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Drew Leder

Chapter 5

Conclusion: An Emerging Framework
It is beyond dispute that the greatest change in the history of modern medicine came with the Cartesian revolution. Descartes’ strict division between mind and body led physicians to concentrate on the body-machine and to neglect the psychosocial and environmental aspects of illness. The idea of a disease being caused by a single factor was in perfect agreement with the Cartesian view of living organisms as machines whose breakdown can be traced back to the malfunctioning of a single mechanism.

As a matter of fact, the rise of medical technology favored advances in biology during the nineteenth century. New diagnostic tools were invented and surgical technology became more sophisticated. Pathologies were located, diagnosed, and labeled according to a definite system of classification. Thus began the trend toward specialization that was to reach its heights in the twentieth century.

Following the Cartesian approach, medical science limits itself to the attempt of understanding the biological mechanisms involved in an inquiry to various parts of the body. These mechanisms are studied from the point of view of cellular and molecular biology. This mode of inquiry leaves out all influences of non-biological circumstances on biological processes. The biomedical approach studies only a few physiological aspects though a lot of
other phenomena which influence health are also to be taken into account. Knowledge of these aspects is, of course, very useful, but they represent only a small part. It is increasingly recognized by the physicians of this time that the medical practice, based on such a limited approach, is not very effective in promoting and maintaining good health. The attempt of the last chapter was mainly to discuss the demerits of the conventional approach focusing on the issues of the concepts of health, illness and disease and the patient-physician relation. We will now try to go for a brief summary highlighting the implications of this discussion for the practical understanding of all such issues.

The common notion of the people regarding human organism is that of a machine which is likely to face constant failures if not supervised by doctors and treated with medication. The notion of the organism’s inherent healing power and tendency to stay healthy is not communicated, and trust in one’s own organism is not promoted. Nor is the relation between health and living habits emphasized; we are encouraged to assume that doctors can fix anything, irrespective of our life style.

The mechanistic view of the human organism and the resulting engineering approach to health, as we have seen earlier, has led to an excessive emphasis on medical technology. This is perceived as the only way to improve
health. The increasing dependence of medical care on complex technologies has accelerated the trend towards specialization and has enforced the doctor’s tendency to look at particular parts of the body, forgetting to deal with the patient as a whole person. The result is to reduce health to mechanical functioning. Precisely for this reason modern medicine is not prepared to deal with the phenomenon of healing. This is perhaps the most serious shortcoming of the bio-medical approach. Although every practicing physician knows that healing is an essential aspect of all medicine, the phenomenon is considered outside the framework. As pointed out by many, the term healer is viewed with suspicion and the concepts of health and healing are generally not discussed in medical schools.

Indeed, the machine-model of the body has favored the success of many medical practices. As we have already pointed out, major problem with this model is that it neglects the import of psychosocial factors in the etiology and treatment of disease. It is quite natural for the mechanistic model of medical practice to overlook the importance of subjective experience in one’s health history wherein the paradigm is that of a lifeless machine. Obviously, a machine does not experience, does not inhabit in an ‘existential world’. The malfunctioning of a machine could be explained and repaired with exclusive reference to mechanical forces. But in the case of human being, the realm of
experience- emotion, desires, perceptions, interpretations- has a significant role.

There is growing evidence that emotional stress, inter subjective losses, and personality styles can play a crucial role in bringing about illness. While clinicians often acknowledge the importance of such subjective phenomena, medicine’s ability to address them has been systematically hindered by the Cartesian model of embodiment.

We have also seen how this model has also served to distort the quality of physician-patient relation. Patients often complain that they have been dealt with by their health-care providers or institutions in a de-humanized fashion. This practice is rooted not simply in personal insensitivities but in the metaphysical model on which the practice is grounded. In so far as the patient is modeled on the automaton, he or she as living person with wishes, questions, pains and fears could easily be overlooked. When fixing a machine such things need not be considered. Within this framework, human sensitivity to the suffering of a fellow human being remains possible but is not encouraged always. In fact, it demands a shift from examining the machine-body to acknowledging the person to whom it belongs.
When the body is not thought of as the essential self, but a machine placed at the disposal of the will, it is overlooked when it is functioning well. In Heidegger’s terms, “as long as the ready-to-hand piece of equipment works properly it is hidden from view, unthematized”.¹ One remains primarily concerned with the ends it services. It is only when this equipment in some way breaks down or becomes unusable that it must be explicitly addressed. Thus there is a tendency in our culture to focus on the body when ill. In contrast to cultures where the body is viewed as the center of self-actualization, we neglect the cultivation of optimally healthy states in our personal habits and medicine.

