

The radical accuracy of the subjective viewpoint

'It is a truth, universally acknowledged ...' that a statement such as this will immediately provoke a furious antithesis, and I suspect this reaction is entirely what Miss Austen planned.¹ There is but little truth in statements that begin 'there is ...' For all the apparent objectivity, confidence, and observer free nature of such statements, they actually conceal as much as they reveal. They have hidden assumptions within them, usually drawn from what Merleau-Ponty calls 'the perceptual faith.'^{2,3}

In this essay I want to show why there is but little truth in much that passes for 'objective, neutral, observer free, bias free, evidence based', descriptions of reality.

These issues matter to me partly as I have a general concern for truth, and more specifically, because, in my role as a doctor, I am constantly encouraged to develop, and use, medical knowledge which is neutral, unbiased and objective, and to avoid personal involvement and opinion. To the extent that this direction is in favour of avoiding prejudice, and avoiding holding opinions based on flimsy epistemology, it is useful.

However, the delusion of medical objectivity is currently unbalanced and this paradigm has great difficulty in either accommodating the personal (all too subjective), experiences of illness brought to doctors by patients, or my own personal thought processes (just as subjective, no matter how well informed), about what the patients tell me and what I observe about the patients. In short, the meeting of doctor and patient can be seen as the intersection point of two separate individual subjectivities.

Medical science treats subjectivity as if it is dangerous ground: messy, complex, and difficult to describe. It therefore devalues the information gained from subjective sources, (qualitative) and overvalues the apparent precision and objectivity of measurements and numbers, (quantitative,

'gold standard' evidence of randomised controlled trials).

Yet, in my subjectivity is where I live my life and in their subjectivity is where my patients live theirs, and in your subjectivity is where you live yours. If we cannot be comfortable with, and in, our subjectivity we have a problem.

Our engagement with the world is subjective. We are objects within a world of objects. As humans we have the property of consciousness which is our awareness of the fact that we are aware. It emerges from our ability as Locke puts it, 'to reflect on our reflections.' As sentient objects we have relationships internally to our own self and externally to objects in the outside world. These relationships are mediated by sensation, and reflected upon as metaphor. Even our sense organs are metaphorical in that they take one physical phenomenon such as pressure, and transform this into another as a series of nerve impulses. We never know anything as it is, we only know it as it is presented to us by our sense organs.

Appreciating this leads us to realise that our contact with reality is indirect, via subjective representations, rather than direct knowledge. I can know that there is a rock, I cannot know what it is like to be a rock, although I can know all sorts of things about the rock. Similarly, with my knowledge of people I know that there are other people. I cannot know the world from their viewpoint directly, although I can infer their viewpoint from how they relate to our mutual world. To the extent that I can understand another's representations of reality is the extent to which I can understand them as a person.

The check on our subjective representations of reality is the extent to which they correspond with reality. There is only one universe and we all live within it. There are not multiple realities, only multiple views on one reality. This process of checking against reality is not

democratic. For example, Galileo was both subjectively and objectively right about the moons of Jupiter, even when most others had never seen them.

On this ontology the question 'why is there something rather than nothing?' does not arise. We start from what Merleau-Ponty calls the 'facticity' of our existence, and move on to work out what the consequences are of this fact. We are not positivists trying to make statements about the world from a detached viewpoint. We are engaged participants exploring our world, making descriptions of how the world appears to us, not about how it is. We cannot deny our engagement with the world. We need to understand the rules of our engagement with the world.

Representations can be considered to be like maps. As Korzybski⁴ said, 'A map is not the territory it represents, but, if correct, it has a similar structure to the territory, which accounts for its usefulness.' The negation is important, as it introduces distance between an object and our representations of it. Remember that there are several different maps of the UK according to what we want to show. So the map I use for hill walking is different from the geological map, which is different from the one local government use for planning. These maps all cover the same territory, but they look very different as they each highlight some aspects, and downplay others.

