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Understanding Symptoms: diagnosis, cure, and bodily re-integration

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Abstract: What is lost, if we don't have a diagnosis? This article examines the aims of clinical medicine, and the role of *understanding* in this. Starting from a case prompt with a patient suffering from persistent physical symptoms, I argue that understanding is at the clinical core, and that the target of such understanding is the patient body with symptoms. Synthesising accounts of medical understanding and phenomenology of illness, I suggest that the understanding sought in the clinic extends beyond mechanistic explanation to include a sense of bodily intelligibility, and that diagnoses are useful but not necessary tools to this end.

1. Introduction: Understanding clinical medicine

Diagnosing is a central feature of clinical medical practice. This article explores the aims and characteristics of clinical medicine by asking what is lost when diagnosis is absent, and in turn what this tells us about clinical medical understanding. We start from a puzzle: If effective treatment has been identified and made available without a diagnosis, why would patients still ask for one? If clinical medicine aims at cure and this is attainable without a diagnosis, it seems that nothing should be lost in its absence. Yet, patient requests for a diagnosis and disappointment in its absence indicate that there is more to be said.

When patients express disappointment with the lack of a diagnosis, even if already in effective treatment, this reflects, I suggest, a failure to meet the expectations we hold for a successful clinical encounter and thus reveals something significant about what medicine is (meant to be). I will argue that this failure to meet expectations relates to an unfulfilled epistemic expectation of *understanding* (section 3) and *bodily intelligibility* (section 4). More specifically, I will argue that beyond explanatory, mechanistic understanding – helping us to predict or intervene on patient ailments – successful clinical medicine also requires (re-

)gained bodily understanding and re-integration. When diagnosis is absent, patients can be left with a sense that their bodies are alien and unrecognisable, and by extension that they no longer inhabit the world in a proper sense. Addressing this, is a central task of clinical medicine. I end by noting that diagnosis can be an important and efficient tool for making patient bodies (re-)appear as intelligible, though it is neither necessary nor sufficient in this endeavour.

The article progresses by way of synthesis. It starts from an empirical qualitative case-prompt and then integrates insights from analytic philosophy of medicine and phenomenology of illness. This approach reorients discussions of medical understanding away from theories of disease and towards patient bodies by emphasising the importance of symptoms as both biological and existential. Doing so, I do not suggest that existing literature on understanding in medicine is faulty, but that it is too narrowly focused to capture the full scope and potential of clinical medical practice.

2. ‘But… what’s wrong with me?’ – a case prompt

In January 2022, I was working as an assistant on a research project developing a clinically assisted internet-based self-help programme for patients with persistent physical symptoms[1] in general practice (the project was called *eASY – eHealth and Assisted programme for persistent Symptoms*[2]). The programme provides patients with a range of behavioural management tools directed at sleep, stress, exercise, and diet as well as information videos about systemic, medical theories of body-stress-symptom response. It was designed to provide better support for individual patients in a modern healthcare system, where face-to-face time is costly. Access to the programme is provided through a general practitioner (GP) after they have evaluated the patient. The patient then has 6 weeks of engagement, before the

[1] Persistent physical symptoms (PPS) are defined as ‘distressing somatic complaints that last several months or more’, regardless of whether or not we know the triggering or the underlying cause (Löwe et al. 2024). They are typically unresolvable by standard biomechanistic intervention, either because the cause/mechanism is unknown, because we do not have an intervention for the cause/mechanism, because the intervention will take a long time, or for some other reason. While they count, in principle, such things as long-lasting side-effects from cancer surgery or symptoms from autoimmune diseases, the term is usually invoked for symptoms that fall outside of other medical boxes. While PPS captures a certain group of patients it is not typically thought of as a diagnosis, exactly because causes can be disparate, and symptoms vary greatly.

[2] For more information see https://mine-symptomer.dk/My_Symptoms .

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patient and the GP meet for a face-to-face follow-up session.[3] I was involved during the development of the proto-type programme, and my task was to conduct interviews with patients and GPs about the practical functionality of the interface – evaluating technical features and usability to improve day-to-day integration between the programme, patients, and clinicians. However, in an interview with a GP, what was meant to be about practical issues and technical tweaks turned into a conversation on philosophical issues of disease management, diagnosis, patient frustration, and doctor time. This conversation, and the case which triggered it, became the starting point for the article.[4]

The patient, which the GP had prescribed the programme for, was a young woman – let us call her Emily – suffering, through many years from severe exhaustion, fatigue, and head- and body-aches. Prior to being enrolled in the prototype study, Emily had gone through several diagnostic attempts, but with no clear answers. After the 6-week engagement with the programme, the GP had a follow-up consultation with Emily, during which – the GP told me – Emily reported a reduction in symptoms and a better balance between illness and lifestyle. Both doctor and patient were happy and satisfied with the process. However, said the GP, when the 20-minute consultation was almost up, Emily said, 'But ... what's wrong with me?'. This was followed by an additional 20 minutes of a now more complicated conversation – while time was taken from other patients – about a variety of diagnoses, explanations of illness and illness identities.[5] The conversation revolved around diagnostic labels such as fibromyalgia, bodily distress syndrome (BDS), moderate functional disorder, chronic pain condition, and other related symptom diagnoses, but the GP would not identify one of these as 'the diagnosis'. The GP explained – to me, as she had to Emily – that it would not make a difference to the approach and process of treatment, and that committing to one or the other of these terms would come with various controversies and uncertain frameworks. After this extended explanation of various available diagnoses, how they fit and diverge from Emily's case, and the reasoning for the lack of diagnostic outcome, Emily seemed satisfied; the GP, however, was frustrated by the time-consuming character of this exercise.

[3] Later this was changed to 8 weeks, as will be visible in published materials on the project. The difference is not significant for the case as used here.

