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DUALISM AND ITS IMPORTANCE FOR MEDICINE

ABSTRACT. Cartesian dualism has been viewed by medical theorists to be one of the chief causes of a reductionist/mechanistic treatment of the patient. Although I aver that Cartesian dualism is one culprit for the misapprehension of the genuine treatment of patients in terms of both mind and body, I argue that interactive dualism which stresses the interaction of mind and body is essential to treat patients with dignity and compassion. Thus, adequate medical care that is humanistic in nature is difficult (if not impossible) to achieve without physicians adhering to a dualistic framework in which the body and person is treated during illness.

KEY WORDS: clinical narratives, effective diagnosis, effective treatment, interactive dualism, lived experience of illness, objective perspective, reductionism, subjective perspective, Cartesian dualism

INTRODUCTION

Despite recent trends that suggest some physicians are actively involving the patient in the treatment of illness,[1] medical practitioners still tend to believe that their primary medical role is to diagnose and treat a patient's illness by treating the body to the exclusion of the person who is experiencing the illness. When a physician treats an illness, (s)he prescribes medication to relieve certain bodily symptoms. However, these bodily symptoms affect the individual's psychological and mental states as well. This presupposes that illness has two interacting dimensions, a bodily and a mental, psychological or personal dimension. In other words, illness affects the "lived-experience" of the patient. When a physician merely treats one part of the patient's illness (the bodily dimension), (s)he is not treating the illness in a way that includes the whole patient, and excludes one important curative component of illness (the mind). Thus, an interactive form of mind-body dualism is essential for the patient's illness to be adequately treated. However, some forms of mind-body dualism, i.e., Cartesian dualism, are too restrictive since they presuppose that the mind and body are two completely separate entities, and that interaction between the two entities is impossible to sustain. This interpretation of Cartesian dualism has become known to be the chief cause of the segregation of mind and body, a paradigm that is part of the medical context. According

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to several medical theorists (who will be outlined in Section I), Cartesian dualism has been the major cause of patient objectification and reductionism; therefore, dualism of the Cartesian variety, must be revised so that the personal, subjective dimension of a patient's illness can be adequately taken into consideration.

Thus, the purpose of this paper is twofold. The first purpose is to develop an interactive, dualistic account that treats the patient as a complete person, i.e., as comprising both mind and body. I turn to this task in Part II of the paper. The second purpose is to show how the dualistic framework can create a more humanistic and adequate account of patient care within the medical context. To this end, Section III outlines four major benefits of adhering to interactive dualism in the medical context. Briefly, these are as follows. First, the patient is treated as a whole person and not merely a diseased body. Second, the physician gives a considerable amount of attention to the "lived-experience" of illness since it is an integral component of diagnosis and treatment. Third, the physician discovers that it is relevant and important to include both the subjective and objective criteria of illness to ensure a proper diagnosis and treatment. Lastly, the physician takes the patient's clinical narratives to be an essential part of diagnosis and treatment, which is the personal report of how the illness is affecting the patient's life and well being. First, however, I will catalogue four theorists who believe that Cartesian dualism (which postulates that the mind and body are two completely separate entities) is the chief cause for the reductionist view of the patient.[2] Descartes has been associated with this reductionistic view[3] since he was operating from within the scientific tradition that postulated materialist trends that separated mind and body.

I. FOUR CURRENT THEORISTS' VIEWS OF CARTESIAN DUALISM

A significant number of theorists[4] have argued that Cartesian dualism has been one of the chief causes for the medical practitioner's insistence that the mind and body can be treated separately, and that illness only affects the body but not the mind. I will catalogue four such views held by Mark Sullivan, James Gordon, Kay Toombs, and Eric Cassell. This is not an exhaustive list since there were many other theorists in the past decade who have been emphasizing this point. The overall purpose of presenting this research is to outline one possible cause for the prevalence of the reductionist view of the patient that is an inherent part of the medical tradition.

