The "Lost" of Meaning and Case Writing in Health Care

A Phenomenological Study

Assistant Prof. Shin-yun Wang
Faculty of Medicine, KMU
Assistant Prof. Hui-ju Lin
Faculty of Respiratory Therapy, KMU

This paper is a part of an on going research project to discuss the dialogue between medicine and philosophy in dealing with medical ethics, or more precisely, the ethical technology of clinical ethics which is constituted from such a dialogue[1]. Specifically, this is an article of introspection, where ideas were drawn out from three well-organized workshops (held from 2007.07.28 to 08.11). The topic of this workshop is "clinical case writing", more specifically, associating narrative and phenomenology with clinical case writing. There are approximately ten members in a team for this activity, which consisted of clinicians, nurses, hospital administrative staff, social workers and others-so organized as a focus group. This discussion is outlined by three main issues: I. What is the special characteristic of medical knowledge? II. The living world and the fulfillment of intention of medical professionals. III. What is the purpose of these workshop about clinical ethics case writing?

From years, medical knowledge has been regarded as part of natural science. Training a good doctor, namely to teach him/her how to obtain an objective and proper diagnosis, and to possess good medical skills. However, we ask, what is the foundation in intuition of the medical knowledge? Is medicine merely referring to the detailed examination and observation of an individual's body and each organ? But as we know, medicine deals with a living person. So, it might be a sense-bestowing variance between the body and the living person, doesn't it? Such issues will be

1 "Exploring the Indigenous Model of Clinical Ethical Consultation: The Ethical Reasoning of Clinical Cases" is a research project granted by Ministry of Health at Taiwan (DOH95-M-1001S, our website for this project: http://ethicist.kmu.edu.tw/), from April, 2007 to December, 2007. Since September, 2005, an unprecedented research group has been formed by senior professors, Min-tao Hsu (許敏桃) from Nursing School of Kaohsiung Medical University (KMU)and Cheng-yun Tsai (蔡錚雲) from Philosophy Institute of National Sun Yet-sen University (NSYSU), with junior faculties who were trained by philosophy, Shin-yunWang (王心運), assistant professor of medical department at KMU and Hui-ju Lin (林慧如), assistant professor of faculty of respiratory therapy at KMU, and licensed MDs., Chao-Tang Hsieh (謝朝唐), Shou-chih Tang (唐守志), and Mei-chun Shen (沈眉君), who are enrolled in the master program of Philosophy Institute at NSYSU, and a graduate student in biology Yi-lin Hsieh (謝一麟). This group has met every other week to have a dialogue between medicine and philosophy. In the meeting, Prof. Wang and Prof. Lin report their encounter in medical facilities and Dr. Shieh, Dr. Tang and Dr. Shen reports their experiences in philosophical institute. Their reports is given analysis and comments by Prof. Hsu and Prof. Tsai respectively and recorded by Mr. Yi-lin Hsieh. During the execution of this project, there added another philosophy graduate student from National Chen-chi University, Bing-Jie Lee (李秉潔).

discussed later in the first section.

In the second section, what we are going to investigate is the living world of medical professionals. Besides involved in medical practice, their lives are filled with sorrow, birth, death, and other extreme experiences. Furthermore, their minds are interwoven with a variety of intention and consideration, such as medical treatments, health systems, laws and ethics. As a result, the major problem is "What is the best thing I can do?". We discovered that, a different experience fulfillment could be obtained from a different intention in a complicated clinical situation. However, the way they used to gain fulfillment was via an inappropriate way or so called a misunderstood way of accomplishment. This is why we used the word "lost" instead of "loss" in the title of this article. Clinical situation is flooded with a varied possibilities of fulfillments. Nevertheless, the loss of meaning fulfillment due to the lost of the proper relationship between original intentions and their fulfillment, frequently, was the reason where medical professionals are affected by psychological distress, as well as various unbearable weight from ethical dilemmas.

Next, we will discuss the purpose of clinical case writing in the third section. In the same way, writing is a way to rearrange the lost of meaning and to unload the unbearable weight of ethics. We have been observing the purpose, as well as the way it's written, of different clinical case writing in the hospitals in Taiwan nowadays. Some introspections and experiences, gained from the three "clinical case workshop" are reported by our team.

I. What is the special characteristic of medical knowledge?

What kind of natural science does medical science possibly assigned to? For example, besides a large quantity of internships during fifth year to seventh year of the seven-year course in Kaohsiung Medical University, there are also programs on body systems as the major integrated subjects for third year and forth year students. Other than that, first and second year students focus more on basic and general education. In contrast to general engineering courses, for example, medical education is, in fact, lack of some science courses such as Advanced Mathematics, thermodynamics and dynamics, which we usually called deductive science. Apart from that, neither physics nor chemistry researchers would identify themselves as the research object when he/she was doing a research on a certain element. But, the target which medicine deals with is a living person, including body, life and death, not just a simple natural object. At the basis of serving humanity as a whole, doctors often come to mutual agreement with their patients. Therefore, comparing with other natural science, medical science research is much more profoundly related to ethics.

