confirmed the diagnosis were also negative, while the evidence of serious illness continued.

V. RESPONSIBILITY VERSUS THE DESIRE TO KNOW

By this time, the patient had been in the hospital three weeks. Her fever had continued, her weight decreased, and she had become progressively more anemic. It appeared inevitable to most of the staff that she should have exploratory abdominal surgery. The evidence that the disease process was within the abdomen seemed unequivocal. Her physician felt that little was to be gained by delaying. It is important to reiterate that while the belief that the diagnosis could be made by surgery was probably justified, the chance that she would be directly benefited by making a diagnosis was, by this time, even less probable than earlier in the case. It was still most likely that she would either improve spontaneously, the diagnosis manifest itself without harm coming to her, because of the delay, and/or the disease would prove to be untreatably fatal. That being the situation, the search for a diagnosis would now become for her a source of a danger in itself. In other words, she was now being directly threatened by the various pressures to know. Different physicians had somewhat different views of the matter. The surgeon saw no point in waiting, indeed he felt she should have been operated on ten days earlier. The students, interns and residents generally believed the operation should be carried out promptly. Her own doctor felt that surgery should proceed but was concerned by the risk and by the patient's manifest fear of surgery. It was, after all, a matter of weighing risk against benefit. The benefit was that a diagnosis would be made, but the risk was more direct. As there are institutional pressures in medicine to know the diagnosis, there are also very strong institutional pressures that protect the patient from undue risk and reinforce the responsibilities of the physician and all of medicine for the patient. The risk of death in exploratory surgery in patients like this is

probably less than 1 percent. If the risk were to approach 3 percent, I doubt whether anyone would have felt surgery justified in this patient. Throughout medicine, patients are exposed to risks in order that knowledge be gained and a spectrum exists of risks that are considered acceptable. It seems fair to say that when the primary desire is knowledge, as in research settings, the risk to the patient that may be acceptable to the physician is higher than when the primary goal is patient care.

While I have assumed that there exist two needs within the physician – the need to care for the patient and the need to know – more must be said to substantiate these needs, and to show that they may exist in tension within the profession of medicine and are ideally, internalized within each physician. Earlier, I discussed some of the roots of the doctor's responsibility for his patient. Another might say that it is unnecessary to prove that doctors have responsibility for their patients; the profession of medicine arose out of the need to care for the sick, indeed is in bondage to the sick for its very existence. While some may argue the nature of professions in general, in medicine (as in divinity and law) responsibility is inherent in the definition. Also inherent in the definition of these professions is a body of knowledge developed in the service of responsibility. But it is the case that knowledge comes to have a life of its own. As the mysteries of the body have been exposed throughout the history of medicine by the operation of disease, systems of thought have arisen to solve the problems posed by the mystery. It is the nature of any system of abstract or formal thought not to be content with mystery, but to continue operating on any problem until understanding results. Mystery is a threat to the adequacy of the system of thought itself. But, as I noted earlier, where knowledge is inadequate, so too may the owner of that knowledge find himself inadequate, so inextricably bound are the person and his knowledge. Mystery is the point where the responsibility to patient and the desire to know may come in conflict. The ancient but respected aphorism of medicine "above all do no harm" makes clear that, out of fear of harm to the patient, the body cannot be invaded merely to resolve mystery. That conflict was exposed in this case.

VI. THE FORCE OF TECHNOLOGY

At this point another force entered that seems, at least in part, responsive to the tension between the desire to know and responsibility for the patient – technical novelty.

A bone marrow examination was done in the hope of revealing the cause

of the illness which would be possible if the disease were lymphoma. The results were not helpful, but the hematologist suggested that instead of surgery, laparoscopy should be done. The laparoscope is a recently developed instrument which, when introduced through a small incision in the abdomen, allows visualization of the abdominal contents. It has been very helpful in examining the pelvic organs of women and in recent years has been used more widely for examining other abdominal contents. It is not necessary here to examine the lure of the novel, although it does seem to be basic to mankind and to be related to the desire to know. In medicine, at least, new techniques and technology frequently seem to offer the double reward of reduced uncertainty and reduced risk. That experience seldom bears this out may account for the reluctance of older physicians to leap to new techniques. Yet, the lure is there for young and old. Another consultation was sought from an experienced clinician who believed some kind of abdominal exploration was necessary and recommended laparoscopy as the least risky.

