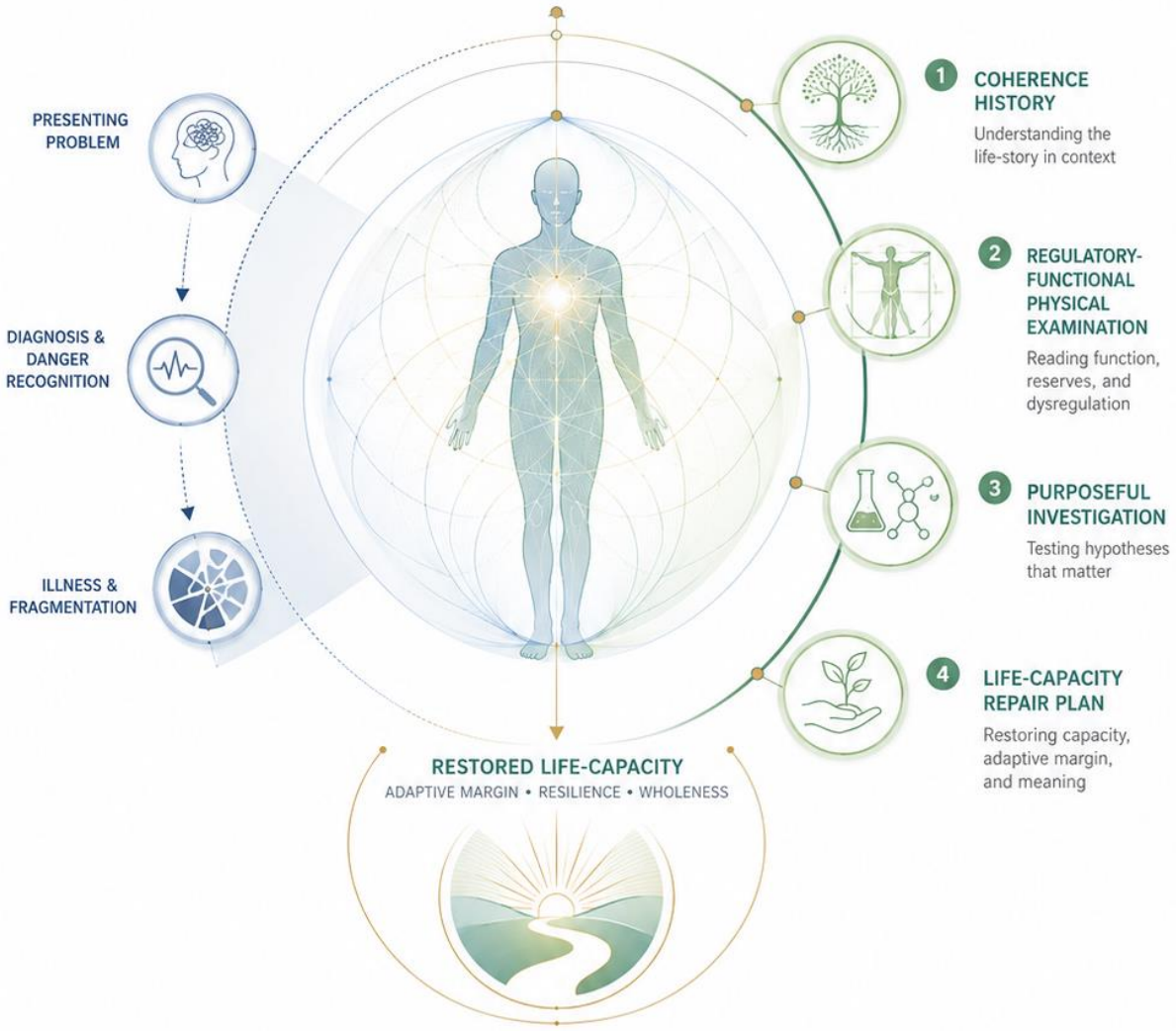
ACADEMIC WHITE PAPER

# The Life-Coherence Clinical Assessment

## A Method for Reading Disease as Loss of Life-Capacity





Dr. Bichara Sahely,

BSc, MBBS, DM (Internal Medicine)

# The Life-Coherence Clinical Assessment

*A Method for Reading Disease as Loss of Life-Capacity*

**Academic White Paper**

**Dr. Bichara Sahely, BSc, MBBS, DM (Internal Medicine)**

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*Clinical medicine, at its most complete, is the disciplined restoration of life-capacity.*

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## Abstract

Modern clinical medicine is powerful at identifying disease, stratifying risk, and applying evidence-based interventions. Yet the clinical encounter is often organized around symptoms, organ systems, diagnostic categories, laboratory thresholds, and treatment protocols in ways that can leave the patient's lived field under-examined. A diagnosis may be correct, a guideline may be followed, and a prescription may be appropriate, while the deeper pattern constraining the person's capacity to live, adapt, heal, and participate remains insufficiently seen.