At the moment, we are not going to discuss the internal ethical relations of medical science in this section. Purely looking for the special characteristic of medical science, we should ask, what kind of knowledge should it be? There is an obvious distinction between *medical science* and *medical art*. So, "doctor-patient relationship" and other ethical relationships between people could be classified under the medical art section which will be discussed later. If the differentiation is reasonable, the exploration in medical science could be classified as a purely epistemic problem. Thus, due to the knowledge of medical science, it is possible to investigate problems such as what is

the foundation of intuition in medical science and how medical knowledge could be fulfilled by intuition. It is similar to the foundation of intuition explained alongside with the analysis of mathematics in the book of Husserl-- "Die Krisis der europäischen Wissenschaften und die transzendentale Phänomenologie".

A doctor once said, "Medicine can never purely be a science; it contains too many immeasurable. Clinical medicine must not be regarded merely as the application of physics, chemistry and physiology to the sick person. A human being is much more than a number of organs packaged into a minimum amount of space. It may be the man or woman rather than the disease that needs to be treated."(from William Boyd, in Ding-zhu 2004:103). Obviously, it does correspond to what we had mentioned above. Indeed, the division of labor in medicine has mostly contributed to the development of medicine nowadays. Each organ is seemed to be partly independent to its function. But, it is still impossible to assign medicine as one of the strict natural sciences such as mathematics or physics, because medical knowledge contains more profound uncertainty. The complexity of human body is not the only reason for the origin of uncertainty, the practical nature of medicine is another reason. Most clinicians understand that there is no guarantee of a second success after one successful treatment on a particular diagnosis. Therefore, words have been spread among the clinicians, "When you hear hoofbeats, don't think zebra", "As medicine's epidemiological watchword, it reminds clinicians that the presence of signs and symptoms shared by a number of diagnoses is not likely to indicate the rare one on the list. Useful advice in itself, the zebra aphorism epitomizes the practical reasoning used by physicians in the never wholly certain task of caring for sick people."(Montgomery 2006: 122). So, "Variability is the law of life. As no two faces are the same, so no two bodies are alike and no two individuals react alike and behave alike under abnormal conditions, which we know as disease. This is the fundamental difficulty in the education of the physician." (from Sir William Osler, in Ding-zhu 2004:103).

For all that, medicine self-regarded as an evidence-based practice, hardly accepts uncertainty and variability. Indeed, medical research will become easier if the object of the research excludes the entire person, and if medical knowledge is only limited to the function and the structure of certain organ. But, from the perspective of phenomenology, perhaps this represents a loss of the foundation of intuition, isn't it? When an intern is having his first internship in the surgical department, came in contact with living organs such as the subarachnoid of cerebrum, the relationship between sense-bestowing and fulfillment of intuition caused by this experience is extremely complicated and beyond the medical knowledge taught before — At this moment, experience, being part of the process of "fulfillment of intuition", not only just verifies the knowledge previously gained from medical textbooks or lectures, it is also part of the process of understanding the concept of "sense-bestowing". All these lead to Husserl's ideal concept of "adequation". On the contrary, perhaps intuition itself could also be the new "sense-bestowing". More so, we quoted words from Levinas, "It brings us to a notion of meaning prior to my Sinngebung and thus independent of my initiative and my power"(Levinas 1969: 51), or "it's ideatum surpasses its idea"(Levinas 1969: 49). In fact, the condition is much more complicated

than what we think. It is because while one is witnessing the mystery of body, one is also experiencing a totally strange and odd feeling at the same time as well. Suddenly, I notice my body, a kind of realization that I had never experienced before. In other words, the body exist as *being in itself*. The strange feeling of the body and the body purely being in itself, like what Sartre said, produces a powerful urge to vomit. Indeed, patients who requested treatment in hospital have similar feeling as we described above, when their body was either publicly exposed on medical apparatus, or to doctors. Originally, these mysterious or unfamiliar feelings are directed towards the person as a whole. However, when the whole body is not treated as an inseparable entity, where medicine is systematically taught according to different organ systems, and if the "sense-bestowing" in medical knowledge is so conceptual fulfilled, then we can see, the ideal of "adequation" of knowledge will never be achieved in medicine. Therefore, the medical knowledge will become more and more objective, but its origins are still underlying uncertainty and inadequation, mysterious and unfamiliar as they are.

