Kierkegaard's Existential Philosophy in the Physician-Patient Relationship

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ABSTRACT:

This thesis aims to show the existential relationships that exist within the physician patient relationship in regards to Søren Kierkegaard's existential philosophy. I will introduce Kierkegaard's philosophical concepts of anxiety and despair (Chapter 1), apply his philosophy to the perspective of patients seeking aid (Chapter 2), explain the existential importance of the family as caregivers (Chapter 3), explain the challenges and existential relationships physicians have with their patients (Chapter 4), and lastly discus instances faith and spirituality in modern medicine (Chapter 5)

CHAPTER 1:
Introduction to Kierkegaard's Philosophy

In today's medical field there are many changes in health policy, law, and administrative business models. What remains constant is the importance of the physician patient relationship. It is critical that healthcare professionals have insight how it is to be a patient, and are able to relate to people who come from different walks of life. One of the best ways to understand others is to understand oneself. The philosophy of Søren Kierkegaard can teach healthcare professionals a great lesson, especially physicians. It has been well documented that faith is a powerful force in the ability of a patient to recover from serious illness and cope with disability. With his perspective we can find significant value from his Christian existentialism which offers supporting evidence for this phenomenon. In this chapter, I will introduce the philosophies of Kierkegaard and use his terminology to analyze and appreciate more deeply the subjective condition of psyche which patients, their families, and their physicians undergo in dealing with illness.

Kierkegaard was born in 1813 and lived until 1855 writing in Copenhagen Denmark, he was a brilliant mind but also lived an incredibly difficult life, suffering the loss of his parents and all but one of his siblings at an early age. He is someone who constantly battled with the issues of despair and anxiety, but also sought to equally find joy in life and in particularly in nature. Kierkegaard's life is well documented in his journals, many of which describe the importance of his relationship with a woman named Regine Olsen. Kierkegaard was madly in love with her, but he never married because of his obsession with his philosophical work. This ultimately led to the end of the relationship, but he held on to the hope that like Abraham's call from God to sacrifice his beloved son Isaac, Kierkegaard would be rewarded by God for pursuing his real vocation in

philosophy.[1] Sadly Kierkegaard never fully recovered from this loss of Regine. He was a very progressive man in his time in history who held women in high regard in that his philosophy proclaimed women possessed a greater amount of spirit than men, and that they have a greater innate potential for spiritual growth.[2]

Kierkegaard is dubbed the father of existentialism, which may be a surprise to many laymen because the majority of popular existentialists today typically are classified atheists (for example Sartre and Heidegger)[3]. Kierkegaard was a devout Christian, and practiced an intricate existential philosophy of duality. This duality is an incorporation of his two philosophical inspirations, Socrates and Jesus Christ. Kierkegaard was revolutionary in western philosophy in his way of trying to understand the human psyche as well as trying to reconnect spiritualism to the growing scientific analytical mentality of early nineteenth century Denmark. Although this thesis does not seek such a monumental task as Kierkegaard's mission, we can find great value from his insight to better

[1] Kierkegaard's book Of Fear and Trembling revolved around the analysis of the religious figure Abraham and his trials by God to sacrifice his son Isaac. He concludes that by ethical standards, such a gesture is despicable and insane, and thus religious belief and morality lies outside of the realm of ethics and law. This concept is mirrored in The Concept of Anxiety. His reflection on the topic was directly inspired by his decision not to marry Regine. (McDonald, 2012)

[2] Thomte, Reidar. Anderson, Albert B., The Concept of Anxiety: A Simple Psychological Orienting on the Dogmatic Issue of Hereditary Sin. Kierkegaard proposes that women in general have a greater amount of spirit because they are gifted with greater possibility with their lives. Women are of course responsible for giving birth to children and their lives are accordingly more anxious. He also suggests that women have greater influence over others than men do from his analysis of the Genesis mythos, because Eve was the one able to convince Adam through seduction to eat the apple. For Kierkegaard's philosophy, a useful relationship to remember: more anxiety = more spirit = more possibility.

[3] Sartre and Heidegger are examples of famous European existentialists who took Kierkegaard's philosophical formula and removed the religious aspect into a secular philosophy. It is still a topic of debate in the existential field of philosophy and psychology as many modern Christian existentialists are also major voices. (McDonald, 2012)

understand our emotional and spiritual turmoil in medicine today, specifically Kierkegaard's philosophies of anxiety and despair[4].

It is important to expand on Kierkegaard's writing style and approach to his philosophy. Many of his published works consist of an alias author which each offer a different perspective on the world.[5] Some of the aliases are religious and others are more focused on ethics or simply affairs of daily life. It can be inferred he adopted this style of writing from Plato's works of philosophy which were dialogues. Each part of his work leads the reader to contemplate and reflect on his words

Kierkegaard makes it abundantly clear that Christianity, or faith in God in particular, is absolutely necessary to find transcendence, and that the journey is difficult because we are imperfect beings, but in the end we may find salvation with God. However he was against the systematic religion of Lutheran Christianity of his time, and raises the tough question in whether anyone baptized into Christianity truly are Christians in truth. He claims that even he himself is not good enough to call himself a Christian because the task is so demanding. Kierkegaard makes an excellent parallel to his faith with that of a relationship with a physician in Practice of Christianity:

> "When in sickness I go to a physician, he may find it necessary to prescribe a very painful treatment-there is no self-contradiction in my submitting to it. No, but if on the other hand I suddenly find myself in trouble, an object of persecution, because I have gone to that physician: well, then there is a self-contradiction. The physician has perhaps announced that he can help me with regard to the illness

[4] It is important to note that these terms are not necessarily negative philosophies, as Kierkegaard believes that we are all capable to overcome the burdens that we face on a day to day basis through faith and turning to God. Kierkegaard regards the phenomena of despair and anxiety to be a calling from the divine to do be all we are capable of, a kind of opportunity.

[5] (McDonald, 2012)

> from which I suffer, and perhaps he can really do that-but there is an "*aber*" [but] that I had not thought of at all. The fact that I get involved with this physician, attach myself to him-that is what makes me an object of persecution; here is the possibility of offense. So also with Christianity. Now the issue is: will you be offended or will you believe. If you will believe, then you push through the possibility of offense and accept Christianity on any terms. So it goes; then forget the understanding; then you say: Whether it is a help or a torment, I want only one thing, I want to belong to Christ, I want to be a Christian."[6]

Much of Kierkegaard's philosophy focuses on the duality of what we are made of: a finite physical being, and an immortal spiritual being known as our soul.[7] There is a conflict of expression between the two beings synthesizing to become our "spirit" the people we are: our expression of what we show to others around us. The conflict of anxiety resides in the existence of sin in the world which causes our "freedom" or pure expression of ourselves to become complicated with the finite necessities of the world.[8] This complication of anxiety Kierkegaard regards as the "dizziness of freedom". Anxiety, is explained to be the possibility of possibilities, a fear of what others or we ourselves could possibly express. This fear which hinders our ability to perfectly express ourselves is the concept of sin, a nothingness, which can be described as the temptation to choose something else lesser or easier than perfectly expressing ourselves in freedom.

Kierkegaard's book *The Concept of Anxiety* lends a very thorough analysis of this relationship and overlaps into most of his other works. The point of the literature is to take a closer inspection of Original Sin, dating back to the Christian mythological first man and woman Adam and Eve, and the start of humanity's unique ability to have free will through the fall of Adam. Through his analysis he points out how the current

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[6] Hong, Howard V., Hong, Edna H."Practice in Christianity" pg 115
[7] Thomte, Reidar. Anderson, Albert B., The Concept of Anxiety: A Simple Psychological Orienting on the Dogmatic Issue of Hereditary Sin
[8] (Thomte & Anderson, 1980)

metaphysical, psychological, and scientific measures that we had during his time were insufficient to fully understand or define the concept of sin. The way we can evaluate it is through earnestness, our individual subjective feeling. He reaches the conclusion that our free will and therefore anxiety existed in the world before the existence of sin because Adam and Eve chose to eat the apple and disregard God's order thereby creating the concepts of good and evil. The importance of this conclusion is that it implies that there is a higher level of moral choice before ethics; it is subjective moral reasoning. It is in this subjectivity where the heart of Kierkegaard's philosophy lies, how we interact with others and express ourselves is unique to ourselves yet we share the same situation with the rest of humanity. In turn the key to find this subjective truth in our expression is through communication with others as well as prayer to the divine.

Interpersonal relationships are explained in detail by Kierkegaard; what love and friendships are, as well as their antithesis, which he calls states of the demonic. His philosophy indicates that the positive expression of freedom and spirit are what lead to community and overall communication between one another. "Agape" the ancient Greek word for divine selfless love is an example of true expression of freedom which God calls us to love thy neighbor and most importantly our enemies. The demonic is a state complete reverse of freedom, it is the anxiety of the good.[9] It is an inwardness a seclusion and a silencing of oneself from others.

Keirkegaard evaluates the demonic in his three categories of being: the esthetic, the ethical, and the medical therapeutic[10]. When it is viewed Esthetically-Metaphysically, one

[9] (Thomte & Anderson, 1980) pg 118

[10]. (Thomte & Anderson, 1980) pp 118-123 Kierkegaard's states of being are fully discoursed in his book *Either/Or*. The aesthetic is a focus on the finite things in the world such as beauty and empirical

is driven towards sympathy. However Kierkegaard says that this is not good for the sufferer but is a means of protecting one's egoism,[11] He explains that true human sympathy must make clear to what extent the demonic is an aspect of fate (ie the belief it could happen to anyone), and to what extent it is the responsibility of the individual. From an Ethical view, the demonic has always been viewed as condemnable, and punished severely. Kierkegaard believes that this view allots a better kind of sympathy because it instills the mindset "it didn't happen by fate, I am guilty I chose to do it", it is a sign of ethical development and responsibility.[12]

The final view of the demonic is of a purely physical and somatic observation, the Medical-Therapeutic view.[13] All three views combined show the demonic belongs in both the somatic and the psychic. Therefore, because man is a synthesis of the body and the psyche, a disorganization in one shows itself in the other. Kierkegaard continues to say that many who want to deal with the phenomenon are themselves demonic, because there are traces of it in every man. In terms of psychology he explains that the demonic is a state, but a sinful act can break forth from it.[14] The only way to observe these situations is when the demonic comes into contact with goodness, he explains this phenomena with theological references to the New Testament Gospels of Mark, Luke, and Matthew when Christ approaches sinners[15].

