Appendix: The Nature of Persons and Clinical Medicine

Eric J. Cassell

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Eudora Welty said, "Relationship is a pervading and changing mystery…brutal or lovely, the mystery waits for people, whatever extreme they run to" (*Writing and Analyzing a Story*, Eudora Welty 2002). Nowhere is that mystery more important than in clinical medicine where relationships abound, waiting to provide information and aids or barriers to the attentive clinician. How odd is this? A person can go to see a physician who is a stranger and within minutes the physician has a finger in the patient's rectum. And the person (now a patient) says thank you. What made that otherwise inexplicable event possible? We know it was the doctor–patient relationship, but the name does not explain it. What happened was guided by a complex set of rules and entitlements that applied to both the patient and the physician. We might guess that the doctor learned those rules and entitlements (not called such) during the long years of training. For all we know, this exact situation has never happened to the doctor (or the patient) before, yet we expect the physician's behavior to be as described. Why did the patient undress, much less bend over to expose the reluctant anus to the finger's penetration, something almost universally abhorrent? Perhaps the patient contains the same rules and entitlements (or their mirror image). This suggests that role behavior (for they were playing the parts required by their respective roles) resides in both of them. The degree to which our daily behaviors are rule guided is startling, since we generally believe our behaviors are spontaneous and responsive to our chosen purposes.

E.J. Cassell (✉)
Emeritus Professor of Public Health, Weill Medical College of Cornell University, New York, NY 10021
and
Adjunct Professor of Medicine, Faculty of Medicine, McGill University, PO Box 96, Shawnee on Delaware, PA 18356, USA
e-mail: eric@ericcassell.com

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We all know these rules, at least tacitly (or they would not work), which makes it possible for clinicians to take a history from a patient and use daily living as a test of function. Knowledge of the rules of daily living is a crucial part of our *clinical knowledge.*

Knowledge of persons then is knowledge of people in the complicated web of relationships in which life is conducted. In every facet of life, the person is functioning in a largely rule guided manner. Spend some time observing people in their daily lives, but stop and dwell on the different situations for sufficient time to see how similarly persons in each situation behave. If you look closely at each individual in these situations, however, the careful observation will also reveal how differently each acts and how different is each from the others. This is each person's own perception; as an individual acting individualistically. I have spelled it out in such detail to make clear how much most, usually without awareness, already know of clinical utility and how much there is to be known.

All persons have a capacity to love to a greater or lesser extent. Even when we are in love or are sure of our loving and being loved, it is a wonderment. On the contrary, except for the most unfortunate, love – flowing in both directions – is a fact of infancy and young childhood. From that young experience, we get the basic characteristic of the feeling of love; it is a merging – a connection – between two people. Of course, under even the best of circumstances the merging of loving persons (or at least the feeling of merging) is of relatively short duration, but their belief in their love may be enduring.

When people are sick, especially very sick, their ability to connect to others – particularly caregivers – is greater than at other times. This is the source of the sometimes very strong attachment of the very sick to their clinicians. Here is one of the situations when the fact and the manner of the attachment of sick persons to their caregivers are reminiscent of the attachment of these persons to their mothers in infancy. Not surprisingly, many persons who care for the sick also seem to have more than the usual ability to form connections. With these strong connections goes the ability to be more aware of the feelings of the other person. In general, the loving attachment seems to be a conduit to the feelings, thoughts, and even the body of the merged persons. We know so little of this because it is so difficult to study and because it shares in the disbelief in such things in daily life.

All persons are sexual to one degree or another. Physicians in general were often not good at taking a sexual history from patients because they were often embarrassed by the subject. When the HIV/AIDS epidemic came along, a sexual history became very important and clinicians learned that it was not difficult; you just had to know how. Very sick patients usually lose sexual desire and do not have sexual thoughts until they start to recover. It is one of the functions, like reading the newspaper, lost in serious illness but a good sign of recovery when it returns. On the contrary, patients who are chronically ill, even if dying, may experience sexual thoughts and sexual desire. For that reason, questions about sexuality should be part of taking a history even in a dying patient. Sexuality is not simply about physical desire and orgasm even in healthy persons; intimacy and the feeling of connection is an integral part of the experience and may be vitally important to a patient

even in the absence of normal erectile or vaginal function. Because people may be embarrassed to ask for help in these circumstances, clinicians should remain aware of the possibility. Clinicians show their recognition of these and other intimate problems by asking simple and unembarrassed questions.