Furthermore, when our body is attended to in illness this attention usually consists in handing it over to the doctor. As external to the essential self, the body can be placed fully in the care of another. Recast now not as shaman or healer but as scientist-technician, it is the doctor who is best able to understand and fix the complex mechanism at hand. Drew Leder says that “as he/she thoughtfully adjusts the patient’s laboratory values with medication and intravenous fluids there is an ironical fulfillment of Cartesian dualism – a mind (namely, that of the doctor) runs a passive and extrinsic body (that of the patient)”.²
The paradigm of the lived-body, as we have tried to explain, could help to reorient health care and medical practice in positive directions. The body is here not regarded as a passive, impersonal object fit to be neglected or given over to the professional. The body is the very center of one’s experience, moods, expressions and projects. As such, a heightened awareness of the body in health, not just at times of breakdown, can result. The cultivation of corporeal self through exercise, diet or whatever emerges is no less important than the development of mind encouraged by Descartes. A sense of personal responsibility for bodily functioning is called for, for the body is what I am. If the objectifying model tends to emphasize an interventionist approach at the point of illness (i.e., fixing the machine), the paradigm of lived embodiment helps to focus attention on the healthy body and personal participation in prevention and treatment.

Flaws in medical practice can thus arise from the Cartesian tendency to isolate the body from the essential self and its life-context, and to further divide the body into isolable parts and functions. On the contrary, the paradigm of the lived-body effects a re-unification. First, the body itself is viewed as a unity of sensory-motor intentionality.
This suggests that illness, even while bringing a specific physical modality to prominence, will have its effects and significance in a general realignment of our bodily functioning. The specialist cannot neglect the body as unified field. Moreover bodily function is regarded as always unified with its world. Thus, the etiology and meaning of disease and the possibility of treatment cannot be understood except by reference to the surroundings and life-projects of the patient. “The medical tendency to view disease as occurring within an isolated entity is counteracted by this recognition of the existential enworldment of the body”.

In addition, the concept of the lived-body re-unifies body with mind, as it ascribes to corporeality the intentional attributes hitherto reserved for res-cogitans. This helps to emphasize and clarify how such subjective factors as the patient’s attitude and emotional state can play a crucial role in determining health. Viewed as intentional, bodily functioning can express affective and cognitional influences in a way perhaps in explicable within the Cartesian model. It is in its overcoming of the mind-body antinomy that the paradigm of lived embodiment may be of greatest interest to medicine. We will thus examine further the import of such a notion in rethinking the etiology of disease.
5.1. Paradigm of the lived body

In recent times the importance of subjective and psychosocial factors in the etiology of disease has been widely recognized than ever before. The question which needs further elaboration is whether these factors can be adequately modeled by the Cartesian approach. This is generally attempted either via a materialistic monism or by a modified dualism.

Materialistic monism advocates a strong version of reductionism whereby all mental factors are collapsed to the physical level. In modified dualism, the mental factors are retained. Those recognizing the need for preserving reference to the subjective factors, as in the field of holistic medicine, frequently employ a secretly dualistic or multi-causal model of disease. According to them, “One must look at a human not just as body but as body and mind, or perhaps as a complex interdependency of body, mind, emotions, and spirit”. This paradigm attempts to assert the unity of all such levels. But, however, it is often pointed out by many that this approach fails to truly address the perpetual problem how physical and mental factors are interconnected. The proponents of this holistic approach often find themselves leaping from one level of discourse to another. While such phenomena are interconnected, the languages used to describe them are not, for they are derived from the two
sides of the Cartesian dichotomy and thus have no linking terms. If purely physicalistic description loses the subjectivity of the individual, this holistic approach fails to articulate a unity.

The paradigm of the lived-body, wherein subjectivity is always corporeally expressed, avoids these problems. As such it may be better able to address the role of psychological factors in the etiology of physical disease. When disease is understood as arising out of bodily intentionality it can no longer be seen as a merely mechanical event. Falling ill is to some degree a culmination of a purposive response to the perceived ‘enworldment’. However, this process is not the result of separable “mental” factors, i.e., conscious reasons and decisions or analogous unconscious processes. The intention is in the body, expressing, as Merleau- Ponty points out, a ‘pre-conceptual grasp of the world’.