As a result, medical science has been marked as an imperfect science. Meanwhile, medical practice has also been described as imperfect. Particularly, to train a novice to become a good and skillful doctor, the journey is full of failure and hardships. It seems like there is no difference between clinical skills training and other learning processes, such as cooking and physical training. Yet, during the enhancement of knowledge and the enrichment of experience, gaining medical knowledge contains experience similar to a "scandal". For instance, to train a surgeon, it is the education of a knife. Indeed, "In surgery, as in anything else, skill and confidence are learned through experience-haltingly and humiliatingly. Like the tennis player and the oboist and the guy who fixes hard drives, we need practice to get good at what we do. There is one difference in medicine, though: it is people we practice upon."(Gawande 2002: 18). Another example, "When an attending physician brings a sick family member in for surgery, people at the hospital think hard about how much to let trainees participate. Even when the attending insists that they participate as usual, a resident scrubbing in knows that it will be far from a teaching case.... Conversely, the ward services and clinics where residents have the most responsibility are populated by the poor, the uninsured, the drunk, and the demented. Residents have few opportunities nowadays to operate independently, without the attending docs scrubbed in, but when we do-as we must before graduating and going out to operate on our own-it is generally on these, the humblest of patients.... We want perfection without practice. Yet everyone is harmed if no one is trained for the future. So learning is hidden, behind drapes and anesthesia and the elisions of language." (Gawande 2002: 24) "In a sense, then, the physician's dodge is inevitable. Learning must be stolen, taken as a kind of bodily eminent domain." (Gawande 2002: 32).

Mentioned above is one of the hidden aspects of surgical training, not known to others. As we mentioned before, medical knowledge is generally formed by the experience of examination and the constant improvement of clinical skills. The year of experience is the main way to determine the position and the promotion of all doctors, as well as the method to distinguish the difference between a veteran and a novice. From this point, we know that induction is more frequently used in medicine than deduction, which is commonly used in the general science. We recognize that as

long as young physicists could verify the error in certain calculations or the early hypothesis, then they can point out the mistake done by veteran. But, in clinical judgment of medicine, frequently, the more experience a doctor possesses, the more authority he has on the subject. Due to the distinction of the characteristic between different knowledge, having certain classification system is very important and necessary to pass on medical knowledge to future generations.

In spite of this, medical knowledge is expanding everyday by geometric progression due to the advancement of medical science and technology. Therefore, it is impossible for anyone to acquire new knowledge completely. "The descriptions of diseases in standard textbooks are out-of-date, not only because medical knowledge is advancing, but also because the diseases are changing. All textbooks are medical history." (from Alfred J. Bollet, in Ding-zhu 2004:103). Clinicians are unable to personally participate in many experiments of new therapies and drugs, because it takes a huge amount of time and costs a lot of money in clinical trials. So, what they need are the data and the results from those experiments, taking part in publicly discussion and announcement, to learn and introduce new techniques and skills. Upon a great extent, the fulfillment of medical knowledge is achieved by the accumulation of actual knowledge, and is isolated from the foundation of intuition. Nowadays, with rapid development of science and technology, the development of majority of our knowledge follows the same mode as above as well. But, the uniqueness of medical science is always due to its imperfectness and its "scandalous" characteristic.

If we look further to the entire development of the history of western medicine from the perspective of imperfectness and scandal, we discovered that the ethical burden hidden behind medical knowledge is heavier and profound. Briefly speaking, the history of medicine is synonymous to the history of human suffering. All of us are just temporary survivals from disasters. If medical science is to be improved, it must have built up from the suffering and sickness of many people who have experienced torture for a long time. Possible solution can only be discovered with endless experiments and repeated failure. Just like the training of surgeons, the advancement of medicine always accompanied by the suffering of human being. Medical students, sitting in the classroom and gaining medical knowledge, may understood the mechanism of certain diseases and how serious the damage caused. Also, they may know the amount of cure rates or survival rates with different usage of drugs or therapies; it could be either 60% or 90%. Evidence-based medicine always teaches medical students that there are a lot of uncertainties existing in clinical problems, and rates are often the representation of these uncertainties. For example, "according to my experience, you have 50 percent of living more than six months." Nevertheless, this evidence-based form of narrative is just the way to cover up the sorrowful side of medical knowledge. From the perspective of Levinas, history is written by those who survived. Even if history is covered by data and evidence, the imperfectness of medicine and its foundation of fulfillment always linked closely together with human suffering. More over, it could possibly link with certain human sins. For instance, chemotherapy used against cancer nowadays is originated from the experimentation with drugs on human subjects during World War Two. In the modern technological world today, not only human experimentations, consent agreement and other controversies related to medicine involved in medical ethics or research ethics, they also contain certain compunction that even

under the cover of natural science, is unavoidable. In the meantime, the imperfectness of medicine, coupled with the emptiness and compunction associated with medical knowledge, could always be felt by medical professionals when they are dealing with those helpless patients.