To the patient, it was a reprieve from surgery and she accepted the idea gratefully. Her physician was doubtful that it would be useful, but he hoped that it would reveal the diagnosis and he was relieved that he would not have to bear the responsibility for the surgery.

The laparoscopy was done (and also a liver biopsy through the instrument) and no disease was found. Unfortunately the limitations of the instrument precluded visualization of that area around the liver which the patient's symptoms suggested might be the site of disease. The laparoscope also could not examine the intestines, and other areas where disease might be hidden, but the laparoscopy ended the active search for a diagnosis. No one was willing to expose the patient to further risk. It was almost as if the laparoscopy, having served the purpose of searching for the sake of searching had made further probing unnecessary. The physicians were now willing to fall back on the probabilities, cited above, that she would either get well or would not be treatable and that the disease would ultimately show itself.

Before we discuss the nature of the thing everybody was looking for, I should describe what ultimately happened. After all the weeks of hospitalization, two things occurred. First, the young woman began to improve. Her fever subsided, her appetite began to return and pain almost disappeared. Second, a resident, reviewing the entire case, discovered that although the stomach and large intestines had been X-rayed, the small intestines had not. Promptly done, those X-rays revealed the pattern (X-rays are only pictures of shadows) of the disease, regional enteritis, involving the end of the small intestine. That particular inflammatory disease of the small intestine does,

uncommonly produce an illness similar to that of the young woman. Thus, although the X-rays were only suggestive and the extent of visualized disease was small compared to the severity of her illness, the diagnosis was accepted with both relief at its essentially benign nature and a wait-and-see attitude. The first consultant, whose special interest is inflammatory bowel disease, was chargrined that he had been diverted from making the diagnosis because of the more dramatic Fitzhugh–Curtis syndrome.

VII. CONCLUSION

The case of the young woman in whom a search for a diagnosis proceeded to a point where the search seemed to represent a greater threat than her disease has allowed me to examine the sources of the pressure to know. Whether expressed as social, emotional, intellectual, institutional, power oriented, or technological, these forces seem to reveal a desire to know and an admiration for knowledge whose only check in medicine is the conflict of that desire with responsibility for the well being of a patient. The evidence suggests that it was the push to know from *within* individuals – socialized, institutionalized and reified, rather than primarily a pull from the object about which knowledge was desired – that motivated the search of the physicians. The word object seems to be the key. Knowledge itself becomes the objective increasingly detached from that which is to be known, until at length the knowledge itself becomes the object. Throughout this case and in general, knowledge is dealt with as though it is a thing. The scientist told to suspend his research, because it may be dangerous replies that "if we don't find *it* someone else will." As though there is an *it* in nature that is calling and to which man responds. But that is not the case, from man's response the call is constituted. On the other hand, it cannot be denied that there was something inside the patient that made her sick. In fact, the thing ultimately made shadows on an X-ray and, one presumes, could have been seen directly, if the small intestine had been exposed.[2] The thing has a name, regional enteritis, (also called granulomatous colitis or Crohn's disease), and defining characteristics that distinguish it from other inflammatory bowel diseases. In that sense, regional enteritis seems to be almost as unique an object as is, say, an oak tree.