5.2. Towards a medicine of the intertwining

One of our central arguments was to show many of the flaws of modern medicine can be traced to medicine’s reliance on the Cartesian model of embodiment. Here, the machine body or the ‘dead body’ is made paradigmatic. But what if we were to ground medical theory and practice on a notion of the lived body? As we have already seen the notion of lived body implies an
intertwining of intentionality and materiality, subject and object. A medicine that is being grounded on lived body would be a medicine of the intertwining. Our notions of disease and treatment would always involve a *chiasmatic*\(^5\) blending of biological and existential terms. Here these terms are not seen as ultimately opposed. They are, as Drew Leder puts ‘mutually implicatory and involved in intricate logics of exchange’\(^6\).

This point can be further clarified with the help of an example given by Drew Leder himself: A woman approaches her health-care provider with a chief complaint of headaches and dizziness. On examination, the patient is found to be hypertensive. The hypertension might be understood and treated primarily in mechanistic terms. The patient is advised to take low-salt diet and medications. The body’s circulatory dynamics are thus mechanically readjusted. According to Drew Leder, to begin from the perspective of the lived body need not imply that such interventions are prohibited. The lived body, after all, exhibits the aspect of a thing-in-the-world, a complex of physiological mechanisms. However, to begin with the lived body is to understand the physiological as always intertwined with the body’s intentionality. As such hypertension should be understood in the context of the person’s existential grasp of the world.
Drew Leder wants us to imagine this person as involved in a difficult marriage and stressful job situation. So, the patient inhabits ‘a constricted world’. (This constriction expresses itself through both surface and visceral musculature. So, too, is the temporality of her life-world. Perhaps she is impatient and always rushing to finish projects and make her next appointment. In her struggle to compress time, even her visceral functions – breathing, heartbeat – become compressed and accelerated in ways that can lead to dysfunction).

From the above example, it can be understood that the existential account does not replace the biological account, but rather places it within a broader perspective. The anatomy and physiology of the lived body are always intertwined with the body’s intentionality in ways that undermine facile claims of priority. “Just as our physical structure lays the groundwork for our mode of being-in-the-world, so our interactions with this world fold back to reshape our body in ways conducive to health or illness”. A medicine of the lived body dwells in this intertwining.

According to Drew Leder, diagnosis also must dwell in the intertwining. In the context of the above example, through hearing the patient’s story, one comes to know in detail of her world as she embodies it: her habit of exercise, diet, the state of her job and her emotional proclivities or marriage. Only in
this broader context will the full significance and etiology of her illness emerge. Drew Leder says, “From this perspective, a diagnosis of essential hypertension is woefully inadequate, telling us little about the dis-ease that has arisen in the patient’s life and body”. Diagnosis must address the aspect of intertwining, illuminating the intentional/physiological dimensions of illness.

Similarly, treatment takes on a fuller profile when it is understood not as ‘fixing the machine’ but as addressing the lived body and its world-relations. The health care provider may indeed employ relevant medications, but this by itself does little to counter the existential pre-conditions of disease. Other more complex options are opened up by a medicine of the intertwining. The lived body always reaches beyond itself, and medical interventions need not be bounded by the flesh. Insofar as the body is directly addressed, attempts may be made to alter its intentional style, not simply its mechanics. “As the lived body is a multi-leveled structure of conscious and autonomic functions, a place where psychological history is sedimented, interpersonal relations enacted, biological mechanisms homeostatically maintained, a medicine of the intertwining recognizes multiple points of possible intervention”.

This work has attempted to show how diverse features of medical theory and practice are related to the fundamental metaphysics of embodiment on
which medicine rests. Recent critiques of modern clinical practice; current research concerning the importance of psychological factors in health; the appearance of novel treatment modalities, have all suggested new directions for medicine. However, these developments cannot be fostered by piecemeal revisions in our conceptual structure. Their cumulative effect is to call for the advancement of a new notion of embodiment which will not replace but complement the traditional view. The paradigm of the lived body, emphasizing its intentional structures, provides a promising direction for further exploration.