The crossing between life and death in the hospital, the approval of medical behavior, emptiness, compunction, and the confidence which need to be possessed by doctors on their profession, the differences between a variety of staff in this real medical world, moreover, intention that often crosses with consideration, a question arises: how to get the final meaningful fulfillment? The answer to this question is uncovered in the next section.

II. The living world and the fulfillment of intention of medical professionals

Clinical situation varies all the time. Whenever there is an emergency, different intention and voice are filled everywhere: doctors try their best to find out the problems of their patients, nurses busy with the preparation of various apparatus and perform the examination on patients. On the other hand, patients and their family members are determined to know about their health condition, treatments that would be taken on them and the most significant issue which they are concerned about is, could there be any threat to their lives? If dilemma occurs in situation that involves the crossing between life and death, the consideration that we have to make is not only for a short term problem, there are many more problems that could possibly happen in the wake of time. What is the development in the future? Is the current management corresponds to the legal procedures if dealing with legal or ethical problems? Is what we have done so far legal? Should I carry on or give up? How about others' opinion and wish? Am I right to make this decision? Is that really good to him? Sounds of patients groaning and babies crying, the "beeping" sounds which come from apparatus, all these set up the scene of crisis in a corner of the hospital.

The most troublesome problem to medical professionals under a critical ethical situation is: what is the best can I do? So far, the major theory of medical ethics is "Principalism". According to the perspective of Principalism[2], it is necessary to reduce a complicated situation of clinical ethics to the various conflicting ethical principles involved. Then, balancing and overriding approaches are manipulated to prioritize the principles. After determining the principles, the following step is to focus on its internal problems, to make the final decision whether certain medical behavior should be taken or not, and settle down the problems of ethical dilemma at present. These problem-solving methods correspond to the idea of normative ethics. Simplifying the question from "What is the best can I do?" to "Should or shouldn't I take this action?".

However, in real ethical situation, there is hardly any easy solution to a problem. Principalism of medical ethics is consistent with the formalization of science that we described above, and corresponds to the simple request of medicine which could solve the clinical problems immediately. But, as we plan the execution, we discovered that even if many medical problems have been settled according to the formalization, there is still a great deal of unfinished or misplaced intention kept

2 Principalism; the principle-based approach: such as the principle of respect for autonomy, the principle of nonmaleficence, the principle of beneficence and the principle of justice.

deeply in medical professionals' mind. Those intentions have never ever truly emerged in their consciousness, either because they have no time to think about them, or they totally don't have any suitable word and phrase or even the ability to think about these questions. All these complicated matters could only become part of the silence in their life. On the surface, everything has come to an end or maybe certain solution has been found. But, from the perspective of phenomenology, the fulfillment of intention that they thought, in fact, has been accomplished via a wrong method based on a misunderstanding. As we mentioned before, such process of fulfillment of meaning is actually referred to the lost of meaning. Clinical situation certainly won't lack of any possible kind of experimental fulfillment. But, under the thinking mode of formalization, the direct impact that originally should be the most obvious to medical professionals has been gazed at without being noticed, and reduced to a heavy silence, without any expression.

"How to express the heavy silence from our heart?" is one of the purposes of the clinical case writing workshop today. This question will be discussed in the following section. According to Husserl, if living world is the source of every intuition, then the real living world of medical professional and its complicated process of fulfillment of intuition will be explored in the next section. This is the theoretical foundation of clinical case writing.

First, let's take a look to a real case[3] written by a member of our workshop:

> Once, a pregnant woman was sent to the delivery room, requiring Caesarean section. When I took over the next shift from the delivery room nurse, she turned to a particular page in the medical history chart rapidly. Without saying a word, she urged me to look at the particular page, my mind went blank immediately after I finished reading. That was a No. 2 history chart, its contents are as below:
>
> **Agreement of Infant Abandonment:**
>
> This pregnant woman is having pregnancy at 38 weeks, an amniotic fluid test along with chromosomal analysis is done during the 16th week of gestation, and the embryo was detected with Down Syndrome. I personally agree to give up this embryo. Therefore, after the Caesarean section is done, do not perform any lifesaving treatment on the baby, let him/her die naturally.

3 This case is written from a nurse, and we keep the original source as secret. This case has been shown once to a gynecologist, and he means, this description may have some difference to the actual situation, because it should not happen in Taiwan according to the law today. What we want to analyze here is the personal experience or explanation from the nurse, and leave the problem about whether it is suitable to the law behind.

