The Violence of Knowing: Medicine, Metaphysics, and the War Against Death

A review of

The Anticipatory Corpse: Medicine, Power, and the Care of the Dying

by Jeffrey P. Bishop

Reviewed by
Stephen A. Diamond

Jeffrey P. Bishop, the author of the scholarly, literate, and clinically well-informed treatise The Anticipatory Corpse: Medicine, Power, and the Care of the Dying, is a practicing physician, ethicist, philosopher, and humanist. He is also a vocal critic of modern medicine’s “metaphysics,” especially of medicine’s negative and mechanistic approach to death and dying. Here, he follows in the footsteps of Foucault, Kübler-Ross, Becker, and others, but particularly historian and philosopher Michel Foucault. For my taste, the author relies far too heavily on Foucault’s work, which makes the early chapters slow going. Fortunately, the later chapters prove more readable, engaging, and relevant.

Twenty-first-century medicine, according to Bishop, “gives no thought to its metaphysics; it might even deny having one. And it gives no thought to its practices, because medicine is about doing and not about thinking” (p. 21). Here, he applies to the pragmatic
practice of clinical medicine what by now is a quite familiar criticism leveled against clinical psychiatry during the past century by practitioners such as Jung, Szasz, and May, among others.

The author’s main thesis is that not only is clinical medicine more focused on fending off death than on cultivating quality of life, but that it does this technically, inhumanely, and mechanically in the service of a society that strives desperately to control, suppress, sugarcoat, deny, and defeat death. “[I]n so doing,” says Bishop, “it too often demeans the patient’s understanding of the meaning and the purpose of life” (p. 24). For example, the icy-cold, sterile, life-sustaining technology of the intensive care unit pretty much precludes any existential, spiritual, or religious reflections about death’s possible meaning and significance. “What if,” he wonders of medicine, “instead of highlighting function, it paid attention to purpose?” (p. 27).

That is to say, medicine—including and especially psychiatry, about which Bishop surprisingly says almost nothing—needs to become less scientific and biocentric and more humanistic: more concerned with the particular and unique person or “patient” who experiences symptoms, suffering, and dysfunction than with simply physiologically fixing the dysfunction itself. This is why psychoanalyst Rollo May (1983), concurring with existential philosophers Gabriel Marcel and Jean-Paul Sartre, insisted that in psychiatry and psychology, “when you see a person as a composite of drives and deterministic forces, you have everything except the existing person him [or her] self” (p. 50).

Clinical medicine can clearly learn much from humanistic and existential psychology about not treating patients as malfunctioning machines with broken parts (or, in biological psychiatry, broken brains) to be separately repaired or replaced while ignoring or, worse, dehumanizing, disempowering, and degrading the whole suffering person. But then, so can today’s biologically, behaviorally, neurologically, and cognitively inclined clinical psychology and psychiatry.

In both medicine and psychology, we have been drifting for decades now—despite the humanistic movement’s positive influence during the 1960s and 1970s on the development of the so-called biopsychosocial model—in a dangerously regressive direction. The question now is whether we can find the requisite courage to correct our disastrous course, striking some more balanced middle ground between biologism and psychologism, body and spirit.

Both medicine and its subspecialty of psychiatry are obsessed with controlling, subduing, or eliminating suffering in all its symptomatic manifestations. Medications are rotely and reflexively used to minimize emotional and physical suffering. Some of this serves as much to alleviate the physician’s discomfort, anxiety, and feelings of helplessness as the patient’s. Research indicates that denied (and therefore excessive) death anxiety in physicians and nurses impairs their capacity to maintain caring and empathetic connections with terminal patients.

But the fact is that much of life’s suffering, like death itself, cannot be avoided. As psychiatrist C. G. Jung is reported to have said, “Neurosis is always a substitute for
legitimate suffering.” And the denial of death is, as Ernest Becker (1973) contended, a kind of collective neurosis.

Medicine provides, both culturally and personally, our last bastion, our final defense against the stark and terrifying reality of death. As Bishop recognizes, death, its delay, and the prolongation of life at almost any cost have become medicine’s raison d’être. Medicine mirrors our collective neurosis regarding the denial of death and death anxiety—the existential anxiety of nonbeing, ego loss, and the unknown. So it could be said that medicine, like the society it serves, must be cured of its core complex regarding the perceived evil of death.

Bishop sees the social meaning of modern medicine as being geared toward correcting disrupted or disturbed functioning; in precisely the same way medical psychiatry and psychology seek to modify deviant behavior and promote “normal” social “adjustment.” Physicians have become mere technicians of the body, like auto mechanics, skilled scientific tinkerers dedicated to keeping our bodies running by staving off disease, decay, and death. And those of us who have suffered serious illness and benefited from the sometimes life-saving and restorative powers of such technically trained physicians are truly grateful.