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information. The ethical is a focus on the ideal and infinite, a more reflective and mature mentality than that of the aesthetic. The third view is that of the religious life, a synthesis of the other two. The religious life is the highest mentality for people to strive for according to Kierkegaard. (McDonald, 2012)

[11] (Thomte & Anderson, 1980). pg 120

[12] (Thomte & Anderson, 1980) pg 122

[13] (Thomte & Anderson, 1980) pg 122

[14] (Thomte & Anderson, 1980) pg 123

[15] (Thomte & Anderson, 1980) pg 119 "Whether the demon is legion (cf. Matthew 8:28-34; Mark 5:1-20; Luke 8:26-39) or is dumb (cf. Luke 11:14), the phenomenon is the same, namely, anxiety about the good, for anxiety can just as well express itself by muteness as by a scream. The good, of course, signifies the restoration of freedom, redemption, salvation, or whatever one would call it"

Kierkegaard thinks that the moment you label another you negate the rest of their possibility which then hinders their spirit and increases their anxiety about expressing themselves optimally in freedom. This psychological observation is very important and insightful to understanding ourselves. We can explain this idea of labeling anxiety by imagining a simple hypothetical scenario, let us just imagine our favorite food and drink; there is a little stand that sells only our favorite meal a block away from our hypothetical home. There is however a restaurant that makes equally priced and quality food right across the street but it has a much larger selection of food drink. We are all typically according to Kierkegaard's philosophy drawn to the place with greater selection even if we seek to have our favorite meal. The possibility, the options of choice, are incredibly appealing to our psyche (or in Kierkegaard's philosophical term, necessity: our finiteness). When we have limited choices that are taken away from us, we are filled with despair over the change, and we wish to have the prior options available.

My simple example reveals that we are naturally anxious and there is no situation where anxiety and despair hits a higher magnitude than when we are injured. Kierkegaard offers perspective for healthcare professionals when interacting with patients in the emergency room setting. It has been common to hear a patient being labeled as "the broken leg" or "the AIDS patient" for quick reference between the medical staff, however from Kierkegaard's philosophy this dehumanizes the patient and turns him into a very basic nobody, simply a case to be tackled or addressed. Some might find this critique perhaps too sensitive, but we can see in the second chapter that bigger labels tend to have bigger impacts on patients lives, as well as their quality of life.

Coupled with the concept of anxiety, which can be explained as sin's complication of our finite and eternal beings, Kierkegaard speaks of his concept of despair in *The Sickness Unto Death*: a fascinating metaphysical analysis of the turmoil expressed spirit. The work is essentially an expansion upon *The Concept of Anxiety*.[16] Kierkegaard's term for despair is a complicated situation that is much bigger than the general feelings of melancholy or depression, it is a desire to consume oneself out of self loathing and an inability to do so. Unlike someone in anxiety someone in despair to Kierkegaard is always responsible for their situation: while anxiety might be considered a feeling of guilt, despair is considered a suffering.[17] There are varying occurrences of this despair as well: despair considered only with regard to the constituents of the synthesis (finitude and infinitude) as well as despair as defined by consciousness.[18]

Kierkegaard illustrates despair considered only with regard to the constituents of the synthesis; if there is an imbalance in the finite self or infinite self the expression of spirit is compromised. An example of an imbalanced intensification of the finite, or our physical selves (the immediate), is how it is typical of ambitious people to desire to become "like Caeser or naught"(all or nothing).[19] If one is unable to obtain such desired power or status they are filled with despair because they did not accomplish their goal and they detest the person that they are, but similarly if they do somehow accomplish their goal, there still is an element of despair for they would hate who they used to be. He

[16] (Hong & Hong, The Sickness Unto Death: A Christian Psychological Exposition for Upbuilding and Awakening, 1980) pg xi
[17] (Hong & Hong, The Sickness Unto Death: A Christian Psychological Exposition for Upbuilding and Awakening, 1980) pp 144-145
[18] (Hong & Hong, The Sickness Unto Death: A Christian Psychological Exposition for Upbuilding and Awakening, 1980)pp 39-74
[19] (Hong & Hong, The Sickness Unto Death: A Christian Psychological Exposition for Upbuilding and Awakening, 1980) pg 19

points out that generally people are in despair always but for the majority of the time they are unaware of it. This is a good example that must be noted how despair is typically unknown to us and how it is always in the background.[20]

Conversely, the intensified despair of the infinite self (the soul) leaves an individual vexed by possibility (fantasy). This situation is called "Infinitude's Despair Is to Lack Finitude".[21] Normally the idea of possibilities is a good thing, and through the tool of imagination can be applied to the real world and made reality through work. Imagination is the key to self reflection, but the state of the "fantastic" in a person "leads him away from himself and thereby prevents him from coming back to himself."[22] Someone in this extreme state of fantasy is escaping from his real life, that he only dreams and thinks of grand designs never striving to make them real. Kierkegaard explains that this type of person loses himself within himself. Kierkegaard uses the example of comparing someone in this state of fantastic despair is similar to someone suffering from rheumatic arthritis who is overly sensitive to the weather: they are in no way a master of external stimuli but a prisoner to it.[23] Knowledge or reflection of himself does not improve his well being, but rather hurts him. The person then wanders aimlessly

[20] Kierkegaard notes about the phenomena of despair in the situation as if someone was standing with their back to a town hall in the city center points away from it and yells "There is the town hall" he would be right as in its in his proximity, but he does not see it or is addressing something else that is not the actual source of despair.

[21] (Hong & Hong, The Sickness Unto Death: A Christian Psychological Exposition for Upbuilding and Awakening, 1980)pp 33-35

[22] (Hong & Hong, The Sickness Unto Death: A Christian Psychological Exposition for Upbuilding and Awakening, 1980)pg 31

[23] (Hong & Hong, The Sickness Unto Death: A Christian Psychological Exposition for Upbuilding and Awakening, 1980)pg 31

away from the person he actually is and becomes absorbed in an infinite self abstraction and isolation in his mind.[24]

In addition to these two extreme simplistic forms of despair there are additional more complicated and developed forms. When a person adopts a secular view of the world, a world of finiteness, Kierkegaard calls this a "despairing reductionism".[25] In this situation the view is that all interest lies in the intellectual and physical while irrational ideas such as faith and spirituality fit into a category of indifference.[26] Explaining that the secular narrowness is a form of "emasculat[ing] oneself in a spiritual sense", Kierkegaard passionately argues that such mentality destroys an individual's uniqueness and self identity before God and within the world.[27] This idea of despair essentially ties into the previous point of labeling in anxiety, it negates the infinite's possibility of which we are all capable, claiming that we are all just the same as anybody else or anything else.

Furthermore to add to the issue "despairing reductionism", another advanced situation of despair is necessity's despair of lacking possibility: a state of hopelessness.

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[24] (Hong & Hong, The Sickness Unto Death: A Christian Psychological Exposition for Upbuilding and Awakening, 1980)pg 32 Kierkegaard discusses that despair does not necessarily ruin the persons appearance to the world in terms of social demeanor or wealth, but it is rather an internal destruction, much like an internal disease a patient never knew they had. "But to become fantastic in this way, and thus to be in despair, does not mean, although it usually becomes apparent, that a person cannot go on living fairly well, seem to be a man, be occupied with temporal matters, marry, have children, be honored and esteemed-and it may not be detected that in a deeper sense he lacks a self. Such things do not create much of a stir in the world, for a self is the last thing the world cares about and the most dangerous thing of all for a person to show signs of having. The greatest hazard of all, losing the self, can occur very quietly in the world, as if it were nothing at all. No other loss can occur so quietly, any other loss- an arm, a leg, five dollars, a wife, ect.- is sure to go noticed."

[25] Hong, Howard V. Hong, Edna H. The Sickness Unto Death pg 33

[26] Hong, Howard V. Hong, Edna H. The Sickness Unto Death pg 33 Kierkegaard points out that this secular mentality which focuses on what makes man different from the animals completely ignores what is essential and truly important: spirituality.

[27] Hong, Howard V. Hong, Edna H. The Sickness Unto Death pg 33

To explain this occurrence of despair, Kierkegaard uses an analogy to compare someone suffering from hopelessness to the other situation of losing oneself in possibility as someone who is completely mute to a small child only being able to pronounce vowel sounds. He explains that necessity, the things of our world that we need to survive, require the ability to give us hope for the future: a requirement of belief. When someone runs out of options in their life, they essentially suffocate, they cannot go on. Kierkegaard argues that faith in God makes all things possible, so to believe in God gives us the ability to move forward in our lives. When reflecting on this argument, the old adage of there not being any atheists in a foxhole (or some may say in an operating room) came to mind, when a person's back is against the wall the only option is to believe in something and it will give a person a reason to carry on. This is also a situation which can be seen in medicine, when healthcare professionals administering palliative care give their patients options so as not to run out of hope in their time of terminal illness.

This leads to the second category of despair: despair as defined by consciousness. Instances of this kind of despair vary in intensity and consist of two major categories: despair of the earthly and the despair of the eternal. Amidst these categories there are groups of subcategories, but in interest of this thesis let us focus mainly on the categories of earthly despair as eternal despair focuses around turmoil of finding religious faith.

In earthly despair there is the subcategory of ignorance, wishing to be another self, wishing to not be a self, and wishing to be a new self. The subcategory of ignorance is simply that, an ignorance of having a synthesis of the self and a measurement of happiness based upon society and worldly expectations. Someone in this state of mind could live their entire lives and perceive themselves to be perfectly happy, however they

would never know the types of happiness they could have had or the possibility they could achieve by having faith.

This is the most common situation there is a despair of consciousness in the world. Following this first level of conscious earthly despair is the wish to be another person. This Kierkegaard calls an almost comical form of despair because it is an insane desire, every single person equally consists of the same synthesis and the focus on finite desires is shortsighted and immature. The third and most severe form of despair is someone who wishes to start over completely with their life, to be a new self, because they have realized how hard and painful life is. This situation, according to his philosophy, is most dire because it takes a great magnitude of reflection in despair to lead someone to this conclusion. Instead of letting good into their life and believing in future possibilities or putting faith in the divine, someone in this despair would rather take his own life.