By

Husband__________

Wife__________

The surgery has begun on the operating table and everything was going very well. After the newborn was delivered from her mother's abdomen and uterus, the intern put her onto the newborn processing station. Instinctively, I gave the newborn an appropriate stimulation and keep her body warm. Thus, the newborn baby started her first cry, her pink skin obviously showed that she can still survive. "Pass me the oxygen supply", I instructed the nursing student next to me. In the meantime, the surgeon who was suturing the wound on the uterus said," Don't be too aggressive!" So, the oxygen mask in my hand was slowly put back to its original position. Looking at the newborn baby girl, her pink skin gradually turned paler. The newborn baby was still being identified by me with special wrist bracelets and her footprints were recorded down along with her mother's fingerprints. After that, I wrapped her up with prewarmed clothes and carried to her mother (Meanwhile, her mother was still receiving surgery.). I said," Baby's mom, I think you better have a look at your baby girl." The mother asked," Does she have any finger?" I replied," Sure!" She asked again," How many finger does she have?" I answered," Ten fingers!" Once again, she asked," Does she have any toe?" I replied," Of course she does!" " How many toe does she have?" asked the mother again. I said," All together, there are ten toes!" At that moment, I could feel that the newborn baby's mother seemed to regret signing the agreement. There was not much time left for this mother-daughter pair to be together in the same room, the only thing that I could do was just to leave them alone to enjoy the last few seconds of happiness. About one minute later, abiding the rules, I brought the newborn baby into a nursery room and left her at the newborn processing station (waiting for the delivery nurse to take her away). I had to deal with other important things in the operating theatre, there is no room for me to spend a long time with this young life. Before I left, I spoke softly to her," Amitabha, I hope you will be reincarnated into a healthy person, to another happy family." Looking at the newborn baby girl, her pale skin slowly became dark purple, and finally turned into black in color. The baby girl was quiet and didn't move during the entire deterioration; everything seemed to be happening in a peaceful way. I wasn't sure whether she understood my words or not. Besides, I wasn't even sure whether this lonely baby girl would know the destination she was heading to. Will this small and weak soul able to successfully navigate her way in her afterlife, heading towards a new life?

I, as an operating theatre nurse had not been early informed would encounter such an incident. Thus, I was the executioner in this case. Though it happened twelve years ago, it still remains fresh in my mind. I think it is impossible for me to forget it in my entire life!

In this case, the young nurse had been given an order to let the baby girl leaves this world forever silently, to proceed with a procedure of what we called passive euthanasia. Indeed, she had to obey this order consciously. But, her heart thinks the opposite way; it was a torturous. Facing the baby girl directly, looking at her tiny movement, with a tight hug, she could feel the baby's body temperature and respiration. But, all of her intention of action eventually was to bring an end of this young life, by giving up any medical care on her. Perhaps in this young nurse's heart, she could go against this intention of action at the same time, positioning between the conflicts of to do or not to do. Her consideration could possibly be the agreement of infant abandonment from the family members and the order from the doctor in-charge. Thinking of the futility of medical care and considering future benefits, finally, she decided to obey this order according to the laws and ethical principles. Perhaps, while fluctuating between to do or not to do, eventually a solution must be determined. She could make a decision, or she has to make a decision. But, the direct experience and fulfillment that she previously faced with the newborn baby were beyond range of "to do or not to do". In other words, when the young nurse faced this newborn baby, her direct experience or impact weren't cared and managed properly due to the torture of "to do or not to do". On the contrary, the doctor in this case had just followed the rules and gave the order. He didn't need to deal with the impact face to face, and didn't have to accept direct callings for help from the Other. In this case, this is the great distinction between the order given by a doctor and its execution by a nurse.

Therefore, it is just a formal operation between the balancing principle and the rational decision-making of "to do or not to do" according to Principalism. However, in clinical case, the real "difficult ethics" which often make great impact on all of the clinical participants are basically due to its admission that "to do or not to do" on a certain meaning, in fact, is just the impossibility of totally "nothing-more-to-be-done" (Levinas 2003: 67). The impossibility is actually the insomnia status or the experience of "il y a" described by Levinas. In the case above, it is certainly not the predicament brought on by death, but the suffocation brought on by the impossibility of "il y a", that completely created a trapped situation without any way out.

Amithaba, is the only way out for the young nurse, her solution to ethics and her outlet to the Other!