All persons have a past, present, and a future. The past as remembered is a lived series of events, and when they are spontaneously recounted it is in terms of the things that matter personally: events, relationships, primarily, but sometimes circumstances such as sickness. Persons generally see the present and themselves in the present as an unremarkable extension of that past – the past merely unrolling to the present. In questioning people about the past, it may be portrayed as a series of discrete events that represent what is important to the questioner or it may be sought and described as a narrative, a story about the person in which events are embedded in the more general story and tied to other events, such as holidays or anniversaries. In doing this, the narrative prepares the person for its extension into the future as the future is continuing to unroll. It is not surprising that illness in the past and experiences with caregivers, medications, and hospitals will condition a person's reactions to present illness, caregivers, and hospitals. It is interesting that the family's past is often considered by persons as part of their past and it also conditions present illness.

The future is always uncertain, and it cannot be otherwise. People tend to have enduring ideas about what the future will bring and how they will make it happen. The future is the canvas where the optimists and the pessimists paint different pictures. Everybody indulges in hoping and their hopes are part of their construction of the future. Hope seems to be constructed of both desire and expectations and is a process of thought arising in part from personality and the contributions of others – particularly physicians. The desire to remain one's self, no matter how bleak the expected future, is more important than the wish to merely remain alive. Maintaining or restoring hope is an important function of physicians. It allows patients to regain purpose, motivation, expectations, and goals even in the face of death.

A person is more than a spatial object, something you can see and touch. A person is also a temporal object like a piece of music that extends through time. As such, *persons have an esthetic dimension* where one can judge whether the seeing or knowing about the person through time presents a harmonious aspect to consideration. This understanding of the esthetics of a life over time fits nicely with the use of the narrative to describe a person over time. One part of the story of a life or a part of a lived life fits with the preceding and the following parts of the narrative. This is like reading a book where its parts hang together or conversely the parts of the life are in discord or unbalanced, or like looking at a picture and seeing that one element "goes" nicely in relation to the other parts of the picture or, conversely, is jarring. There can be no objective measurement of this idea of "fit," but it is not usually idiosyncratic and there will mostly be agreement among observers. Reflect on what you know of the lives of different people and you will see that in some, life is lived in a harmonious fashion, while in others the parts – lasting days, weeks, months, or years – are discordant, out of balance, or do not fit together. It is almost as if parts of the life were lived by different persons. The belief that the life as lived

should be concordant allows us to say that what happened to someone does not seem to fit their life as lived.

Illness may represent an unpleasant shift in the narrative, a disruption of the preceding story, a bump in the pattern – sometimes of major dimensions. Little can be done about this because it is in the impersonal nature of sickness. The process of care, however, can be carried out with active thought given to fitting into the esthetic balance of the person's story and thereby reducing the ugliness of the illness and its care. This requires that clinicians acquire an esthetic viewpoint of their patient's life, and this requires conscious effort. Most of us have practice in taking an esthetic perspective because that is what allows us to know about the coherency and accordance of characters in movies or fiction. This is innate because all persons have an esthetic sense, a sense of order, harmony, and beauty (as they know it).

Persons are thinking all the time. Your mind is almost certainly and almost constantly occupied by a stream of thought varying from moment to moment as your focus, interests, occupations, and preoccupations shift. Content of the stream of thought, which is mostly like silent speech, also arises from memory as the information from the world evokes ideas and associations that have been stored in both distant and recent memory. These thoughts are *personal.* Mine are mine and yours are yours, and as far as we know or have thus far discovered (despite clues to the contrary), yours do not become mine, nor does mine become yours. The mental life is not a machine; it is personal so that as all this activity goes on material is provided for further thought and that thought influences the focus of the subsequent mental activity that may change what is of interest and further change the direction of thought, and so on. As I suggested, the train of thought is also a commentary on activities so that as the person is occupied, for example, with illness or symptoms, the train of thought will offer a meaning to explain the symptoms. Sometimes, the focus of thought becomes captured by one subject – for example, a fear, so that all aspects of thought are in the service of what can become monomania. Actually, what is thrown up by all this mental activity are ideas in the form of words and their meanings, and it is the meaning that we dwell on when thoughts become concrete. So, the sick person interprets everything in terms of sickness and its manifestations; fearful person sees only further support for fear, and so on.