[4] A version of this case study previously appeared in an opinion piece (Scott-Fordsmand 2022).

[5] Readers may want to note that the typical consultation time in general practice in Denmark, where the study took place, is 10-15 minutes, and that 20 minutes added to the initial 20 minutes is a significant 'expense' in the medical resource use.

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Retelling this story to practicing clinicians, nodding usually spreads in the room – the patient request for a diagnosis is well-known. So much so, that a chapter in Jutel's sociology of diagnosis is indeed called 'What's wrong with me?' (Jutel 2011). On Jutel's account, what is at stake in this request, is the question of legitimacy: a diagnosis turns (patient) illness experience into a legitimate (scientific) medical disease (Jutel 2011, 63). Jutel also highlights how the explicit request for a diagnosis can be a political act, resisting medical authority, especially in cases of medically unexplained symptoms (Jutel 2011, 94). Other accounts add to this that requests for diagnostic categories may arise from medically 'external' roles that diagnoses play, such as excusing one from responsibilities, triggering access to benefits, etc. (e.g., Maung 2019) – for example, needing a diagnosis to receive sick-day compensation. Recognising that all of these factors may be important forces in the dynamics of clinical diagnosis, they do not seem to be the motivation in Emily's case: the GP already recognises Emily's symptoms as severe and worthy of medical attention and treatment, Emily expresses no disagreement with the GP's judgement, and relevant structures of exemptions and benefits are already in place. Rather, what Emily expresses is an *epistemic* request – a request for medical insight.

3. Understanding and curing disease

What is troubling in Emily's case, is that while we seem to have enough of a grasp on her ailments to bring about improvement, there is no available disease category. And so, it seems on one hand that the 40 minutes conversation was a waste of clinical resources. On the other hand, the latter 20 minutes seem to have provided something of importance, addressing, at least to some degree, her ask. And while the clinician may have found the time-use frustrating, a better sense of what difference these 20 minutes made may help reduce the timespan or, if not, at least provide a sense that it is time well spent. To understand this, we need a better grasp on what and why Emily is asking what is wrong. This is what I will try to offer.

3.1 Diagnosis as a step towards cure?

The usual story about diagnosis goes that we need to identify and understand the problem in order to fix it, hence the view that diagnosis is a step towards cure: an assertion that forms the basis for an informed clinical decision about interventions and treatment options. If we fail to obtain a diagnosis, this is an issue because it will make the following steps – solving the problem – less clear or even potentially misguided. This does not mean that diagnosis is a simple or even a static matter, there can be an iterative relation between treatment attempts and diagnosis. However, it does mean that if we could (reliably) decide on the appropriate intervention without a diagnosis, diagnosing would become superfluous. In this conception,

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diagnosis is 'subservient to the overarching [medical] goal of cure' (Broadbent 2019a, 43). Broadbent argues that this view is broadly assumed in philosophy of medicine, and calls it the *curative thesis* (Broadbent 2019a, 40). As indicated above, we may of course have 'external' reasons to care about diagnosis even if we could cure without it, but if we take Emily's request as 'internal' to medicine, the case provides a challenge to the curative thesis, and in fact prompts support for Broadbent's alternative *inquiry thesis*. That is, as it stands, Emily's case indicates that even when cure is there, understanding, in the form of naming, may still be expected. Emily is not exactly cured, of course, but there are signs of effective intervention and improvement without the diagnosis, and so, an account that sees medical practice as only oriented towards cure – or 'reasonably effective intervention', as Broadbent puts it (Broadbent 2019a, 39) – will struggle to make sense of her request.

It is worth noting that the curative thesis can be upheld if Emily's request is seen as a request for extra-medical purposes, motivated by the question of legitimacy or resource allocation, and that this is often how cases like Emily's are discussed (as we saw with Jutel). Such 'external' roles are of course by no means less valid or valuable; it is a crucial, burdensome, and highly complex activity to navigate the power dynamics of medical structures and societal resource distribution. And debates about their significance in medical practice are important. While important, however, we cannot expect medical professionals to be particularly skilled on 'external' matters.[6] Conversely, it is exactly on 'internal' roles of diagnosis that patients can reasonably expect the clinician to be an expert. Emily's frustration and expectation to have her question answered indicates that her request operates within the medical sphere: she is asking for medical expertise rather than challenging it.

Broadbent's *inquiry thesis* says that while the ultimate goal of medicine may be cure, the 'business' of medicine – what it does – is 'understanding and predicting' (Broadbent 2019a, 62). Broadbent then has a story about how these relate, but for the purposes of this article, I focus on understanding. The claim is motivated by the observation that a successful clinical encounter does not require cure, but it does require demonstrable understanding, or as Broadbent writes: 'patients hope for a cure, but they expect a diagnosis; and a doctor who

[6] They may be, of course. More than once have I observed clinicians discuss the insurance consequences of formulating a diagnosis one way or the other, and very often different partitions of the medical professionals will themselves get involved in the politics of, for example, medically unexplained symptoms. But to some extent, we take these structures to be a shared societal responsibility – and possibly a responsibility where you may need other experts, like philosophers, sociologists or economists to part-take – rather than the domain for expert doctors.

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cannot cure them will not necessarily be regarded as incompetent, if she can explain to the patient why cure is impossible' (Broadbent 2019b, 106).[7]

So, Emily may be asking the doctor to demonstrate understanding, but how would a diagnosis do the trick? And how might a 20-minute conversation also to some degree satisfy her expectation? While the *inquiry thesis* gets us some way in making sense of Emily's case, we still need to specify what kind of understanding we expect in a clinical encounter and what role diagnosis plays in this.

