KARL JASPERS ON MEDICAL THERAPY

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1.

The philosopher and psychiatrist Karl Jaspers (1883-1969) sketched out a model of medical therapy (including medical treatment as well as psychotherapy) which deserves to be more widely known. His reflections on this topic seem to be highly instructive, despite the fact that they are not as logically transparent as one would wish. Whoever seriously ponders the nature of medical therapy is likely to come across the problems which Jaspers grappled with and the basic distinctions he introduced. Not surprisingly, some recent critical movements in medicine and psychiatry appear to be inspired by ideas similar to Jaspers's own.

Jaspers was without doubt well qualified to comment on the idea of medical therapy. He had studied medicine and, having completed his medical education, turned to psychiatry. From 1908 to 1915 he worked at the Psychiatric Clinic in Heidelberg, first as a medical probationer and later as a voluntary assistant. In 1913 appeared his *General Psychopathology* (GPs).[1] It went through no less than eight editions during his lifetime, of which the fourth (published in 1946) amounted to a substantial revision and extension, especially as regards the theme we are interested in here[2]; but the author insisted that the intention of the book remained unchanged.[3] The work became a classic in its field well before it was translated into English.[4]

Subsequently, Jaspers changed his sphere of interest, first to psychology and then to philosophy. His *Psychology of World-Views* (PW) of 1919 marks the threshold between his scientific studies of man and the later predominantly philosophic orientation. In the twenties his new philosophy of man took shape. He is now mainly remembered as a founding figure and main exponent of twentieth century existential philosophy. However, he remained in touch with psychiatry and medicine, as the revisions of the text of the *General Psychopathology* and a series of essays from his later years testify (AZ).[5] His existential philosophy grew in a sense out of his work in psychiatry and psychology, but this same philosophy then enabled him to clarify his approach to medical therapy.

Jaspers was intimately concerned with the problem of sickness, not just from a philosophical and from the objective medical point of view: since childhood he suffered from bronchiectasis with cardiac decomposition (PA 9). He learned how to live with his illness, and as if to disprove an early pessimistic prognosis he remained active and intellectually creative into his eighties. He produced a remarkably detached report on his illness and the way he coped with it.[6]

During the whole period of the Hitler regime, Jaspers remained in Germany but refused to collaborate with the National Socialists and in 1936 he was removed from his chair of philosophy at Heidelberg University. As a man of liberal-humanistic conviction he despised national socialism, its racist theories as well as its totalitarian and inhuman practice.

2.

The model I shall discuss is described in Part Six of the fourth and subsequent editions of the *General Psychopathology* (GPs 795-800; also in: AZ 84-90). It is also sketched out in the first volume of *Philosophy* (Phl 121-129).[7] It is clearly informed by Jaspers's newly elaborated existential philosophy. Readers unfamiliar with this philosophical background are likely to be puzzled by some of Jaspers's assertions about medical treatment. I shall therefore explain the model first without going into the details of existence philosophy with whose bearing on medicine I shall deal at a later stage (in section 4).

According to Jaspers, medical therapy is *in a sense* both holistic and pluralistic. It is *holistic* in the sense that the human being as a whole is in the centre of treatment and care. The doctor has to be "alert to the human individual as a whole" and must not dogmatically discard any of the vital approaches or groups of facts. In another sense, however, medical therapy and medicine cannot be holistic. Jaspers insists again and again that the whole human individual can never be known; not just because the range of facts transcends the scope of medical knowledge, but also for the more fundamental reason (crucial to Jaspers's

B. *The organic approach.* - Here the main concern is the living organism as a whole, or its *life*. The measures taken on level A are often insufficent; other kinds of measures such as diet, change of environment, exercise and training have to be introduced to bring about the patient's recovery. That is, arrangements have to be made to enable the organism to help itself (GPs 796).[9] On this level the doctor is required to pay close attention to the organism as a whole, to the extent that this is possible at all. His attitude towards the patient's body is not anymore primarily that of a technician attempting to mend a defective mechanism but that of somebody caring for a living organism. "He acts like a gardener by cultivating, fostering, continually trying, and altering his procedure in view of the result" (GPs 796*). However, an individual organism and its conditions of survival are never fully known. Whatever is done for the sake of its health remains in principle an experiment, whose course and final outcome are more or less uncertain; medical treatment remains a trial in this sense. Hence the importance of taking individual circumstances into account, of continually assessing progress and being ready to change course. We may say (elaborating Jaspers's point a little) that, due to the complexity and individual character of organisms and their environments, and as a result of the limits of our knowledge of them, predictability of their behaviour is drastically limited. Consequently, the scope for scientific medicine is much restricted. Level B ist "the domain of therapy as a rationally regulated art, based upon an instinctive feeling for life" (GPs 796*). Thus, the organic approach differs in at least three respects from that of level A: (1) it is characterised by an attitude of care for the body-organism and its life; (2) it is by intention "holistic" as regards the body rather than piecemeal; (3) it is an art rather than a science or "applied science".