For example, shortness of breath previously interpreted as meaning that the stairs are steep becomes evidence suggesting heart disease, fatigue become evidence of escalating weakness; gradually, a case may be built that further supports both the idea that the person is sick and a pessimistic picture of the future. It matters little (in the short run) whether the individual *actually is* sick; what matters is the evidence arising from the inevitable flow of thought. The clinician can have a major impact on the content and direction of the stream of thought.

Also continuous and in part feeding the stream of thought and fed by it is the *unending assessment of its world by and the assignment of meaning to events* – mostly out of awareness. Sensation – the major senses and the minor – are joined to perception, and mood, which are also constantly in play. Each of these is a distinct mode of appraisal and together or separately they provide constant (but personalized) intelligence about the world – both inner and outer – that may or may not

become part of the flow of thought. The output of the mind's continuous activity of appraisal is a flow of meaning. Meaning has an impact in virtually every dimension of the person from the molecular to the spiritual. That is to say that meanings not merely are ideas in a dictionary but also contain body sensations, feelings, and spiritual expressions. Meaning are both social – the meanings of words and many other things – held in common in social groups, but also personal – supported by a private glossary. That is to say that the word apple is the common meaning applied to the round, firm, fleshy fruit of the rosaceous tree that comes in many varieties, and which also makes sense in the phrase, "She's the apple of my eye." But apple also has personal meanings to you – taste, the feel in your mouth, etc. – which may be different than that to me, and so on. Similarly, you know that certain clinical facts mean that the patient has pneumonia, an infection of the alveoli, but pneumonia has some special meanings to you because of the cases you have seen.

Persons understand their world as they believe it to be primarily by two kinds of thought, reasoning and emotiveness. Reasoning is based on what are accepted as facts and is able to follow ideas to their ends, take them apart, combine them to form new ideas, and generally go beyond the information given. Truth is generally thought to come from correct reasoning, but logical thought only produces truth if the ideas on which it is based are true. Reason is a method of thinking that can be used to understand and follow any set of ideas whatever their subject is. If the ideas are faulty – internally incoherent, or such as that cannot be logically connected with other ideas, then the reasoning will be faulty.

Emotive thought also operates on content from perception and memory producing specific instantaneous evaluations that are felt as emotions. Emotions are feelings, affections such as pain, pleasure, love, amusement, amazement, anger, sadness, dejection, joy, etc. Much less is known about emotion and emotiveness than about ideas and reasoning because from antiquity emotions (which were called the passions) were thought to contaminate thinking and interfere with reasoning. This is incorrect; they are a central and essential element of the mental life. Certainly, the emotions that sick patients have about their sickness are as much a part of the sickness as are the symptoms. Sometimes, when patients tell us about something we ask, "How do you feel about that?" That is really a request for their emotional reactions, but the phrase has come to mean both thinking and feeling. There is certainly no thinking about sickness that is free of emotion if you are the one who is sick.

Emotion is as primitive as the existence of animals. Motion, the sine qua non of animality from paramecium to man, requires at least two feelings to explain why the animal goes here rather than there: desire and fear. Just as there is a flow of thought where ideas seem to be central, there is a stream of thought where mood is the content. The list of human emotions is well over a hundred in number. Emotion may be experienced in three distinct ways: First, as transitory where one brief experience of emotion may follow another as the emotional reactions to thoughts and experiences. Or one emotion may endure. For example, anger may last for hours past its inciting event. Finally, an emotion such as anger may become the dominant mood. Then, we might not say that the person is angry but that the person is an angry person. The dominant mood could as well be joy, despair, sadness, or love. It seems to be the

case that the emotiveness of sick persons is blunted, just as their cognition is impaired and executive control diminished. While there is experimental evidence of the impairments of cognition and executive control, the evidence for the impact of sickness on emotiveness is anecdotal. Patients may report, for example, that although they know that they should feel love for a family member visiting and they say the words, they do not feel the emotion.