3.2 Understanding disease?

In a recent article on 'Understanding in Medicine' Varga argues that clinical medicine requires two kinds of understanding that are combined into 'clinical understanding', namely biomedical understanding and personal understanding (Varga 2023). One secures the clinician's understanding of disease, the other the clinician's ability to apply this appropriately to individual patients. In this sub-section, I focus on his account of understanding disease.

Biomedical understanding, Varga argues, is an *objectual understanding* of disease(s). By this, he means to say that biomedicine aims at grasping medical conditions 'in a reasonable level of detail' such that we understand not just why symptoms occur but also 'why intervening on one variable makes a difference to the value of the other' (Varga 2023, 3038). The goal of medical inquiry is thus more demanding than single-event causal explanation, it requires that we understand the phenomenon (the disease) in a systematic and integrated way (Varga 2023, 3029), providing a coherence-making theory which makes 'symptoms now stand out as a coherent whole'(Varga 2023, 3036). Varga includes elements that are not strictly explanatory – such as classification and diagnosis[8] – in this kind of understanding (Varga 2023, 3030); however the central player for Varga remains a form of holistic mechanistic explanation (Varga 2023, 3038). In other words, the target of biomedical understanding is the disease, and the understanding of this disease is constituted by a grasp of the mechanism which explain the phenomenon *as a whole*. In this context, the diagnostic moment is part of objectual

[7] Broadbent is neither alone nor the first in observing that explanation is important in (clinical) medicine. See for example Carlton Ernstene arguing that explaining to the patient is a professional obligation (Ernstene 1957) or Kirmayer and colleagues on how providing explanations is an important tool for maintaining medical legitimacy (Kirmayer et al. 2004, 664).

[8] See also (Gijsbers 2013) arguing that unification provides its own from of understanding.

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understanding – although not explanatory – in so far as it enables us to identify the whole, that is, the disease or the phenomenon and its relevant factors.[9]

While it is not clear what Broadbent's position on understanding is,[10] Varga's characterisation of biomedical understanding works well for at least some of Broadbent's claims. Broadbent characterises medicine under the inquiry thesis as 'an inquiry into the nature and causes of health and disease, for the purpose of cure and prevention' (Broadbent 2019a, 64) – highlighting disease as the target of understanding. Like Varga, Broadbent emphasises explanation – sometimes literally using the term as interchangeable with understanding (see for example Broadbent 2019a, 64 where 'understanding' has been swapped with 'explanation' in the 'explanations and predictions' pair) – but also prediction (Broadbent 2019a, 65).[11]

While the biomedical-mechanistic inquiry characterisation of medicine may be accurate for medicine as a broader discipline, or as a large-scale scientific enterprise that works from bench to bedside towards abstracted knowledge production, it seems less plausible that this is the right way to characterise inquiry in clinical medicine. Clinicians usually do not send patients for an x-ray in order to learn something about bone fractures as a phenomenon or ask patients about their family history to learn about the mechanisms of hereditary breast cancer. They inquire in order to gain understanding of the individual patient body, and to advise on the appropriate means of intervention or predict likely outcomes *for you*. The target of understanding in *clinical* medicine, thus is not disease entities, but patient bodies.[12] And

[9] It is worth noting that Varga explicitly stays neutral on whether or not objectual understanding of disease can ultimately be reduced to explanatory understanding (Varga 2023, 3030), arguing that even if that is the case, emphasising objectual understanding in medicine is useful, because it helps us see more clearly what the target of understanding is.

[10] Hints are scattered throughout his work, sometimes indicating an explanatory view, sometimes a practical view, sometimes an objectual view. I will not try to work out the exact notion operating behind the scenes – if there is one. As you will see in the next footnote, there are tensions, at least on the surface level.

[11] There are places where Broadbent does not seem to hold an explanatory view of understanding. He argues, for example, that cure is only cure if it is based in understanding rather than luck (Broadbent 2019a, 71). If we were to hold an explanatory view of understanding, this would exclude quite a range of the interventions we have, where we are not sure why they work but still know how and when to apply them effectively. Presumably Broadbent would not want to claim that in such cases we are not curing patients.

[12] As put my Malterud and colleagues when discussing the importance of symptom understanding in the clinic: 'The GP's attention is directed toward the person with the disease rather than the disease itself' (Malterud et al. 2015, 421).

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while theoretical understanding of generalisable disease entities is undeniably a very useful resource in this endeavour, it is not the full story.

3.3 (not) targeting the patient

Both Broadbent and Varga recognise, of course, that it takes more than biomedical understanding to be a skilled clinician. Broadbent notes that successful medical practice requires (1) 'having (or having access to) a substantial body of medical knowledge' and (2) 'being able to apply it to the particular patient in question, to work out where in that large body of knowledge the particular case fits' (Broadbent 2019a, 69). And Varga emphasises that clinical understanding requires a combination of biomedical and personal understanding.

On Broadbent's account, the translation into the clinic seems subsumed under genuine medical understanding: understanding a disease includes being able to recognise it in patients and understanding what things to look for in patients to place them in different locations of the medical landscape. This is a rather standard view of patients as instancing particulars of a general disease, which tells us why diagnosis may, in Broadbent's eyes, both require and demonstrate of understanding. It aligns with Varga's point that objectual understanding also involves classificatory understanding, that is, the ability to identify the phenomenon in concert instances.

For Varga, on the other hand, *personal understanding* is something quite different from biomedical understanding. He highlights that without personal understanding clinical practitioners will not be able to grasp (a) the illness descriptions provided by the patient, (b) values and wishes expressed and necessary for respecting patient autonomy, and (c) the kinds of solutions that would help the patient in their particular life circumstances (Varga 2023, 3041). He is undecided as to whether personal understanding is a form of skill or practical understanding that the clinician should have – an ability to empathize and engage socially – or a special kind of second-person explanatory understanding that is gained in the course of the clinical encounter, but with a focus on (psychological) reasons rather than causes (Varga 2023, 3042).[13] The important point is: clinicians must employ an interpersonal understanding to get at the illness (i.e., the personal experience of the disease), and only then can they act in accordance with medical ethics, respecting patient wishes and enabling patient autonomy, and more pertinently for this article: only then can they draw appropriately on their objectual, mechanistic understanding of disease (Varga 2023, 3041).

