Raymond C. Barfield

The Practice of Medicine as Being in Time

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For my parents, Pearl and Ray Barfield

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Preface

I am a pediatric oncologist and palliative care physician. A few minutes ago, I walked out of the room of a teenage athlete who was recently diagnosed with Ewing's Sarcoma after two months of pain. He is an outstanding student, with only a few courses left in high school. He wants to build something in business. I hope he gets to do that. If he does, it will be in part because oncology teams have run carefully constructed research protocols over decades, systematically trying to improve cures for cancer in kids. Progress has required scientific creativity, passion, fiscal ingenuity, logistical genius, risk, partnership, tenacity, and outrageous courage on the parts of patients, families, and medical caregivers. This is beautiful to me.

I could describe a thousand moments from my own practice that are beautiful in this way. I could describe a thousand moments in the careers of friends who have chosen all sorts of paths in medicine, and who have become better human beings because of their encounters with the profundity of human existence, gifted repeatedly through their patients. I could describe the work of nurses, housekeepers, administrators, financial analysts, and others who contribute to the complex work of helping the sick, the suffering, the dying. The practice of medicine brings together an astonishing variety of talents, gifts, and services at some of life's most difficult moments of crisis, worry, doubt, and fear.

At the same time, I believe the corporate transformation of American medicine is often at cross purposes with the good I have seen in the practice of medicine. I believe this transformation threatens to turn human suffering into a commodity leveraged for profit. I believe that the good in the practice of caring for sick and dying human beings has been diminished by this transformation. I believe some of the more brutal corporate practices are evil, and that they use the history of good medicine to disguise themselves as good, thereby improving public relations to increase profit, which is the fundamental value of the corporation. I believe much of what has been called "burnout" (inaccurately) is a result of this corporate transformation with its obsessions over money and power, its disregard for the pace and value of human experience, its disdain for distributive justice, and its degradation of some of the most important parts of human life.

This book is a philosophical argument for the foundation upon which those beliefs rest. I could make an argument that is not overtly philosophical, but that argument would still be rooted in philosophy. I am probably wrong, or at least hyperbolic, in parts of my thinking. This book is a preface or prolegomenon to my own very personal attempt to account for what I have witnessed in my life as a physician. I am trying to find my own footing in the strange new world of medicine, where life-altering human events are sequestered inside contemporary corporate structures that generate massive profits by monopolizing the tools created by non-corporate ventures over centuries that were aimed at addressing human suffering.

The clarity of a philosophical argument depends in part on the reader's familiarity with philosophical terms. Such language is not the usual parlance of medicine. That is one problem with writing a philosophical book about the practice of medicine. Another problem is that philosophical terms, while they might act as placeholders for mysteries or gesture toward mysteries, do not make the mysteries any less mysterious. This kind of philosophical language can sound strange and vague, rather than clarifying. It can seem unnecessarily opaque, which is annoying to many people. It is frequently annoying to me too.

Nonetheless, such language serves a purpose. It can be provocative, if only because it makes us see familiar things in unfamiliar ways. It can help to maintain humility in the face of the mysterious so that we resist the temptation to carve up the world too neatly. Vague language is sometimes the best language for talking about realities that do not have clear contours, but which still affect us. The risk of vague language, however, is that it can claim to be pointing to something real that does not exist. It is easy to get lost in vague language and the language of gesture. This is not a reason to avoid it when no other language suits the process of philosophical exploration. It is simply a reason to remain humble and open to correction, both of which are habits fitting to the practice of medicine in which a too-rapid presumption of clarity about diagnosis can blind us to the deeper reality of what is happening to a patient.

The chapter titles I have chosen riff loosely on the language of one of our more bewildering philosophers, Martin Heidegger. At first glance they might seem like examples of needlessly obscure language. Maybe they are. But I also find them suggestive. They have helped me think through several aspects of the practice of medicine for which I was given a clear language in medical school, only to discover that the apparent "clarity"

derived from a simplistic reduction of human realities. This reduction carried me away from the truth rather than toward it. Reductionistic thinking has been important in the effort to achieve practical solutions for many of the problems that disrupt the biological function of the human body. But it has also eased the monetization of human illness and suffering by corporations fixated on efficiency as a means of increasing profit. This malevolent development is my motivation for taking a second look, rethinking the nature of the practice of medicine, and resisting the neat categorization of human experience that allows the corporate transformation of medicine to proliferate unchecked. Once the assumptions undergirding the worst tendencies of the contemporary practice of medicine have been exposed, perhaps the strange language can be discarded. Meanwhile, think of it as a kind of playful testing of ideas, keeping in mind the importance and seriousness of human play.