People generally seem to consider themselves unitary beings. If you ask them that if they are more than one "I," they usually don't think so. "Who are you?" "I am me." "Are you more than one me?" "No, just me." "Okay, if you are just one, who writes your dreams?" "I do." "So, why don't you understand them?" "I don't know."

It appears to be the case, however, that below the surface of consciousness there are other entities that in certain circumstances (for example, in hypnotic states) can openly voice opinions that are not necessarily the same as those expressed in ordinary everyday conscious states. This has been known for at least 150 years, demonstrated in the famous French neurology clinics of Jean Martin Charcot and Pierre Janet. The importance of highlighting ordinary everyday consciousness is that in the everyday setting, persons are strongly influenced by rules of everyday life. The rules are not merely precepts that apply in daily society but also beliefs, acceptable behaviors, and conventional modes of dress, patterns of speech, and other guidelines for living in the world of dailiness. These *other, inner, voices* are not ruled by dailiness. On the contrary, they are shy and hesitant. They are easily dismissed, and they are overridden by doubt. Doubt is the everyday mind's pronouncement that these inner thoughts and ideas should not be heeded and are perhaps nonsense. Actually, however, when doubt arises it means the inner voice is suggesting something that would be denied as impossible in the everyday world. By the time you have finished reading this section, many of you will experience this aspect of doubt for yourselves. The reason to point up this phenomenon is to make it clear that the inner life of the mind is more likely to be complex than simplistic. It is also evident that the experiences of sick persons, their reactions to their illnesses and care, and their behaviors may in part be responses to events, feelings, and experiences of early or later childhood, which are lost to conscious recall. Some offer their past experiences back to early childhood as an explanation for what they think now, or what is happening now. Memory of the past is quite clear for some and variable for others. The accuracy of these early memories may, however, be open to question. It has been said that unhappy or negative memories are shorter-lived than happy ones, but traumatic memories back to childhood may be selectively remembered in considerable detail. There can be no doubt, on the contrary, that there can be selective rejection of information from awareness. This means that although past memories may be quite clear, what reaches awareness may not be the whole memory. It is also the case that the past can be rewritten to serve the purposes of the present.

It cannot be disputed that events in childhood back to infancy may form the basis for an adult pattern of behavior and that these events, even though they have this impact, may not come to awareness. Events in this sense are restricted not only to brute facts but also to the person's emotional response to recall of early relationship

with parents, siblings, caretakers, or others. These memories may not be merely forgotten in the sense that with a little jog from another person or a subsidiary recollection they will again come to mind, but may be actively repressed. Even actively repressed early memories or their emotional content – memories that are not and cannot be brought to consciousness – may have an impact on behaviors, including speech and bodily responses to stimuli (including sexual stimuli), which seem to come out of the blue or seem completely unexplainable. All of this may be particularly important in illness in which things happen, for example, complete dependency, which are in themselves reminiscent of childhood. When that happens, the door may be opened for the effect of childhood events and their emotional content, remembered, dissociated (incomprehensible and, therefore, shoved aside before even being remembered), or repressed (remembered, but hidden from consciousness), to have an impact on the course of the illness.

Fear is an emotion as universal as desire in animals. Generally, fear is described as an aversive emotional response to a specific stimulus – persons know what, in the situation, they are afraid of. Sometimes, the fear is momentary, perhaps in response to an impending needlestick. Other times, the fear is a pervasive emotion that invades everything, the fear of the hospital for example. Fear of surgery is another example. Sometimes, fears seem to be less specific such as about dying, unfamiliar situations, loss of control, or dependency. When that is the case, it is often possible to track down what the patient is afraid of about hospitals or surgery: loss of control or dependency. If the exact details of the fear can be elicited, it can often be laid to rest. It has become common, especially in specialized surgical settings such as cardiac surgery units, for the patient to be told in exquisite detail about what is going to happen. Well-prepared patients are less afraid, have less postoperative pain and other complications, and generally do better.