The Sickness Unto Death also makes a similar discourse on sin in the world as does Kierkegaard's work in The Concept of Anxiety. Kierkegaard states that all the forms of despair in the world the embodiment of sin, for it is a loss of earnestness and humility. That it is in our own pride and inability to put ourselves before God, that despair strikes at us. Kierkegaard makes a theological argument about the innate offense to the Christian life the secular world holds, "There is so much talk about being offended by Christianity because it is so dark and gloomy, offended because it is so rigorous ect., but it would be best of all to explain for once that the real reason men are offended by Christianity is that it is too high, because its goal is not man's goal, because it wants to make man into

something extraordinary he cannot grasp the thought."[28] He believes it is this difficulty that suspicion is so prevalent in the world to the Christian life. Moreover, this offense is a parallel to the idea of envy, an "unhappy admiration".[29] Thus one reason despair is sin is because of the offense faith causes: that the idea of Christianity's high calling and ability to be one with a being so powerful and loving sounds absolutely insane to secular wisdom.

With understanding and reflection of the concepts of anxiety and despair, one has the tools to deal with the many struggles that life presents. To have faith and to trust in yourself, others, and in God gives a person great ability to overcome incidents which would be crippling to others who cannot. This empowering philosophy of the self, and perspective on life, is built into the very fabric of the professionalism medicine holds: a field based in the intimate relationship of people who begin as strangers. Although Kierkegaard certainly is an intimidating read for the average person, he was a thinker who was brilliantly complex and changed the conversation of western philosophy forever, inspiring some of the greatest minds of the twentieth century. Like his philosophical inspirations Jesus and Socrates, he raised the hard questions of what is truth about our existence, how a good man should live, and instilled a great aspect of hope for transcendence with determination. His philosophy is one that is applicable to all walks of life, but in healthcare it can be used to understand the human condition and the anxieties of illness.

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[28] (Hong & Hong, The Sickness Unto Death: A Christian Psychological Exposition for Upbuilding and Awakening, 1980) pg 83

[29] (Hong & Hong, The Sickness Unto Death: A Christian Psychological Exposition for Upbuilding and Awakening, 1980) pg 86. Kierkegaard explains that admiration is a "happy self surrender" while envy is an "unhappy self assertion"

CHAPTER 2
Application of Kierkegaard's Philosophy to the Patient's Perspective

There is no situation in life more inherently stressful than being a patient. Imagine yourself sitting in a strange room, people you never met before are rushing about asking questions, and you are most likely not feeling well at all. All of a sudden the door opens and in walks the physician: it is at this vulnerable moment that a special relationship begins. The gravity of being ill is not unique to our time. There is an innate existential fear of being an outcast. In this anxiety lies subjective chaos that the patient, the family, and the physician each need to work around. Physicians and other healthcare professionals have the special opportunity to be at a patient's side during this time period; their responsibility to improve the quality of their patient's life is often no small feat. To be cognizant about their patient's lives can be invaluable to render appropriate care, and to build a proper level of trust.

Medicine is the science of humanity. A healthcare professional's ability and wisdom is directly related to the number of subjective relationships they build. The objective of this chapter is to illustrate and reflect on Kierkegaard's philosophy of anxiety and despair from the perspective of a patient in the physician patient relationship. In order to attempt to encompass the varying situations that present themselves in medicine, I will use examples from case studies and narratives of patients afflicted with disease, mental illness, and physical disability. From these independent categories, I will apply his philosophy to the struggles of recovery, illness, and death.

When we go to see a doctor for a symptom of physical illness or injury, we are in a relationship of building and becoming. I use these terms because Kierkegaard refers to faith based relationships. There are revelations over time (such as the progress of the treatment: a becoming) and there is an innate trust in someone (a building) for something

that we do not understand (the ailment that we suffer). Because we do indeed put our faith into the professionals that take care of us, anxiety and despair are present in this relationship because of the possibility of outcomes we could experience.

HIV/AIDS is an infectious disease that remains a global threat, carrying not only the potential for death if left untreated, but also social stigma that leads to severe anxiety. In a narrative, Achim Nowak presents his story as a gay man who contracted HIV in the late 1980's. He explains how the illness effected his relationships with loved ones as well as professionally working as a director at The Creative Arts Team in New York City.[30] In "coming out" to his coworkers he elicited responses of despair over his condition from his colleagues, but also notable concern about his ability to do his job from his employers and judgment upon his request for extra time off to receive alternative medical treatments.[31] The anxiety of his health in addition to the anxiety about his job security caused him to hide his medical information from his future job's human resource department as he requested for medical aid. What can be learned from Nowak's story is that personal medical ailments are resonate into realms which we might not even consider. The disease which he carried did not cause him any physical harm during his day to day life outside of his treatments every month, but it affected every relationship in his life.

Communication between patients and their doctors was also not an easy matter according to a study by Dr. Randall Curtis MD, MPH and Dr Donald L Patrick PhD, MSPH: "Barriers to Communication About End-of-Life Care in AIDS Patients". This

[30] (O'Brien, 2004) pp 55-69
[31] (O'Brien, 2004) pp 55-69

older study in 1997 illustrates some important barriers and fears of end of life care that still exist in our society, and certainly existed in Norwak's battle with his illness during the time period of his narrative. In the study a few quotes from patients really jump off the page about the anxiety of being judged or labeled bringing up personal information about their lives to their doctor: one patient said, "It's hard to bring up… what my life is about and stuff about the end until I feel like [my doctor] isn't gonna judge me. It's relevant… [for] my doctor to know my history around addiction. But it wasn't until I got to know him that I was able to disclose."[32] Inversely another patient liked his physician so much that he did not want to burden her with too many details about the patient's illegal drug use or bad habits because he did not want the doctor "to be upset".[33] The largest factor the patients in the study had issue with was signing a living will, because they had negative feeling as if it was an act of signing away their own lives.[34] As is the case in all three of these examples we can see instances of Kierkegaard's philosophies of anxiety and despair: the anxiety of being judged, the despair of oneself being unworthy or hurtful toward another, and of course the despair of losing possibilities by acknowledging ones mortality from a serious illness. The answer to all of these problems lie (as the authors of the study agree[35]) in improved communication between the physician and patient by breaking down walls of fear between the two parties to better understand and build trust.

[32] (Curtis & Patrick, Dec. 1997) pg 737
[33] (Curtis & Patrick, Dec. 1997) pg 737
[34] (Curtis & Patrick, Dec. 1997) pp 737-738
[35] (Curtis & Patrick, Dec. 1997) pg. 740

Cancer is another disease that is met with aggressive medical therapy and invasive surgical procedures. Over the past few decades we have been able to raise our society's awareness of the many forms cancer can arrive in and have discovered increasingly effective forms of treatment. However the autobiography of Lucy Grealy, *Autobiography of a Face*, reveals a much more painful image into suffering. Grealy was diagnosed with bone cancer within her jaw at a young age and had to undergo disfiguring surgery, removing one third of her jaw. She lived a brutal childhood, rejected and mocked by her fellow classmates because of her deformed face and loss of hair due to chemotherapy treatments. She struggled with the existential issues of finding purpose and meaning, in addition to forging relationships and finding love.

Grealy's struggles can be applied to Kierkegaard's philosophies of anxiety and despair. The Concept of Anxiety as I mentioned, explains that because women have a higher innate spirit than men, they also have a higher amount of anxiety. Kierkegaard reasons that women's natural strength lies in the aesthetic, as their power lies in roots of beauty, there is the increased anxiousness to preserve and enhance their youthfulness. Grealy's physical deformity directly challenged this possibility, filling the woman with despair and isolation. Her painful life as a pariah pushed her to lock herself away from the world, a state of Kierkegaard's demonic: she believed she was "too ugly to go to school".[36] She sought so desperately to be loved, she began to enjoy undergoing surgery because the necessary care would make her feel "somehow special":

> "In post-op the specially trained nurses checked on me every ten minutes. I was too groggy to sense what was going on, but I relished the aura of attention, the cool hands on my warm arms, the way my name distantly sounded in their soft, I-

[36] (Grealy, 1994) pp 146-147

> won't-let-anything-bad-happen-to-you voices, the notion that I was somehow special, that I mattered."[37]

Despair is another powerful force in her life, as she was constantly wishing to be someone else, and like most people undergoing cosmetic surgery, she had an unrealistic expectation in what could be done to improve her aesthetic beauty. Grealy would eventually go on to become an award winning poet because of her perseverance through her difficult childhood. She found writing a release of her creativity and in telling her story a chance to show the world who she is: a beautifully unique person.

Mental illness presents a situation much more difficult for both the patient and physician due to innate barriers in understanding pending on the intensity of the patient's disease. While care and treatment for the patient is the same, there can be a loss of understanding and building within the physician and patient relationship. While it might be tempting to use the clinical appearance of mental distress and depression can apply it directly to philosophical metaphysics Kierkegaard presents, it would be inaccurate. The medical definitions of the disease model are based upon analytical observation and measurement, in contrast to Kierkegaard's metaphysical philosophy of the soul and spirit. In fact the most damaging aspects of mental disorders is experienced by the people in the patient's life, which is where we can apply Kierkegaard's philosophy. It is through the eyes of the caretaking family and friends that we can learn how life changes from the disease. The medical narrative is an excellent tool to help people both in and out of healthcare understand the journey taken in by the mentally ill. In the third chapter I will focus on this.