(1) Mark Sullivan argues that Descartes's dualism is the cause of the reductionistic treatment of patients in the medical setting. He writes:

> One of the most prominent reasons offered for medicine's inability to respond to the distinctively human dimensions of sickness is that it employs a dualistic image of the patient. The patient and his body are seen as composed of two radically different kinds of substance. Certain aspects of the patient are focused upon as essential to medicine's task of curing disease while others are set aside as inessential to this task.…
>
> The most famous dualism and the one most frequently cited as the source of medicine's ills is that of René Descartes. Within the ethical and social sciences literature on medicine the conviction is widespread that the Cartesian division of the person into mind and body, into *res cogitans* and *res extensa* is basic to the reductionist approach of medicine and therefore the source of its tendency to ignore the human dimensions of health and disease.[5]

Sullivan blames Descartes's dualism for the scientific/materialistic view of patients that physicians advocate. Since Descartes argues that a human being consists of two incompatible substances, *res cogitans* and *res extensa*, the mind and body are completely separate and distinct. This interpretation of the person is deficient, and further reflection can result in a different interpretation, one that postulates an interaction of mind and body as defining features of the person.

(2) James Gordon, also claims that Cartesian dualism has set the medical practice backwards. He writes:

> Since the philosopher Descartes separated a transcendent nonmaterial mind from the material and mechanical operations of the body, science has been concerned with evermore accurately resolving that body into its component parts.[6]

Gordon accuses Descartes of introducing an interpretation of the body as a machine. Thus, for Descartes, the body can be viewed as a machine completely separate from mind. There is ample textual evidence in Descartes's writing to suggest that this interpretation is not too far off the mark, except for one possible twist. Descartes had at least a hunch or intuition that there must be some interaction between mind and body, and that was in the pineal gland. The least amount of reflection on our everyday experience strongly suggests that there is some (fundamental) interaction between mind and body. Thus, the body (even on Descartes construal) is much more than a mere machine.

(3) S. Kay Toombs, makes similar remarks about the deleterious effects of Cartesian dualism on medicine. For over a decade, Toombs has focused on how restrictive forms of dualism have contributed to mechanizing the experience of illness. It has been her aim to show that both the body and the mind experiences illness and is relevant to treating illness. She certainly has first-hand experience for arguing against the reductionistic view of health care since she has multiple sclerosis and feels dehumanized by the illness because of how medical practitioners treat her illness. She writes:

Medicine has, for the most part, adopted a "Cartesian" paradigm of embodiment (i.e., a dualistic notion which separates mind and body and which conceptualizes the physical body in purely mechanistic terms). The physical machine-like body is assumed to be extrinsic to the essential self. This paradigm has been successful in many ways. The body-as-machine is susceptible to mechanical interventions; it can be divided into organ systems and parts which can be repaired, removed or technologically supplemented; it can be tested experimentally, and so forth. Nevertheless, the paradigm is incomplete.[7]

Toombs is right to suggest that the 'paradigm of embodiment' as it is stated here is "incomplete." How, one may ask, could one enrich the paradigm so that it could become more complete? One possible way would be to reinterpret the body not merely as a machine, but to include the lived aspect of the physical body, which comprises of certain cognitive features. As Toombs makes clear, it is also necessary to make the cognitive features as essential to the self as the physical attributes when diagnosing and treating illness. In this way, the body would be intrinsic to the self, since the self needs the body in order to have experiences and pains. This is certainly not a complete solution but perhaps one that can be further revised in order to properly account for human experience. This presupposes that when a physician treats a patient's illness, (s)he must also include psychological aspects of the patient as essential features to the treatment and recovery of illness. Without including the psychological, subjective features of the patient, the illness cannot be adequately treated. Thus, a physician must take the "lived-experience" of illness into consideration when diagnosing and treating illness.