Fear is an emotion that can have bad consequences from the molecular to the spiritual, and the effort to resolve it is worth whatever time it takes. The most effective antidote to fear is information; however, to be useful, the information should be focused around the particular concerns of the patient, at a level the patient can understand. Too much information, or undesired information, can lead to more fear. Information is transmitted in the context of a therapeutic relationship, and for the information to be accepted and to do its job the relationship must be trusting. Trust is not blind trust. That is why it is so important to be truthful and honest. If you say something will not hurt, that has to be true. It is much better to be honest about a painful procedure explaining in detail what you (or others) will do about the pain. Simple reassurances are rarely helpful, and the words “Don’t worry” are probably as useless as anything in medicine.

People in strange and threatening settings, such as, for some, hospitals or other medical situations, can be expected to be frightened. If they deny fear or if fear is unapparent, it should be actively, but gently, sought and once understood, specific reassurance can be offered. Sometimes, people have fears that seem understandable, but on further questioning the fear is not what it first appeared to be. The fear of death is very common, but often – perhaps most often – the real fears are not death but the fear of separation from others or from the group, or fear about the dying process.

The importance of finding the true source of fear is that effective amelioration becomes possible.

Anxiety, like fear, is a normal response to certain kinds of threatening situations. Anxiety is, however, more complex than fear. It is important to distinguish the kind of anxiety that can occur in anybody as distinct from the psychological anxiety disorders such as generalized anxiety disorder, post-traumatic stress disorder, panic disorder, and social anxiety disorder. Whereas fear has an identifiable object, anxiety is vaguer, and it is less easy to identify what is at the root of the anxiety. For example, persons may have distinct fears of death or of dying, but they may also become anxious where they believe death threatens. When anxiety is present, it is experienced as variable feelings of dread, tenseness or jumpiness, restlessness, and irritability. There may be an anticipation of bad things or general apprehension. Restlessness, trouble concentrating, anticipating the worst, and waiting for the ax to drop are characteristic, as are nightmares and bad dreams. The anxious person's world threatens, but what is actually the source of the threat is not obvious. Physical manifestations are almost universal and can, at times, be quite extreme: heart palpitations, shortness of breath, and chest pains that may seem like a heart attack to the person. Fatigue, nausea, stomach aches, headaches, diarrhea, or other physical symptoms may make the anxious person sure that he or she is physically ill. Physiological manifestations are common such as elevated blood pressure, increased heart rate, sweating, pallor, and dilated pupils. However, anxiety can make itself known by mild feelings of unease, irritability, and apprehension without obvious physical symptoms or go all the way to a full-blown panic attack where the person is sure that death is imminent.

Why all of this is present may often be completely unknown to the person. Sometimes in a patient who is sick, threatened by serious possible consequences, or in a threatening (to the person) environment, the source seems obvious to an observer. But it is not obvious to the patient even as the cause is pursued. There are a number of reasons for the obscurity of the causes of anxiety in individuals. One is that the source is so scary to the person that it is repressed. That is, the person not only does not know the source of the anxiety but also cannot know because the idea is intolerable.

Here is a simple but illustrative example, a mother is anxious each time her child is on a trip – not fearful, anxious – but she does not know why. Everybody says that it is obvious that she is afraid something is going to happen to the child, and she agrees that it must be that, but the anxiety persists. A physician asks whether she is afraid of a car crash in which the child will be killed. As she listens to the words, she is almost overwhelmed with horror at the thought, but agrees. The anxiety stops and now she is sometimes fearful when the child is away, but does her best to insure that the child will travel safely and not be involved in an accident. The idea of a car crash was repressed because the thought of her child's death was impossible to bear, so she repressed it. It may have been that a trusting relationship with the physician provided the safety that allowed her to confront and accept the fear, and not be so overwhelmed by it. This is an uncomplicated example, but many are not so simple. Even in this instance, conflict is present between the apparent need to repress the

danger to the child and the need to protect the child from the danger. Different voices, more than one self and myriad memories, some conscious, some forgotten, and some repressed, suggest a mental life below awareness that might be marked by more than one meaning and more than one emotion for the same events and relationships. Where there is more than one meaning, conflicting memories for the same event, and more than one way of responding to similar stimuli, there is the potential for conflict. Where action to mitigate threat is thought to be necessary but conflict exists whose nature is not available to consciousness, anxiety follows. This is because persons cannot defend against a threat whose real nature is not known to them. The source of the conflict that is always present in anxiety may be as simple as in the instance noted above where a fear is repressed but situations in which the fear is evoked continue to occur.

