Cancer Health™

Philosophy in the Wild

I am invested in my care, treatment, and recovery because I have received treatment from medical practitioners who help me understand it.

November 4, 2016 By Adam Hayden

The choice to tag line Glioblastology with “A Graduate-trained philosopher documents his battle with glioblastoma” pays more than lip-service to my background and formal education. I completed undergrad and graduate work in philosophy at IU, Indianapolis (IUPUI). Outside of academia I held analyst, instructional design, training delivery, and project management roles with a Fortune 500 company and recently a smaller consulting firm. Through formal and informal channels I developed the following skills that equip me in my battle against brain cancer: research acumen, data analysis, written and spoken communication, and leadership. Surprising weapons to battle cancer, but my strength, resolve, and even attitude are thanks to the perspective gained by taking what Thomas Nagel called the view from nowhere: a view of the world that includes both one’s own perspective, yet sees oneself as a part of that view.

Adopting this view from nowhere, I value my own perspective; my own narrative, and I am eager to share the lessons that have benefited me as patient. But also, viewing myself as one piece of a broad portrait that includes family, friends, caregivers, a medical team, blog readers, and my sisters and brothers battling alongside me, I realize my unique draw is my ability to translate the technical into the digestible. Ultimately, it is my goal that technical terminology and narrative anecdote walk hand-in-hand; the former providing a background of knowledge against which the latter narrative plays out more vibrantly.

A good friend of mine—a good friend of the family, really, and a (retired) career professional in the pharmaceutical industry—gave me a lift a handful of times to radiation therapy. These were always great trips given the great conversation. Few life experiences shake us free from our own bullshit: a cancer diagnosis and adjusting to retirement after a successful career are two of those things—though not likely so equivalent in other respects; hence, our conversations were relevant, poignant, thoughtful, and mutually appreciated. My friend shared the gist of a conversation he had with an oncology friend of his. It went something like this. “GBM is a terminal diagnosis, and difficult to deal with, but few of us have the opportunity to gain insight into our own passing. Think of the people on their deathbeds, wishing they had done this or that. Adam has an opportunity to consider those things he would like to make a priority.” Dead on. A benefit of receiving a difficult medical diagnosis is receiving, with the bad news, an opportunity to revisit priorities and align actions with values.

Writing this blog carries worries: worries about my many terminological and theoretical mistakes, worries about circulating misinformation—though I do my best to perform due diligence and write with integrity, worries about sustaining the engagement of my audience, and worries that hours spent reading and writing, posting and sharing, turn out to be of little use to myself and others, now or in the future. Worries notwithstanding, the alignment of my actions with values encourages me to press on, speaking with the voice I trust, which is my own, informed by research, eager to offer new insights into old problems, helping others discover the joy of research as it informs a more intimate connection to our context, better relationships with our medical teams and caregivers, and feelings of empowerment that we may elect to participate in our care and treatment more actively, less passively.

I think this is what I mean by 'Philosophy in the Wild': the discipline is highly technical, specialists seemingly writing only for other specialists, and those unfamiliar with the jargon, unable to join the conversation. As with physical barriers, emotional barriers, legislative and systemic barriers, folks create barriers against our better judgment. Within philosophy much has been invested to understand human inference, reasoning, and decision-making, yet the technical nature of the discipline, the disproportionately high rates of white, male, and middle class undergraduate and graduate enrollment, the disappearance of tenure track professorship, and the adjunct faculty crisis and contribution to growing income inequality and poor access to healthcare reflect institutional barriers erected that stand between philosophers, studying reason and inference, and a general audience who would benefit from learning more.

The barrier I hope to break down for you is to provide tools to approach the study of your own diagnosis and treatment, informed by our best attempts to describe reasoning and inference. Not to dissent or deny treatment, but to understand why? Why this treatment, and not another?

Here are my tested skills, weaponized for battle against brain cancer: research acumen, data analysis, communication, and leadership.

Why?

Patient-centered healthcare is about empowering the patient to engage in their own treatment, care, and recovery. Doctors often prescribe medication, therapies, write referrals to specialists, and order tests, yet how often are these instructions offered in such a way that the person receiving care is empowered to articulate why the order was given?

I sat for my vile of blood to be taken for regular CBC, checking counts following a Temodar week. My veins are good, my demeanor calm, and my sleeves rolled up. The gray vinyl armrest tinged with blood, from a quick cleanup job. I am inclined to grab a blue glove and sani-wipe from the wall-mounts to volunteer a more thorough pass when a woman is called in and directed toward the seat next to me. A curtain separates us. She begins, "I don't know why I am here. My doctor didn't tell me about any lab work," she grumbles, frustrated, disgruntled, and I get it. Our lives are busy. Where can I save time? What will I make for dinner? Why am I here?

I am a cancer patient, and like mallrats, cancer patients are clinic rats: we have had daily radiation therapy, chemo, we give blood usually every week or two, during therapy weeks. I have brain cancer, so I have an MRI scan every eight weeks. I get to wear scrubs on scan days! The hospital billed insurance $115k for my debulking surgery, so I've learned for what procedures Anthem requires a pre-certification. I like to interpret my own labs available in my electronic health records because I'm starting to get into some biomarker ranges concomitant with my nutritional choices. All this is to say, I'm a happy stick for the nurse. Woman on that side of the curtain: she is not.

See how we are different? What could her doctor have said in 30 seconds during an office visit to save our nurses some anxiety at the lab—and maybe get that old blood cleaned up?

I am invested in my care, treatment, and recovery because I have received treatment from medical practitioners who help me understand why such and such treatment is required. This has sparked my own research, examination of the facts, and seeking to answer that all important why?

What's to Come?

There are competing theories to best explain the origin of cancer. The accepted view is that cancer is caused (primarily) by genetic mutations that cause cancerous cells to rapidly divide, metastasize, and obstruct vital body functions, leading to morbidity. The acceptance of this theory—the genetic theory of cancer, drives clinical practice. Theory informs our treatment options for cancer. Radiation therapy and chemotherapy among them, targeting and ideally impairing the cell division processes of genetically mutated cancer cells.

The medical community asked itself a question, and this question, although steeped in decades of clinical research, empirical findings, replication studies, and analysis, is not dissimilar from the question on the lips of the woman on the other side of the curtain. She is curious, why? The medical community is responding in clinical practice to the theoretical question: if cancer is a genetic disease, why should we treat with this therapy and not another? A more fundamental question is, why should we accept the genetic theory to explain the origin of cancer and not a competitor theory? We have uncovered further considerations: what makes for an acceptable theory? Why are some theories accepted and not others? How does theory acceptance drive clinical practice? Maybe most interesting to readers: what other cancer origin theories are out there? What clinical practices are impacted should the community accept an alternative theory?

Philosophy can help us, out here, in the wild. In the next post I will get us thinking about alternative cancer origin theories by way of discussing our cells and our bodies. Medical theories are data. Once two or more competing theories are on the table, we can speak to the reasoning method called inference to the best explanation (IBE). Good news! We are already thinking like someone trained in this method! The late philosopher of science Peter Lipton asserted that so-called contrastive questions (those of the form: Why P and not Q?) are central to the IBE method of reasoning.

Cheers —AH

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