But, for the most part, medical doctors (and many psychologists) today have lost touch with what is essentially curative and healing in health matters: the sacred doctor–patient relationship. This is why Rollo May (1996), in speaking of dealing therapeutically with the daimonic and life’s inevitable tragic quality, proclaimed: “I do not believe in toning down the daimonic. This gives a sense of false comfort. The real comfort can come only in the relationship of the therapist and the client or patient” (p. xxii).

Whether used by surgeon or psychotherapist, technical skills can go only so far: There is some suffering and discomfort that cry out for caring, empathy, and compassion more than medication, technical procedures, or surgical interventions.

In this intelligent, thoughtful, and valuable book, Bishop points out that, prior to the publication of psychiatrist Elisabeth Kübler-Ross’s groundbreaking (but not necessarily scientific) On Death and Dying (1969/2003), in which final acceptance of death becomes synonymous with psychological growth, “medicine could not speak of death. Doctors would not mention the word, for fear that the psychological blow to patients would be detrimental to their physical ability to fight their disease” (p. 227).

This led to the revolutionary rise of George Engel’s systemic biopsychosocial model, followed more recently by what Bishop calls a “biopsychosociospiritual” model: a more transpersonally informed, comprehensive, holistic, and humanistic medicine that “addresses all features of human thriving” (p. 228). Both treatment paradigms recognize that “the relationship between patient and physician can ‘powerfully influence therapeutic outcome’; something mysterious happens in the communion of doctor–patient” (p. 231).

As with psychotherapy, the supportive and empathic relationship between doctor and patient is central to the healing process in medical practice. But sadly, though studies consistently validate the healing power of the clinician–patient relationship in
psychotherapy, this is something scarcely touched upon in medical practice and training today. And it is slowly and insidiously being lost and devalued in the increasingly technique-driven and neurobiologically based practice of psychiatry and clinical psychology.

Bishop further proposes that despite these helpful humanistic innovations, modern medicine is still primarily about the dreadful phenomenon of death and its prevention via the materialistic reductionism and disintegrative dualism of rational scientific knowledge. “Knowledge is the power to subject one’s object to one’s categories, and it is the power to control, to bring about the effects one desires in the world” (p. 92). He seems to see that such scientific knowledge, whether in physical medicine, psychiatry, or psychotherapy, can be destructively and often unconsciously used to distance ourselves from patients and their suffering, and to assuage or avoid our own anxiety about death.

In this regard, our hyperrationality, intellectualism, defensiveness, and dogmatism undoubtedly do disintegrative violence to being: They create a false separation between subject and object, tearing the human apart in the name of healing. Here the author, who toward the book’s end draws heavily upon Heidegger’s phenomenological philosophy, starts to sound a lot like an existential therapist, a clinical phenomenologist like fellow physicians Carl Jung, Ludwig Binswanger, or Medard Boss (see, e.g., Boss’s 1977 book *Existential Foundations of Medicine and Psychology*), but curiously never once mentions them.

All of this fundamentally affects and informs how physicians today deal with and manage death and dying during palliative care. The contemporary hospice movement provides comprehensive care for the dying, what has been called total care, which is “offered as a remedy for the abandonment of patients whose physiology cannot be fixed” (p. 254). This type of palliative care addresses what Dame Cicely Saunders, the founder of the hospice movement, termed “total pain,” the somatic, psychological, social, and spiritual pain “that is unmasked in dying” (p. 254).

Nonetheless, the author’s thesis is that even biopsychosociospiritual medicine seeks today to control death and grief rather than accepting and respecting it. In other words, modern medicine remains biologically reductive, mechanistic, and materialistic, much more comfortable at cura corporis, the care of the body, than cura animae, the care of the soul.

In Jungian terms, we could say that medicine remains more attitudinally “masculine” than “feminine,” what in Taoism might be described as more yang than yin, emphasizing actively and aggressively “doing” something to the patient over merely “being” with him or her and passively, compassionately, and patiently waiting for time and nature to heal—or not. “For the sake of compassion,” writes Bishop,

medicine thinks it has to offer care by doing something. It thinks that it must deploy assessments and interventions. Medicine cannot not do something; as a science, palliative medicine must measure and show that it, too, is doing something and manipulating something. (p. 283)
This one-sidedness or lack of balance is what Bishop’s book is basically all about. But although it may be news to his fellow physicians, it is a problem to which psychologists and psychiatrists have been speaking for almost a century now. This is especially true today in both psychiatry and clinical psychology’s blind love affair with “evidence-based” treatments, near-religious worship of scientific method, and mechanistically biased dismissal of psychotherapies more focused on the patient’s *being*, the clinical relationship, and the making of meaning than on directly manipulating cognitions, behaviors, symptoms, or neurochemistry. “Medicine,” says Bishop, “cannot let the dying be” (p. 284).