In the first chapter I address the concepts of disclosure and anxiety. The odd title of this book, *The Practice of Medicine as Being in Time*, is a slightly tongue-in-cheek nod toward Heidegger's strange and beautiful early work. But it also underscores the uncanny backdrop for the practice of medicine, which focuses on the complete human being whose participation in the world depends upon a body that lives for a time and then dies. Transience, uncertainty, and mortality are the kinds of things that provoke anxiety. We often hide from them. Telling the whole truth is difficult. The practice of medicine is one very important arena in which disclosure, and therefore anxiety, occurs. But facing disclosure and anxiety can also lead to growth and genuine discovery for both patients and doctors.

Whatever growth and discovery might follow from courageously facing the truth of reality, the experience of showing up in any form and context in this life is an experience of being thrown into the world. Chapter two begins with a couple of disarming facts: we did not choose to exist and we cannot choose whether or not life ends in death. In between birth and death, we find ourselves inhabiting bodies we did not choose, cultures we did not choose, and languages we did not choose. Disease likewise comes upon us without our consent, and we are thrown into circumstances over which we have no control. This heightens anxiety and we are again tempted to hide reality from ourselves. Understanding the character of thrownness is important for understanding the dynamics of the practice of medicine as being in time. Patients and families find themselves thrown. So do doctors. From the start of their training, most new doctors feel

thrown into something larger than themselves. They frequently work under the false belief that they have to be big enough to face the entire enterprise on their own and that they must show no "weakness" of any sort—including fear, doubt, anxiety, fallibility, or incomplete knowledge, all of which are as common as they are profound in the life of a person. This is a recipe for disaster. We know this, because the disaster has already occurred and the consequences are becoming ever-more apparent.

We are thrown. Over time we become aware of our condition. We do so within a dawning reality that is variably veiled and disclosed. Primordial reality underlies the truth we discover in the course of our lives. The practice of medicine is a philosophical cauldron in which people experience threats to their own existence over time against this primordial backdrop. To say what the practice of medicine is, what it ought to be, and why it ought to be one way rather than another requires a sense of the larger context and the local circumstances of the practice—a concept of reality as a whole. Chapter three explores this idea of primordial totality and its relevance to the practice of medicine as an arena in which we become newly aware of the human condition.

However strange existence might be, we cannot live in continual upheaval and crisis. We experience the rhythms and repetitions of our days as normal, our version of average everydayness. This is what is disrupted by the crises we experience when we are thrown into disease. Chapter four considers the importance of understanding what is interrupted in the life of a patient as the starting point for decision making and care within the practice of medicine.

Chapter five turns to the physical, philosophical, and ideological spaces within which medicine is practiced. These spaces have been radically changed by the corporate transformation of contemporary medicine. Within the structures deformed by corporate greed, some spaces can be redeemed even without institutional change. One of the most important of these spaces is the clinic or hospital room. Within such rooms, after the door is closed, the practice of medicine as being in time can continue on a human scale. The room can become a small theater in which human-sized needs, hopes, fears, and realities are played out. But seeing and shaping rooms in this way is to make a deliberate philosophical choice that requires intention and long work to achieve.

History is the larger story of forces that have shaped the practice of medicine. The way in which history is told affects our understanding of

what the practice is and what it should be. Justice and injustice weave through the history of the practice of medicine, determining the effectiveness of the practice as definitively as human biology does. Individual histories are also fundamental to the practice. Any decision that cannot be determined by biological realities alone (which includes nearly every decision made in the practice), must turn to history for insight into the possibilities and goals that make a decision good, right, and fitting. Chapter six considers the importance of history and the problems we encounter as we try to explore historical realities.

Part of the history a patient brings to a doctor is the history of symptoms that suggest the nature of disease. Part of the problem of history is the hiddenness of symptoms. Chapter seven addresses the reasons we sometimes hide our symptoms from doctors, from family members, and even from ourselves. Hiddenness can obstruct the diagnostic process. But it can also be a necessary part of achieving goals besides cure, if those goals are deemed more important than the agenda of medical intervention. Understanding the nature and role of hiddenness is important for understand the doctor-patient relationship, communication, and the value of discerning the fears, hopes, assumptions, and goals of patients.