(4) Eric Cassell outlines another major difficulty with Cartesian dualism that has contributed to physicians separating the patient's body from the self. Although Cassell's characterization of the difficulty is labelled differently in terms of a "moral-technical duality," the result is the same since the dualism is between the mechanical/technical (i.e., bodily) and the moral (i.e., personal, subjective and mental), and physicians have insisted that the personal, subjective domain be eliminated from consideration when making medical assessments and treating illness. Thus, the separation of mind and body is still an implicit component of Cassell's characterization. Cassell describes the dualism as follows:

The historical roots of the problem can be traced back to Descartes's mind-body duality, which was also effectively a moral-technical duality: physicians, in company with other scientists, were given the (technical) body, while philosophers and theologians were assigned the (moral) mind. Obviously, this controversy has not cooled. At issue is the degree to which the mind-self-soul is part of the human machine, and therefore understandable in the terms that define that machine. That part not understandable in scientific (machine) terms is involved with values and morals.

Physicians are clearly involved in the care of the machine. They make technical decisions based on their understanding of the body and its malfunctions. Pragmatically,

they remain out of the area of morality and philosophy, except as regards certain standards of behavior that are expected of them and that are discussed in moral terms. This morality involves their interaction with patients and other physicians, but it does not define what their behavior should be concerning moral decisions about their patients lives; it does not define for them, except in the most general terms (i.e., saving life), how they are to make ethical decisions that concern the patient.[8]

From the above quote, it is apparent that Cassell believes that the personal features of the patient are not taken into consideration in the medical context since the physician is partial to the reductionist program of human experience which asserts that the physician must only be concerned with the body or mechanical/technical dimension of the patient. The personal dimension belongs to the moral realm, which is the jurisdiction of philosophers and moral theorists. This view (which underlies the scientific framework within which the physician is quite familiar) objectifies the patient and leads to diagnoses and treatments that fail to take the patient as a person seriously. This undermines the patient's sense of self, and may hinder his/her ability to fully recover from illness. At least one aspect of illness involves the patient's willingness to recover, and this involves much more than prescribing and administering medication, and getting bed rest. It involves treating the whole patient, not only the body.

Viewing the disease state in an abstract mechanistic manner is problematic because the cause, diagnosis and treatment of illness involves the patient's personal/psychological features, as well as the bodily. Every medication and treatment has an impact on both the mind and the body. One demonstration of this claim is when a patient experiences side effects upon taking a particular medication or undergoing a particular treatment. The medication may affect memory, sleep patterns, concentration, and energy levels. Thus, treating an illness can have many psychological effects, from mild to quite severe. Viewing illness and disease reductionistically is misguided since it is a counterintuitive view of illness. Most individuals are quite aware that illness affects their ordinary lives and their well being, and, therefore, recognize that illness affects the body as well as the mind. Thus, medical practitioners must also take this into consideration.

II. THE NEED FOR AN INTERACTIVE TYPE OF DUALISM

Some theorists would deny that there is any need for a dualistic approach to the person.[9] For many contemporary theorists, reductive materialism is the only option available to viewing the person, and the materialism acceptable by such theorists asserts that the only entities permissible in any

explanation must be those acceptable to standard physical theory. Many medical practitioners still tend to operate within this reductive, materialistic approach which affects how they diagnose and treat a patient's illness. The scientific paradigm within which the physician is trained is also partial to the materialistic framework through which the medical practitioner views illness as merely based on a bodily diagnosis and treatment. For medical students, clinical impressions and attitudes are created and revised in light of autopsy findings, which solely involve the diseased body but not the person. It is difficult for the physician to revise this medical perception which has been so deeply entrenched during medical training without careful reflection. However, physicians can step back and revise the habitual reductionist framework in favour of a more humanistic approach that takes the whole patient into consideration. Once the physician steps back from his/her prior reductionist predispositions, (s)he will recognize that the patient consists of much more than his/her body, and in diagnosing and treating illness, it is also essential that the medical practitioner realize that treating an illness also involves more than the body. Thus, the patient should be considered to be a duality of mind and body.