When we are dealing with a patient we are dealing with their maps, their representations, of reality, which, like all maps will be partially accurate and partially inaccurate. We use our medical knowledge to help them see the territory more clearly and with the help of the useful extra details we can bring to help from the medical map of their particular problem. The patients need to plunder the useful bits of the medical map. This view of the blending of the patient's map and the medical map is far more balanced than binary formulations

COGS IN A MACHINE

Once upon a time we were staff, then we became personnel. Latterly we have been human resources, an expression completely lacking in humanity. The NHS has trouble with HR directors, in the sense that they don't seem to stay long. A little while ago, there wasn't a permanent HR director in any of our local Trusts. Things are better now, although ours has become 'Director of Organisation, People and Performance'. Our whole Trust is an organisation, so what does this mean? Is he organising just the people, or the whole Organisation? Should we read something sinister into his direction of performance? Why has the job title changed from Director of Personnel, which, like 'dustman', is a self-evident description of the job, to Director of Organisation, People and Performance, which, like sanitation collection operative, is recognised by everybody as just being a dustman?

Our Trust is anxious to become a Foundation Trust, and is planning a super new PFI hospital. There are great things ahead (we are told). I hope this is true, though not because I want a better place to work, because I shall be long retired before it opens its doors to patients. This enthusiasm, which I cannot fault, has spawned a flurry of e-mail cascading down from the Press Office about our future, and which features heavily the Trust's 'Big Five' objectives. Four of these are to improve patient safety, to aim for no waits for treatment, to make progress towards our new hospital, and to achieve Foundation status.

No contention there, and who could argue with the remaining objective: to become a great place to work? Eager to learn more, I read further, to the list detailing how this would happen. The first item read, 'Organisation Development and Workforce Strategy developed, incorporating core values and key workforce metrics'. I do not understand what this means. It is not obvious to me how this will make the Trust a great place to work in the way that, say, having excellent crèche facilities would do, and in a way that every member of staff would understand. Reading further, staff contribution will be maximised by 'learning-needs analysis mapped based upon individual, team, job and organisational needs for the future'. If this means more than, 'We will tell you what you are going to do', I'd like to know how.

My polite request for some explanation of how all this will be so good for us was eventually acknowledged and passed on to our Director of Organisation, People and Performance, who so far has not replied.

such as 'powerless, information poor patients' and 'powerful, information rich doctors.'

Of course, doctors are information rich in our sphere of practice. It is what we have spent our lives learning and practising, not for our own benefit, but to the greater end of putting our knowledge to the service of patients. If we were not information rich we would be without use. The patient may as well consult their plumber or hairdresser. The great joy of sharing information freely is that both parties to the transaction end up richer, and neither can be poorer as a result of the sharing. Ironically, it is also more respectful than pure patient centeredness, as it acknowledges the agency of both participants in the consultation.

The world is primary, and as part of it, and made of the same stuff as it, so are we. Our relationship to the world is a second order issue and our representations of this relationship (thoughts/feelings/ perceptions/ decisions/actions) are beyond this. Words are tools we use to describe these relationships but they have no meaning except insofar as they relate us, and others, to the world we experience. Words are representations of meaning, not meaning itself.

And so we arrive. The map is not the territory. We cannot have the map or the territory, we must necessarily have both together, and be aware of the relationship between them. We must not take the one for the other, for that way insanity and confusion lie. We all have our maps and they all have some accuracy and some inaccuracy. The criterion for truth is correspondence and correlation between the map and the world, and this restores great objectivity to our subjectivity. There is more accuracy to our subjective impressions of the world than we realise.

And delusions are still delusions, as the map-territory correspondence is recognised as being broken in delusions.

My conclusion is that there can be much accuracy and much inaccuracy in both subjective and objective viewpoints. The ultimate reality test is correspondence with the world. To the extent that our views match the reality we, and others, encounter, they are accurate and to the extent they mismatch, they are inaccurate.

But there is more accuracy, and more valid, if not readily verifiable, information, in subjective viewpoints than modern science cares to admit. To return to Jane Austen, 'a single man in possession of a good fortune, must be in want of a wife.' Objectivity and subjectivity are married together in our search for knowledge of the world, and try as we might, what God has joined we should not struggle to put asunder.

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