C. *The collaborative approach.* - On levels A and B the doctor focuses on the patient's body. However, for at least two reasons he cannot confine himself to the body. Firstly, the patient is a "rational being who wants to know what is going on" (PhyI 151; see also GPs 796). Secondly, in order to make the measures of levels A and B work, the doctor has to secure the patient's co-operation. Thus the doctor has to communicate with the patient about the latter's illness and the measures taken to restore his health. Let us assume that the doctor will let the patient know "everything that he knows and thinks, leaving it to

the patient to decide what to do with this knowledge and how to come to terms with it" (GPs 796*). Two difficulties arise from such unrestricted information. Firstly, the patient's body and his mental condition may be affected by what the doctor tells him. For the patient is not an entirely autonomous personality able to control or detach himself so as to keep away all negative effects; anxieties, uncertainties or disappointments are bound to arise and may have their bodily repercussions. Secondly, what the doctor communicates to the patient may include more or less probable conjectures and even non-scientific personal views. Some of these views may not be true at all, although they may be taken as such, and even as "scientific", by the patient, or the doctor, or both (PhyI 196-197; GPs 797). The first of these difficulties is addressed on level D, the second on level E.

D. *The psycho-somatic approach.* - The patient is now treated as a mind-body unit. Psycho-somatic phenomena and the interaction of mind and body are taken into account. Psychotherapy enters: "The patient will not be freely told anymore what the doctor knows and thinks (about him), but every word, every measure taken, every action ought as a matter of principle to be calculated for its psychological effect", and in view of what is likely to improve the patient's health (PhyI 153*; GPs 797). Thus the doctor is bound to distance himself to some extent from the patient, and the naive and genuine communication of level C is suspended. The "psychotherapy" involved may constitute itself more or less subconsciously for both doctor and patient. For instance, the doctor may limit his communications with the patient or give them an authoritative form without being fully aware of this. Alternatively, he may decide what psychotherapeutic measures to take, and proceed in accordance with a set of consciously adopted rules. Such measures may vary from "crude shock therapy" to the application of sublime psychological (hermeneutic, depth-psychological, psychoanalytic and psychosynthetic etc.) methods. However, all these methods are of only limited use, Jaspers tells us, and involve an element of faith, sometimes even of superstition. The limitation is partly due to the fact that no doctor is really able to maintain the required distance between himself and the patient; sympathies, antipathies, participation in the patients' faith inevitably play their role. A further limitation arises because man as a whole cannot be objectified (a fundamental thesis of Jaspers's, as has already been mentioned). To come to terms with these difficulties doctor and

stence philosophy is a kind of unconditional inner action; and it has to terminate in a philosophical life (MM - chap 9: "Inner Action").

Existence, then, has to be understood as a non-empirical origin manifesting itself in the empirical world through our decisions and actions. Now, Existence and communication are in Jaspers's view inseparable. Only in and through communication with other existing beings can a human being become genuinely himself or herself; and in this sense communication may be said to be the origin of Existence (MM - part I, chap. 3: "Limits of Existential Communication").[10] The crucial point is that existential communication offers the possibility that one human being can realise, or enhance its self-being with the help of another. This may come about in various ways. For instance, by being with others and communicating with them I may become aware of possibilities of Existence which before I did not see; or I may be encouraged by others, perhaps their "example", to make certain existential choices which I would otherwise be unlikely to make; or my mode of Existence may become more transparent to myself; or in disagreements and even conflicts with others I may be "thrown back upon myself" and have to re-examine my attitudes towards them. Returning to medical therapy, we can say that the doctor has realised existential communication if and only if he has become the patient's *partner*, helping him to realise, enhance or maintain his self-being under the trying conditions of illness and suffering. The doctor's attitude must be that of love - not merely compassion with the patient nor just the charitable attitude which doctors are expected to display, but love of the patient as a free and unique being. In existential communication, furthermore, reason (in Jaspers's sense, i.e. "Vernunft" as distinct from "Verstand") is operative, as thinking concerned with the non-objective, "Existenz", and its (always inadequate) linguistic articulation. As a partner in existential communication, the doctor relates to the patient neither as an authority nor as a medical expert; and the problems he faces cannot be solved by means of science and technology. However, his personality - e.g. his strength of character, dedication, self-awareness and translucency - and his philosophic orientation may be decisive. It is obvious that existential communication involves a strong ethical component; regard for the other as a free individual and the determination to assist his or her struggle for self-being. These are minimal requirements the doctor has to fulfill. But how precisely he ought to act and under what circumstances he ought to engage in existential communication, about this Jaspers does not formulate any rules. Indeed, his idea of existential communication seems to preclude the possibility of such general rules.

5.