[37] (Grealy, 1994) pg 144

How then can we learn from the patient's perspective if it cannot be reputably communicated by patients with severe mental illness? Disorders such as autism, schizophrenia, and bipolar syndrome are barriers between the patient, their family, as well as doctors in understanding what is occurring in their minds. Physicians, neuroscientists, and therapists use models of the mind to understand and analyze a patient's status; some similar to Kierkegaard's system. Harry R. Brickman, MD PhD, suggests a useful model to compare the human mind's neurons to an expansion on Plato's Allegory of life in the Cave, as we learn about events in the world in a closed neurologic system similarly to viewing shadows of different things on the wall of the cave.[38] Through this objective lens, Brickman suggests that Darwinian theory to "utilize new neurobiological perspectives on subjectivity, intersubjectivity, and analytic theories of development, pathology and cure" to form better models for professionals to use.[39]

The subjective aspect of mental illness Kierkegaard can lend insight into, because he also was inspired by Plato's works including the Allegory of the Cave. The opinion of both men on the concept of faith is inherently different: Brickman and other like-minded psychiatrists would claim a secular/somatic view of faith as an evolutionary development of beneficial irrational action algorithms while Kierkegaard would hold faith to a higher sacred standard (Ironically, it is not surprising that they have subjective opinions on subjectivity). In *Fear and Trembling* Kierkegaard's argument is that faith stands above the universal ethic, that God's word is intrinsically greater than any established by humanity: the ethical is a temptation.[40] The fact that Abraham was willing to sacrifice his

[38] (Brickman, 2008) pg 319
[39] (Brickman, 2008) pg 321
[40] (Hong & Hong, Fear and Trembling, 1983) pg 115

only child Isaac is monstrous and terrifying for any person to consider, but this test was intended to be terrible to show that God is capable of anything and Abraham was infinitely rewarded for having faith.[41] In instances with disorders with addiction, most twelve step programs include a belief in a higher power, to show that in this power there can be transcendence over the physical world and the mental illness including addiction. In treatment of mental illness, Kierkegaard's point about faith is that to have it in the world is brutally hard, but if you enter the sphere of the religious life he advocates in *Either/Or* you can transcend much of the pain in life.

The World Health Organization: International Classification of Impairments, Disabilities, and Handicaps defines disability as a restriction in or lack of ability to perform an activity because of impairment.[42] The inability or hindrances of ability that disabilities cause us great anxiety and despair. This anxiety is not mutually exclusive to the patients undergoing a disability, as some other people are often filled with anxiousness around others with a disability. In theory one can argue any disease be it physical or mental is disabling. In this case the greatest despair for patients with disabilities, to be isolated from society because of their impairments.

There are multiple accommodations granted to persons with disabilities to protect them and their rights defined by the Americans with Disabilities Act (ADA).[43] The ADA consists of four titles. Title I offers antidiscrimination protection to people who are

[41] (Hong & Hong, Fear and Trembling, 1983)

[42] World Health Organization: International Classification of Impairments, Disabilities, and Handicaps: A manual of Classification Relating to the Consequences of Disease: Geneva, Switzerland: World Health Organization. 1980.

[43] (O'Brien, 2004)

looking for work.[44] Title II mandates that all state and local government programs and services be accessible to the disabled. Title III prevents discrimination of the disabled from private businesses.[45] Lastly Title IV requires all major phone providers allow hearing and speech impaired individuals to communicate with hearing people, a responsibility of service either individually supplied or in concert with other carriers.[46] People from younger generations might find it surprising that these protections for the disabled are relatively new, these mandates were instituted in George H.W. Bush administration.

American society has always been famously democratic and self-reliant. For a country with freedom of speech and individualism however, we have criticized and looked down at others who are different or live differently. Because of this there is still great fear and anxiety about revealing ones medical disability. Even the President of the United States, Franklin D. Roosevelt, famously concealed his paralysis to Polio so as to not seem weak and unfit for his job. The power the label of disability or illness holds overs us is immense, unjustifiably so as Kierkegaard points out, despite the capabilities for good and the potential that we all hold.

In 2001 a case study was done by Eric J. Lenze M.D. et al.: "The Association of Late-Life Depression and Anxiety with Physical Disability: A Review of the literature and Prospectus for Future Research". Within this study the authors reach a conclusion

[44] (O'Brien, 2004)
[45] (O'Brien, 2004)
[46] (O'Brien, 2004)

which can be compared to Kierkegaard's dynamic synthesis of body and soul: depression can be caused by and/or be brought forth by disability and physical disease:

> "Depressed individuals with cardiovascular illness have greater incidence of stroke-related and cardiac-related mortality. This may be due to poor health behaviors, such as smoking or physical inactivity, which are risk factors for vascular illness: also, depression itself may cause coronary and cerebrovascular events. Elevated cortisol levels and other signs of immune dysfunction associated the depressed state may lead to the increased risk of cancer seen in some but not all studies. Depression may increase risk for osteoporosis, which, combined with the increased incidence of falls in elderly patients, leads to an increase of risk of hip and other fractures."[47]

In addition to depression causing somatic health crises, the study also addressed that inversely physical disability can result in clinical depression. This happens because disabled individuals typically have increased negative life events, a loss of perceived control, low self-esteem, social activity restrictions, and strained interpersonal relationships.[48] Because the self is a synthesis, as Kierkegaard suggests, a disturbance or turbulence in one aspect will affect its counterpart.

Naturally the concepts of anxiety and despair carry over toward the elderly and the incurably ill. An interesting journal article by Wink and Scott investigates the relationship that faith and religiousness have in the elderly in regards to coming to terms with death.[49] The study resulted in no direct linear relationship between religious faith and fear of death and dying in late adulthood, however a curvilinear relationship existed to faith in God as a buffer for fear of death, meaning that the extreme ends of the study (high religiousness and no religiousness) had lower fear of death while those in-between

[47] (Lenzie, Rodgers, Martire, & al, 2001), pg 128
[48] (Lenzie, Rodgers, Martire, & al, 2001) pg 128
[49] (Wink & Scott, 2005)

had the largest fear.[50] The study notes though that other similar studies have found linear relationships in their results to increased religiousness and fearlessness.[51] The majority of the subjects in this study were elderly Caucasian Christian Protestants. Kierkegaard's subjective philosophy could explain this phenomena, as he believes that the greater the spirit the person has the more anxiety they feel therefore greater fear.

Upon reading this study I reflected on it as a practicing Roman Catholic. I can personally attest that there are many secondary factors involved with my religious faith. Among these secondary factors: the action of prayer involves self-reflection resulting in the creation of feelings of guilt. These feelings are then addressed by feelings of forgiveness through repentance. To say that someone has faith is much more complicated than saying someone has a certain nutritional diet, there are so many moving parts both positive and negative to our lives, two of the largest being our physical and mental health, which makes faith very difficult to empirically observe. I believe like Kierkegaard that it is incredibly hard to be a perfect Christian, and likewise can understand why different studies on faith produce varied results that cannot always prove statistically relevant.

Regardless of this theological ambiguity, end of life palliative care is an aspect of healthcare getting much more attention in medicine today. There has been a transition in medicine to a more holistic and less invasive approach to treatment of disease in the elderly and the dying. In 2004, a study by Anjali H. Anselm M.D. et al focused on revealing the major barriers that existed in treating end-of-life patients, the overall

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[50] (Wink & Scott, 2005) pg 212
[51] (Wink & Scott, 2005) pg 213

consensus among healthcare professionals were the greatest barriers lay with the recipients and their families, the major issues being: the exclusion of patients or their wishes, difficulty in designating a decision maker or reaching consensus, family tensions, differences in culture or values, variable capacity to understand and appreciate discussions, appropriate timing of discussions.[52] These problems isolate the sick patient from appropriate care and cause extreme levels of stress for medical team as well, and certainly vary from case to case. Patients look to their palliative doctors and caretakers to do their job to give them peace and freedom in a time where there is a chaos of anxiety around them. This topic shows how essential everyone in society, not only healthcare workers and patients, reflect on concepts such as Kierkegaard's philosophies.

Therefore in this chapter I have introduced examples from case studies and narratives of patients in instances of bodily disease, mental illness, and physical disability, and from these independent categories, I applied Kierkegaard's philosophy to the struggles of recovery and life with these ailments as well as the fears of mortality in severe cases. The subjectivity surrounding medicine and individualizing patient care can seem overwhelming for a physician or healthcare worker. However each patient and their sometimes or extreme differences is what makes medicine the most humane science. It is not a controlled setting like a sterilized laboratory; medicine is the art of life. The challenges of understanding, accepting, and improving the lives of patients at every stage of illness makes communication crucial, and complex.

[52] (Anselm, Palda, Guest, McLean, & al, 2005) pp 215-216-.Although the role of family in the physician patient relationship will be the focus of chapter 3, addressing these difficulties is important to encompass the existential position of the patient in the relationship.

CHAPTER 3
Application of Kierkegaard's Philosophy to the Patient's Perspective

From the perspective of the patient, family and close friends play a major role to the overall efficiency of a medical relationship. As a supporting cast, these core groups of individuals are essential to maintaining and managing their loved one's therapy. There are situations in medicine when a patient might become incapacitated and lose the ability to make decisions, where a grey area of medical ethics occurs if a living will does not exist. There are instances with a living will when a patient's family fight to oppose the patient's wishes in favor of their own desires. There has been a large effort to educate patients and their families about medical rights, however there is still a conflict between them that results in argument to act in the best interest of the patient. When working together, the physician and the family can be advocates for the patient, but when there is friction and lack of communication between the patient and family, the situation could not be worse. In this chapter, I will address friction as well as examples of successful collaborative efforts between the patient's two camps of medical team and family while applying Kierkegaard's philosophy of life.

In a letter Kierkegaard wrote to his cousin, he included a valuable quote that depicts the responsibility of family in caring for their loved one:

> "Above all do not forget your duty to love yourself; do not permit the fact that you have been set apart from life in a way, been prevented from participating actively in it, and that you are superfluous in the obtuse eyes of a busy world, above all, do not permit this to deprive you of your idea of yourself, as if your life, if lived in inwardness, did not have just as much meaning and worth as that of any human being in the eyes of all-wise Governance, and considerably more than the busy, busiest haste of busy-ness - busy with wasting life and losing itself."[53]

[53] (Rosenmier, 1978) pg 280

This passage speaks eloquently to the proper family/friendship dynamic, to be supportive and encouraging to those we love no matter what the situation might be. In illness and disability.there is a fear of isolation as well as the temptation for self-loathing. Medical narratives are very useful to give introspection into family dynamics and can teach us from their experience.

