A Philosophical Basis of Medical Practice

Toward a Philosophy and Ethic of the Healing Professions

Edmund D. Pellegrino
David C. Thomasma

New York Oxford
OXFORD UNIVERSITY PRESS
1981

5

Ontology of the Body

The first step in a critique of medicine has been accomplished. We have shown how the epistemological problem of medicine is a search for an explanation of the way the abstract is applied to individuals and extracted from them. In our opinion, the histories of the philosophy of science and medicine demonstrate that explanations of this process have developed from reductionistic and mechanistic models to a complex and richer milieu in the practice of medicine itself. In other words, they have moved closer to the human center of the discipline.[1]

In this chapter, we will address the epistemological problem of medicine from a systematic standpoint, rather than from the descriptive one used in the previous chapter. We will focus on the human body, with which medicine deals as it establishes the human center of medicine. Thus, the role of the practice of medicine and its experience by physicians and patients underlines a continuous entré into the human condition of life itself.

Practical Ontology

Although our purpose in the previous chapter was to explore the epistemological problem of medicine, we will here indicate the major areas of current research in the philosophy of medicine by way of introducing the need for a practical ontology. While the four

categories of current research bear on the epistemological problem, they do so less directly than the classic and modern views already presented. However, a brief discussion of these views permits the illustration of both themes we intend to cover and points of departure between our method and those of our contemporaries. We discern four major areas of current philosophical research which have a bearing on the practical ontology of medicine: the object of medicine; mind-body issues; clinical judgment; and theory and practice. The last category establishes the moral nature of medicine.[2]

Object of Medicine

Physicians are traditionally less interested in medical ontology than in the practical objects of medicine: curing and caring. As we have seen, this practical object led to classifications of medicine as a technique or craft. Early in the 1100's, for example, Hugh of St. Victor classified medicine as a form of mechanics, a set of disciplines which derived their form from their matter. He meant that the definition of medicine stems from its experience with curing and caring for the body, the person, and the social milieu. It even includes a concern for cultural standards and norms.[3]

Because medicine is a practical theory of human reality, knowledge applied to human ends and purposes,[4] the aim of medicine is to discover knowledge of man. As Steven Levenson notes, "Medical Science becomes Medicine only when it is used to promote health and healing, and thus becomes an intervention into an individual human life."[5] In this intervention science, values, society, and cultures are all intertwined. Thus a concern for curing and caring does entail questions of values, culture, and ontology.

If the object of medicine is seen as curing disease and caring for persons such that they are restored to some quality of life and function, then several important ontological themes result. The first is that science is involved in medicine primarily as a defense of explanatory theories of disease and their application to human life.[6] This pragmatic utilization of science is heightened by a second theme: that medical knowledge and craft are value-laden. Hence a critical concept such as "normal" clearly engages the physician and philosopher in a discussion of personal, social, scientific, and cultural values. Canguilhem concludes, after a survey of positivistic

leanings in medicine, that "those who themselves tried most vigorously to give 'normal' only the value of a fact have simply valorized the fact of their need for a limited meaning."[7]

Therefore a physician must combine compassion for the human situation[8]—which is *not* synonymous with learning—with an insight into that situation involving a treatment of the "whole person" and his or her cultural context.[9] This requires an attention to values to achieve results. A practical ontology, such as we propose, can examine these values, the impact of practice on them, and their source in the body as revealing the human condition.

While not asserting that this chapter establishes a philosophy of life, which Yanovsky claims is necessarily propaedeutic to a philosophy of medicine,[10] we do claim that an ontology of the body is the matter which establishes the form of medicine, its source and end of explanatory theory, and the basis of its judgments and axioms.

In this respect, attention to the object of medicine guides our method toward the "human center" of the discipline, a process not found among those who use philosophy of science as their tool to examine medical concepts. While valuable, such examination is usually confined to a realm of abstract and objective concepts, rather than the realm of life in which these concepts arise.

