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Body; Where You Visit Patients

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Editorial

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The question is: Where do we communicate with our clients? In a clinic, our office, or his/her home? Each clinical setting has its specific resources and barriers and necessitates proper adjustments to facilitate rapport and adherence. Of course, we should orient ourselves towards social and cultural contexts. We know that doctor-patient communication is formed in multi-layered intersubjective contexts as well as problems. We should consider each sign within the context it appears because the actual meaning of each sign is its function in its context. Therefore, for an appropriate interpretation of signs and symptoms, we need contextual orientation. Most of our clinical instructions are about the universal interpretations of signs and symptoms. Positive knowledge is based on generalizability and reproducibility, and for such a science, we should decontextualize the objects. We have only some very rare and inefficient pieces of training to instruct caregivers on how to deal with the singular constellation of the contexts of each visit.

The most hidden context – read *neglected!*- in which all the contexts are perceived and interpreted is our bodies. There is a great absence of the medical discourse on the caregiver's body. Cartesian dualisms like mind vs. body or subject vs object are still dominant in our mindset. That is why we imagine ourselves as bodiless subjects who manage the bodies and/or minds of our clients. Beyond this imaginary picture, the client's body and words actually figurate in the caregiver's body. We perceive and feel our patients in our bodies, and then, recognize these affections and interpret them based on our medical codes. Our openness to the illness and life contexts, and accuracy of interpretation depend on our memories, sentiments, and awareness.

If our body is where we immediately visit our patients, should we not make it fit for care? Is there not a difference between a secure and integrated body and a distressed and ambivalent body in the process of diagnosis, care, and treatment? If yes, how can we render our bodies fit and integrated to tolerate more affections and reflections?

Baruch Spinoza (1632-1677) explained in his monistic mind-body model how we perceive our world and our body only through body awareness:

"…the human mind perceives the nature of a variety of bodies, together with the nature of its own" (Ethics, P; II: XVI.) because *"The human mind is the very idea or knowledge of the human body" (Ethics, P; II. XII.).*

Spinoza liked to show with his genius, centuries before modern neuroscientists, that the foundation of human consciousness is bodily awareness. We experience our bodies as patterns of energy flows and a container of images. Energy flow and container are the main image schemata that form our embodied cognition and the conceptualization of our feelings and perceptions (see: Johnson 1987).

The more power we have to direct aroused energy through the body, the more we can be open to the emotions and experiences of others and, as a result, more capable of caring. Being flow and being a container are the golden keys of caregiving, and body awareness is the way to find these keys. We need to return to our bodies to provide a better locus of care because the body is where we immediately visit others.

Conflict of Interests

Authors have no conflict of interests.

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