The conflict may be more complex. For example, a person may seem to be very anxious in response to the threat of death, but it is really not death itself, but conflict about it that is evocative. A very sick person has come to terms with his impending death, but his wife is extremely upset at the idea of his death and he feels that his acceptance of death is a betrayal of his intense love and loyalty. He is afraid of what will happen to his wife when he dies, but he is tired of fighting an illness when the inevitability of death seems to offer surcease. As a consequence of this conflict of which he is unaware, he becomes anxious, and his anxiety is wrongly interpreted by observers as evidence of his fear of death.

Anxiety is sometimes aroused in situations where different selves in the same person come into conflict. An older woman found herself anxious in situations where she kept asking herself, "which me am I supposed to be, the compliant, hard working, but resentful me, or the hardworking but interested and creative me." Without being aware of such a conflict, anxiety is evoked, which resolves when the conflict is made clear. Anxiety is extremely common, especially in the medical setting. There are effective antianxiety drugs, but they do not expose, clarify, or generate understanding of the conflict that always exists. It may not require sophisticated psychotherapy to uncover and resolve the conflict. This is preferred to medication and certainly better than allowing someone to endure chronic anxiety.

For some clinicians, what I have described as the conflict always found where there is anxiety would be described as ambivalence, in serious illness wanting to live but not wanting to suffer, wanting to be cared for but feeling guilty about it. The person is of two minds, ambivalent, conflicted, and these feelings are commonly sources of anxiety. There may be partial awareness of these feelings of conflict, or even perhaps clarity about them, but the tension that creates the anxiety is not being able to have both desired outcomes even when they are known.

Every person has a body. The body can do some things and not others. People become habituated to their body's enormous range of abilities and incapacities. They generally know exactly what every part can do of which they are or can be conscious. These capacities become accepted as a part of their person ("me"). This physical view of persons has been partly hidden by the cultural importance of and attention to individuality developed over the past number of centuries in Western European and American societies. Individuals presented as though there were no

bodies. People also generally know when parts are not working properly and these impairments of function – if they come on quickly enough to be noticed and are lasting and important enough – become symptoms as they are joined to other incapacities. On the contrary, if impairments of function emerge only slowly, are easily accommodated, or are deemed unimportant, even quite impressive impairments will soon be adapted to or dismissed. This is why careful questioning is so important as a part of the evaluation of a patient. This is particularly so because of the importance of impairments of social, psychological, and spiritual function that is part of the understanding of sickness described in this chapter.

Things happen to bodies – they can be injured or get sick. Bodies sometimes bleed, smell bad, make embarrassing sounds, have embarrassing functions, make inopportune demands, create strong desires, sometimes look bad, and become old and slow, and sometimes ugly (These facts are frequently denied or hidden in everyday life.). Persons grow up with profound ignorance about how the body works, even though most people learn about it in school. Certain functions such as that of the bowels and urinary system are even less well known because of everyday stigmata about them. Sexual organs are also poorly understood, although, in general, sex education has advanced greatly in recent years. Modesty keeps people from really knowing about their sexual function.

Unfortunately, clinicians can have considerable knowledge about diverse diseases but be quite ignorant about the body's everyday functions. This limits their ability to ask questions in the hunt for impairments. It also reduces their ability to make things function better.

Everybody dies. Human beings, alone among the animals, know about the inevitability of their death. This knowledge has effects at virtually all ages, is often the hidden listener in the clinician's communications with patients, and has its place in the process of care at many of its stages. Dying, as we have come to know, may not be the passive event of somebody becoming dead, but a human function that may go well or ill depending on clinicians' actions (including their words).

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