



Medical Practice and Mental Health

And reflecting on our project within this framework

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How should we define medical practice? Two potential definitions come to mind.

1) The term “medical practice” describes the meeting between health care professionals and patients, where the goal is to treat and help the individual who is suffering.

2) The term “medical practice” describes the application of medical knowledge to biological organisms in order to understand and alter them.

Let us call the first for the person-oriented definition, and the second the biology-oriented definition. Of course, these two definitions are compatible. One can focus on understanding and changing some biological process, while simultaneously caring for the personal well-being of a patient. Conversely, a vital part of alleviating the suffering of a patient is understanding and changing the biological processes causing pain. However, the definitions carry different emphasis. How one puts the emphasis can be important for how one understands what it means to be sick, and how being sick can severely affect mental health. In order to see this, it is necessary to get somewhat acquainted with the philosophical discipline of *Phenomenology*.

In short, phenomenology is often described as a return to *lived* experience. For the phenomenologist, the starting point of inquiry is not the world of science (or theory of any sort), but the world as experienced by an individual. These experiences are inherently meaningful in the sense that someone always has them, and that someone can not help but project meaning onto the objects it perceives. Martin Heidegger illustrates this by talking about the relationship one might have with a hammer. In seeing, or interacting with a hammer, one (usually) does not take the disinterested standpoint of an analyst or scientist. Instead, one takes a more active approach. The hammer is seen as an instrument that serves a purpose. It is seen as something completely atheoretical. Importantly, the hammer is seen as an object laden with meaningful uses. If the hammer were to break, it would cease to be an object laden with meaning. It would become somewhat alien to us, as we fail to see its use.

A key aspect of humans viewing the world as meaningful in this way is that our subjective experiences are always *embodied*. I do not only *have* a body, I *am* a body. My body is my point of view, and the way I experience and understand the world as meaningful is dependent on my body. The way I perceive a hammer as meaningful is dependent on the possible uses my body can make

of it. The body is the focal point of all my experiences, and it serves as the necessary background for my experiences to be meaningful.

So, we always view the world as inherently meaningful, and our body is a key component in how the world presents itself as meaningful to us. With that out of the way, we can start to see why the different emphasis in the definitions above is important.

The person-oriented definition emphasizes the suffering of the patient. The goal of medical practice is not primarily to bring some deviant biological organism back to its normal state. Rather, it is alleviating the suffering experienced by a human being. The biology-oriented definition takes a more analytical approach. The primary focus is understanding the underlying biological mechanisms and altering them appropriately.

Let us say that the person-oriented definition focuses on treating a person's *illness*, while the biology-oriented focuses on treating *diseases*. Illness is best understood in phenomenological terms. The philosopher Jean-Paul Sartre, while not explicitly talking about medicine, offers an illustrating example when talking about having a headache. The experience of having a headache is not limited to an isolated feeling of pain. The headache permeates the way I experience the world as meaningful. Sartre describes this as the world becoming "mooded". The world itself becomes tinted with pain, and the way I am able to interact with it changes. Objects and activities which I would normally find meaningful suddenly have new meanings or ceases to be meaningful all together. For example, under normal conditions, I would view a football as "inviting" me to kick or play with it. When I have a headache, such an object might not present itself to me as meaningful at all. *Illness* describes the deviation of how we normally experience the world as consisting of meaningful objects and activities.

The biology-oriented definition of medical practice focuses on treating *diseases*. As mentioned, this amounts to viewing the problem as some kind of biological process which has malfunctioned. The subject, and its experiences, do not feature in treating a disease. Foucault famously called this the "medical gaze". The medical gaze describes the tendency of medical practice to take the disease, and not the person, as the object to be investigated.

This article is about mental health. So far, we have not touched on this issue. The reason for the long preamble is that I want to argue that only focusing on treating an individual's disease potentially neglects a range of issues regarding their illness. Issues that are important for the mental well-being of people suffering from some disease.