A more promising approach to Cartesian dualism has been suggested by Thomas Nagel.[10] He writes:

> What is needed is something we do not have: a theory of conscious organisms as physical systems composed of chemical elements and occupying space, which also have an individual perspective on the world, and in some cases a capacity for self-awareness as well. In some way we do not now understand, our minds as well as our bodies come into being when these materials are suitably combined and organized. The strange truth seems to be that certain complex, biologically generated physical systems, of which each of us is an example, have rich non-physical properties.[11]

It is accepted by many theorists that consciousness is an emergent event, that there was a time when there was no conscious experience, and at some point conscious experience appeared on the evolutionary scene. There is no explanation how this came about, or even any agreement why it came about. To say that organisms with the property of conscious experience were able to survive better than those without such a property is, no doubt, true but it is hardly an explanation since no indication is given what it is about consciousness that makes an individual superior to a nonconscious automaton. If one accepts the evolutionary account, it will follow that states and events of conscious experience interact with brain and other bodily events. What happens within the domain of conscious experience will bring about some physical events. The evolutionary account therefore presupposes mind-body physical interactionism. Without some interaction between the events and contents of conscious experience and the bodily operations, conscious experience would be redundant.

The primary difficulty with any form of mind-body dualism is whether interaction between the states of mind and the states of matter is a conceptual possibility. Weak interactionism would require only that the interaction between the states of mind and the physical states of matter should be conceivable, even though there is no available explanation how the interaction comes about. Strong interactionism requires that, at a minimum, there be a two-way causal relation between mental states and physical states. It is not, however, difficult to show that there is a strong interactionism between mental and physical states, and it is here that Nagel's proposal has much more merit than traditional Cartesian dualism.[12] If the properties and states identifiable and discriminable within conscious experience are produced by the brain, the properties of conscious experience are analogous to the production of radio or microwaves by physical mechanisms.[13]

Nagel's dualism is referred to as the dual-aspect theory,[14] which asserts that each individual has two irreducible properties, mind and body. This presupposes that to each individual we must ascribe both states of consciousness and corporeal characteristics if we are to take the entire human being into consideration. Thus, Nagel advocates a dualism but the dualism does not postulate two incompatible substances but two aspects of a similar thing. However, the two aspects are not reducible to each other; thus, there is absolutely no hint of monism in Nagel's account. Nagel's dual-aspect theory makes it possible to explain human experience in much more accurate terms than Descartes's dualism.

Nagel's dualistic account can readily be applied to the medical context in a way that is beneficial for creating a humanistic approach to illness. By viewing the patient as a duality, the physician becomes aware that if (s)he only treats the patient's body, his/her diagnosis will be missing one fundamental component. Thus, the physician is not treating the patient in a way that is conducive to administering adequate health care since the bodily component of illness is only one aspect of illness. The patient's psychological well being and emotional equilibrium is also affected by illness, and it also substantially affects how the patient will accept certain medications and treatments. In addition, some treatments have a substantial effect on how the patient functions on a daily basis. What the interactive approach to patient care postulates is that the physician must treat both the diseased body and the self. If the physician accomplishes this, there will be several positive benefits for the patient, which I will outline in the next section.

When physicians recognize the interactive nature of the human being, (s)he will also become aware of the interactive nature of illness. Once the physician recognizes that an illness has two dimensions (a bodily and a psychological/mental), (s)he will diagnose and treat the illness

interactively as well, and this will result in treating the patient's illness adequately. An adequate treatment of illness is a therapeutic measure that takes both the mental and bodily manifestations of illness into consideration. This way of diagnosing and treating illness is part of the interactive dualistic approach. An inadequate treatment of illness is a medical procedure that only concentrates on treating the body. This type of treatment is incomplete and incompatible with the interactive dualistic approach since it advocates a reductive mind-body dualism.