[13] Perhaps hermeneutic/humanistic understanding is a relevant framework to consider here as well (see Grimm 2024).

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While there is more to be said on the role of empathy in clinical medicine – and much has already been said (see for example Svenaeus 2014; Whitehead and Woods 2016; Betzler 2018; Guidi and Traversa 2021, just to name a few) – its role for Varga is primarily one of ensuring that biomedical understanding can be 'adequately contextualized and supplemented' (Varga 2023, 3038). Varga is careful to state that personal understanding is indeed a *necessary* component of clinical understanding, but in an instrumental way. Reading Varga's account, one is left with the impression that personal understanding is an activity quite like that of experimental calibrations in the sciences – essential as a means of getting at and manipulating the target phenomenon in a responsible way, but not in itself of epistemic interest. In other words, personal understanding is not the core competence of medicine – its 'business' as it were. While clinicians must indeed be able understand the patients, the target of clinical medicine for Varga remains the disease.

This view addresses the previous observation that clinicians do not send patients for x-rays to learn about bone fractures, by framing the clinical medical encounter as a domain of application. Understanding is a matter of identifying the disease, of diagnosing. My grievance here, is that this necessitates a generalisable object – a disease – in order for medicine to do what it does. This leaves Emily, and other patients like her, out of reach for clinical medical understanding, because we do not yet have a holistic grasp of the mechanisms of her condition, or perhaps because her condition is not one that lends itself to mechanistic explanation (Eriksen et al. 2013). I want to argue for a conception of clinical medicine and clinical understanding, that helps us see how and why the GP can address the epistemic request that Emily posed, even if not with a diagnosis.

To sum up: understanding is central to medicine, doctors having, demonstrating, and gaining it. Philosophers of medicine characterise the target of this understanding as 'disease(s)', and argue that the understanding works through grasping holistic mechanisms – or sometimes, merely through causal explanation (Maung 2016). In the context of the clinic, Broadbent and Varga emphasise the ability to identify diseases in particular patients, and the ethical and communicative ability to understand patient values, perspectives, and explanations. While this seems mostly uncontroversial, such a characterisation of clinical medicine leaves a large group of patients outside of the scope of clinical understanding. In the following, I reframe the view on clinical understanding to encompass the existing accounts while providing a wider scope of possible successful clinical encounters.

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4. Understanding symptoms

Instead of the distinction Varga suggests between understanding the disease and understanding the person or illness, I think it is useful to see the clinical medical encounter as an inquiry into *symptoms*, that is bodily or mental phenomena that appear as signs or traces of pathology in the specific patient bodies. I use symptom here in a commonsense meaning, arising from the nineteenth century tradition (Aronowitz 2001, 803), and for the sake of this article I do not distinguish between symptoms and signs. Other scholars have captured a similar notion as something which 'warns against possible disease' (Eriksen and Risør 2014, 89), an 'indicator of bodily malfeasance' (Staiano-Ross 2012, 34), or as a prompt for meaning attribution (Malterud et al. 2015). This latter emphasis on meaning attribution will be important later, for now, the main gist of the term is that symptoms are seen broadly as expressions – subjectively experienced or observed by others – of some form of pathology.[14]

While biomedical and personal understanding may be powerful resources that help us understand symptoms – the same way that acquaintance and calibrations with established theory is in the experimental sciences – neither disease nor personal values are the target for the clinician. Taking clinical medicine as an endeavour to understand symptoms means the separation between biomedicine and patient becomes less clear. This helps us break with the stereotypical bifurcation of disease and illness, and of medicine proper as biomedical knowledge, and the rest as add-ons – 'art' or humanities. It also opens up a range of resources as legitimate tools of clinical understanding, in cases where we do not know the underlying mechanisms or cannot point to identifiable disease labels, thus providing a framework for us to better see how medicine may be a successful epistemic activity across a wider range of cases.

4.1 Symptoms as signs of underlying causes

The standard biomedical way to understand symptoms in medicine, is to see them as signs of underlying disease – or at least of some underlying cause. This conception follows the same sentiment as the biomedical view outlined above by Varga, where understanding symptoms reduces to a question of grasping causes or mechanisms, with the one difference that these mechanisms provide a coherent explanation of the patient's symptoms rather than

[14] I take it that this would also cover what is usually called silent diseases, such as hypertension. In that as soon as the test reveals hypertension, this measurement as a sign/symptom/expression has real effects for the patient and needs to be medically understood. This is, however, an argument for another article, if needed, I am happy to restrict my claims to conditions that are not silent.

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generalisable disease. From this perspective we might take it that when Emily is asking for a diagnosis, she is asking for her symptoms to be causally explained, assuming that a diagnosis would do the job. Maung argues a position along these lines.[15] In particular, he posits that diagnoses are explanatory because they provide a coherent causal explanation of 'the patient data' (Maung 2019, 509).