Mind-Body Issues

The advances in neurosurgery, neurology, and the classification of mental diseases have all contributed to a renewed discussion of the relation of mind to body, free will, and medical anthropology. Only the vaguest outline of a new anthropology is possible at this time, however.

But some important features of the debates spawned by this issue are worthy of mention. First, the overpowering dualism of Western civilization continues to divorce the body from the mind and even from the personality.[11] Second, the debate has illustrated the descriptive, evaluative, and normative functions of medical explanations.[12] Third, the debate has given rise to the use of the term "lived body" as a philosophical antipode to its neglect in theories of human consciousness.[13] And finally, the categories of mental diseases, as Engelhardt points out, have more bearing on the integrity of persons than the categories of physical diseases.[14]

We have avoided any suggestion of dualism in our philosophy of medicine. However, as we shall shortly describe it, the ontology of the body in medicine must take into account at least three levels of experiencing the world: the level of objective experience, the level of experience not objectified, and the level of physical survival. The distinctions are unavoidable, but are meant in the Kantian sense of different perceptions of the world by the same unity.[15]

The distinction between body and soul by Descartes, and his attempt to locate the organs in the body through which the soul operates, are still with us today. It is not unfair to claim that Descartes' distinction made possible the enormous gains in anatomy and physiology during the two centuries after its formulation; the body could now be examined as an object of experimentation and observation. However, as the section "Theory and Practice" will show, it is not only objective science which establishes the norms of clinical judgment, but engagement with the forms of life presented by the body.

In this regard, the mind-body problem may, as Spicker suggests, be a nonproblem,[16] a kind of philosophical bromide which neglects current advances in vigorous philosophical research and in the neurosciences. For it appears that the neurosystem is not an organ but an embodiment of the mind.

It is therefore opportune to construct a practical ontology of the body as the human center of medicine prior to any distinctions between mind and body. By doing so, we avoid the distinction as far as possible. We claim that such an ontology can contribute to overriding the distinction for medical practice and can demonstrate the *sine qua non,* the absolute necessity, of the body in any philosophy of man and epistemology of discovery.

Clinical Judgment

Clinical judgment has received philosophical attention in three areas. The first is the scientific aspect of medical judgment, especially those features which may possibly be computerized. These will be discussed in detail in the next chapter. Here it is important to note that a shift from disease entities to diseases as patterns makes computer diagnosis especially practical. This shift in perspective is simultaneously more complex and more realistic.[17]

The second area of research respects the role of art, not only in the development of scientific models of explanation but in the crucial moment of applying science in the clinical decision to human beings. Feinstein notes that the artistic aspects of medicine are not confined to the "bedside manner," as per the usual misconstrual.[18] Clouser and Zucker argue that the real "art" in medicine is precisely the act of linking the general to the particular.[19] Cassell calls this "applying the abstract to the usual."[20] Apart from the details already sketched regarding this problem, we will offer arguments in the next chapter on the artistic status of clinical judgment. However, it is important to note that in the ontology of the body, "application" to and "extraction" from the body occur on more than one level. Ignoring this multiplicity leads to confusion about whether clinical judgment is scientific or artistic.

Third, the moral nature of medicine has been explored through analyses of clinical judgment. Moral issues arise in the conflict between physician as scientist and as healer,[21] the contexts of the practice of medicine,[22] the role of moral and philosophical ideas in framing medical practice,[23] and the profound sense of communal ethics through which the physician is dedicated to the preservation of life.[24] These examples are hardly exhaustive. But they serve to illustrate the fruitfulness of exploring moral issues in medicine from the perspective of clinical judgment. Based on an ontology of the body, a refined exploration of clinical judgment and consequent moral issues is possible.

Theory and Practice

The fourth category of current research in the philosophy of medicine concerns theory and practice—in particular, concepts of health and disease and the moral end of medicine.