While fully acknowledging the spectacular advances in medical practice as a result of scientific discovery and technological advance in recent times, Jaspers pointed out that these advances went hand in hand with a kind of disruption and deterioration of medical practice, to the extent that one could justifiably speak of a crisis of modern medicine (cf. AZ 40). As early as the 1950s he was saying, "One could have the impression that the good doctors become rarer, while scientific know-how continually increases" (AZ 12). He drew attention to the negative repercussions of the technological organization of medical treatment on the one hand, and of the scientific approach to illness on the other. There is no sign that the crisis which Jaspers commented on has abated; rather it appears to have aggravated over the last few decades. His critical observations seem at least as relevant now as they were then. According to Jaspers, the problem of how to be a good doctor poses itself today in a new way and "within the all-embracing process of the technisation of the world" (AZ 42). As modern technology enters into medicine, medical practice becomes an integral part of organisational units - clinics, hospitals, research laboratories etc. With this goes a certain division of work and an increasing degree of specialisation within the medical profession (AZ 8, 12). More and more doctors turn into "functionaries", that is, they merely fulfil a certain function in some medical organisation (AZ 43). The doctor as an independent personality gives way to the doctor as a member of a medical collective (AZ 42). Furthermore, as the importance of technological equipment and technological processes increases, doctors are required to take a greater interest in technology, acquire technological know-how and become technicians to a degree they were never before (AZ 45). As a result the traditional idea of what it is to be a doctor is being eroded away (AZ 57), or its realisation obstructed. The patient, on the other hand sees himself confronted with doctors none of whom is *his* doctor and none providing him with the personal attention and service he needs (AZ 45). He finds himself processed in a world of technological equipment, sees himself as some kind of material, without

standing their intentions, beliefs, fears etc. (b) a sense for organic life which no science can teach, (c) views concerning the psychic which have either no scientific status at all or whose scientific credentials are dubious, and (d) existential communication. Jaspers's model is also at variance with all those types of holistic medicine which claim that knowledge of the patient as a whole is actually within reach. Here, however, a confusion may easily arise; for Jaspers's model is in a sense itself holistic, and he frequently speaks of the necessity to keep the human being as a whole in view, or to pay attention to the human being as a whole. But by this he means that doctors should keep their minds open and not exclude, in some "a priori" fashion, certain parts or features of the human being and its situation. Jaspers's medical holism may suitable be called an open holism and contrasted with some types of dogmatic holism. (readers will notice the parallel with the Kantian contrast between the regulative and the constitutive use of the ideas of reason.) This openness and the mobility of mind that goes with it, the ability to combine the various dimensions and the art of judging their relevance in individual situations - all this forms an essential part of Jaspers's idea of a good doctor. Here again we see how medical practice is meant to transcend the purely scientific approach.

Let me now turn to a philosophical difficulty which is likely to strike the reader, given that he critically relects upon Jaspers's thoughts. This fundamental difficulty shows up in two contexts: on the one hand in Jaspers's discussion of the mind-body relationship, and on the other in his reference to ethical matters. Concerning the so-called mind-body problem, Jaspers seems to be a dualist. That is, he seems to believe that there are human bodies, and, distinct from them, human souls (or minds), and that a human being is made up of a body and a soul. He also appears to hold that body and mind interact. In short, he seems to commit himself to the basics of the well-known Cartesian "solution", and the ease with which he does it is surprising indeed, in view of the possible alternatives and the philosophical difficulties pertaining to each of them. Crucial terms such as "body", "psyche" (or "soul", "mind") are hardly analysed at all; in this respect his treatment seems vague and rather unphilosophic. However, a closer study shows that for Jaspers monistic, dualistic and similar "mind-body" theories come under the heading of "metaphors" in which man has been spoken of but which cannot give us a unified, objective, let alone a scientific picture of human beings (GPs 758-759).

He holds that such ontological theories do not provide us with any knowledge, yet they are (misleadingly) put forward as if they provided us with objective knowledge of man. Such ontological claims (including Heidegger's Fundamental Ontology) Jaspers rejected as arising from a confusion of objective theories with "metaphors" (or ciphers) for philosophical self-illumination (GPs 776-778). The being of man is dealt with as if it were in the same sense an object of research as are things of the world. At this point it becomes clear that Jaspers is caught in a dilemma. Either he presents his model of medical therapy as a cipher or "metaphor", one among many, and all suitable for self-illumination (then his way of differentiating psyche and body and correspondingly psychology and the natural sciences, is on a level with monistic, epiphenomenalistic and other "metaphors", and it is in no way obvious why it should be preferred); or his model claims some degree of objectivity (in which case Jaspers would seem inconsistent).

A similar objection can be brought against his way of introducing ethical considerations. He was no doubt of the view that a doctor's ethical personality is as important as his medical knowledge and skill, and that living up to the idea of a doctor involves fulfilling a number of ethical requirements, including the following:

- a doctor ought to give help irrespective of the sick person's religious faith, world view, political orientation, origin or race (AZ 40);
- he must act in a humanitarian and benevolent way, even when there is no hope that the patient can be cured (AZ 9, 16);
- he must respect the patient's dignity, appreciate his unique value as an individual, and recognise him as a free being (AZ 7, 28);
- he is responsible for what he tells the patient or does not tell him, and for the way he affects the patient through his communication with him (AZ 11).

Quoting Sydenham, he seems to approve of the maxim: "Treat your patient as you would like to be treated yourself if you had the same illness!" (AZ 8). However the doctor is also a free being, and on the level of existential communication, doctor and patient are meant to recognise each other's freedom. Here again, Jaspers has to face a