The Grealy family from *Autobiography of a Face* is depicted in a somewhat negative light by the author, as there were many dysfunctions in the family dynamics since Lucy was a young age. Lucy elaborated on how her parent's marriage was not a happy one: her father was always under economic strain, her mother suffered from depression, and her oldest brother was diagnosed with schizophrenia.[54] These complications over the course of her life in addition to her illness attributed to a certain detachment from her family. When talking to physicians and other medical personnel however her parents seemed "normal" as if they were fictional characters from television shows.[55] Because Grealy's Ewing Sarcoma was revealed in her childhood, every single interaction she had with her parents in regards to her health was a critical to her development; every emotional rejection she received from her parents made her hope that her bravery undergoing medical procedures would earn her love or affection from the doctors and nurses at the hospital.[56] The care and treatment for a disease such as Grealy's cancer carries over outside the walls of the hospital, and although the social environment in which she grew up in was not ideal we can all relate to her challenges. She was

[54] **Invalid source specified.** pp. 34-35
[55] **Invalid source specified.** pp. 33-36
[56] (Grealy, 1994) pp. 30-38

emotionally scarred and the extreme stress in relationships with her parents reveals a notable level of miscommunication.

The Grealy family suffered great pain from Lucy's cancer, I have no doubt, that cancer affects every aspect of family life. As my own family has had to cope with cancer, I can attest that building communication with a loved one over the fear of the disease and its consequences is not easy. There are feelings of powerlessness and anger as you watch a loved one undergo the side effects of chemotherapy. What remains constant however is your love in the family, and the compassion we share. You want the loved one to be strong, brave, and healthy and not think about the negatives possibilities. The only way to do this though is to give them real love and support such as Kierkegaard wrote in his letter, to have them feel the love around them, because it is love that makes all things possible and can make you brave. I can say in retrospect I love my family even more than I did before the diagnosis because of how we came together and I am grateful for our time together.

Sadly there are instances where the family cannot communicate and are paralyzed by their loved one's medical circumstances. Autism is a disorder that is shrouded in mystery as to how it originates. It is a burden to children's lives as well as society. A child may develop normally and then suddenly stops talking.[57] Ron Suskind presents his family's remarkable relationship with his autistic son Owen who developed "regressive autism".[58] Owen was able to formulate words and the ability to acknowledge others until

[57] (Suskind, 2014) pg 1
[58] (Suskind, 2014) pg 1

he turned three years old where he completely "disappeared".[59] Owen became fixated on Disney movies, he and his older brother had always watched them together, but in time that is all the little boy wished to do.[60] Ron and his wife Cornelia both were still reeling with the sadness of losing connection with their youngest son until something remarkable occurred, Owen appeared to be trying to communicate to them through the movies:

> "…on a cold and rainy Saturday… Owen is already on the bed, oblivious to our arrival, murmering gibberish… 'Juicervose, juicevose.' It was something we've been hearing for the past few weeks. Cornelia thinks maybe he wants more juice; but no, he refuses the sippy cup. 'The Little Mermaid" is playing… it's at one of its best parts: where Ursula… sings her song… 'Poor Unfortunate Souls'… When the song is over, Owen lifts the remote. Hits rewind.
>
> 'Come on Owen, just let it play!' Walt moans. But Owen goes back just 20 seconds or so, to the song's next-to-last stanza, with Ursula shouting:
>
> *Go ahead - make your choice!*
>
> *I'm a very busy woman, and I haven't got all day.*
>
> *It won't cost much, just your voice*!
>
> He does it again. Stop. Rewind. Play. And one more time. On the fourth pass, Cornelia whispers, 'It's not 'juice'.' I barely hear her. 'What?' 'It's not 'juice.' It's 'just'… 'just your voice'!'
>
> I grab Owen by the shoulders. 'Just your voice! Is that what you're saying!?'
>
> He looks right at me, our first real eye contact in a year. 'Juicervose! Juicervose! Juicervose!'"[61]

Ron and Cornelia then pursued validation from speech therapists about this startling event but were met by disappointment as their pediatrician explained autism often has the attribute of echolalia where the person mimics a phrase of what they just heard without any understanding of it.[62] Later, there is another event where Owen

[59] (Suskind, 2014) pg 1
[60] (Suskind, 2014) pg 1-2
[61] (Suskind, 2014) pg 2
[62] (Suskind, 2014) pg 3

becomes lucid with the family after Walt's ninth birthday party, "Walt doesn't want to grow up… Like Mowgli or Peter Pan."[63] After hearing this articulate and pertinent statement, the parents were not going to give up on the idea that their son was aware and engaged. Ron decided to do an experiment on his own with a hand puppet of Iago the parrot from "Aladdin".[64] To Ron's amazement, Owen would interact with the hand puppet character, having insightful, emotional conversations, through these fictional characters. The family would discover that this is not typical of the disorder, a child with autism is usually not capable of communicating even passively.[65]

This experience sets the family on a path to memorize and watch Disney movies as a means to interact and their son who would read his lines with emotion as if "method acting". There came a point of crisis in Owen's life where the private school for mild learning disabled children, The Lab School of Washington, decided that he was not mentally appropriate for their curriculum.[66] Owen had set up relationships with other children there and the move caused him a great amount of pain emotionally; unable to outwardly express it, his father believed that Owen expressed his anxiety by constantly drawing Disney characters with looks of sadness or fear on their faces the following months.[67]

Owen through his art showed signs of Kierkegaard's despair, the desire to be someone else because he wanted to stay with his friends. For dissociative disorders like autism, one of the largest hurdles is to reach into the person's emotions. These drawings

[63] (Suskind, 2014) pg 4
[64] (Suskind, 2014) pg 5
[65] (Suskind, 2014) pg 13
[66] (Suskind, 2014) pp 7-8
[67] (Suskind, 2014) pp 8-10

signified despair of the change and the anxiousness of potentially not having any friendships at the new school.

Over the course of the following years, through his specialized "Disney therapy" with psychologist Dan Griffin, Owen began exclaiming altruistic and social connections as he imagined himself to be a "side-kick" like Phil from "Hercules", to help other people like himself be all they can be.[68] He eventually graduated from high school, and enrolled into a private school for high-school and college aged young adults called Riverview where he started a Disney club for other classmates who share autism spectrum disorders who also fixate on Disney movies. Owen eventually falls in love with one of the girls from the club, and at the end of the article after his father warns him about the potential for heartbreak, he shares a profound existentially reflective conversation:

> "He cuts me off. 'I know I know,' he says, and then summons a voice for support. It's Laverne, the gargoyle from "The Hunchback of Notre Dame."
>
> 'Quasi,' He says. 'Take it from an old spectator. Life's not a spectator sport. If watchin's all you're gonna do, then you're gonna watch your life go by without you.'
>
> He giggles under his breath, then does a little shoulder roll, something he does when a jolt of emotion runs through him. 'You know they're not like the other sidekicks'
>
> He jumped ahead of me again. I scramble. 'No? How?'
>
> 'All the other sidekicks live within their movies as characters, walk around, do things, The gargoyles only live when Quasimodo is alone with them'
>
> 'And why is that?'
>
> 'Because he breathes life into them. They only live in his imagination.'
>
> Everything goes still. 'What does that mean, buddy?'

[68] (Suskind, 2014) pg 13

> ‘He needed to breathe life into them so he could talk to himself. It’s the only way he could find out who he was.’
>
> ‘You know anyone else like that?’
>
> ‘Me.’ He laughs a sweet, little laugh, soft and deep. And then there’s a long pause.
>
> ‘But it can get so lonely, talking to yourself,’ my son Owen finally says, ‘You have to live in the world’”[69]

There is so much affirmative power to this narrative’s story because it follows a family who never gave up faith on supporting their son, no matter how difficult or challenging the road was, and had a team of medical professionals who were at their side through Owen’s entire life. The growth this autistic boy had into becoming an emotional and insightful young man was a huge team effort. If hypothetically Owen had been born into a different household like the Grealy’s the outcome would have been most likely different, without the hands on parenting and necessary funds. The Suskind family’s story can be useful to the other families who have autistic children: the largest moral being to never stop loving them and to know your child more deeply than outsiders and naysayers.

The barriers of communication with the autistic Owen, can be mirrored by the story of Cathy Crimmins who lost touch with her husband Alan Forman after he suffered a traumatic brain injury. In her memoir, Crimmins discusses the journey of recovery for her husband as well as how their family coped with the challenge. After an accident during a family vacation involving a boat striking him in the head, Alan fell into a coma, leaving Cathy and her family waiting to see when or if he will awaken from it.[70] Throughout his coma, Cathy had an overall negative experience with the neurosurgeon

[69] (Suskind, 2014) pp 20-21
[70] (Crimmins, 2000) pp. 11-42

overseeing his case, to the point she demanded he be removed for his lack of bedside manner and sensitivity. She had concerns that he was indifferent to her husband's situation because the injury did not require surgery. In spite of this bad relationship, she had positive experiences to other caregivers such as the nurses and technicians, and is relieved that her husband's new doctor was more approachable and caring.

Moving forward the family progressed slowly with Alan's recovery. For the family the road ahead was long, because after Alan awoke it was necessary to teach him how to do everything all over again. There are traumatic experiences for both Cathy and their daughter Kelly, as spontaneously Alan would have intense outbursts, verbally and physically, reaching a fever pitch when he kicked Kelly in public after his discharge home.[71] Ultimately, Cathy comes to terms that someone after traumatic brain injury is not the same person as before the injury, and the man she married had died the day of the accident. While Alan was able to make a recovery to the point of being a functional and involved member of society again, he had a complete change of interests, attitude and personality.

Cathy nobly decided to stand by Alan throughout and after his recovery, but she obviously experienced great existential stresses of despair and anxiety throughout the journey. She always made the effort to support and be positive to Alan, despite the many negative emotions she was dealing with inside, especially the grief of losing the man that she married. The grief can be paralleled to Suskind family and their son Owen, the fact that a loved one that you were so thrilled to have in your life disappeared in an instant.

[71] (Crimmins, 2000) pp 201-208

This despair takes its toll in multiple ways be it in anger, depression, or the loss of all hope. At the end of her memoir, Crimmins leaves a touching message to her husband:

> "All along, he's had to accept my narrative of events he will never remember. I thank him for allowing me the gift of honesty. His courage and dignity are truly amazing and a great part of why so many people have felt drawn to him over the years as a TBI [Traumatic Brain Injury] survivor."[72]

Despite all the pain and struggle she and her family endured, she in the end acknowledged the respect she had for Alan's dignity to the world, just as Kierkegaard endorsed his cousin.

