# The art of medicine

## “How do you feel?”: oscillating perspectives in the clinic

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“The body is originally constituted in a double way: first, it is a physical thing, matter […] Secondly, I sense ‘on’ it and ‘in’ it: warmth on the back of the hand, coldness in the feet.” These words were written by Edmund Husserl, the 20th-century philosopher and founder of phenomenology, the philosophical study of human experience. For Husserl, this duality of experience is a unique feature of human existence. Humans are both physical matter, like kettles, trees, and rocks; but they are also capable of having conscious experience. On the one hand, we are physical objects; on the other hand, we are consciousness. What is the relevance of this dual existence to medicine? We consider the philosophical basis for this view and its potential importance to clinical consultations.

In his *Ideas II*, Husserl uses the example of two hands touching each other in order to reveal the uniqueness of human existence. When the right hand is the active, touching one, it is at the same time touched by the left hand. If we consciously decide to reverse the roles and concentrate on the left hand as touching, we can still experience both dimensions: the active touching and the passive being touched. In order to be touched one has to be a thing among things, a physical object. Such an object is always open to the possibility of being touched. But in order to touch one needs to be able to *sense* the touching. One needs a consciousness that can perceive the touching. Our embodied consciousness contains both aspects.

With this idea in place, let us now turn to the clinical situation, which can be seen as containing an objective and a subjective component. The physician is often construed as an objective observer, palpating, listening, looking and examining an object that is laid before her: the patient’s body. The patient is a subject, experiencing pain, discomfort, or relief. However, we would suggest that the situation is more complex. The patient’s view of her body might become objective, while the physician’s presence is often also subjective, because it perceives and senses as only subjects can.

The physician’s approach is traditionally characterised as objective and active. She guides the patient’s telling of her story by structured questioning, aided by appropriate encouraging and empathic responses, to achieve the main task of the consultation, which may be to make a diagnosis, review treatment, or decide on further action. The development of a relationship with the patient is seen as facilitating these tasks, and involves the doctor knowing a lot about the patient’s life, and the patient very little of the doctor’s. When it comes to touching the patient in the course of a physical examination, the doctor’s stance is the same. Her hand becomes an instrument on which her whole sensory awareness is focussed in order to detect the slightest abnormality in the body beneath it: a lump that should not be there; a roughness where it should be smooth; dullness where it should be hollow. This concentration on the touching hand requires a kind of shutting out of the world to the extent of being unaware of the rest of the patient attached to that part being examined. Doctors have been criticised for this, but this is crucial to the practice of the examining art, like a musical performance in which the pianist is absorbed only in the music under her hands.

But of course, unlike a pianist and her piano, doctors are made of the same stuff as their patients. Aware that being touched by cold hands may be uncomfortable, the doctor will try to warm them; conscious that rough hands are unpleasant, she will keep them supple with cream. Medical students are taught to watch the face of a patient they are examining, but in fact it is the touching hand that gets the message if there is a problem, because the body can touch back. The examining hand can sense even a slight quiver or tensing of muscles if it finds a painful area, even before the patient utters a word. This touching back not only gives information to the objective examiner, it transforms the doctor into an experiencing subject. So we can see that throughout the consultation the doctor oscillates between the position of an experiencing subject encountering another subject ("I must warm my hands so they are not cold to the touch"), to objective examining instrument (analysing the physical flesh under her hand), and back again.

Let us now turn to the experience of the patient. When lying down on the examination bed the patient cannot help but feel like an object, a thing laid out for scrutiny. Anyone who submits herself to the gaze of the doctor may feel her body become a medical object. But at the same time, the patient is also thinking about the touch as it feels to the physician. Thoughts might include: am I clean enough; how does she feel about touching me there; does she think I am fat? The patient presents herself to the touch and judgment—real or imagined—that ensues. In this sense the patient recognises the limits of the physician's objective stance.

A further objectification takes place in the clinical setting. When entering the CT scanner, for example, some feel they are being converted into data points, sliced by the x-ray making its way down their torso. When a patient is shown ultrasound images of her own body, these images are unrecognisable to her as images of her body. Even if she feels curious about the images and the processes they capture, it is still hard for her to reconcile these objective images with her subjective feeling of her body. These experiences, especially when repeated, may lead to a sense of alienation from one's body, and indeed to treating that body as an aberrant object over which one has little control. The patient is a subject, but a subject that is objectified.

So how are we to think about the subjective and objective perspectives in the clinic and why is it important for clinicians to recognise these different ways of experiencing? Our suggestion is to try to move from viewing the physician's perspective as objective and the patient's perspective as subjective towards a greater appreciation of the oscillation from one position to the other. This oscillation does not denote an inconsistency. On the contrary: it marks the unique duality of the human body, which is capable of both subjective experiencing and of being experienced by others as an object. Recognising the oscillation as key to understanding human experience in its openness and vulnerability might serve as a step towards contesting the expectation that doctors should be purely objective in their clinical practice.

Recognising this oscillation between subjective and objective, active and passive, roles can also introduce a second-person perspective that is available to the physician. This perspective, that of being there without pretending to stand in their patient's shoes, avoids patronising assumptions and does not objectify the patient. We suggest that the second-person perspective ('I can see that you are feeling bad') may offer a way of improving communication in the clinic by emphasising the subjectivity of the physician—

her normal exchange with another human being—despite her objective role. Emphasising the subjectivity of the clinician may make her more approachable to the patient, and enable the patient better to share her illness experience. By recognising each other's subjectivity both physician and patient stand to gain. The physician gains a more natural mode of expression, and the patient has a feeling of being listened to by a fellow human being who neither purports to stand in her shoes, nor to be completely objective.

Finally, this reconciliation may also create a shared world of meaning in another way. When the physician observes the patient objectively, she also sees the patient's body as an instance of an anomaly or pathology. From this point of view the patient presents as a "case". But from the patient's subjective point of view, their illness is a way of being, a particular world they inhabit. By bringing closer the objective and subjective points of view and recognising the constant oscillation from one to the other, we may also bridge the gap between the view of illness as a pathology and illness as a way of being, and so reduce the distance between these two contrasting perspectives present in the clinic.

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## Further reading

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