commentary

Encountering Particulars: A Life in Medicine

Anna Luise Kirkengen, MD, PhD

Medicine Around the World

Over the course of time, I have come to see how easy it is to believe that what we do and believe medically in the US must generally be the way medicine is viewed and practiced in other modern countries. We hope, therefore, that readers of *The Permanente Journal (TPJ)* will be interested every so often to hear physicians around the world describe *their* medical practices so that we all may better understand the wide range of what we do.

The first writer in this series is Anna Luise Kirkengen, MD, PhD, a highly perceptive German physician who has spent her professional life as a general practitioner in Oslo, Norway. Dr Kirkengen is author of *Inscribed Bodies,* a medical book we reviewed in the Spring 2003 issue of *TPJ (7(2):84)*. —Vincent J Felitti, MD

For 30 years, I have hoped that someone would ask me, a general practitioner, the following question: "In your opinion, what is the most important source of your ongoing professional satisfaction and your best professional contributions to your field of work, human medicine?"

My main and inexhaustible source of professional inspiration is in my everyday encounters with patients who, as individuals, present the "particulars" of his/her lived life. Each embodies these particulars quite differently, and each generously enables me to become ever more knowledgeable about what it means to live a life. The fascination of encountering such particulars is what, in my eyes, makes medicine in general worth practicing, and general practice in particular a privileged task.

Situated Humans

Human beings are suspended in webs of significance they themselves have spun.[1:p5] Every person, be s/he healthy or sick, patient or doctor, is *situated*; that is profoundly shaped and influenced by the cultural time and place s/he inhabits. To inhabit does not merely mean to be located, but rather to be embedded–in a fellowship constituted by customs, rules, rituals, conventions and–yes–habits; as such, it designates both being a part and being confirmed. In *The Interpretation of Cultures*, Anthropologist Clifford Geertz sees these webs of significance, the texture of cultures, as fields of an interpretative search for meaning.[1] Thus, being situated involves both implicit and explicit knowledge about the meaning of life's experiences and active and passive participation in the maintenance and construction of that meaning.

Human fellowship and cultural situatedness are the great frames for any encounter between persons, particularly in the roles of a patient and a doctor. The embodiment of life experience is the predominant topic of such encounters, though not necessarily appraised or recognized as such by the patient. Meaning and embodiment are doubly related. First, our bodies are shaped by the meaning that each of us attributes to our lived experiences. Thus, a person experiencing a threat to life or integrity without an option for defense usually will integrate this experience of powerlessness as a permanent state of insecurity. Second, because our bodies are our means of living a meaningful life, a person experiencing bodily ailments or functional impairment without an option for solution will find the meaning of his/her life threatened.

Ethics of Nearness

Medicine, and especially family medicine, must deal with this double relationship between meaning and embodiment. There we are, those of us doctors who have chosen to be on the first line. Our challenge is *understanding*—a prerequisite for comforting and helping, supporting, and healing. What does it mean to understand another person in his/her need? Literally: to stand below, which means to be in the same place

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and, from there, to share somebody else's perspective. Practically: to unfold and make explicit personal experience and life details in order to grasp the significance of events, relations, and situations. These must, in turn, be professionally explored together with the patient with regard to the specific logic and rationality inherent in his/her lived body.

What such an exploration of embodied logic implies may be exemplified in Katarina Kaplan's[a] sickness history:

> *Recently authorized as a physician, Katarina was completely disabled. Her training and internship had been interrupted and prolonged by several acute and severe diseases. She had presented symptoms indicating gastric ulcer; after suffering a whiplash from an accident, she had gained sixty pounds while restoring her injury; she had been incapacitated for nearly a year by mononucleosis; and she had been hospitalized due to viral meningitis. Unknown to her doctors (who also were her colleagues), she, in addition, suffered from frequent panic attacks, binge eating, vomiting, bowel dysfunction, and abdominal pain. When finally having completed her internship, Katarina had had a breakdown, and neurologists, after several months of medical examination, had diagnosed chronic fatigue and ordered long-term rest while expressing concern regarding Katarina's medical career.*
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> *The rationality connecting these attacks, habits, and diseases was finally disentangled in a long dialogue between Katarina and her new general practitioner: Since early childhood, and in the name of punishment, Katarina had been physically abused by her parents. But her main abuser had been her brother, who, fooling the child into dangerous situations, frequently had caused her severe harm. Later, he had battered her, and he had continued to do so even after she had left home for medical training in another town. Her state of being had, from childhood to early adulthood, been informed by fundamental insecurity, horror, and alarm. This had resulted in a heavily compromised immune system. And by the time of her graduation from medical school, her adaptability to threat had been exhausted.*

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As primary care doctors, not only do we have the privilege of coming close, we also have the obligation to come close: to familiarize ourselves with the lives, hopes, intentions, defeats, and longings of our patients —respectfully. And in this we are subjected to the ethics of nearness: we must remain near, and we must witness—honestly. The ethics of nearness in the medical encounter spring from "the therapeutical dyad of trust and care," and are, as such, profoundly defined by a particular relationship that is "essentially tenuous, unequal, and asymmetrical."[2:p319] "On the one side, the vulnerability and *appeal* of the ill person; on the other, the *response* from the would-be healer" endow this relationship with "all the characteristics of being fundamental to moral life."[2:p319]

While applying an ever more sophisticated technology when exploring and investigating the objectified human body, biomedicine as a field of knowledge and a basis of clinical practice renders the human subject invisible.[3-8] Current biomedical research and practice does not routinely and consistently recognize a patient as a person. This means that medicine does not integrate the patient's perspectives with regard to his/her lived experience, intentions, goals, and purposes.[6-9] Consequently, the aforementioned moral core of the medical relationship between two *persons* is, in fact, not accounted for with regard to certain fundamental aspects.