From the exploration in the previous chapter, it should come as no surprise that philosophers of medicine have recently become interested in the connection between theory and practice. We have already cited Wartofsky on this point. Findlay, commenting on Hegel's methodological insights, says, "What intelligent activity aims at, however, practical activity achieves, i.e., the complete mastery of *individual* natural reality by rational pattern."[25] This mastery is the guiding motive of medicine in dealing with individuals. Yanovsky

considers attention to individuals and the patterning of diseases essential to relieve medicine's excessive dependency on deterministic cause-effect explanatory models.[26]

The impact of the practical nature of explanatory models in medicine on theoretical constructs has also been noted. Romanell has demonstrated Locke's interest in practical ideals in life, profitable knowledge, and his philosophical method of experience and conjecture was derived from his medical background.[27] More to the point of this chapter, Engelhardt has argued that models derive their explanatory force from their applicability to treatment and observed response.[28]

Thus it is not just the scientific ability to match complaints to concepts of health and disease derived from pathology, but the additional consideration of what these concepts do for patients, that is of interest in linking theory to practice. As Mack Lipkin argues, "The practice of medicine is to a large extent what the individual doctor makes it. His ideas of what illness is and how it is caused determine the first steps in his deciding what to do for his patient."[29] Consequently, if health is not just an absence of disease, then judgments about the health of a patient require weighing the complaints against *clinical* norms and the previous standards of function of this *particular* patient.[30] It is at this point that the moral nature of medicine is revealed to its fullest extent, in an ontology of the body of the patient and the physician's approach to this body.

This insight about the link between concepts of health and disease and the patient's actual functioning leads Engelhardt to the conclusion that disease is a relational concept, both normative and descriptive.[31] A judgment of what is "normal" rests on a *technique* of establishing or restoring the normal in patients. The normal cannot be reduced to a single form of physiological knowledge because it rests in part on man's action on his environment. Kant recognized this clearly.[32]

For the same reason, Canguilhem concludes his assay of theories of normality in medicine with this observation: "It is life itself, and not medical judgment, which makes the biological normal a concept of value and not a concept of statistical reality."[33] Life is fundamentally not an object of study but a struggle which engages both physician and patient in the realm of sheer physical survival.[34] We

discuss this feature of the ontology of the body by exploring the wisdom of the body and its role in cures.[35]

The profound connection between theory and practice can supply a missing component in theories about the link between science and ethics. If both the latter are viewed as limited and perspectival, and, as Kuhn suggests, are developed by researchers interpreting their communities' view of the world, then no clear connection between science and ethics can be drawn.[36] But if both science and ethics can be drawn from the particulars of the body and the anatomy of persons found in a practical ontology of medicine, then the moral end of medicine can contribute to the moral ends of science and society. We have set out for ourselves no less a task than this.

Conditions of Possibility of Clinical Interaction

In Chapter Three we described the form of medicine as a clinical interaction working in, with, and through the body. The ontological critique of medicine focuses on this form and asks what the necessary conditions of possibility are for clinical interaction to work. Thus, the critique handles the capacities of action found in medicine. Guiding this critique is the critical question developed in Chapter Four: How is it possible for medicine to apply theory to an individual living body?

One should note that the conditions of possibility established herein are conditions of a *reality* experienced in an effective medical setting of healing. Cures take place. How is it possible? Such a critique leaves aside ineffective medical events as well as some of the complex aspects of care which are part of modern medicine (e.g., preventive, community, crisis, experimentation, and so on). However, insofar as these participate in medicine as we have defined it, what is established applies to them as well.

In order to simplify language, we will call the necessary conditions of possibility "structures" of medicine. Furthermore, we will treat these structures under the logically distinct categories of the scientific realm (world of the lived self), everyday realm (world of the lived body), and survival realm (world of the living body).[37] Reflections on an anthropology based on the body conclude the section and the chapter.

While the distinction between these three realms of perception is borrowed from philosophy, it has been suggested by the dialectic developed in the first section of the chapter. If the clue to establishing the normal in medicine derives from both the realm of scientific models of disease and the life of patients in their social milieu, then at least these two realms should be included in the ontological examination of the conditions of possibility of cures. However, the explanatory force of the models also requires direct engagement with the physical survival of the body independent of its social milieu. Thus an "originary" or primal realm of the individual physical characteristics of the body must also come under ontological purview.