Yet, letting nature take its course may sometimes be the most compassionate, humane, and ethical thing to do. Certainly in the practice of psychotherapy, there is a time to do (e.g., actively intervene and interact) and a time to passively and empathically just *be* with the suffering patient.

Though not trained as a psychiatrist himself, Bishop perceptively recognizes that “our clinical knowledge is always that of a subject who encounters its object” (p. 92). He notes that, in medicine as in psychiatry, “one can be declared defective when one no longer adheres to the approved functions of society” (p. 92). The author cites and appears to endorse an assertion by Robert Veatch (1976) that “death, as never before, is looked upon as an evil, and we are mobilizing technology in an all-out war against it” (p. 121).

This, of course, has been the case throughout the 20th century, and probably for much longer than that. For when has humanity not been at war with death? When have we not sought to somehow overcome or outwit death, like the sly Sisyphus from Greek mythology, for instance?

Yes, Bishop is accurate when writing, “At the heart of medicine is a dead body” (p. 223), his titular “anticipatory corpse,” and in observing that, following Foucault, “death is medicine’s transcendental” (p. 53). Death was also Egypt’s transcendental, and the dead, mummified bodies of pharaohs rested at the very heart of their pyramids and religious system. Death has always, in all cultures, been a *mysterium tremendum*. It can be said that religion in general arose essentially to help people cope with death and make some meaning of it.

Though death and its causes may be medicine’s central subject of fascination and study, says Bishop, “we should treat death as the mystery that it is . . . rather than rationally attempt to categorize and master it. Death is an insoluble perplexity” (p. 135). Here Bishop, the medical man, takes a decidedly spiritual turn. Indeed, he terminates his book with the provocative closing question: “Might it not be that only theology can save medicine?” (p. 313).

Religion or spirituality is recognized as “another mode of helping someone cope with death, dying, loss, or illness” (p. 241). Yet the author is dubious about the dying patient’s spiritual, religious, or existential suffering being measured, assessed, quantified, and treated as part of palliative or “total care” under the watchful, hypercontrolling, and scientifically biased eye of the physician: “Whereas the care of the dying, the ill, and the poor was once a
handmaiden to the theological virtue of hospitality, now spirituality becomes the professionalized domain of a totalizing medicine. Death is medicine’s dominion” (p. 274).

Presumably, Bishop sees spirituality as the exclusive domain of theology and the ministry. But spirituality is something psychotherapists deal with daily, and it may be high time for physicians to recognize that they themselves cannot treat a body (or mind) without also, at least to some extent, treating a soul or a Self.

What happens after death—if anything at all beyond decay, decomposition, and eventual dispersal—is still pure speculation. And historically, such speculation serves one primary purpose: the demystification of death in an effort to mediate or eliminate our anxiety about it. This is precisely what medical science strives to do, but, despite its best efforts, cannot.

Of course, in the end, as neurologist and existential psychiatrist Viktor Frankl (1959/1985) suggested, we cannot choose whether to die, but we can choose our attitude toward suffering, disease, and dying. As with the problem of evil in general (see Diamond, 1996), Western medicine still considers death and the dead body a disturbing reality, a disastrous disease, a preventable failure, a blow to our grandiose sense of narcissistic omnipotence, an ultimate evil to be eradicated, deterred, disguised, dissembled, and despised rather than recognized and treated as a necessary, natural, and integral part of life (see my prior review of Healing With Death Imagery, 2007).

Eastern culture and religions, including Buddhism, Sufism, and Hinduism, take a healthier and more direct approach to the enigmatic phenomenon of death, encouraging regular conscious contemplation by the young and healthy in meditation and mental imagery of death’s ruinous inevitability, capriciousness, and physical finality. Such constantly practiced acceptance of death and existential death anxiety, humbly, consciously, and willingly becoming this anticipated decomposing corpse—the physical symbol of death’s unfathomable facticity—might, indeed, be the best medicine for medicine, and, along with clinical phenomenology as employed in existential psychology, the most effective antidote against the defensive violence of knowing.

---

**References**


doi:10.1037/a0009236