Studies have been done to analyze the emotional and physically stress that defines being a caregiver. One study done by Tsara et al. focuses around noting the objective burdens and subjective burdens of families caring for patients with chronic respiratory failure requiring Noninvasive Home Mechanical Ventilation (NHMV).[73] Documenting the investigation of fifty caregivers, the study found that the objective burdens were much higher than the subjective burdens the caregivers reported. Reasons speculated for this contrast is because caregivers adopted healthy coping strategies in dealing with the burdens of their loved one's care, specifically the change of feelings of guilt and ambivalence into the reorientation of goals and emotional resignation.[74] This change toward an emotional and mental maturation can be paralleled with what Kierkegaard suggests with his philosophy of despair, that to overcome it there needs to be a belief in future possibility, and to make active changes in our lives is exactly what he prescribes.

[72] (Crimmins, 2000) pg 257
[73] (Tsara, Serasli, Voustsas, Lazarides, & Christaki, 2006)
[74] (Tsara, Serasli, Voustsas, Lazarides, & Christaki, 2006) pp 62-64

Family grief and bereavement about illness does not always bring a family together. In a case study of a middle aged mother with breast cancer, Judith Erlen presents a situation where the patient opted to refuse additional aggressive chemotherapy to treat the disease. This decision however was not supported by her family who pressured her and her physician to proceed with the treatment because they claimed she was too emotionally drained from the experience.[75] Erlen lists examples for why such resistance might exist between the patient and her family. One reason might be a level of separation between the patient and their family members who might not have been involved with care until a later point who believe their opinion should hold valid weight in the treatment plan.[76] A second reason might be a lack of advanced care planning which sparks conversation between the patient's medical team and the family excluding the patient.[77] Erlen then introduces solutions for the dysfunction including ethics committees acting as an unbiased platform to mediate the disputes within the family, in addition to/ or the consultation of palliative care specialists who will put the patient's desires first.[78] Respecting a patient's autonomy and quality of life is essential to healthcare and a family's care for their loved one, through these avenues these responsibilities will be promoted and protected.

All of these narratives and studies show how the existence and functionality of a support group is essential for medicine to be successful, and in the most successful examples with the best success there were intimate relationships present between the

[75] (Erlen, Jul/Aug 2005) pp 279-280
[76] (Erlen, Jul/Aug 2005) pg 280
[77] (Erlen, Jul/Aug 2005)pg 280
[78] (Erlen, Jul/Aug 2005) pp 281-282

patient, the medical team, and the family. Granted that each of these narratives presented were told from different perspectives, either from the patient's mind or from a loved one's, the truth of healing came when there were no feelings of isolation, which is relevant to the philosophy of Kierkegaard. These narratives present perspective of the family in medical situations, and showed the value of communication to provide effective care. The parameters and struggles of the relationships physicians form with their patients and their families are critical, and it is the spirit of being a caregiver that I will explore in the next chapter with the existential barriers and struggles physicians have with their vocation. Health care professionals must have the insight to see the big picture, despite the difficulties.

CHAPTER 4
Application of Kierkegaard's Philosophy to the Physician's Perspective

Throughout this thesis, I have evaluated the philosophical perspectives of patients and their families. As a patient seeking help from experienced professionals, whose health is managed within a system they do not fully understand, there is much anxiety. Physicians have multiple existential stresses in addition to their ultimate responsibilities to each patient. This includes (as discussed in chapter 3) excellent communication and micromanagement skills. In ancient Greece the Hippocratic Oath set the moral and ethical standard for physicians who still recite it at medical school graduation. The cardinal rule has always been to do no harm.

In this chapter I will apply Kierkegaard's philosophies to show how aspects of hope and faith play a crucial role for physicians in the care for their patients. I will elaborate on the barriers that exist within the system of medicine that can inhibit the quality of medical care. To Kierkegaard, physicians held the ethical ownership over medicine and all matters of health. Because his philosophy was written in the nineteenth century it is not surprising that he acknowledges the paternalistic nature of physicians of his time who were overwhelmingly male. He views the responsibility of physicians is to lead their patients to truth through avenues of faith as well as science.

A neurosurgeon, Dr. Eben Alexander, in his book *Proof of Heaven*, sites Kierkegaard to help him understand and evaluate his near death experience "There are two ways to be fooled. One way is to believe what isn't true; the other is to refuse to believe what is true."[79] His reflections of his out of body experience as a physician-scientist is a powerful testament to his narrative and raises philosophical questions about

[79] (Alexander, 2012) pg 129

what is consciousness.[80] Dr. Alexander fellgravely ill to bacterial meningitis, a severe brain infection with high mortality rate.[81] The disease put him into a deep coma, but to the shock of his colleagues managing his care, he made a miraculous recovery.[82] After his rehabilitation, he looked at his medical charts during the coma and saw that his brain was overrun by sepsis that all his brain functions had ceased.[83] This near death experience transformed Dr. Alexander with an intense spiritual growth, reevaluation of his values, and a deep faith in a divine being. This is an example of how through profound stress, a person can undergo a complete philosophical metamorphosis; a personal vision of life itself, and the very real belief in a God who embraces all humanity with peace and faith in eternal life.

> "Truth has always had many loud proclaimers, but the question is whether a person will in the deepest sense acknowledge the truth, will allow it to permeate his whole being, will accept all its consequences, and not have an emergency hiding place for himself and a Judas kiss for the consequence… Certitude and inwardness which can be attained only by and in action, determine whether or not the individual is demonic."[84]

Patients and their families all go through aspects of fear, denial, regret, and often enter a state of Kierkegaard's "demonic"[85] (self-inflicted isolation and exclusion): the role of the physician is to guide them to Kierkegaard's category of freedom which is to have faith in their lives; to have hope in their critical situation.

[80] (Alexander, 2012) pg 130
[81] (Alexander, 2012)
[82] (Alexander, 2012)
[83] (Alexander, 2012) pg 131
[84] (Thomte & Anderson, 1980) pp 138-139
[85] (Thomte & Anderson, 1980) pp 118-155

Palliative care advocates Janssens, Zylicz, and Ten Have[86] introduced a case in the Netherlands where a woman was diagnosed with cancer. The woman had a strained family relationships with her ex-husband and had lost contact with one of her daughters who was in his custody. The cancer eventually metastasized to her spine and brain, causing paraplegia and eventual enrollment into hospice care.[87] With her total dependence on others to care for her the guiltier she felt about being a burden to her children and caregivers. She refused to even discuss the idea of her death, she angrily lashed out at her family, and she would not speak to her pastor.[88] One day when the hospice physician entered her room, the woman's suspended fear and anxiety overwhelmed her and she spoke of her deep despair of being unable to mother both of her children, and that she was scared that after she died they would never be in each other's lives.[8990] This powerful reaction is very similar to how Kierkegaard illustrated the state of the demonic and its reaction to the good:

[86] Janssens, Zylicz, and Ten Have also introduce a critique of Kierkegaard's philosophy and existentialism in general that should be included and addressed in the discussion in regards to being philosophically authentic in palliative care situations. They claim that existentialism puts too much fear into the idea of death because existence is all that really matters. (pg 41) However, it seems that they missed the point of Kierkegaard's philosophy: it is all about finding hope. In Either/Or part I the entire book is from the view point of someone of the aesthetic life style, someone who finds other people and relationships a complete bore, that the world was meaningless and fleeting from one sensation to the next, thus it is the aesthetic individual's duty to make life interesting by manipulating it (McDonald, 2012). In Either/Or part II the author takes the perspective of the ethical life where relationships and the society around us mean an incredible deal. (McDonald, 2012) The ethical author is supposed to be a more mature teacher of the aesthetic author. Perhaps other existentialists such as Sartre and Heidegger you can make a case for their nihilistic regard for the fleeting aspects of life and relationships. (Rien MJPA Janssens: Zylicz & Have, 1999)

[87] (Rien MJPA Janssens: Zylicz & Have, 1999)

[88] (Rien MJPA Janssens: Zylicz & Have, 1999)

[89] (Rien MJPA Janssens: Zylicz & Have, 1999)

[90] The emotions and despair the woman feels are mapped out to be "the most beautiful and noble" in Kierkegaard's supplement notes of *The Sickness Unto Death*: "…unhappy love, grief over the death of a beloved, sorrow of not having achieved one's place in the world, the forms the 'poet' loves and that only Christianity dares to call sin, while the human attitude is that the lives of such people are infinitely more worthwhile than the millions that make up the prosy-pack" (Hong & Hong, The Sickness Unto Death: A Christian Psychological Exposition for Upbuilding and Awakening, 1980) pg 163 It is through avenues of

> "The demonic does not close itself up with something, but it closes itself within itself, and in this lies what is profound about existence, precisely that unfreedom makes itself a prisoner. Freedom is always communicating (it does no harm even to take into consideration the religious significance of the word); unfreedom becomes more and more enclosed and does not want communication… It manifests itself in hypochondria, in capriciousness; it manifests itself in the highest passions, when in a profound misunderstanding they introduce the silent treatment. When freedom comes into contact with inclosing reserve [muteness], it becomes anxious."[91]

The woman with the help of hospice was able to go through a transformation to approach her death in a more positive way and bring her two children together by communicating about her death and setting up her funeral arrangements with them.[92] She eventually died with peace and dignity in her sleep, with both daughters at her bedside.

The prioritizing of one's life is something Kierkegaard lectures about in great detail in *The Sickness Unto Death* and *The Concept of Anxiety*, that in our lives there are many sources of fear and past decisions that haunt us. In palliative medicine, the reprioritizing of goals and objectives for a patient is vital. The focus of the patient's life in palliative care is in the present as opposed to the anxieties of the future and the despair of the past. There is a mentality of hope to live the day to the fullest and get the most out of the life they have left. This philosophy is exactly what Kierkegaard prescribes, and thus physicians have the responsibility to lead their patients to this greater ethical truth by instilling hope and faith into their lives.[93]

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despair that people have the chance to make a leap to faith and find hope as the patient seems to do with the help of the hospice care.