I would like now to explore in greater detail the nature of that object which the doctors had sought. In common with the patient, when the physicians were seeking an explanation for the event represented by the woman's illness, their explanation also had to satisfy the demand for antecedent conditions, characteristics and post-cedent conditions (outcome). It is clear

that the characteristics of the physicians' conception labelled, regional enteritis, are quite different from the patient's conception with the same label. As noted earlier, the patient's view of the disease is primarily experiential and self-related. What she means by antecedent conditions – where did the thing come from – is most probably "what did I do?" or, "what in me caused me to get this disease?" By outcome she means, "what will happen to me?". The physicians are looking for a more generalized knowledge. Under what circumstances do individuals acquire regional enteritis? What is the usual age, sex, predisposing situation, or even personality make-up of patients with the disease. The doctors' description of outcome will also be more general. In a certain percentage of patients, healing is spontaneous. The frequency of recurrences, how it spreads, when surgery is necessary and what are the responses to treatment are also assigned probabilities. These are statistical descriptions. These probabilistic statements are attached to a pathologic description of the disease. The intestinal wall has a certain appearance to the eye and the microscopic appearance of the cells has certain characteristics. All these things together form an idealized conception of the disease to which this particular woman's disease is only an approximation. In a certain sense, the object the doctors sought was not real but rather a classifactory device. An occurrence existed in her small intestine and the classification is only good to the extent that it can include this occurrence. Further, each doctor's conception of regional enteritis is only useful to the degree that it can accommodate individual variations in the disease (will not *exclude* bona fide cases of the disease nor *include* situations which are not truly regional enteritis). That means that each doctor's conception is useful to the extent that experience fleshes out the conception and moves its content away from the generalized ideal towards the particular. The problem to be solved is uncertainty. The more nearly the instance is approached by the conception, the less the uncertainty. The less the match between the instance and the guiding conception, the greater the uncertainty, as in the case of this young woman. One of the things that frequently startles patients, when they become seriously ill, is the enormous amount of uncertainty with which physicians work. In instances where things go as expected, the uncertainty is not revealed; however, the more questions raised by the circumstances, the more the uncertainty is manifest. We are not prepared for uncertainty, because we come to confuse the conception of an object with the object itself.

Thus, in their search for a diagnosis, for the real thing in this patient, the physicians are guided by a conception of the object and that conception is contained within themselves, but that conception is not the object itself. That

conception serves the function (among many others) of guiding perception and of reducing the stimuli from the outside world (and from other parts of thought) that must be dealt with in order to solve the problem introduced by the event of the woman's illness. But it must be the case that if the conception guides perception and indicates what information must be considered in solving the problem, then the same conception must indicate what information is not relevant. To put it metaphorically, as the conception clears the vision for some things, it must blind the vision to others.

To return to the original problem, the hunt for knowledge as represented by the search for a diagnosis in the sick young woman was a result of a complex push from within (the basic desire to know and reduce uncertainty, the social, institutional, power oriented and technological aspects of the desire) and a pull from outside. But that real object called knowledge (the diagnosis) is not an object at all. From its place in the continuum of nature, it is formed up into its status as object, as discrete entity, by the search for it, and no matter how tenuous its original claim, its status as object is retained and even grows by the fact of being named and having that name (which *is* an object) communicated from person to person. Another might say that it achieved its status as entity, because of its operation in this patient simply because the illness presented an event to be solved. But, other eyes in other worlds (historically or culturally) looking to solve the uncertainty raised by the same event might see a different entity. Physicians may object that I have confused *a-patient-with-regional-enteritis* with the pathologic entity known as regional enteritis. The way we see this young woman, her symptoms and the findings of examinations are the expression of that pathologic entity in this particular patient – dependent for the way it expresses itself in this particular woman on variables as disparate as the state of her nutrition and her unconscious conflicts. The pathologic entity, regional enteritis, it might be argued, is much more discrete, better defined, and less subject to variation. The confusion of the two – the patient with the disease and the disease entity – is quite common. Indeed, I think the patient-with-the-disease is the more real object than the pathologic entity itself. Regional enteritis is an occurrence, but it acquires its form as object – its boundaries and definitions as an individual disease in the course of the search for it – in this patient and in all the preceding patients back to its first description, all of which gave the conceptualized entity its history and status as object.

If it were truly an object as discrete as (say) a pine tree, there would not be so much current argument about the classification of the inflammatory bowel diseases. My own guess is that in this instance and in the other increas-

ing areas of medicine where diagnostic categories are being called into doubt, the question is not about this or that definition of a disease, but definitions of disease in general as they have been inherited from the past.