This white paper proposes the **Life-Coherence Clinical Assessment** as a complementary renewal of the clinical method. It does not replace biomedical diagnosis, urgent intervention, physical examination, investigation, or evidence-based treatment. Rather, it widens clinical attention from disease entities alone to the patterns through which adaptive margin, functional capacity, agency, relational participation, and practical possibility are progressively constrained.

The method is organized around four pillars: the **Coherence History**, the **Regulatory-Functional Physical Examination**, **Purposeful Investigation**, and the **Life-Capacity Repair Plan**. History taking becomes an inquiry into the patient's life-field and lost capacity; physical examination becomes an assessment of embodied regulation, reserve, and function; investigations are ordered to clarify danger, diagnosis, lost margin, modifiable causes, and meaningful trends; and management is reframed as feasible repair in service of restored life-capacity.

By integrating clinical medicine, the biopsychosocial model, person-centred care, social determinants of health, salutogenesis, multimorbidity care, systems thinking, and the biology of living systems, this paper offers a practical framework for restoring wholeness to clinical seeing without diluting diagnostic rigor. It argues that medicine does not need to choose between precision and humanity. It needs a clinical method capable of both: one that detects disease while also understanding the life that disease has interrupted.

## Keywords

Life-coherence medicine; clinical assessment; clinical method; organism-niche coupling; person-centred care; adaptive margin; life-capacity; salutogenesis; multimorbidity; social determinants of health; functional assessment; evidence-based medicine; whole-person care; treatment burden.

## Executive Summary

Clinical medicine begins with the patient's suffering, but modern clinical systems often translate that suffering quickly into symptoms, diagnoses, organ systems, risk categories, investigations, prescriptions, and performance indicators. This translation is necessary, but it is not sufficient. A clinician may correctly diagnose hypertension, diabetes, depression, chronic pain, heart failure, autoimmune disease, or multimorbidity while still failing to understand the lived pattern through which the patient's capacity to live has been diminished.

This white paper introduces the **Life-Coherence Clinical Assessment** as a complementary method for renewing clinical practice. It does not oppose biomedical diagnosis, evidence-based medicine, acute care, guideline-directed treatment, or specialist knowledge. Instead, it asks medicine to recover a wider and more disciplined form of clinical seeing. Disease is not only a pathological entity located in an organ, biochemical pathway, or

diagnostic code. It is also experienced as a loss of life-capacity: a narrowing of adaptive margin, function, agency, participation, rhythm, relationship, and possibility within a lived field.

The central question of the Life-Coherence Clinical Assessment is:

> *What pattern is constraining this person's capacity to live, adapt, heal, and participate?*

This question does not replace the conventional clinical question, "What disease is present?" It completes it. A life-coherence approach insists that diagnosis must be understood in relation to the person's biological regulation, life history, environment, social conditions, emotional field, functional capacity, treatment burden, and feasible options for repair. The patient is not an isolated disease-bearing body, nor merely a self-managing consumer of interventions. The patient is a living being structurally coupled to a world.

The method has four core components. First, the **Coherence History** expands history taking beyond symptom chronology. It asks how the presenting problem affects the patient's actual life: what the person can no longer do, what has become harder to sustain, where adaptive margin has been lost, and what pressures, losses, exposures, relationships, or institutional conditions are narrowing the possibility of recovery.

Second, the **Regulatory-Functional Physical Examination** preserves the diagnostic discipline of the traditional examination while becoming more attentive to embodied regulation and reserve. The clinician examines not only for signs of disease, but also for signs of lost capacity: frailty, deconditioning, impaired mobility, nutritional depletion, autonomic strain, affective constriction, cognitive vulnerability, pain-limited movement, medication effects, and reduced resilience.