The terms "lived self," "lived body," and "living body," although previously introduced, may still cause some confusion. They should be viewed as a shorthand for complex human characteristics. First, "lived self" refers to the objective catalog of characteristics human beings create and present to the world as their personality. These are the public aspects of a human personality. Second, "lived body" refers to the experience of being a body which cannot be objectified. This experience is conditioned by continuous interaction in a world of physical objects and other persons. But the objectification of these experiences into a personality in civilized society always leaves a residue of nonexpressed and nonobjectified material. It is for this reason that as social animals and as individuals, we constantly search for more and more adequate expressions of human life in the scientific world. No object, word, symbol, category, or social structure in that world is safe from tampering with its meaning caused by its inadequacy in the everyday world of experience. Finally, "living body" refers to the ontologically prior realm of individual survival as a physical organism, ingesting, interpreting, and modifying its environment in the struggle and defense of its own existence.

Two additional points are necessary before continuing. The three worlds of human experience are distinguishable from the whole that is human life only by the fact that their actions have different ends: the creation and preservation of meaning in symbols, the creation and preservation of experience, and the creation and growth of life itself, respectively. A second point is this: Our use of these

distinctions is motivated by a desire to clarify somewhat a decidedly complex process of curing patients. We have already noted that the ability to classify a disease (the scientific realm) does not mean that greater knowledge of the personal impact of the disease than that of the patient is present (the everyday realm). Further, if the process of diagnosis and theory is confined to the realm of scientific probity and the social milieu of the patient, no real engagement with the moral center of medicine (the commitment to the survival of life despite its race, class, social standing, or personality) occurs. Unless the physician engages the patient toe to toe as a biological entity, the entré to the human condition is neglected. It is this very entré that makes medicine such a satisfying profession. It is demanded by a profession to treat the whole patient.

Thus we have no intention of trying to defend the three categories used as philosophical verities. Rather, they are used as convenient shorthand expressions for clarifying realms of clinical interaction such that, after the treatment of clinical judgment in the next chapter, we can move on to practical applications of this ontological question.

The Structures of Medicine

The Scientific Realm

In order for a cure to take place, clinical judgment must be a complex interaction which, at root, links scientific knowledge with individual human beings. At the very least, this structure implies that:

1. Human bodies are capable of creating scientific (and/or conceptual) formulations about the causes of disease. Three further implications are derived from this one.

a. Human bodies are capable of objectifying themselves in symbols. What is objectified we have called the "lived self," when applied to the entire life or biography of an individual.[38] The difference between human and other animal bodies seems to lie in the ability to symbolize, to create a record of experience *outside* of our bodies.

The capacity to objectify the body also allows the body to objectify parts, or even diseases. Thus Cassell, cited earlier, observed

clinically that patients objectified and depersonalized their illnesses by referring to illness as an "it."[39]

What is noteworthy about objectifying is that it demands a common language and a world of common objects. One cannot describe oneself without referring to analogies of experience of objects in a common language. Thus Kant argues that permanence of the ego (the sense of being "I") does not live in substantial identity or in the flow of inner experience. Instead personal identity depends on the existence of objects in space outside of the ego.

What is objectified, therefore, is *not* unique. To objectify oneself as a lived self or person, or to objectify disease categories and etiological agents, is to enter the world of common characteristics. Uniqueness lies instead in the historical, space-time configuration of the "capacity to objectify but not totally"—that is, the lived body.[40]

Hence one condition of a successful cure is that the general knowledge of science matches in reality objectifications of common characteristics of bodies. When a body objectifies its disease and a physician compares this with general classifications of diseases common to human bodies, the search for scientific explanation takes place. One of the motives of a physician, as noted by Lain-Entralgo, is to explain the etiology of the disease and to understand its pathology as a general condition of human experience.