As already stated, however, we do not have such an explanation available for Emily and patients like her, neither in the strong sense which Varga may insist on, in terms of understanding the constitutive mechanisms of her condition as a whole, nor even in a thinner sense of understanding a single causal relation or even the initiating cause. Perhaps then, it is just the case that here, medicine cures but does not provide understanding. However, Maung argues that all is not lost, even if we cannot get the causal explanation. One kind of understanding[16] we might gain, he says, is negative casual explanation: we can exclude certain causes (Maung 2016, 19). This might be what Broadbent has in mind, when he states that the ability to explain why we cannot explain also counts as understanding. Another kind is probabilistic/disjunctive explanation: having some grasp on the notion that patients with x symptom have some asserted probability of y, even if we cannot explain the relation (Maung 2016, 22). And finally we can come to understand relations between symptoms, even if we do not know their underlying cause (Maung 2016, 22), for example that low mood may be a down-stream cause from fatigue, or the other way around – the direction of this relation can be tricky if we do not know the mechanism. That is to say, even if we cannot presently understand causes, we can understand something about symptoms in the patient that has to do with their biomedical manifestation. Note, that if the target of understanding is disease none of Maung's suggestions would hold.

[15] While Maung and Varga do not comment on each-other, it strikes me as if they may disagree on the reductive move of objectual understanding to causal explanatory understanding. Maung seems to think that the classificatory and diagnostic elements of medicine rely on causal explanation, whereas Varga, as already stated, finds value in staying with the objectual understanding. However, this is between Maung and Varga and should not affect my argument.

[16] Note that Maung does not use this term but instead talks about an alternative kind of explanation. In this article, I take some liberty in reading Maung, Varga and Broadbent as discussing similar things despite them using different vocabularies, and thus, I read Maung's alternative explanations as part of what the two others might take to be a kind of understanding.

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Here, I will need to add some further detail to the case prompt. Part of the intervention that Emily went through, with the online programme, in fact provides the kind of statistical-disjunctive understanding of patients with persistent physical symptoms that Maung discusses. In addition, Emily she already had a lot of prior negative causal understanding from her many diagnostic tests. And so, while Maung's observations are pertinent and useful in making sense of how clinical medicine can successfully provide understanding even if we do not know the mechanisms of a lot of the ailments, this does not seem to get us at what Emily is asking about.

It might be worth stating again that I agree that causal and mechanistic understanding of symptoms are central to medicine, and that even when we lack positive accounts, we may gain something from the attempt of deciphering the patient data in terms of its lack of match with known diseases, the statistical correlations we might expect, or the plausible surface level relations. But while the accounts I have highlighted so far *do* get a lot of things right, I think they narrow in too quickly on causal explanations[17] and thus miss out on broader existential aspects of medicine which are not merely of ethical or 'external' kind. Let me clarify in the next section.

4.2 Symptoms as bodily insults

In a parallel literature that has developed in the phenomenological tradition, philosophers have explored other dimensions of illness, disease, and the nature of symptoms. Here, there is deliberate opposition to the idea that symptoms from the body are mere bounded dysfunctions (e.g., Aho 2018). I highlight Havi Carel and S. Kay Toombs, both of whom live with serious disorders (lymphangioleiomyomatosis (LAM) and multiple sclerosis, respectively).

In their work, Carel and Toombs both describe the initial phases of their illness – the phase before they sought medical attention – as an experience of their body suddenly calling attention to itself, where previously it had been 'transparent'. For example, Carel describes how one day she was hiking up a mountain but was then suddenly overcome by a severe shortness of breath and fatigue that she had not previously experienced on similar hikes: 'The

[17] I suspect this is, in part, and echo of the theory-focus in philosophy of science, whereby the intuitive conception of science is that its aim is theories and explanatory frameworks. While this might be partially true, recent philosophy of science in practice have demonstrated that science looks different if we pay more attention to the activities that come before or exist alongside theorizing. Similarly, I suspect that philosophy of medicine may see other aspects of medical understanding if it sees the clinical encounter less as an occasion to apply abstracted medical theories or categories, and more as a place of concrete epistemic practices.

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first time I realized I couldn't do something, I felt surprised. It came as an insult, an affirmation of my limited existence' (Carel 2008, 1). As time went by, she experienced more and more of these 'insults' – which in medical terms might be called symptoms – from her body.

To unfold these experiences, Carel draws on Heidegger's analysis of tools. When tools break, they change character from being ready-to-hand, that is, ready for use and in themselves not something we notice, to being present-at-hand, that is, the object of our gaze and focus. Heidegger's own example of an object of use is the hammer (Heidegger 2007, paras 15 & 33). As long as the hammer works, we are absorbed in the world, in building – focusing on the nails rather than the hammer itself. If the hammer breaks, however, it becomes the focus of our attention as a useless object which now seems difficult for us to do anything with. Similarly, Carel writes: 'the [sick] body turns from being a ready-to-hand entity, poised to act and immersed in a world, to a present-at-hand that has lost its capacity for intentional action and is suspended from the world' (Carel 2016, 99; See also 2008; Toombs 1993).[18] This may seem consistent with a mechanistic view of medicine as dealing with physically 'broken' bodies. However, Heidegger's analysis differs from a classical mechanical understanding of the world in highlighting how the present-at-hand does not merely imply some physical breakdown and halt of current activities but invokes existential change. The breakdown radically changes the object for the experiencer – not only its physical form, but its meaning, in the sense that it loses it: The hammer that cannot hammer no longer is a hammer. And the physical leftovers of it take on an alien appearance. In the context of the body, Toombs writes: 'What is peculiar about bodily objectification in illness is that the apprehension of body-as-object is such that it renders the experience of 'uncanniness' explicit, often resulting in a profound sense of alienation from the body'(Toombs 1993, 75).

To this, both Carel and Toombs add the Merleau-Pontian point that human beings are embodied beings: we are first and foremost bodies, and our thinking and understanding of the world takes shape through our bodily interaction with it (Merleau-Ponty 2012). Bringing these points together, Carel writes: 'Whereas my malfunctioning car [or hammer] can be sold

[18] Perhaps the notion of the unreadiness-to-hand [unzuhandenheit] is more apt here, as the description of something which appears not merely as a neutral object to be given theoretical/conceptual meaning (present-at-hand) but as an object which somehow hinders the desired engagement with the world (by being broken – conspicuous, absent – obtrusive, or in the way – obstinacy) (Heidegger 2007, para. 16). However, the details of Heidegger are not essential, and I follow the established distinctions as set out by Carel and Toombs. I thank a participant at the *International Philosophy of Medicine Roundtable 2025* for this observation.