Nevertheless, in many cases, patient's family members are trapped in the sorrow of losing their loved ones. On the other hand, medical professionals also entered a solitary closed world. "Doctors belong to an insular world-one of hemorrhages and lab tests and people sliced open. We are for the moment the healthy few who live among the sick. And it is easy to become alien to the experiences and sometimes the values of the rest of civilization. Ours is a world even our families do not grasp. This is, in certain respects, the experience of athletes and soldiers and professional musicians. Unlike them, however, we are not only removed, we are also alone.... The slew of patients and isolation of practice take you away from anyone who really knows what it is like to cut a stomach cancer from a patient or lose her to pneumonia afterward or answer the family's accusing questions or fight with insurers to get paid." (Gawande 2002: 86-87). Such isolation is caused by the heavy burden of clinical ethics, and the imperfectness of medicine which has deepened the

depression of "nothing-more-to-be-done". But, being an outsider, he/she could hardly understand the inner world of doctors, especially the deep minds of surgeons. "Most medical students are attracted to surgery. Its positive results please them. The bloody drama of the operation fascinates them; the dramatic force of some greater operator stirs their admiration. They note decisive achievements and wonderful successes. They hear little of failures. They know nothing of the haunting anxieties, the keen disappointments, the baffling perplexities, the dread responsibilities, and the numerous self-reproaches or one who spends his life as an operating surgeon." (from William J. Mayo, in Ding-zhu 2004:142). Therefore, the double closed properties, which lead to sorrow and silence in medical professionals, are caused by the demands of ethics and the impossibility of medicine. If the operation fails, medical professionals have to confront the pressure of informing the truth to the family members. Even with understanding and support from the family members, "but neither of us felt any pride about what had just happened." (Gawande 2002: 196). Or, if there is still a legal problem that has to be dealt with, it is better to emphasize the more trivial issues and avoid the serious ones in the report.

How high the rate of misdiagnosis is? "According to three studies done in 1998 and 1999, however, the figure is about 40 percent. A large review of autopsy studies concluded that in about a third of the misdiagnoses the patients would have been expected to live if proper treatment had been administered." (Gawande 2002: 197). This research sounds like astonishing, it seems as though there is some deviation from medical profession that we once recognized. What kind of remarkable message does it try convey, besides representing the imperfectness of medical practice? And, why do we have to believe in doctors?

In eastern countries, doctors have a very high social and economy status. Especially in the hospital, doctors definitely have more authority in ordering treatment. But, look further into the study, it shows that, in fact, doctors possess only the power, not the right. Because of having certain rights, it should be compulsory that there is someone else who is liable and responsible to doctors. But, obviously, besides following medical contract and obeying medical orders, patients need not to be responsible to doctors. So, where does the power of doctors come from? First, the faith and trust patients have on doctors' professional knowledge, which they believe can cure their diseases. Secondly, patients believe that doctors utilize their power only for the sake of the patients, but not for their own benefits. In fact, both of them are built upon trust. This also reveals the close relationship between medical practice and ethics. However, the phenomena that often appears is, medical professionals unwilling to accept the heavy ethical burden, and think that they just have the responsibility of curing diseases. Thus, once the effect of a medical treatment is unclear, even worse is when a bad consequence emerges, the source of power possessed by doctors would be cut off by patients immediately. So, a weird phenomenon appeared among doctors who only have power but no right. Also, their power was basically drawn from the imperfectness of medicine. This internal intertwinement is the origin of many medical disputes. "Overall, illness is an accident. Normal life is just everything for hope. But, if the disease unable to be cured, then how could we bear after all? As what we said, there is a flaw existed in the theory of modern medical systems. It means that, if till the moment it has no effective at all, then what shall we do?" (Tsai 2004: 31-32).

Hence, medical professionals, faced with the suffocating il y a in a clinical situation, have extreme desires to get rid of the heavy ethical burden. But, discarding the burden this way also empties the foundation of power of medical practice. If there is no outlet from ethics, medical professionals will become lonelier. Overloaded works have deprived their opportunity of introspection and the chance to rearrange their experience. The only thing left will be a blank space with heavy silence. Those medical professionals lack of expression and signification. But, facing with patient as a helpless other, how could a medical professional reply his responsibility? And how could he face himself? "It is because subjectivity is sensibility - an exposure to others, a vulnerability and a responsibility in the proximity of the others, the-one-for-the-other, that is, signification." (Levinas 1998:77). The confusion between the intention and fulfillment will produce suffocating burden to medical professionals, without any word or expression; are we supposed to express such suffocation and to release the burden of ethics by writing?

III. What is the significance of clinical ethics case writing workshop?

The purpose of clinical ethics case writing workshop is very simple, that is to hopefully pull medical professionals out of the isolated world and the world of monologue, to let them breathe by releasing the suffocating burden, and rearrange the relationship between intention and fulfillment. The progress is separated in detail into three steps: 1. Narrator has to recall the most impressive thing in the clinical situation and write it as a title with a short sentence. The aim is to draw the subjectivity back into the writing territory.[4] 2. Add some elements of dialogue in the ethical case writing, so that the concretion of experience, individuality of subject and exteriority of the others will become more prominence.[5] 3. The significance of writing is to express the common wound between the intersubjectivity.