Phenomenology

Peoples' experiences, intentions, goals, and purposes represent the most central issues in phenomenology, a philosophy concerned with an understanding of human being-in-the-world.[10,11] The perspectives of the human subject are at the core of its interest, and it regards the human body as the embodiment of life.[8-13] Understanding the body as the embodiment of lived experience renders human bodies mind-full and interacting particulars within the different systems of values and signs that constitute human societies and human lifeworlds.[6,7,9-18]

As members of societies, humans are embedded in social processes that determine their existential basics. The most central among these are trust, belonging, nourishment, respect, care, honor, and pride; their opposites are defeat, loneliness, neglect, violation, abandonment, disgrace, and shame. Because these central phenomena of social life are, in the practice of everyday life, a matter of consent, meaning, intention and purpose, the qualities of a particular experience that is embodied are never predictable only from the event as such; they cannot be fully deduced from objective characteristics. The impact of shattered trust, social abandonment, shameful exposure, or public disgrace, though regarded as disruptive in general, can be massively destructive for some individuals.[8,15,16] Certain painful experiences can unmake the world.[12] Neglect, abandonment, or disrespect can make persons feel lost in familiar places, and alienated in their perception of

body and self.[8,15,17] Betrayal, particularly in times of general uncertainty, may endanger selfhood and life.[10,14,15]

The meaning of such a general threat to existential preconditions may be exemplified with Serena Sager's[a] sickness history:

> *An acute pain attack in her left body when Serena was nearly twenty years old resulted in a referral to the emergency clinic. However, no somatic origin of this pain could be verified. Serena reported having had such left-sided pain in her body since she had been raped at age 16 years. She also reported to have suffered from anorexia at the age of 14 and to have been examined for left-sided pain in body and head, seizures and loss of consciousness; to have been in psychiatric care since the age of sixteen; to have intoxicated herself with suicidal intention at age 18 years; and to have suffered and been examined for pelvic pain over a period of several years. She was referred to a psychologist and was advised to see a general practitioner for general follow-up.*
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> *During extended dialogues with her new doctor, Serena was gradually able to figure out how a rape performed by an uncle had split her body perception and resulted in chronic left-sided pain, frequent seizures, and loss of consciousness. After her parents' divorce when Serena was twelve years old, she had lived with her mother, who abused alcohol. Burdened by concealing her mother's alcoholism and managing the household, Serena would turn to an aunt. In this "safe harbor," in the absence of her aunt, she was raped by her uncle at age 16 years. Approaching her from behind while she was sleeping on her right side, he imprinted his heavy body on her left side. Serena, being alienated in her body and simultaneously endangered in her only safe place, increasingly experienced cramps and loss of consciousness triggered by conflicts in her family. Decoding the meanings of her pain and mental absence during the seizures enabled Serena to integrate her "sickness history," the impact of abuse, into a meaningful life history. In doing so, she facilitated her healing.*

Consequently, phenomenology is both a philosophical framework and a methodological tool for the interpretation of subjective and intersubjective issues of human life. As such, it is an adequate means for approaching the meanings of human experience with regard to sickness, disability, pain, deviation, marginalization, and suffering.[6-8,10-18] Any medical interpretation of sickness reports might be fruitfully guided within such a frame of reference.

Professional Witness

Witnessing professionally means to communicate salient knowledge to the medical community about the lived body, with its particular embodiment of a particular life. This means that, as general practitioners, we also must be researchers and reporters from a very special place: from medical encounters with the details of human lives, their particulars. To do proper research and honest reporting from here, we must also be skilled in a theory and methodology other than that of biomedicine. And we must contribute to scientific knowledge in ways that account for the values that inform human life in the sense of the human sciences.

The theories and methodologies of the human sciences aim for the development of knowledge that appraises diversity, ambiguity, plenitude, difference, and particularity. As a nonabstract but rather enriching way of exploring human life conditions, we must communicate our findings in "thick descriptions."[1:p3] Thick, detailed descriptions, however, require time to collect —and space to communicate and publish. This is the price of insight and understanding in medicine.

Privilege and Contribution

I am convinced that the noblest professional privileges of a general practitioner and the most important contribution of family medicine to the body of medical knowledge coincide. Their nearness to particulars both nourishes the individual primary care doctor and renders research and reports from general practice unique. Such research is, in its very nature, an unfolding of the logic and rationality of embodiment. Unfolding meaning takes time and demands space. Consequently, the medical community should welcome the thick descriptions which general practice has the privilege to provide. This would, in fact, be the response to Richard Baron's question, "Why aren't more doctors phenomenologists?"[18]

Finally, there might be yet another important gain that, in times of increasing professional strain, would show utmost value: "In the end, it is not only the patient's getting better that counts; it is equally, though perhaps more subtly, that the physician, no less than the patient, morally benefits from the relationship."[2:p320] ❖

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a The names and contents of these stories have been altered. Any direct similarity to individuals, living or dead, is coincidental.

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To Live for Yourself

No one can live happily who considers only himself.
You must live for others if you wish to live for yourself.

— Lucius Annaeus Seneca, 3 BC–65 AD, Roman dramatist, poet, philosopher and orator