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and a new one bought, my body is me. This is an essential feature of our embodied existence that is brought out by illness' (Carel 2008, 27). While there is similarity between the defective tool and the dysfunctional body, there is also an essential difference: the body is hers and she is it. A symptom – the body's insults – then, is not just an expression of some underlying pathology which interrupts a specific activity. The breathlessness on the mountain does not just slow down Carel's walk; she is 'put before' both the mountain and her body as incomprehensible or meaningless objects. She is alienated, and her focus shifts from an engagement with the world to a distrustful monitoring of her own body. As Toombs puts it: 'As a malfunctioning physical entity the body is not only disclosed as hidden and alien presence in an overt and persistent manner but, additionally, in a manner which is necessarily perceived as threatening to the self' (Toombs 1993, 100).

4.3 Understanding bodily symptoms: regaining the world through bodily re-integration

If we take Carel and Toombs' descriptions seriously, the 'insults' that first appear as surprises and then perhaps become permanent features of patients' lives are not just practical challenges (such as not being able to walk up the mountain) or limited discomforts. They constitute a breach of trust and alienation from oneself, one's body and the world. This is not the case, of course, for every minor 'dysfunction'. Our lives as bodies are filled with small inconveniences that we accept as a kind of standard deviation. A single day when the knee creaks or the head is heavy might not trigger existential rupture. Some scholars draw a distinction here, between bodily *sensations* and *symptoms* in order to analyse more closely when and why some sensations take on a symptom-character (e.g., Eriksen and Risør 2014; Staiano-Ross 2012). Toombs writes: 'If the immediate experience of bodily disruption is sufficiently unusual, prolonged, uncomfortable, and so forth, then it must be explicitly attended to by the patient and reflected upon. Consequently, at this point the experience becomes one that must be given meaning' (Toombs 1993, 33). For the purpose of this article, the dynamics of this change are not important. Patients who seek out medical help in the clinic typically come because the sensations are of a severe or prolonged nature and have already taken on a symptom character, constituting the kind of obstacle Carel and Toombs discuss. Note that the quote from Toombs does not frame the symptom as a call for cure but as a call for meaning – for understanding. When symptoms, or insults, are persistent or of a particularly severe nature, they do not only invoke short-term loss of meaning that can be written off ('I wonder why my head hurts – oh, never mind, it's gone now'), but necessitate conscious and purposeful attempts at making sense: what is happening to me, what can I expect for the future? Can it happen again? Will my body continue to fail? It is usually at this

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point – that is, when bodily sensations become prompts for meaning attribution – that people seek medical attention, and they expect the clinical encounter to address this.

As noted, two things are lost with such symptom insults: The most obvious one is the practical ability to engage in the activity – hammering or building when the hammer breaks, inhabiting the world when the body does. But the second one, which brings about Carel's anxious bodily monitoring and Toombs desire for meaning, is the ability to see the now alienated object *as* meaningful, that is, as open to being understood. We might call them the practical and the existential bodily loss, respectively. Medicine can help with the first, in so far as it can repair the damages – cure – as well as provide means and guidance for how to live with the condition and advise on what to expect from its progression. That is, exactly as Broadbent highlights: even without cure, understanding is important to the business of the clinic because it allows the clinician – along with a host of other medical professionals (physio- and occupational therapists, dietitians, nurses, etc.) – to support the patient in regaining their ability to inhabit the world. That is, returning to the example of the hammer: even if we cannot fix the hammer, we may be able to advise on how to go about building with a broken hammer or how to adjust the building project to one that is doable without it. However, this first practical ability cannot be regained, without the latter existential loss addressed.

Carel and Toombs both suffer from identifiable diseases, which will however not go away, and so, when they receive their diagnosis, and their bodily symptoms can take shape as meaningful patterns, they focus on symptom management and re-adjustment. In Emily's case, there is a promise of efficient intervention. However, while this intervention may address the 'dysfunctions', it does not address the loss of ability to see her body *as understandable*. The persistence of her symptoms come with a worldly alienation and a rupture of her embodied integration with the world, merely removing the insults ignores the existential impact and the breach of bodily trust that has already taken place. The question 'but… what is wrong with me' thus may not as easily be reduced to a question aimed at mechanistic explanation, but can also be heard as a key question for the patient to make sense of what her body – and by implication she – has gone through in order to re-establishing a body that is meaningful and 'poised to act and immersed in a world', as Carel puts it.

If we accept the phenomenological account of symptoms as bodily insults, a central task of clinical medicine in its aim to understand symptoms, is also to see their existential aspect. That is, a successful clinical encounter involves aiding the patient in practically mitigating symptoms, but also conveying the symptoms, or insults, as intelligible events. In other words,

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the task is also to re-establishing what we might call a 'feeling of intelligibility' or a sense of understanding which counters the existential body-alienation of the patient. Admittedly, the epistemic value of something like a 'sense of understanding' is controversial in the philosophical literature (Trout 2002). This controversy lies in the question of whether a sense of understanding is a reliable way to tell that actual understanding has occurred (see also de Regt et al. 2009, 8), the worry being that we sometimes feel we understand something only to discover minutes later that we did not, and so it appears that the (mere) sense of understanding is not a reliable indicator of correctness. However, in the context of Emily, Carel and Toombs, and other patients, the function of the feeling that their bodies are intelligible is not to confer or indicate correctness on the particular understanding demonstrated by the clinician. Rather, it is to address the sense of alienation – the anxious monitoring and the loss of meaning – that is, to convey a sense that there is a possibility of understanding at all; that the body is not an alien threat but a resource in regaining the world.[19]