Third, **Purposeful Investigation** shifts the use of tests from reflexive panel ordering toward coherence-guided inquiry. Investigations should clarify at least one of five purposes: danger, diagnosis, lost margin, modifiable causes, or meaningful trends. The purpose is not to generate more data, but to generate information that changes care, reveals risk, identifies reversible constraints, or helps track recovery.

Fourth, the **Life-Capacity Repair Plan** reframes management as the restoration of adaptive margin and participation. Treatment is not limited to normalizing biomarkers or suppressing symptoms, though these may be necessary. The clinician asks what intervention would restore the most capacity with the least unnecessary burden. This may involve medication, referral, investigation, rehabilitation, deprescribing, sleep restoration, pain relief, social support, explanation, family involvement, or follow-up.

The Life-Coherence Clinical Assessment is especially relevant to chronic disease, multimorbidity, frailty, mental distress, chronic pain, metabolic disease, post-acute recovery, long-term continuity care, and clinical handover. These are situations in which disease categories alone often fail to capture the complexity of the patient's condition. A person with diabetes may not primarily be "failing treatment"; they may be living under food insecurity, grief, shift work, medication cost, poor sleep, and fear. A person with hypertension may not simply need another drug; they may need restoration of rhythm, trust, safety, and feasible self-regulation. A person with multimorbidity may not need more fragmented specialist instructions; they may need a coherent plan that reduces burden, protects function, and prioritizes what matters most.

This approach also has implications for medical education, documentation, clinical teamwork, and health system design. It invites clinicians to document not only diagnoses and medications, but also capacity, constraints, margins, burdens, and repair pathways. It invites teams to ask not only whether care is guideline-concordant, but whether it is feasible, proportionate, and life-serving. It invites health systems to measure not only disease control, but restored function, reduced burden, increased agency, and improved participation.

The risks of such an approach must also be acknowledged. A widened clinical gaze can become vague if it loses diagnostic discipline. It can become moralistic if it blames patients for the conditions constraining them. It can become impractical if it asks clinicians to solve social problems alone. It can become unsafe if it delays urgent biomedical treatment. For these reasons, the Life-Coherence Clinical Assessment must be explicitly bounded. It is not a substitute for emergency care, specialist assessment, pharmacotherapy, surgery, public health, psychiatry, rehabilitation, or evidence-based protocols. It is a way of ensuring that these interventions are placed in service of the living person rather than becoming disconnected from the conditions of healing.

The argument of this white paper is therefore simple: medicine does not need to choose between rigor and wholeness. It needs both. The clinical method must remain capable of detecting disease, but it must also become capable of reading loss of life-capacity. A more coherent medicine asks what is wrong, what is dangerous, what is treatable, and what is biologically happening. But it also asks what has been interrupted in the patient's life, what margin has been lost, what pattern is keeping illness stuck, and what would make healing possible.

The Life-Coherence Clinical Assessment offers one path toward that renewal.

## Preface / Author's Note

This white paper arises from a clinical and philosophical concern that has become increasingly difficult to ignore: modern medicine often knows much about disease, but less about the loss of life-capacity through which disease is lived.

As a physician trained in internal medicine, I have been shaped by the discipline of the conventional clinical method. History taking, physical examination, investigation, diagnosis, and treatment remain indispensable. They allow us to recognize danger, identify disease, relieve suffering, and intervene with precision. Nothing in this paper is intended to weaken that discipline. On the contrary, the Life-Coherence Clinical Assessment depends upon it.

Yet decades of clinical practice also teach another lesson. Patients do not come to us as diseases. They come as lives interrupted. They come when breath, energy, sleep, mobility, work, family, memory, appetite, dignity, trust, or hope can no longer be taken for granted. They come when the body is no longer able to carry the person's world in the same way. They come not only with symptoms, but with burdens, histories, constraints, losses, adaptations, and questions that do not fit neatly into organ systems or diagnostic codes.

The clinical encounter therefore always contains two tasks. The first is to ask: **What disease, danger, or pathological process is present?** The second is to ask: **What has this illness interrupted in the patient's capacity to live, adapt, heal, and participate?** When the first question is asked without the second, medicine risks becoming technically correct but existentially incomplete. When the second is asked without the first, medicine risks becoming compassionate but clinically unsafe. A coherent medicine must hold both.