Because the world of common objects and the objectified lived self are the results of a capacity to objectify on the part of lived bodies which cannot be objectified, scientific explanation of disease is not the only, or even the major, task of medicine.

b. A second implication of objectifying and explaining causes of disease is that the etiological agents are real. Bernard noted that Hume's description of causality as constant conjunction is insufficient to explain the real, experienced effect of agents on the body, or the real effects on the body of therapy used to minimize or delete the agents.

The search for proximate causes of disease by medicine is a search for objectively existing agencies which act upon and within the body. Another condition of a cure, therefore, is a scientific knowledge of real causes.[41] The requirements of medical knowledge include a knowledge of a cause, prediction of the effects of its agency, and knowledge that this cause is specific for *this* disease.

These requirements parallel the requirements of Aristotle for *propter quid* or essential demonstrations, which establish a science. To object that medicine does not always or even often know the cause of a disease is only to recognize that medicine is science in the making.

c. A third implication of objectifying the causes of disease is the specificity of medicine. The history of medicine is the history of a search for more and more specific causes and treatments.[42] Thus "cancer" is discovered to be of various types which may not even be related in structure or process. The search for specific causes leads medicine from external agents, such as environment or bacteria, to actual reactive processes in the body. In a profound sense, then, all diseases are caused by self-destructive processes within the body.

The implication of specificity leads to the unique methodology of medicine. As will be discussed in the next chapter, the process of diagnosis is aimed at specificity for the sake of action. Physical and laboratory diagnosis is a process of narrowing the range of possibility by comparing a specific body with normal values. The process is governed by the nature of the interaction, a requirement to reach a decision on behalf of the body in need. Hence the method of medicine is not the same as that of the other physical sciences, which have no requirement to act on behalf of a body in need.[43]

Also, the greater the specificity, the less medicine acts like a science and the more it acts like an art. For as specificity increases, the uniqueness of a body as an individual also increases. The pressure to decide, or the therapeutic imperative, gradually leads to evaluative connotations of the disease for the particular patient. These value coordinates, in turn, influence the mode and extent of therapy.

2. A second feature of the structure of a cure is that clinical judgments differ from those in pure science in that they are governed by individualization. Clinical judgments must be a complex process of perceiving individual uniqueness in the midst of common objectivities.

Consequently clinical judgment must also include modes of convincing and persuading patients about appropriate actions, features which Aristotle called dialectic and rhetoric. The specificity of medicine leads it from the realm of scientific thought to the realm of the everyday world, the realm of the lived body.

If disease is primarily a self-destructive process of a body, then the art of medicine produces cures by working in, through, and with that body. If one accepts Aristotle's definition of an art as a cognitive discipline which produces either a work or action, then the "work" of medicine is an action in conjunction with the body. In this sense, rehabilitation depends upon the extent of individualization. Individualization, in turn, depends upon the physician's discovery and utilization of the wisdom of the body.[44] The response of each patient to therapy cannot be predicted scientifically.

The extent to which individualization is possible is one source of the distinction between primary, secondary, and tertiary care. If the lived self is the historical result of the ability to symbolize, then as active bodily engagement is diminished, so too is the lived self. Thus the body is treated more as an object in tertiary care, where the lived self is diminished or even threatened, whereas the lived self is more actively engaged in primary care. Treatment in primary care can more actively utilize the wisdom of the body than the more interventionist care in tertiary settings.

Because a living organism is a system which takes advantage of favorable opportunities, the wisdom of the body includes an anticipatory note.[45] It is by this preconscious organization of itself for maximum effectiveness that living matter, even a cell, is distinguished from inanimate matter. Hence the physician's response to specificity and the possibility of a cure must ultimately be grounded in a unique organization of matter which we have called the living body.

The structure of a cure must therefore imply that medicine be multi-etiologic. Clinical judgment involves a search for real causes; a comparison of categories reflecting normal values with an individual body in need of help; the values of the patient as a lived self; the world of common objects; responsibility arising from an imbalance of knowledge in the relationship; trust; and a share in the experience of a living body.