Present day re-examination of the definitions of disease should be seen, I believe, more as attempts to put in question our whole classification of disease than as attempts to make "better" definitions. Whatever classification emerges, however, will be essentially a product of human thought. But as we begin to see the sick in a more holistic manner, purely cellular or biochemical definitions, to say nothing of definitions comprised solely of arbitrary statements of abnormality will begin to become increasingly inadequate. The conceptions represented by those disease names will begin to come in conflict with other, newer understandings that guide our views of the sick.

More is involved. "Regional enteritis" did not make this patient sick but rather a number of basic biologic mechanisms involved in her disease. (It would be common to say basic biological mechanisms that went wrong – pathophysiology, but the word 'wrong' is also definitional.) The beauty and robustness of twentieth century medicine lies in the search for the fundamental mechanisms of disease. Increasingly, what matters in medicine is not a knowledge of sophisticated criteria for disease classification (as was the case in nineteenth century medicine) but knowing how the body works in health and disease. Such information certainly leads more truly to knowledge in the universal sense than does knowing a diagnosis. Since the body does exist, no argument can be made that the mechanisms uncovered by science are mere artifice created by the search. But the direction of the search, what knowledge we value, what technology we use to find it, how we relate each part to another, under what categories we organize it, our priorities (in the modern argot) are clearly more derivative from the search itself than the phenomenon pursued. If all of this is true for diseases and their biologic mechanisms, it is much more true in research on DNA recombinants where the knowledge truly does not even exist before it is found.

Knowledge is not an object; knowledge takes the form of object by the act of seeking for it and by the fact of being communicated. Using the case of a woman severely ill with an undiagnosed disease, I have tried to show the various sources, within us and outside us, of the desire to know. But clearly, we have this drive to know inherent in our existence. The only check on the force to know that otherwise would have caused her to be taken apart as one opens a stopped watch, was the sense of responsibility felt towards her; by herself, by her physicians because of their bond to her, and by medicine in its institutionalization of that bond.

If knowledge is not a thing waiting only to be found; if it is even in part a desire of man, then it is subject to moral restraint like any other drive or desire. If this case is even in part a metaphor for man and his world, then the author of moral restraint on the desire to know is man's responsibility for mankind and the world.

"All men by nature desire to know. An indication of this is the delight we take in our senses; for even apart from their usefulness they are loved for themselves; and above all others the sense of sight."[3] The love of knowledge exists in us like the love of seeing. But it is possible to control our desires, as all men learn out of the love of humanity, that some places we look and from some things we turn our eyes.

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NOTES

[1] A physician is authenticated at least in part by his ability to help his patients. His role as physician cannot be seen wholly separate from other aspects of his person. Where his medicine is helpless, the instrumental element of himself is blunted. Where his knowledge does not explain and cannot predict a part of himself is threatened. But further, as we know, his acts, if they are wrong, directly threaten the very existence of his patient. Thus there is a bond between the doctor and the patient which can be better understood, if one sees that the physician cannot be a physician without a patient and to have a patient is to have the ability to act. The patient is there, because she believes the doctor will act for her benefit. Thus to act, and he himself is part of his actions, the doctor must accept responsibility for the effect of his actions on the patient. Otherwise, he would be rejecting the patient's trust and dealing with the patient as only an object, a means by which he exercises himself. Since neither his role nor even his knowledge exist apart from his person, what threatens the patient must at least in part be a threat to him.

[2] For the sake of completeness I should point out two things. First, because so little disease was visualized on the X-rays and because what was seen was open to interpretation the diagnosis was by no means certain, when the woman left the hospital; and second, the diagnosis might have been missed even if she had undergone exploratory surgery.

[3] Aristotle: *Metaphysics*, Book A, 980a, 20–24. *The Works of Aristotle*, trans. W. D. Ross (Oxford: Clarendon Press, 1963).