In order to help patients relearn how to skilfully re-inhabit their surroundings, clinicians need to reframe the patient body as intelligible by demonstrating that the symptoms *can* be understood. They need to do this, of course, in a relevant and sustainable way. For example, if clinicians provide explanatory frameworks that are too generic for the patient to feel it is about their bodies[20] or provide explanations or meaning-making tools that do not match the experiences the patient will have once they step outside the consultation room, the bodily re-integration will not be successful. I grant, and in fact am entirely on board with the idea that demonstrating or conveying biomedical or causal-explanatory understanding may be a very strong tool for conveying such a robust feeling of intelligibility. And as such, I am not arguing against the kinds of understanding explicated by Broadbent, Varga and Maung. However, they are not the only way to reestablish the body as intelligible, and they fail at this, if they explain abstract diseases rather than symptoms specific to the patient body. In the

[19] In conversation Oscar Westerblad remarked that perhaps we see something similar in imposter-syndrome, here, a person may have a perfectly good understanding of a topic, but the lack of a sense or feeling of understanding can lead them towards passivity or confusion. That is to say, the feeling of understanding may be unreliable as evidence for correctness but still serve a very important function for our ability to engage with the world.

[20] In fact, anthropologists studying of the programme from the case prompt found that one of the main issues in the use of the programme was that patients did not find the theories and explanations provided in the programme to relate to *their* bodies (personal correspondence with Michal Frumer & Mette Bech Risør, findings still under peer-review).

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phenomenological conception of a symptom as something which renders one's own body alien and the world incomprehensible, the understanding we require from clinical medicine is thus not merely an objectual understanding of the underlying disease applied to the patient case, nor necessarily a causal explanation of the 'patient data' – although both may be very helpful. Instead, I suggest we think more broadly that the business of medicine is to provide means of bodily re-integration by way of conveying a robust sense of intelligibility along with more theoretical or generalisable kinds of understanding which can guide the patient in getting back to grips with the world.

5. An intelligible body and diagnosis as a means of worldly re-integration

Returning to Emily's request, what remains is to address what function diagnosis could have had in the picture I have painted. I have argued that although Emily sees effective intervention, allowing a restoration of her body's practical abilities, cure without understanding misses out the element which addresses the restoration of a sense of ownership and trust in one's body and one's world which persistent symptoms disrupt – it does not address the existential loss. Emily, and patients like her may feel physically better but still be left alienated and thus feel disappointed with the clinical encounter. Let us then rephrase the question: how might diagnosis help dispel alienation and restore a sense of intelligibility?

As mentioned at the outset, there are a host of diagnostic functions – Maung lists nine, including the 'semiotic' meaning-making function for patients, which relates to some degree to the existential re-integration I have discussed here (Maung 2019, 511; see also Brinkmann 2014). While Maung's errand is to show that most functions gain justification by reference to the (biomedical) explanatory function – noting, for example, that '[p]art of why a diagnosis serves as a meaningful sign for the patient [i.e. has a 'semiotic function'] is because it is taken to provide an explanation of why he or she has been suffering from his or her symptoms' (Maung 2019, 514) – he is also careful to say that this reliance on biomedical explanation is not necessary, even if desirable. One other important function of diagnosis is what Maung calls the 'classificatory' function (Maung 2019, 510). A diagnosis sorts items of the world into entities of one or the other class. Again, on a standard view, this function is important because it points us to the causal explanation the disease that we need to understand. However, classification involves more than linking cases to abstract concepts of diseases (the intension), it also involves an extension, that is, labelling concrete items as being or not being of that class. When a diagnosis is asserted for a patient, it picks out their body as an instance of a larger group. This is what is lacking the disjunctive/probabilistic

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explanations which Maung discusses, and which Emily has already had access to prior to the clinical consultation: the disjunctive/probabilistic explanations are generic and anonymous, and so, they may provide information that helps the patient address the practical symptom, but they do not address the own-body alienation because they are not *about* the patient body. Naming a class for one's body offers the possibility of bodily intelligibility in at least two ways, first, it signals familiarity, conveying to the patient 'we recognise what is happening to your body', even if as a matter of fact we don't know much else. Second, even if we do not have explanatory understanding, a class provides access to a network of cultural and social resources for meaning making in patient groups of different kinds, as described by Brinkmann in the case of ADHD (Brinkmann 2014).

Jutel writes: 'Receiving a diagnosis is like being handed a road map in the middle of a forest. It shows the way – but not necessarily the way out. It indicates what the path ahead is going to look like, where it will lead, the difficulty of the climb, and various potential turnoffs along the way. Perhaps it identifies the destination, but not necessarily. With a diagnosis, things don't necessarily get better, but they become clearer. The unexplained becomes explained, and management is defined' (Jutel 2011, 1). In other words, a diagnosis is a tool which helps both patients and practitioners organise many pieces of information into meaningful, coherent patterns – making a complex situation graspable and the body manageable, both practically and existentially. This way of describing diagnosis might sound akin to Varga's objectual understanding, perhaps now with the patient body as object and the note that having or obtaining this kind of understanding is not merely valuable for the reasoning of the medical professional, but also important for the patient. It is hopefully clear that my view is not one that disagrees with the content of Varga's analysis: that standard clinical understanding is about connecting the biomedical understanding and knowledge we have meaningfully to the patient body. A diagnosis can be a very efficient and convenient to do this. However, my claim is that to some extent, Varga gets the priority the wrong way round: biomedical understanding is of instrumental value in aiding a sense of bodily intelligibility and worldly re-integration (both practical and existential), rather than personal (communicative) understanding being instrumental in ensuring correct biomedical identification. Returning to the map metaphor: clinical medicine does not aim at map-making but at understanding landscapes. The upshot of seeing it this way is that there is still a task for the clinician in cases where we do not have maps.