[91] (Thomte & Anderson, 1980) pg 124

[92] (Rien MJPA Janssens: Zylicz & Have, 1999)

[93] In an excerpt from The Sickness Unto Death, Kierkegaard includes a useful quotation to explain his state of faith:

"Moreover, the opposite of being in despair is: faith. Therefore, the formula given above, which describes the condition in which all despair is eradicated, is altogether correct. This is the formula for faith: in relating itself to itself in willing to be itself, the self rests transparently in the power that established it –

Integration of the humanities into medical treatment and palliative care have become a focus in recent years for hospitals such as Atlantic Health's Overlook Medical Center. There are multiple programs the medical center provides for patients such as art therapy for patients with pain to help cope with chronic pain conditions, or the hospitals pastoral department which offers spiritual support to patients in need.[94] Within the pamphlet for the pastoral center, there is a "Prayer for Healing" that is profoundly similar and relatable to Kierkegaard's philosophy:

In the comfort of Your Love, O God
I give you thanks for the
Blessing of my life

I pour out to You
The memories that haunt me
The anxieties that perplex me
The fears that stifle me,
The sickness that prevails over me
And the frustration of all the pain
That weaves about and within me

God help me now to experience
Your Presence
Your Peace
Your Compassion

Pap. VIII B 153:1 n.d. 1848" (Hong & Hong, The Sickness Unto Death: A Christian Psychological Exposition for Upbuilding and Awakening, 1980) pg. 151

[94]

Your Forgiveness
And Your Eternal Love in my need
Touch me, O God, with Your
Healing Power and Strength,
I give you thanks for the blessing
Of my life
Amen[95]

Drew University offered a unique and invaluable opportunity to observe various meetings, conferences, and rounds at St. Barnabas Hospital in Livingston NJ. During my enrollment in the Clinical Practicum course, I had the opportunity to sit in a Morbidity and Mortality Conference.[96] The presiding physician made an observation during the conference to the residents that was profound but simple, he said that all of medicine is at its core palliative. The very definition of the term care is palliative. Physicians in today's healthcare are highly educated board certified experts; they have immense theoretical knowledge about diseases and the treatments required to combat them. As someone who has bared witness to the contrast of an attending physician and new third year medical student on clinical rotation, the greatest difference is the ability to apply the knowledge in an efficient, clinical, and humane way. Granted that new residents are seldom placed in critical situations immediately, the Socratic way residents are trained emphasizes how each relationship with a patient is individually important, so there is a great deal of anxiety in the students of letting their patients, peers, and teachers down.

[95] (Overlook Medical Center -Pastoral Care Center, 2014) "Prayer for Healing"
[96] (Hall J. C., Mortality & Morbidity Conference, 2012)

Medical ethics and bioethics are two fields of philosophy which have evolved in recent time to serve as guidelines in healthcare and assist in protocols that benefit the physician patient relationships. These emerging specialties have been vital to aid patients and physicians alike to define the best and most humane course of care. Kierkegaard's philosophy parallels these schools of thought, however because of his skepticism of grandiose all-encompassing objective systematic philosophies (ie Hegel's and Kant's philosophies) that limit individuals' subjective options in any particular situation. These types of generalities are inhuman and unrealistic, so much so that the very philosophers who create them do not even live within them.[97]

> "A thinker erects a huge building, a system, a system embracing the whole of existence, world history, etc., and if his personal life is considered, to our amazement the appalling and ludicrous discovery is made that he himself does not personally live in this huge domed palace but in a shed alongside, or a doghouse, or at best a janitors closet. Would he be reminded of this contradiction by a single word, he would be insulted. For he does not fear to be in error if he can only complete the system- with the help of being in error."[98]

This critique of course can be directed back at Kierkegaard for his elaborate dialectical metaphysics of explaining human existence. He would however say that his own philosophy is very much the core of his being which he lives every day.

Contrary to Kierkegaard's concerns, Tod Chambers in his article "Centering Bioethics", states that there is a movement of bioethics from the academic theoretical realm to an active and involved moral application. Chambers states that ethicists have moved from the towers of academia to the bedside of patients, citing narratives of

[97] (Hong & Hong, The Sickness Unto Death: A Christian Psychological Exposition for Upbuilding and Awakening, 1980) pg 43
[98] (Hong & Hong, The Sickness Unto Death: A Christian Psychological Exposition for Upbuilding and Awakening, 1980) pp 43-44

medical ethicists who had the paradoxical experience of learning about medicine on site from the people to whom they are supposed to teach ethics.[99] He makes the observation: "All of these scholars use the metaphors of inside-outside to describe this shift in their work. In moving to bedside and into the world of the health care professional, they have left their "ivory tower' and thereby the abstract "periphery" of academic moral philosophy."[100] This transition however positive, applies academic philosophy to medicine and would be the equivalent of someone living in Kierkegaard's "janitor's closet", according to Mark Siegler because an academic ethicist is still an outsider, and only an observer in the medical world. Siegler believes that physicians should be responsible for making ethical policy for health care because they work within the metaphorical "domed palace".[101] Chambers brings up an astute question to counter Siegler's argument by noting how super-specialized medicine is today; would a neurosurgeon not seem like an outsider in making ethical decisions for pediatricians or psychiatrists?[102]

There is merit to what both men suggest, and a greater relevance to Kierkegaard's critique on systematic ethics. To have non- medically trained policy makers see firsthand the moral and ethical decisions they make go into effect can be very positive for exacting dynamic and effective health policy. In addition, physicians should be competent and versed in the schools of ethics and have the moral professionalism to lead the creation of health policies. Thus the fields of medical ethics and bioethics should not be mutually

[99] (Chambers, 2000)
[100] (Chambers, 2000)
[101] (Chambers, 2000)
[102] (Chambers, 2000)

exclusive to medical providers or to academics, but rather be a coalition of ideas that can offer a diversity of approaches to ethical problems. Limited perspectives can result in biases and ignorance of the practice of medicine leading to an incomplete understanding of the human condition in health care; a flawed "domed palace" that is isolated from reality.

Administrative and government regulations run the risk of imposing broad spectrum care models that could change the dynamic of the individual physician patient relationship forever. The days of a family practitioner like my grandfather caring for a child, aiding her through her teenage/young adult years, and then managing the delivery of her first child will be gone forever. The moral and ethical responsibility, the vocation of medicine, remains real and relevant to today

These changes have caused great existential anxiety and despair in the medical professional lives of physicians. Ignoring the economic strains the disappearance of small private practices into corporate hospital groups or privately owned physician medical groups has and will continue to effect the independent physician. The patient can also suffer from these changes. The subjective nature of each patient, with complex circumstances that require adequate time for a physician to sit and listen, is now considered a standard of efficiency.[103] During observations at Saint Barnabas, I

[103] (Hall J. C., Ambulatory Rounds, 2012) During my observation of residents in clinical rotation with outpatient examinations, I was impressed by the efficiency the staff had with each patient, but observed that many times the Doctor had his/her back to the patient while filling out history on a computer. This observation bothered as the communication could be better. In addendum to the observation at Barnabas, my observation within a private practice was even further hindered by the technological barrier, the patients enjoyed the physician and his wit but appeared slightly off put by the lack of face to face time they had with the doctor, making my presence in the room as an engaging personality very helpful for the physician.

experienced this strain on residents and doctors who had to spend the majority of their time typing out forms on the computer than making eye contact with their patient. This all makes someone who has passion for the art of medicine despair because it mandates that the flow of patients through the waiting and examination rooms is more important than building a relationship between the physician and patient.

In fact in the very fields of primary care and internal medicine, in response to the shortage of physicians, patients are often the responsibility of nurse practitioners and physician assistants.[104] Although nurse practitioners and physician assistants are hardworking and valuable members of the medical team providing care, they have a fraction of the training that primary care physicians and internists have.[105] If one could compare the situation to a football league with a lack of quarterbacks: to compensate and fill the demand the coaches and owners put their center or wide receiver in at the quarterback position because they know most of the plays that team might need to call. However these substitutions will not have the sufficient skill set of the position to be effective, they perhaps could learn it over time, but the result of play will drastically suffer. Drastic measures are actively being made in our government and in hospitals to mobilize all health care workers to deal with an aging population with profound chronic illnesses. This can compromise patient trust of hospitals, emergency room providers, and what should be a sacred bond between the physician and patient.

[104] (Gentry, 2014)

[105] (Hall J. C., Emergency Room Rounds, 2012) During my observation of ER rounds in the early morning, there were limited amounts of faculty present for the majority of the hours I was there and no physician at all until a patient's condition required a specialist.

The changing economic and political situation of Japan have caused a very negative perspective on medicine by private practice physicians in study by Tsutsumi, Kawanami, and Horie. The study was done to evaluate the state of private practice physicians after hospital employed physicians received higher medical fees.[106] According to the study, "57% of the [1,317] physicians [who responded to the questionnaire] were exposed to Effort-reward imbalance and 18% of physicians were above the threshold of depression on CES-D".[107] These results are obviously disturbing if one considers the role of the physician in the ideal sense: a compassionate healer, caregiver, and patient confidant. However the reality of a physician in modern medicine is more that of a small business manager, always under intense medical-legal scrutiny, and buried under mountains of paperwork. The idealistic and altruistic goals of those entering this great profession are inevitably scarred by the reality of what is expected every day. Those individuals who enter the field anticipating financial security are faced with the reality of nearly five hundred thousand dollars of educational loans to be repaid for ten years of additional schooling.[108] We can see the real anxieties that are challenging medicine today. The anxiety can destroy the ethical idealism in the physician patient relationship if health policy in the administrative and government do not recognize the signs.

In this chapter, I have applied the philosophy of Kierkegaard to the role of the physician in building hope and faith within the physician patient relationship and addressed multiple existential stresses that exist within modern medicine. As can be seen,

[106] (Tsutsumi, Kawanami, & Horie, (2012)) pg 164
[107] (Tsutsumi, Kawanami, & Horie, (2012)) pp 164-165
[108] (Hall J. C., Ambulatory Rounds, 2012) I had the opportunity to speak with a few residents from D.O and M.D. programs, some of which upon learning about my interest in medicine cynically joked at the large loans that they were paying off, that I have to look forward to.

the intricacies of balance required of healthcare professionals to manage multiple cases at the same time is exceptional, and the weight of expectation and responsibility cannot be higher. In the final chapter I will discuss the ramifications of supplying faith through the physician patient relationship.