The Life-Coherence Clinical Assessment is proposed as a way of holding both. It is not a new specialty, a replacement for evidence-based medicine, or a rejection of biomedical science. It is a renewal of clinical seeing. It asks clinicians to understand disease within the wider field of organism and niche: the living body, the person's history, the social and ecological conditions of life, the emotional and relational field, the burdens of treatment, and the practical possibilities for repair.

This approach has emerged from the broader framework of life-coherence medicine, which understands health not merely as the absence or control of disease, but as the preserved and restored capacity of living beings to regulate, relate, participate, and flourish within the worlds that sustain them. In this frame, illness is not reduced to a biological lesion, nor dissolved into social explanation. It is understood as a pattern of disrupted coherence: biological, functional, relational, environmental, and existential.

The purpose of this paper is practical. It asks how history taking should change when the patient is understood as a person-in-world. It asks how the physical examination should change when the body is seen not only as anatomy, but as lived regulation. It asks how investigations should change when data are interpreted in relation to danger, diagnosis, adaptive margin, modifiability, and meaningful trends. It asks how management should change when the goal is not only disease control, but restoration of life-capacity.

This paper is offered especially to clinicians, educators, students, health system leaders, and reflective practitioners who sense that medicine must become more whole without becoming less rigorous. It is also offered to patients and families who know, often before professionals do, that healing requires more than a correct diagnosis. It requires a care pathway that understands the life in which illness occurs and the life to which treatment must return.

If the clinical method is one of medicine's greatest achievements, then renewing it may be one of medicine's most urgent tasks. The Life-Coherence Clinical Assessment is one contribution to that renewal.

## 1. Introduction: The Need for a More Coherent Clinical Method

Clinical medicine begins with an encounter. A person comes because something has changed: pain has appeared, breath has shortened, energy has failed, sleep has broken, appetite has shifted, mood has darkened, blood pressure has risen, glucose has escaped control, memory has become uncertain, mobility has narrowed, or ordinary life has become difficult to sustain. Before there is a diagnosis, a guideline, a laboratory value, or a prescription, there is an interruption in the patient's capacity to live.

The clinical method was developed to respond to such interruption with disciplined attention. Through history taking, physical examination, investigation, diagnosis, and treatment, medicine learned to convert suffering into intelligible clinical patterns. This remains one of the great achievements of human care. The clinician asks where the symptom began, how it evolved, what worsens or relieves it, what systems are involved, what diseases came before, what medicines are being taken, what risks are present, and what signs can be elicited from the body. This disciplined sequence allows the physician to detect danger, identify disease, stratify risk, and intervene with precision.

Yet the very success of this method has also created a risk. When clinical reasoning becomes too narrowly organized around disease categories, organ systems, laboratory thresholds, imaging results, and treatment algorithms, the patient's lived field may recede from view. The person becomes visible as a case, a diagnosis, a problem list, a cluster of risk factors, or a set of abnormal values, while the life in which illness has emerged and healing must occur is insufficiently examined. A clinical assessment may be technically correct and still fail to understand what has become incoherent in the patient's world.

This concern has a long lineage. The biopsychosocial model challenged medicine to move beyond narrow biomedical reductionism while preserving the scientific discipline of clinical practice (Engel, 1977, 1980). Person-centred care, narrative medicine, social determinants of health, salutogenesis, multimorbidity care, geriatrics, palliative care, and minimally disruptive medicine have all widened medicine's attention to the patient as a person whose illness is lived within a world (Antonovsky, 1987; Charon, 2006; Kleinman, 1988; May et al., 2009; World Health Organization, 2008, 2016). The Life-Coherence Clinical Assessment stands within this broad movement, but proposes a specific clinical grammar for renewing the encounter itself.

The insufficiency of disease-only assessment is especially evident in chronic disease and multimorbidity. A patient with hypertension may receive appropriate medication, but the deeper clinical reality may include exhaustion, grief, shift work, financial strain, sleep deprivation, food insecurity, unresolved fear, social isolation, and a sense of helplessness. A patient with diabetes may be advised to change diet and exercise, while the clinician remains unaware that the patient cannot reliably afford healthy food, has unsafe streets, works irregular hours, lacks family support, or is overwhelmed by caregiving responsibilities. A patient with depression may be prescribed medication, while the loss of meaning, relational rupture, trauma, unemployment, chronic pain, and social disconnection that sustain the suffering remain only partially seen.