Of course, maps are efficient aids in this practice, and here the denotive character of diagnosis is clinically relevant. Just as we can hand over a map from one person to the other,

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so does a diagnosis allow different actors to transfer information efficiently to others (Maung 2019, 510). In other words, a diagnosis, like a map, is an efficient and useful way of conveying understanding. However, it is possible to convey and aid skilful orientation and navigation without maps – it may just take longer or require more extended interactions. While the GP from the case prompt is unable to provide Emily with a diagnosis and unable to provide anything like the mechanistic explanation that Varga and Maung value, Emily finds some comfort in the 20-minute conversation. In light of what I have argued in this article, this might be because the conversation translated and synthesised a complex set of information – about probabilistic knowledge of people with similar symptoms, about previous negative diagnostic attempts, about our generalisable biomedical knowledge or theories of disorders related or partially relevant, and potentially about other patients with similar experiences, into something specifically *about* Emily and the symptoms she has lived with. And so, even if the GP did not have a road map she could easily hand over, she might have still been able to provide some means for worldly re-integration. Just as cure is possible without diagnosis, so is worldly re-integration. However, both become much harder without it.

Before I end, it is worth noting that just as diagnosis is not necessary for bodily re-integration, diagnosis may not guarantee it either. For example, a diagnosis may be entirely correct but highly unfamiliar to the patient – perhaps they are travelling, and their diagnosis is given in a foreign language – in such cases, whether or not the clinician manages to convey to the patient that their body is intelligible will depend on other clinical and interactional clues. It may also be the cases that the diagnosis itself is the cause of bodily distrust or alienation, such as in cases of asymptomatic findings or the ascription of a 'silent disease' like hypertension – in such cases, we might argue that the 'diagnostic finding' is what triggers the existential rupture, while it may still be the case that the diagnosis itself comes with a potential bodily re-integration (see also footnote 21). More radically, diagnosis as a classificatory and explanatory act can cause existential rupture when the diagnostic category carry severe symbolic meaning, such as cancer (see for example Pascal and Endacott 2010; see also Manderson 2020 for more general reflections). In such cases, demonstrating bodily intelligibility may not be sufficient for the reestablishment of bodily trust, and in the best scenario supplementary support in the form of counselling, therapy, or healthcare professionals trained in existential care should be provided. Finally, of course, it is the case that a non-robust diagnosis will only provide very temporary benefits. This can be the case either because a diagnosis is not fitting, or because the variation within a diagnostic category is not sufficiently explained to the patient, such that they quickly find mismatched between

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their own body and what they were told in the clinic. Such mismatches are problematic because they reinforce the bodily monitoring and re-activates the need for explanation but also undermine the trust in healthcare professionals and hence the means to redress this.[21] In Emily's case, the GP's resistance towards asserting any of the diagnostic categories discussed during the consultation may stem from two of these risks: the symbolic meaning attached to some of the options – such as fibromyalgia and functional disorders, which both come with controversy and a notion of incurability. Given the limited interventionist difference these diagnostic categories would offer Emily in her current situation, asserting a diagnosis that may cause further existential rupture rather than help address this problem is not beneficial. In addition, the possible mismatched between each of the potential diagnostic categories and the full symptom picture in Emily's case raises a risk that an assertion of one category may, in the face of discrepancy, lead to questions and doubt rather than bodily re-integration. And again, since Emily is already seeing improvement, addressing the practical re-integration, there seems to be less benefit in making such an assertion. However, the need to address the existential rupture remains, and the GP needs to draw on other resources.

In summary: Drawing from phenomenology, we can characterise the clinical encounter as occasioned by a patient seeking medical help because something persistently (or severely) insults their habitual bodily integration into the world – and so, what they expect from the clinician is means of re-integration.[22] This involves, of course, interventions and predictions based in biomedical knowledge and objectual understanding of disease. It also involves interpersonal communicative understanding to practice medicine ethically and avoid misunderstandings. But in addition to this, it involves an epistemic aspect of providing the means for re-gaining a grasp on one's own body in the world. I agree, then, with Broadbent and Varga that understanding is central to medicine. I think Emily's case supports this claim to the point where understanding is requested even in the face of cure without it. However,

[21] See (Rasmussen 2017) for similar reflections on the complexities of asserting a diagnosis, although centred on the question of bureaucracy rather than understanding.

[22] Here again, I am inclined to say that 'silent diseases' such as hypertension can have this effect, once the blood pressure has been measured it causes various degrees of bodily anxiety in patients, and thus, bring about requests for medical understanding. Similarly, although again only by gesture, I think this account can work beyond stereotypical 'physical' symptoms. In low mood disorders, for example, the insult may be that things which used to cause joy, no longer seem to do and so our own moods become alien and unintelligible to us. Again, however, these claims would need to be worked out properly elsewhere, and for now, I am happy to delimit my claims in this article to cases of noisy, physical symptoms.

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Broadbent and Varga get it wrong, or at least they are not getting it quite right when they centre their account of understanding on disease and providing mechanistic explanation. While this biomedical conception may work from the point of view of medical science and scientific reasoning about disease, it does not fit with clinical practice, where the target of understanding is not generalisable disease, but individual patient bodies and the symptoms that insult everyday life. While biomedical objectual understanding, or mechanistic explanatory understanding are undoubtedly key contributors in regaining control of and understanding the patient body as a whole, they are so in so far as they contribute to for a different kind of understanding, namely a practical understanding of one's own body as intelligible and by extension, transparent bodily integration in the world.

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