To speak more systematically, the structure of medicine implies a discovery of real relationships between causes of health and disease and the effects of these causes on individuals. The material a

priori of medicine is the individual body, which is both the work of medicine and the artist of its own healing. Being a body in the clinical relationship means being alive (the living body), experiencing experience (the lived body), and symbolizing historical identity (the lived self).

The motives of the physician must therefore include scientific explanations of disease; more specific understanding of illness as it interrupts the lived body; and a perception born out of the wisdom of the body to guide therapy and cure.

Constitutively speaking, medicine is an intuitive act that recognizes specificity. This recognition is acquired through skill in perceiving analogous relationships that occur in applications of scientific knowledge to specific health problems. Solutions and rehabilitation depend on mutually satisfactory decisions about therapy. Because the concept of disease is normative on the scientific level, evaluative on the level of the lived body, and structurally linked to the wisdom of the body on the level of the living body, medicine must epistemologically include values. It is at all levels a moral enterprise, where "moral enterprise" means action involving values.

As a result of the above reflections, it should be clear that coherence is an insufficient condition of medical theory. Medical theory must include norms for action and proven applicability. Medicine therefore does not conform to the canons of correctness found in the physical sciences, as Gorovitz and MacIntyre have argued.[46]

Because the structure of a cure implies specificity about the wisdom of individual bodies, it should also be clear that grounding in the everyday world of *praxis*[47] is also an insufficient theory of medicine (Whitbeck, Wartofsky). While it is true that medical concepts are grounded in *praxis,* it does not follow that all concepts are culturally relative or proceed merely from the everyday world.[48] The theory and *praxis* of medicine are both grounded in the specificity of *this* living body.

3. Therefore, the third feature of the structure of a cure is that the threefold aspect of clinical judgment—diagnosis, prognosis, and therapy—depends upon reference to a body.

Diagnosis not only compares scientific classes of disease to symptoms of the lived self but is also guided by the unique historical configuration presented by the lived body. It must create a dialogue with this body to ascertain the nature of the disease.

Prognosis not only links the disease with similar patterns of disease, and not only attends to the scientific record of probabilities, but must also be governed by the values of the lived body and the insight into the wisdom of this particular body in hopes of rehabilitation and restoration.

Clinical judgment is governed by therapeutic necessity because the medical event is constituted by a need for physical help, health being one of the foundational needs of man. Therapeutic necessity is the ground of the legal and moral nature of clinical interaction. Because it is impossible to understand any person, much less any group of persons, all at once and entirely, therapy cannot be viewed as scientifically predictable and secure. And because the values of patients and society enter into all stages of the clinical interaction, therapy is inherently value-laden. If medicine is guided by therapeutic necessity,[49] even in its theory, then medicine in its totality is a value-laden enterprise.

Therefore therapy depends on the biography of the lived self, the dialogue between the physician and the interpreted and uninterpreted signs of the body, and the wisdom of the body. Therapy aids in the appreciation of instinct and dialogue as components of human life.

The Everyday Realm

The condition of possibility that scientific concepts can be applied to a lived self with beneficial effects is that both scientific concepts and the lived self are grounded in the real world of everyday reality. This world contains the capacity to objectify as the uniqueness of individuals. At the very least this structure implies the following:

1. There is a shared world of real objects and a commonality of language by which the process of objectifying is given objective standing. Things and realities are recognized as other—that is, as connected with the lived body without being united to it.

2. Physician and patient must share in the experience of being a lived body. This experience is a recognition, as Marcel pointed

out, that in the last analysis my body cannot be made into an object, where an object is connected as other to me, but not united. An individual is his or her body.

3. A cure implies not only a scientific explanation of disease but a real effect on and in the lived body with all its values. On this level, the physician must have an experience of disease—a disruption of the lived body—and an imaginative preconception of what the truth might be to guide the scientific classification process.

4. The therapeutic process must be guided by the possibility of perceiving the patient as a lived body, a subject rather than an object.