Chapter eight turns to three philosophical concepts operative in the practice of medicine as being in time—curiosity, falling, and that which shows itself in itself. Curiosity is a benevolent orientation toward hiddenness that values the patient by valuing knowledge of what is hidden while respecting the reasons it is hidden. It is one important condition for the disclosure of what is hidden. We cannot control the hidden because we do not know what it is. Because we cannot control it while it is hidden, the process of disclosing what is hidden feels like falling into the meaning of what is disclosed and the effects of the disclosure. We know nothing with certainty. But the work of disclosure is done with a sort of philosophical faith that it will bring us closer to reality and lead to knowledge of that which shows itself in itself. This kind of knowing is a basic act, depending only on the actual encounter with that which shows itself in itself.

The concepts discussed in chapter eight depend on a skillful use of questions and a deliberate openness to answers. Chapter nine explores the nature of questions and answers, as well as the sources of distraction that interrupt the discovery process of asking and answering questions. When questions lead to answers that cause anxiety, fear, or pain, we are tempted to avoid them and to engage in idle talk instead. This avoidance is neither

good nor bad in itself. It is good or bad only in relationship to goals, purposes, values, and ends. But there is also a danger that these sources of distraction allow cowardice and lying to infiltrate the practice in subtle and insidious ways that persist under the cover of the benevolent protection of hope.

Chapter ten turns to the moment of decision in which judgment, assertion, and ambiguity shape action as we choose one path over another. Judgments are made in light of our awareness of reality, including the reality of a patient's own purposes, goals, and values. Assertions are made based upon our judgments. Though we always work within the limitations of our knowledge and insight in an atmosphere of uncertainty, we make assertions as though our judgments are correct. But because we know we are limited in our knowledge and insight, sustained engagement with difficult decisions requires humility and honesty toward the reality of ambiguity, which is ubiquitous in the practice of medicine.

Even when we have done our best to disclose the hidden, to come to terms with reality, and to work through obstacles to good decision-making, we can still decide to bury over our discoveries. Chapter eleven considers the reasons we bury over realities even when we have traded time, money, and labor to gain access to them. Individuals bury over realities and communities bury over realities. But burying over is not simple denial. It often has an important role, and many cultures have rituals and liturgies to guide the burying over. The practice of medicine allows doctors to witness many circumstances in which burying over occurs, and this is a great privilege. Burying over is conditioned by time as a limit of human experience. Grasping the functions and reasons for this human act is a subtle but important part of the practice of medicine as being in time.

Finally, chapter twelve addresses the end of human life as an ever-present reality in our lives. Two senses of human "ends" are relevant. First, our lives end. We die. This is an unavoidable and central part of how human life is framed. Second, when we examine our lives, we discover purposes that drive our choices. These constitute our telos, the true end of our life. Both senses of a human "ends" are indispensable for understanding and shaping the practice of medicine as being in time.

This is an exciting time for medicine. It is also a difficult time. Contemporary medical practice is complex. The good is complex, and the evil is complex. The effects of corporate transformation on the practice are not limited to medicine. I believe this is a large-scale cultural crisis. But the

arena of medicine is so intimately and immediately related to our bodies that it functions as a proving ground for the crisis, a place where many people first wake up to the effects of the crisis.

At the start of this project I worried that I was overstating the crisis. I now believe that overstatement is nearly impossible. It might seem odd that I think philosophy holds some of the most important keys to creating good in the middle of a crisis created by a power as enormous as the corporate juggernaut. But I do. Part of the reason is that philosophy, by its very nature, is a continual reorientation toward reality that draws on every resource, and that functions as a nexus for every mode of human discovery and enjoyment of the world.

Another reason is that philosophy is inefficient and meandering, capacious in its methods, voracious in its curiosity, tender toward human fallibility, courageous in its openness to the strangest parts of human life, and delightfully annoying in its manner of reveling in the accusation of uselessness. It fits no metrics and it can never be relegated to a spreadsheet. It makes no money, but it does make people uncomfortable. It smiles at odd times, laughs in weird places, and uses everything from poetry to stars to Coke cans to make its point. Therefore, it is uninterpretable by corporations. It cannot be translated into any corporate language, so it walks the halls invisibly, even as it changes lives by changing the way we see the world. I am grateful to philosophy. It has allowed me to fail in so many spectacular ways—my efficiency-and-profit-metrics might be terrible, but I love being a doctor.

I am deeply grateful to Alexander Gungov for his invitation to write a book for this series and for his insightful comments along the way. My own views are always evolving, and my best teachers are my patients and their families. I am grateful for the countless gifts they have given me through their invitations to join them on their journeys. I am also thankful to Pearl Barfield, my mother, who deciphered and typed this manuscript from a draft that was rapidly written between weeks on the inpatient oncology and palliative care services, and that exemplified another characteristic ubiquitous among doctors—terrible handwriting.