III. THE PRACTICAL BENEFITS OF ADHERING TO AN INTERACTIVE DUALISM IN THE MEDICAL CONTEXT

(1) *Treating the Whole Patient*. In the medical context, the real difficulty is with the propensity of the medical professionals to view the patient mechanistically and the illness as a disease state that must be treated, with the result that this diseased state is an abstract, theoretical entity that is separate from the self. In this regard, dualism can actually provide an important insight for medical practice, namely, that the patient consists of two things, self and body, and that both are disrupted with illness. The "lived-body"[15] belongs to a particular person, and the person is closely connected to the body. That there is a connection between the self and the body does not presuppose that the self is reduced to the body. Instead, what is presupposed is that there is an interconnection between the self and the body. In fact, the expression "I am my body" captures the real meaning of the lived-body as being an intimate part of the particular patient who is ill.

The traditional paradigm of medicine focuses mostly on a biomedical account of illness which treats the body as a machine, abstracting the body from the self. This reductionistic paradigm undervalues the personhood and integrity of the patient, and makes it irrelevant to diagnose and treat the person and the body during illness. However, this assumption is mistaken since the body and the person are fundamentally connected, and separating them is as erroneous in the medical context as it is in the normal everyday experiences of individuals. The scientific paradigm must, therefore, be supplemented such that illness is not merely regarded as the physical dysfunction of the body but rather as a disorder of the body and self of a particular patient. Thus, how a patient's life in terms of long and short-term projects are affected by illness is just as important as how the body malfunctions during illness. Illness is not experienced by the patient as merely a specific breakdown of the physical functioning of the body but also as a disruption of the patient's life. Thus, a dualistic framework is beneficial for the physician to take the whole patient into consideration.

(2) *Treating the "lived-experience" of illness*. According to the traditional paradigm of medicine, from the point that a patient seeks medical advice, the patient's illness is viewed as a diseased state of the body that could be treated using various kinds of medications and/or surgery. For the patient, on the other hand, the illness is part of his/her body and person since it fundamentally affects his/her whole life (either temporarily or permanently), regardless of whether the illness is chronic or acute. The difference between the physician's conceptualization of illness as a disease and the patient's as a "lived-experience"[16] that affects every aspect of his/her existence highlights the reason why the patient and physician often discover how difficult it is to effectively communicate with one another about illness.

In order to help the patient cope with the disruption of illness, the physician must shift his/her focus from the diseased state of a patient's body to the "lived-experience" of the illness, which requires a dualistic analysis of the illness. When a physician views illness merely as disease, (s)he objectifies the illness and in the process separates or alienates the patient from his/her body and self. However, the patient's body and self is an intrinsic aspect of the illness, and the treatment of the illness cannot be successful without treating both the body and the self. This presupposes that the physician pay particular attention to the psychological and physical disturbances caused by the patient during illness. It is essential that the physician shifts his/her focus from the objective features of disease to the subjective, personal features of the illness during the clinical encounter. Physicians must therefore spend a considerable amount of time during the clinical encounter discussing the impact that a particular illness has on a particular patient's life. Many times the physician will have to reassure the patient by giving him/her confidence to endure and persevere the symptoms of the illness, and by helping him/her gain the strength to resume his/her normal daily activities and long and short term projects. Thus, the physician may have to treat and heal the patient both psychologically and physically since illness has both a psychological and physical component. This is much more achievable if the physician advocates a dualistic framework of human suffering during illness which includes the mind and body of the patient.

(3) *Including the subjective and objective criteria of illness*. The subjective components involve the personal meaning illness has for the patient. The subjective/objective distinction is another kind of dualism that is isomorphic with mind-body dualism since the subjective involves the mind while the objective involves the body. Subjective medical information that involves the "lived-experience" of illness for the patient

commonly collapses into objective/bodily interpretations of illness. In the following, I shall be concerned only with patient subjectivity in the clinical encounter, which involves the patient's psychological features. There are at least three possible meanings of subjective in this context. First, 'subjective' may mean a perception of a state of affairs that is private to the particular patient. This makes his/her avowals idiosyncratic and inexpressible to third parties. This meaning of 'subjective' does not concern me here. The second meaning of subjective points to the inner states or bodily sensations of a patient, which consist of qualitative reports of bodily sensations such as nausea, pain, aches, and so on. Such qualitative reports are difficult to verify by the physician. These symptomatic reports comprise much of the clinical narrative of the patient.