Let's take a look at the way of writing of ethical case generally used as teaching or discussing materials in hospital:

> Madam Y, 32-year-old, suffered from late-stage gastric cancer causing severe pain continuously and vomited non-stop. Although her dose of morphine has been increased gradually by the doctor, her pain condition is still becoming more severe since two days ago. Though death is getting near, she still hasn't given up in pleading to medical professionals to help her end up her sorrow.

The majority of the way of writing used in hospitals to document ethical problems is objectivity, which includes the patient's condition, the treatment that could be taken and the possible consequences. Commonly, it is being used in teaching or in the discussion of morning meeting as well. But, this way of writing could not solve the predicament brought on by the ethics mentioned above. Meanwhile, in the hospital system, medical professionals are hardly able to add

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4 This concrete step is mainly due to the contribution from MD. Chao-Tang Hsieh and Yi-lin Hsieh.

5 This step is then due to the contribution from MD. Shou-chih Tang and MD. Mei-chun Shen.

their own real innermost feeling in their case writing. This is because it will be regarded as descriptions of subjective mood, which is useless in making objective decision of medical behavior. From the perspective of management, perhaps this objective and formal ethical case writing is good and necessary. But, from the perspective of ethics, it could only let the real meaning of ethics vanish without a trace.

In fact, there are obvious distinctions between clinical writing and the expression of subjective mood. This extreme distinction depends on the usage of phenomenological reduction and the progression of phenomenological description. Phenomenological reduction will decrease the validity of ethics, laws, and customs, which are flooded with consciousness, reversing the situation, back into the original ethical situation, where it can be described by phenomenology. The valid description of a clinical situation is via a progressive narrative, which is the best way[6] of responding directly to complicated ethical encounters. Some advices will be given to members - the purpose of clinical case writing is not about decision-making, but for the expression of ethics, also emphasizing that they are not part of the hospital or clinical ethics committee, so their excessive worries and the pressure of disclosure are unnecessary.

Narrative is just like positioning himself in the clinical situation as well. It is impossible to position himself outside of the situation. Many informal clinical ethical cases and documentaries have recorded similar questions: When a patient suffered from diseases, he/she would be trapped in confusion, asking himself/herself "why me?". Did I do something wrong? It is the same question asked if doctors or nurses confronted troublesome cases: why me? Thus, the involvement is unavoidable as long as one is positioned in a clinical situation. In the meantime, this involvement does not look at what has happened to an independent psychological entity from the perspective of another independent psychological entity. In fact, everyone would have experienced an impressive and profound contingency during clinical situations. Why the patient is him but not me? Things that had happened to him could possibly happen on me as well, aren't they? When confronting death and other extreme problems, the common life experience among people will become more prominent.

Therefore, the significance of writing is, to express the individual involvement in clinical ethical situations, to clear up the ethical relationship which has been lost, and to write out one's anger. As mentioned by members in the case before, under formal oppression, summon of others will eventually become the sensibility of loss: the real intention could not be fulfilled, but the false intention has gained false fulfillment. Finally, writing is just like what Pamuk[7]said, a way to express our secret wounds:

6 According to one research, when medical students first come into their clerkship, they will put their experiencein order with narrative. That is, they will use narrative to explain their medical knowledge. But they find that they can't use this way to communicate their experience with other health professionals in order to make clinical decision. They will give narrative up and use more and more objective description.(J. Good 2000:50-69)。

7 Pamuk: My father's Suitcase:2006. We have studied this article during the workshop together.

> "For me, to be a writer is to acknowledge the secret wounds that we carry inside us, the wounds so secret that we ourselves are barely aware of them, and to patiently explore them, know them, illuminate them, to own these pains and wounds, and to make them a conscious part of our spirits and our writing."
> "if he uses his secret wounds as his starting point, he is, whether he knows it or not, putting a great faith in humanity. My confidence comes from the belief that all human beings resemble each other, that others carry wounds like mine – that they will therefore understand."(Pamuk 2006)