5. The patient, as well as the physician, must have the possibility of making "notional judgments," everyday, gradual syntheses of empirical value experiences. For this constitutes the uniqueness of living bodies—namely, that they exist in space and time and create their own histories as a consequence. Because the cure must be satisfactory and rehabilitative, it must be grounded in a cultural and individual value system created by lived bodies. Accordingly, the physician is guided by the *praxis* of the everyday world in diagnostic and therapeutic decisions.

6. The everyday world of *praxis* cannot be viewed as an absolute reality captured by scientific concepts. As Ernest Cassirer observes in this regard:

> It would be a naive sort of dogmatism to assume that there exists an absolute reality of things which is the same for all living beings. Reality is not a unique and homogenous thing; it is immensely diversified, having as many different schemes and patterns as there are different organisms. Every organism is, so to speak, a monadic being. It has a world of its own because it has an experience of its own.[50]

We have made other observations about the relation between the realm of science and the realm of the everyday, between theory and *praxis,* in the preceding section.

Survival Realm: Structures of the Living Body

The ability to cure requires specificity. But the requirements of specificity include clinical entities in a scientific sense and the in-

dividualities of patients. However, in order for a cure to take place, the clinical interaction must include another factor: some common structures of living organisms. This is the realm of the wisdom of the body discussed above. The condition of possibility of cure, therefore, is that bodies organize themselves in a common manner, although the extent and degree varies from one to the next. At the very least, this structure implies:

First, that the body creates the world of its perception and is the object of its own creation. Scott Buchanan illustrates this point: "The human body . . . becomes a most marvelous work of natural art. It is an artist fabricating tissues, organs, fluids and gases out of raw materials . . . it is the product of its own art."[51] The uniqueness of the body is its own "wisdom," its pattern of artistic achievement.

Second, the body is immediate to itself. It is there and needs no scientific justification or proof. The living body is an a priori to the actions of the lived body which distinguishes objective and subjective. The body is experienced as a centered unity.[52]

Third, the origin of seeking and offering help as the condition of the medical event lies in the compassion of living bodies. A direct awareness of pain is conveyed by the body to other bodies without intervening language. The insight into concrete singulars required for a cure depends on this compassion, which might be described as a prearticulated shared awareness of bodies regarding the human condition. This awareness grounds medicine in tragedy and gave rise to the myth of Aescupulus, a myth of the wounded healer. In a very real sense, one must "suffer with" in order to heal.

Fourth, bodies have a common capacity and structure. Otherwise, general medical concepts could not be applied beneficially, since they are derived from therapeutic experience and necessity. *A cure cannot take place without common bodily processes.* All bodies are homogeneous in that they subject their parts to a whole activity. All bodies inhabit and adjust to their environment. All bodies subordinate their activities to an end in view.[53]

Thus a unitary substrate of life and experience exists in the "bionomic order" of the body which unifies all causal factors necessary for a cure.[54] It is our view that the reality of cures in medicine establishes the reality of the human body as composed of its own

unique wisdom and a common bionomic order with other bodies. It is further our view that medical theory and practice are applied to and derived from the wisdom and bionomic order of bodies. Since theory and practice in medicine are part of a moral enterprise, a possibility exists to ground medical ethics in a philosophy of medicine, rather than in older ethical theories or in cultural relativism. This enterprise is the subject of Chapter Eight.

Bodies interact with other bodies in arrangements. These arrangements are not capricious, because they rest on common structures of living bodies. On the other hand, the reality of each living body is unique, because it arranges itself according to its own wisdom.

The source and origin of the everyday and scientific realms is bodies interpreting themselves and the world. Thus facts are already values. Thus medicine as a science is forced by the body it helps heal to be medicine as an art.

The primal experience of the body must be present in medical interactions in order that scientific explanations have a common base. In this way, "it hurts here" is understood by the physician in a direct, compassionate way as body while simultaneously understood in an indirect way through the disruptive effects on the practical world of the lived body and the interruptive effects on the lived self through scientific conceptions of pain. But without the direct experience of "hurting," and its implications for the wisdom of the body, the structure of specificity will be absent from the clinical relationship.