There is a third meaning of 'subjective' that is also of importance for the clinical encounter, and that is the subjective as personal meaning. Subjective information in this sense can most accurately be known by the patient experiencing it. This does not mean that the patient cannot express the pain that (s)he is experiencing in a way that can be understood by the physician. A patient knows what a particular pain or suffering means, when (s)he determines how important it is in his/her personal life. This sense of meaning presupposes a unique kind of particularity. For instance, when a patient experiences the discomfort and restrictions of the patient's normal daily activities as a result of gall stones or appendicitis, the patient's description will be subjective in that (s)he will report on the particular effects that the pain had on his/her body, mind, and long and short term plans. For instance, the patient may report the following debilitating features of an illness: (1) the patient could not participate in a ten kilometer run for MS because (s)he was in pain; (2) the patient could not exercise for a month because (s)he was always exhausted; and (3) the patient was not able to go to work because (s)he could not concentrate and made frequent errors. These reports highlight the particular subjective effects of the illness on the patient's life. This sense of subjective is essential for the physician to achieve an effective diagnosis and treatment for illness.

This shift in perspective from objective to subjective can be extended into the clinical encounter between physician and patient in order for the physician and patient to communicate effectively with one another. The dualistic framework is also beneficial for the physician to establish the objective and subjective perspective of the patient. On this approach, the physician should listen to the patient's verbal reports and avowals of illness very carefully so that (s)he could determine what are the patient's fears and anxieties about the illness, and how his/her life is disrupted as a result of

the onset of illness. On the basis of such information, the physician can then proceed to use proper diagnostic procedures to treat the illness which requires that the physician examine the patient using the various functional or scientific methods of medical assessment. A diagnosis is most often achieved by making use of the laboratory (through blood tests, x-rays, urine samples, stethoscope, and EEGs), which are objective measures that diagnose the patient's illness. However, a more subjective, personalistic assessment must also be included.

(4) *Taking the patient's clinical narratives seriously*. It is important to note that the clinical narrative is distinct from the patient's medical history which consists of the patient's state of health over his/her whole life. A patient's medical history consists of facts about symptoms, disease etiology, potential for treatment, and so on, all of which is based on the biomedical view of medicine. The clinical narrative provides insights about how illness affects the biography and/or life narrative of the patient; it is the story of illness from the patient's unique perspective.[17] The clinical narrative may be less precise than the patient's medical historical report; however, it is no less relevant to the medical diagnosis and treatment. The physician must spend a sufficient amount of time examining the clinical narrative and the medical history of the patient.

Effective diagnosis is incomplete without these two forms of assessment. The clinical narrative then has two features or characteristics: the psychological features of illness, and the physical attributes of illness. Each of these features may be communicated through the patient's voice, and use of words.[18] Patients are not objective observers reporting on their illness; rather, they tell the physician what occurred to them from their own personal perspective. The patient typically emphasizes what is personally significant about the illness, and the impact it has on his/her life. For instance, a patient suffering from arthritis may make the following statements in his/her clinical narrative; I can no longer walk up the stairs without pain; I can no longer walk for long distances; I can no longer do ballroom dancing without severe pain; and so on. Thus, in this particular patient's case, arthritis has substantially affected his/her life. By attending to the dualistic aspects of illness, the physician can understand the patient's illness which is an essential part of the humanistic approach to illness.