This year's iGEM team at the University of Copenhagen is focusing on helping people with chronic inflammatory diseases (CID). We are producing a yeast-based biosensor that will be placed in a patch and will detect inflammation levels in sweat. We hope to replace invasive tests, and reduce the need for CID patients to visit hospitals. The product is designed to make tailoring medication dosage and type to the patient easier. Hopefully, this will make for more effective treatment of CID patients given that the ability to discover inflammation spikes quickly and react accordingly should be a great medical tool.

Often, when we at the team talk about the benefits of our product, we implicitly adopt the biology-oriented definition of medical practice, and as a consequence see the product as targeting a *disease*. However, another benefit is how such a product might treat the *illness* of a person. Living with a CID is not only having part of your biological organism being permanently deviant (i.e a disease), it can also be a permanent state of perceiving the world as "mooded". Arguably, living with a CID can change how one experiences the world as meaningful.

Foucault argues that the medical gaze permeates all of medical practice. A consequence of this is that the clinical jargon associated with the gaze is not confined to academic discussion among experts. Instead, it spills over to how the patient views their predicament. The patient can start to view their situation as a consequence of certain biological processes that are completely detached from their subject. If we analyze this from a phenomenological view, we could argue that the disease causes a loss in autonomy for the person. The disease comes to be viewed as an alien force partially taking control of the person's will and desire.

In psychological terms, one might claim that the medical gaze limits the patient's ability to *cope*. Reportedly, people who are diagnosed with CIDs are more likely to subsequently undergo episodes of depression, anxiety, and generalized distress (Taylor, 2016, p. 641). Furthermore, denial is often an immediate response for patients diagnosed with CIDs. Patients act as if the disease is not severe, and that it will shortly go away (Taylor, 2016, p. 641). This can be understood as a refusal to acknowledge that the chronic nature of the *disease* translates into chronic effects on the *illness*. The disease can have monumental and lasting effects on the patient's body image and self-worth. Treating one's illness amounts to minimizing the effects a disease has on how one perceives the world as meaningful, and when that is not possible, accommodating the disease into a new autonomous way of living.

An Australian study interviewing patients with diabetes and cardiovascular disease highlights the importance of autonomy. Some patients felt that their disease came to be at the center of their lives, forcing them to prioritize certain activities and placing boundaries on what they could do (Warren et al, 2012, p. 329). The monitoring and treatment regimens patients were placed under often felt invasive and disruptive. One patient, Judith, felt that her life was out of her control. According to the article “She resented the doctor imposing restrictions *on* her, rather than working *with* her to develop strategies to manage her weight and thus, her diabetes” (Warren et al, 2012, p. 329). This fits well with the view that certain illnesses can alter the way we experience the world as meaningful.

Patients also reported some of the measures taken by themselves to regain control of their lives. This included taking an active interest in *how* one was treated (such as trying out alternative medicine), and an emphasis on managing stress (by meditation, Yoga, Tai Chi, etc.). Patients reported that when taking direct action regarding their disease they were able to bring normalcy and order to their lives (Warren et al, 2012, p. 331). Again, this fits well with the phenomenological view on illness. The reported distress from the patients was not grounded in displeasure about the efficacy of the biomedical treatment of their *disease*. Rather, the displeasure was grounded in how their treatment plan failed to address their *illness*.

“Patient empowerment” is a buzzword often heard in CID communities. According to one interview we did with Norwegian Rheumatoid association, patients often have a desire to take direct control of their disease by changing their diet, exercise, or by the type of activities mentioned above. Such attempts at self-empowerment can be seen as a refusal to let the disease translate into an illness. Only when patients introduce active measures of control into their lives, are they able to return to a state of “normalcy”.

Hopefully, our product can be used as a tool for such a return to normalcy. CID patients are subject to frequent testing and comprehensive treatment plans. Naturally, these treatment plans primarily focus on treating the disease. By introducing a home testing device for inflammation we can hopefully give some control back to CID patients. As a result treatment plans can hopefully better be structured and tailored to how the patient wants to live their life. As a result, the disease can come to be seen less as a foreign intrusion dictating how one lives life. We hope that our device can aid CID patients in accommodating their illness into a new meaningful way to experience the world.

Sources

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