IV. Conclusion: The Burden is not Death, but il y a

The observation and introspection of this article are part of the results of the 2-year research, and the clinical case writing workshop held last month. At present, there are many phenomenological studies on medicine and clinical ethics, as well as its practical usage. In medicine and medical treatments, the focus of phenomenological studies are the human body, patients' real life experiences, illness, health, and other observation and discussion on various phenomena. To know more about this area of study, Toombs' and other famous works, for instance, Handbook of Phenomenology and Medicine, are highly recommended. Richard Zaner and Mark J. Bliton are authoritative figures in the field of clinical ethics. Both of them work as phenomenologist in hospitals, as well as clinical ethicist. This article aims to analyze the living world of clinicians and the real situation they face from another perspective. In particular, it aims to analyze the fulfillment or frustration of intentions of every clinician involved in this study. The analysis reveals that, contrary to the beliefs of the general public, the worst disappointment or sorrow that medical professionals involving in clinical practice experience is not death or failure, but the experience of il y a, the impossibility of "nothing-more-can-be-done" and the complex feeling of loneliness. Because the authors of this article are involved in teaching medical humanities and ethics in the medical university, we believe that the focus of clinical ethics education taught to medical students should not merely be the application of normative ethics and its principles or theories; it also should not focus on decision-making in the analysis of case studies. Rather, the focus should be to have an in-depth apprehension of the actual situation faced by medical professionals, to discard the predetermined and rigid way of thinking, to make them understand the concepts and jargon of ethics, to express the isolation experienced in clinical situation via writing, and furthermore finding an escape route under hard ethical dilemmas. We believe that only by perceiving ethics as a solution or an exit pathway, the cycle of psychological seclusion can be broken down. If not, the disappointment of "nothing-more-can-be-done" will only force medical professionals deeper and deeper into their own guarded world. Perhaps, they may even lose their original enthusiasm to practice medicine and help people. If this is the case, it will go against the general public's high regards of doctors.

So, let us quote one paragraph from Levinas as our ending:

"Death threatens me from beyond. This unknown that frightens, the silence of the infinite spaces that terrify, comes from the other, and this alterity, precisely as absolute, strikes me in an evil design or in a judgment of justice. The solitude of death does not make the Other vanish, but remains in a consciousness of hostility, and consequently still renders possible an appeal to the Other, to his friendship and his medication. The doctor is an a priori principle of human mortality. Death approaches in the fear of someone, and hopes in someone." (Levinas 1969: 234)

Reference:

Ding-zhu

2004 *Modern medical epigrams*. Taipei: Ju-Jing Co. of Cultural Establishments.

Gawande, A.

2002 *Complications: A Surgeon's Notes on an Imperfect Science*. New York: Metropolitan Books.

Good, B. J. and Good, M-J. DelV.

2000 *"Fiction" and "Historicity" in Doctors' Stories: Social and Narrative Dimensionos of Learning Medicine*. In *Narrative and the Cultural Construction of Illness and Healing*. Edited by Cheryl Mattingly and Linda C. Garro. California: University of California Press.

Husserl, E.

1984 *Logische Untersuchungen*. Zweiter Band: *Untersuchungen zur Phänomenologie und Theorie der Erkenntnis*. Erster Teil. Hrsg. von U. Panzer. Dordrecht/Boston/London.

1993 *Die Krisis der europäischen Wissenschaften und die transzendentale Phänomenologie. Ergänzungsband*: Text aus dem Nachlaß 1934-1937. Hrsg. von R. N. Smid. Dordrecht/Boston/London.

Levinas, E.

1969 *Totality and Infinity: An Essay on Exiteriority.* Trans. by A. Lingis. Pittsburgh: Duquesne University Press.

1982 *Ethics and Infinity.* Trans. by R. A. Cohen. Pittsburgh: Duquesne University Press.

1987 *Time and the Other.* Trans. by R. A. Cohen. Pittsburgh: Duquesne University Press.

1993 *Totalität und Unendlichkeit.* Trans. by W. N. Krewani. Freiburg/München: Verlag Karl Alber.

1996 *Basic Philosophical Writings*. Bloomington and Indianapolis: Indiana University Press.

1998 *Otherwise than Being or Beyond Essence.* Trans. by A. Lingis. Pittsburgh: Duquesne University Press.

Mattingly, C. and Garro, L. C.

2000 *Narrative and the Cultural Construction of Illness and Healing*. Edited by Cheryl Mattingly and Linda C. Garro. California: University of California Press.

Montgomery, K.

2006 *How Doctors Think: Clinical Judgment and the Practice of Medicine*. New York: Oxford University Press.

Pamuk, O.

2006 *My father's Suitcase* in http://nobelprize.org/nobel_prizes/literature/laureates/2006/pamuk-lecture_en.html

Tasi, C-Y.

2004 Introduction in Chinese edition of Conversations on the Edge-Narratives of Ethics and Illness. Taipei, PsyGarden Publishing Company.

Toombs, S. K.

2001 Handbook of Phenomenology and Medicine. New York: Dordrecht : Kluwer Academic Publisher.

Zaner, R.

1993 *Troubled Voices: Stories of Ethics and Illiness*, Berkeley: Pilgrim Press.

2004 *Conversations on the Edge-Narratives of Ethics and Illness.* Washingon, D.C. Georgetown University Press.