CONCLUSION

Thus, as I have shown in the paper, the interactive dualistic approach is beneficial for medical practitioners to adhere to when diagnosing and treating a patient's illness. Without interactive dualism, the patient is

treated merely as a diseased body, and the treatments administered exclude the subjective features of the illness. Viewing illness in a reductionistic manner undermines the humanistic component of medical treatment which is equally essential to diagnose and treat illness. Adding the subjective component may take a few extra minutes of the physician's time during the medical diagnosis to put into practice since it involves changing one's perspective from a solely objective perspective of the patient as a body to a subjective-objective perspective which includes both the body and the self. However, the medical benefits to the patient will far outweigh the effort that may initially be required by the physician.

NOTES

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1 This point was suggested by an anonymous referee. Although there has been a trend over the last decade or so for medical practitioners to actively involve the patient in treating illness, it has always been assumed by medical practitioners that what must be treated is the patient's body and not the whole patient.

2 The reductionist view postulates that the patient's body can be completely separate from his/her mind.

3 Even if Descartes had never developed his reductionist account, it is quite possible that some form of restrictive/reductionistic dualism would have been developed by someone else since the climate during the seventeenth century was scientific and mechanistic in nature. The importance of introducing Descartes into the medical context as being the chief cause of the reductive nature of how physicians viewed their patients is that the medical tradition is also permeated by this materialistic/mechanistic view. Thus, it is possible to argue that at least one culprit for the mechanistic view can be attributed to Descartes's insistence that there is a sharp contrast between mind and body.

4 There are many other criticisms in the medical literature; however, there are overlaps among the criticisms. Some other authors are: Richard Zaner (1964), (1988), Eric Cassell (1976), (1984), (1991), Michael Foucault (1975) and S. Kay Toombs (1987), (1988), (1990), (1991). See bibliography for complete citings.

5 Mark Sullivan "In What Sense is Contemporary Medicine Dualistic?" *Culture, Medicine and Psychiatry* (1986) 10, 331–332.

6 Arthur Hastings, James Fademan, and James Gordon. Health For the Whole Person (Boulder, Colorado: Westview Press, 1980), p. 4.

7 S. Kay Toombs, "Illness and the Paradigm of Lived Body," *Theoretical Medicine* (1988) 9, p. 201.

8 Eric Cassell, *The Healer's Art* (Philadelphia and New York: J. B. Lippincott Company, 1976), p. 112.

9 A few such theorists are: Jennifer Hornsby, Paul and Patricia Churchland, Daniel Dennett, and Alvin Goldman.

10 In Thomas Nagel's *The View From Nowhere*, Oxford: Oxford University Press, 1986.

[11] Thomas Nagel's *The View From Nowhere*, p. 51.
[12] There is no space to defend my claims in favour of Nagel's dualism in this paper since that would be a paper in itself. Therefore, I simply postulate my views on Nagel as an alternative to Descartes substantival dualism.
[13] It is not difficult to find many examples of a causal relation going from events within conscious experience to the physical organism and the physical world. Suppose one has the task of making a decision whether to repair his/her automobile or buy a new one. One considers what the various repairs will cost, and tries to give an estimate of how long the automobile will last. One entertains these possibilities as items within one's conscious experience. A decision is made one way or the other, and this decision is translated into the appropriate action.
[14] Versions of the dual-aspect theory is also held by Strawson, Hampshire, Davidson, and O'Shaughnassy.
[15] The expression 'lived-body' is an expression used by Kay Toombs (1988), and is one that I adopt for my purposes in this paper.
[16] The "lived-experience" of illness is a term that Kay Toombs (1991) uses and one that I adopt for my purposes.
[17] Cf. Eric Cassell's "Clinical Technique," Volume 2 of *Talking with Patients* (Cambridge, Massachusetts: The MIT Press, 1985a).
[18] I discuss 'effective communication' between physician and patient and its importance in the clinical encounter in more detail in *A New Paradigm For Informed Consent*, chapter 6 (pp. 105–117) and chapter 7 (pp. 93–96).

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