CHAPTER 5:
Discussion and Reflection on Kierkegaard's Philosophy

The process of writing this thesis has been a journey, and like all journeys in education there has been a progression of my personal philosophy. Similar to walking up a steep hill to a summit, Kierkegaard's philosophy is an arduous and intimidating path to an elevated point of view. In medicine, as is in life, the relationships we build are invaluable: everyone we let into our lives influences who we are. The magnitude of the relationships we build with our doctors is instrumental to the quality of our lives. This is why Kierkegaard's philosophy can give introspection to physicians, patients, or any policy maker to improve and protect the art of medicine.

The opportunity for clinical observation within the clinical practicum at Drew University for the Medical Humanities program, has been priceless in granting me introspection on the advancement of healthcare. Learning about the developments in technology like the creation of better artificial hearts to increase the lives as well as quality of life for patients attests to the spark of ingenuity and brilliance held by medical engineers.[109] The progression of the diverse medical education residents receive by utilization of online resources, the incorporation of analyzing medical narratives, in addition to the Socratic methods classically used in healthcare promise a bright future for our medical professionals.[110] Lastly the practicum granted the honor to witness the care of patients in emergency room and examination room settings.[111] All of these experiences are united by one common theme, the theme of giving hope to the ill and a faith that the future holds even better professionals, treatments, and devices.

[109] (Hall J. , 2012)
[110] (Hall J. C., 2012)
[111] (Hall J. C., Ambulatory Rounds, 2012) (Hall J. C., Emergency Room Rounds, 2012)

The most profound experience I had in the clinical setting was during my Ambulatory rounds observation.[112] As I entered into the examination room with the young resident, we were met by a middle aged man who suffered a laceration behind his right ear due to a fall at his parents' home. The patient was there with his father, who explained his son has had a brain tumor that was diagnosed when he was a teenager and had to be supervised in case of epileptic seizures. As the physician was talking with the father, I took a moment to ask the patient about his life. The man then proceeded to tell me a profound story of his overcoming his diagnosis of an inoperable brain tumor and his decision to pursue a carrier in academia in biological engineering. He accomplished a PhD and became a professor at a major state university researching a technology known as "gamma blades". He explained the advancement of this research will allow surgeons to cut more finely than any hand-held blade ever could, allowing certain procedures which were inoperable, such as his own condition, to become doable. It is said that there are experiences in medicine which you will never forget, and that there are people who change your life: this man whose brain was ill had one of the most brilliant minds I ever met. The uplifting inspiration I felt from this encounter is in part why I chose to write a paper on Kierkegaard, the man through his personal faith pushed through a situation that many other people would be devastated by.

Faith has been referenced repeatedly in this thesis as an essential concept in Kierkegaard's philosophy, it is the defining trait for what makes us human. Having faith in times of personal crisis is in no way easy, it is easy to close yourself off to the world and curse God or fate and surrender to illness. There are multiple instances Kierkegaard

[112] (Hall J. C., Ambulatory Rounds, 2012)

considers Christ to be a physician, because He provides salvation to the illness of our struggles.[113] The salvation is the possibility of eternal life from despair, "the sickness unto death". In explanation of the essentialness of faith:

> "There is so much talk about human distress and wretchedness- I try to understand it and have also had some intimate acquaintance with it- there is so much talk about wasting a life, but only that person's life was wasted who went on living so deceived by life's joys or its sorrows that he never became decisively and eternally conscious as spirit, as self, or, what amounts to the same thing, never became aware and in the deepest sense never gained the impression there is a God and that 'he,' he himself, his self, exists before this God – an infinite benefaction that is never gained except through despair. What wretchedness that so many go on living this way, cheated of this most blessed of thoughts!"[114]

Theologically speaking, the concept of the divine is the epitome of potential as Kierkegaard exclaims. Faith is a force that pushes humanity along to better ourselves ethically, scientifically, and certainly medically to improve our world and the lives of our children.

As was discussed in Chapter 4, the multi-disciplinary opinions of healthcare are beneficial to provide diverse ideas for independent treatment of patients. Cancer treatment according to Susan Gilbert, is an area of medicine taking a "leap of faith" by physicians and pharmaceutical companies/ laboratories with the increasing understanding of genetic markers for specialized care.[115] With this groundbreaking field of science, patients could potentially get incredible care built for their needs, not having to worry about exceedingly dangerous chemotherapy drugs for more intense forms of the disease. With fewer side effects, patients will have better outlook and better quality of life. Gilbert

[113] (Hong & Hong, Practice in Christianity, 1980)
[114] (Hong & Hong, The Sickness Unto Death: A Christian Psychological Exposition for Upbuilding and Awakening, 1980) pp 26-27
[115] (Gilbert, Sept-Oct 2010) pp 18-19

explains how the Oncotype DX genetic test has changed the way oncologists and their patients approach treatment, granting a sort of "crystal ball" for the therapy necessary for forms of breast cancer.[116] There is a divide however between oncologists, some whom decide to prescribe chemotherapy regardless of low risk scores on the genetic exams, because insufficient survival data with the new genetic result protocol.[117]

To this point there are critics such as H.M. Malm who issued a study on how there is a culture of over screening for diseases: an unethical policy breaching multiple levels of patient autonomy.[118] He argues that there is only speculation in the effectiveness of early screening with not enough evidence to argue it is in the patient's best interest, with lack of long term data suggesting improved survival rates of certain diseases with early detection as opposed to the first symptom.[119] He argues that to order preemptive screening is essentially like conducting a clinical trial without the patient's consent.[120] Ethically speaking he is correct in his criticism, independent non coerced consent should be given for such procedures.

The research into genetic testing and financial coverage for these exams should not be abandoned though in instances where certain patients individually might want to get screened if they have a genetic disposition for a disease so that they can approach it on their own terms. To many people, the idea they are getting screened signifies they are getting the standard of care they are looking for, a sort of peace of mind and relief from anxiety. Hospitals such as Atlantic Health's Overlook Medical Center have personalized

[116] (Gilbert, Sept-Oct 2010) pg 19
[117] (Gilbert, Sept-Oct 2010) pg 20-21
[118] (Malim, 1999)
[119] (Malim, 1999)
[120] (Malim, 1999)

genomic medicine program offer genetic counseling and do have services covered by medical insurance.[121] The evolution of medical technology in screening and our increasing understanding of the genetic code has great potential for healthcare and should be an option for patients.

The road to recovery from an illness as seen with Grealy's autobiography (*Autobiography of a Face*) or Dr. Alexander (*Proof of Heaven*) can greatly affect their outlook on the world and their self-image. In an editorial, Dr. William Breitbart makes an argument to a critic who "attacked" his support of spirituality in palliative medicine.[122] The critic, Professor Salander, considers the term spirituality an ambiguous secular term for religious and existential philosophies which cannot coexist.[123] Breitbart cites that Kierkegaard is a Christian existentialist and father of existentialism, which counters Salander's conceptions of religiousness and existentialism, and continues to conclude through articles by Carl Sagan that spirituality is very useful in palliative medicine.[124] *Proof of Heaven* would have been an excellent contribution to the conversation, as Dr. Alexander was a spiritual man who likened with Carl Sagan and Einstein about scientific conceptions of God, but Alexander's journey into his tour of the afterlife during his coma made him take a Kierkegaard-ian leap into faith as he found his experience transcendent to all labels and concepts of God he ever conceived.[125] Lucy Grealy, in contrast, found her religious spirituality in poetry[126], a stance that Kierkegaard himself is critical of as it

[121] (Overlook Medical Center, 2014)
[122] (Breitbart, 2007) pg 105
[123] (Breitbart, 2007) pg 105
[124] (Breitbart, 2007) pp 105-106
[125] (Alexander, 2012) Throughout the whole memoir, there are quotes from multiple religious and scientific minds as well as philosophers in attempt to somehow put into words the depth of the journey Alexander had.
[126] (Grealy, 1994)

is rooted in his concept of despair,[127] but was her avenue to communicate with a world that had unjustly rejected her for nearly her whole life.

One of the most interesting things noticed during the research for this paper is the multiple interpretations different academic sources had for Kierkegaard's philosophy. In a way his literature is like looking at a great painting in a gallery multiple times, each time you view it you notice something else and a new question arises. It is compelling how each of our subjective natures react to it, looking at how certain minds like Sartre took it one way and myself another, maybe it is the reaction which Kierkegaard intended.

Therefore, in conclusion, this thesis has accomplished its goals: I have introduced Søren Kierkegaard's existential philosophies of anxiety and despair (Chapter 1), applied his philosophy to the perspective of patients seeking aid (Chapter 2), explained the existential importance of the family as caregivers (Chapter 3), articulated the challenges and existential relationships physicians have with their patients (Chapter 4), and lastly discussed faith and spirituality in modern medicine. Although this thesis did not seek to prove anything, it accomplished its task in opening the mind to situations in healthcare we do not necessarily consider everyday: be it the perspective of a chronically ill patient, the viewpoint of a grieving parent over their powerlessness to help their child, or the anxious world of professionals in medicine. Going forward with my carrier, be it as a physician or someone associated in the healthcare field, the introspection the study of Kierkegaard has given me will be a great asset in dealing with the dynamic situations and

[127] (Hong & Hong, The Sickness Unto Death: A Christian Psychological Exposition for Upbuilding and Awakening, 1980) pg 163 Kierkegaard considered the view point of the poet to be a position of aesthetic obsession with despair. His criticism to poetry and art is most likely a self-criticism as he is regarded as a poet-philosopher.

changes within this artful science. There is an aphorism by Hippocrates that gives physicians and all those working within healthcare a moment of reflection and appreciation for the introspection Kierkegaard lends with his subjective philosophy.

Life is Short, Art is long, opportunity fleeting
Experience deceiving and judgment difficult[128]

[128] (Green, Dec. 2013) pg 4061

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VITA

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