Put another way, medicine refers to its own collective body of theories, to the everyday world of values and disease, but primarily to the individual body, both in its universal organic processes and in its unique selective wisdom.

Ontology of the Body: Toward an Anthropology

The conditions of possibility of medicine themselves have conditions of possibility. Because of the structure of medicine, its specificity, is related to a real event, a cure, specificity is a real occurrence in human affairs. Therefore an ontology based on the body is possible and would constitute the outline of a philosophical

anthropology.[55] The topic deserves more extensive treatment than can be devoted to it here. We will simply note some of the implications for an anthropology based on a philosophy of medicine developed so far.

The fact that living organisms not only react to but also shape their world establishes what we have called a bionomic order. Logically prior to individual experience, but in reality concurrent with it, is an organization of reality by a living being.[56] Among the organizations of the world is the active selection of what is best for the organism, which we have called the wisdom of the body. Hence the living body proto-selects health as a desirable goal and considers it obtainable. In this fundamental sense, health is a perduring value of living bodies if "value" is defined as that which is judged both obtainable and desirable, i.e., a good.

These observations are important not only to describe the structure of medicine, but to ground the reality of cures in what are common *living* organization patterns and specific organization patterns individual bodies adopt. Hence the next chapter will explore clinical judgment, the epistemological heart of medical practice, from the standpoint of these conditions of possibility.

The conditions of possibility of a medical event also point to the possibility of an ethics based on the value of health and an ontology of living bodies. Since medicine cannot fully explain itself by understanding the body in purely mechanical terms, neither can human life be so explained. Furthermore, the ancient conjunctions of values and medicine are shown to have their roots in the common and unique functions of living bodies. Thus if a modified natural law theory were suggested by the structure of medicine, such a theory of commonalities would have to be tempered by attention to specificity. In other words, the structure of medicine, its condition of possibility, reveals that as absolute statements may be made regarding commonalities, these must be relativized somehow by the specificity and uniqueness of living bodies. It is for this ontological reason that etiology is more scientific than prognosis and therapy. Similarly, if health is a foundational value, an ethic of medicine must simultaneously consider both individual and social good, as both are rooted in the living body.

Since both health and illness presuppose a personal unity based

on biological organization and historical identity, medicine suggests that individuality and personhood are activities of the body.[57] Thus personal identity, as many realists such as John Dewey have argued, is a symbolization of the body. In this symbolization, medicine presupposes the perfectibility of man, a condition it shares with ethics.

Finally, sorrow and death are part of the tragic condition of man. They are not transcended by medicine so much as made bearable. In this consists the nobility of medicine and its connection to the arts.

6

The Anatomy of Clinical Judgments

For it is uneducated not to have an eye for when it is necessary to look for proof and when this is not necessary.

Aristotle[1]

Introduction

In 1916 Richard Cabot, one of the most celebrated American diagnosticians, labeled his attempts to anatomize the process of differential diagnosis "a very dangerous topic—dangerous to the reputation of physicians for wisdom. . . . Physicians are naturally reluctant on such matters, slow to put their thoughts to paper, and very suspicious of any attempts to tabulate their methods of reasoning."[2]

Sixty years later, most clinicians remain reluctant to detail the process of clinical diagnosis and more than a little suspicious of those who do. Many still take refuge in the "art" and its exclusive mysteries, to resist formalization of their mental operations. In recent years, the "dangerous" subject has been boldly attacked by a few clinicians with unusual facility in the language of logic and statistics so that dissection of the tangle of science, art, and conjecture is now well underway.[3] They have been joined by statisticians, engineers, psychologists, and philosophers who are bringing the more

This chapter is based on a paper presented at the Fifth Trans-Disciplinary Symposium on Philosophy and Medicine: "Clinical Judgment," University of California School of Medicine, 14–16 April 1977. Now published as "Anatomy of Clinical Judgments" *Philosophy and Medicine*, Volume VI, D. Reidel Publishing Co., The Netherlands, pp. 169–94.