In such situations, conventional clinical assessment is not wrong. It is incomplete. The diagnosis may be accurate, the medication reasonable, and the investigation appropriate. What is missing is a sufficiently coherent account of how the patient's biological regulation, functional capacity, social world, emotional field, environment, and feasible options are coupled together. Without such an account, medicine may attempt to correct isolated variables while leaving the constraining pattern intact.

The need, therefore, is not for a rejection of biomedical medicine, but for a renewal of the clinical method. Medicine must remain capable of identifying myocardial infarction, sepsis, malignancy, renal failure, autoimmune disease, stroke, endocrine disease, infection, and all the urgent and non-urgent pathologies for which biomedical training is indispensable. A life-coherence approach cannot become an excuse for vagueness, delayed diagnosis,

therapeutic neglect, or sentimental generalization. It must preserve the clinician's obligation to detect disease and act decisively when danger is present.

At the same time, medicine must become more capable of seeing disease as lived loss of capacity. The patient does not experience illness only as a biomedical abnormality. Illness is experienced as reduced breath, reduced energy, reduced movement, reduced confidence, reduced participation, reduced agency, reduced trust, and reduced possibility. It is experienced as the body no longer supporting the life the person is trying to live. Clinical assessment must therefore ask not only what pathological process is occurring, but what form of life has become harder, narrower, more fragile, or less viable.

This white paper proposes the **Life-Coherence Clinical Assessment** as a complementary method for such renewal. Its central question is:

> *What pattern is constraining this person's capacity to live, adapt, heal, and participate?*

This question does not replace the conventional diagnostic question, "What disease is present?" Rather, it completes it. The physician must still ask what disease, danger, mechanism, lesion, infection, inflammation, deficiency, injury, or dysregulation is present. But the physician must also ask how that disease or dysregulation is embedded in the patient's life-field, how it is reducing adaptive margin, and what would make repair possible.

The term **life-coherence** refers to the alignment of biological regulation, functional capacity, relational participation, environmental support, and meaningful agency in ways that sustain life. A life-coherent clinical method therefore asks whether the conditions of healing are present. Is the patient sleeping? Eating? Moving? Breathing adequately? Safe? Supported? Able to understand the plan? Able to afford the treatment? Able to return for follow-up? Able to participate in decisions? Able to act without being overwhelmed? Able to recover margin before being asked to perform self-management?

When these questions are not asked, treatment may become miscoupled from the patient's actual life. The prescription may be pharmacologically correct but practically impossible. The advice may be medically sound but socially unrealistic. The referral may be appropriate but inaccessible. The lifestyle recommendation may be desirable but unsupported by the patient's environment. The care plan may increase burden rather than restore capacity. In such cases, non-adherence may be less a failure of patient responsibility than a sign that the treatment plan has not been adequately coupled to the patient's world.

The Life-Coherence Clinical Assessment addresses this gap by reframing the four major domains of clinical evaluation. History taking becomes a **Coherence History**, in which symptom chronology is joined to life-field chronology: what changed, what was lost, what pressures accumulated, what rhythms broke, what supports failed, and what options remain. Physical examination becomes a **Regulatory-Functional Physical Examination**, in which the clinician examines not only for signs of pathology but also for signs of lost reserve, impaired regulation, frailty, deconditioning, nutritional depletion, autonomic strain, affective distress, cognitive vulnerability, and functional limitation. Investigations become **Purposeful Investigations**, ordered to clarify danger, diagnosis, lost margin, modifiable causes, and meaningful trends. Management becomes a **Life-Capacity Repair Plan**, directed toward the least-forcing, most feasible intervention that restores adaptive margin and participation.

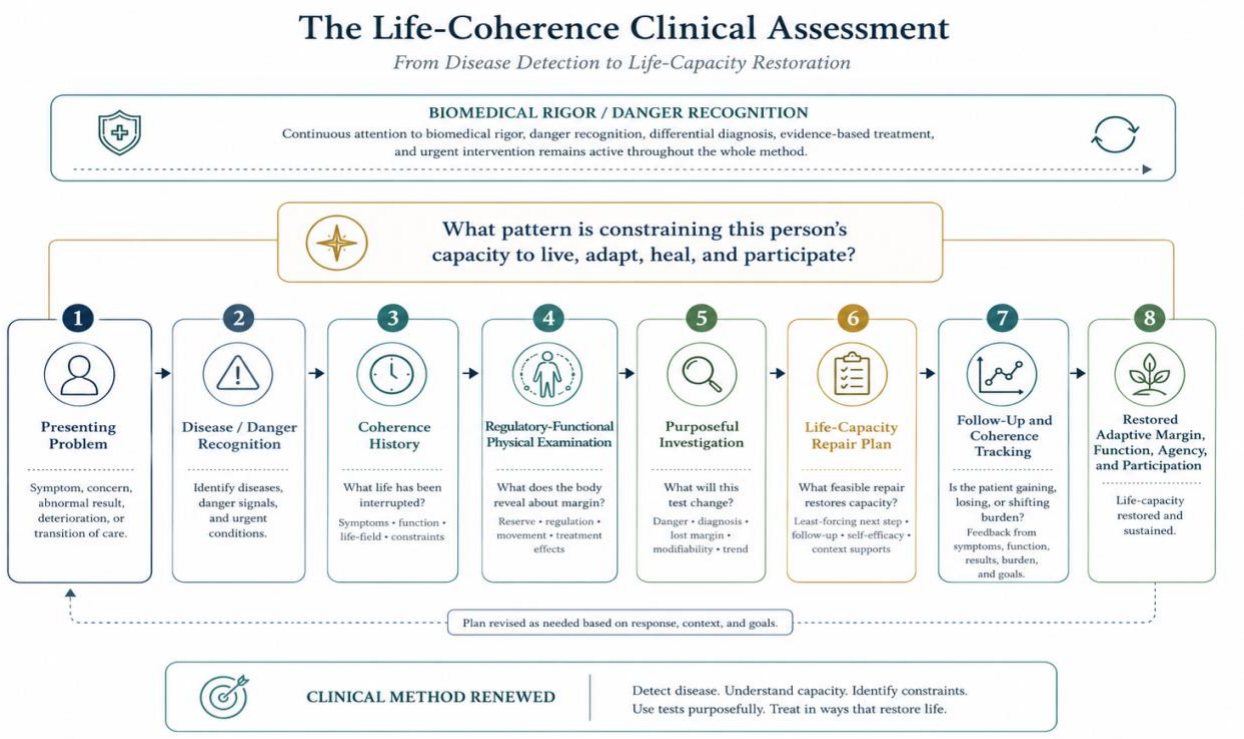


*Figure 1. The Life-Coherence Clinical Assessment. The method preserves conventional biomedical diagnosis while widening clinical attention to life-capacity, adaptive margin, constraint patterns, feasibility, and repair. The clinician asks not only what disease is present, but what pattern is constraining the patient's capacity to live, adapt, heal, and participate.*

The urgency of this integration is increasing. Health systems are caring for aging populations, chronic disease, complex multimorbidity, mental distress, social isolation, ecological stress, economic insecurity, and growing treatment burden. These conditions do not fit well within single-disease models. They require clinicians to think relationally, contextually, and longitudinally. They require medicine to ask not only, "What is the correct intervention for this condition?" but also, "What pattern of care will preserve or restore this person's capacity to live?"

The Life-Coherence Clinical Assessment is therefore proposed as both a conceptual and practical framework. Conceptually, it understands the patient as a living being structurally coupled to a world. Practically, it changes what the clinician asks, observes, investigates, documents, prioritizes, and follows over time. It does not make medicine less scientific. It makes clinical science answerable to the living context in which disease is suffered and healing must become possible.

The sections that follow develop this method in detail. The paper first defines life-coherence medicine and its relationship to existing clinical traditions. It then describes the Life-Coherence Clinical Assessment as a structured method with four core components: the Coherence History, the Regulatory-Functional Physical Examination, Purposeful Investigation, and the Life-Capacity Repair Plan. It then explores clinical applications, implications for medical education and documentation, and safeguards against misuse. The ultimate aim is to offer clinicians a way of seeing that is at once disciplined, humane, systemic, and life-serving.

## 2. What Is Life-Coherence Medicine?

Life-coherence medicine begins from a simple but far-reaching premise: health is not merely the absence of disease, nor merely the control of measurable risk factors, but the preserved and restored capacity of a living person to regulate, relate, act, adapt, participate, and flourish within the world that sustains them. Disease

matters profoundly, but disease is not the whole of illness. Illness is what happens when biological disorder, distress, constraint, and life-world disruption converge to reduce the person's capacity for viable living.

In conventional clinical language, health is often approached through disease categories: hypertension, diabetes, asthma, heart failure, chronic kidney disease, depression, arthritis, malignancy, infection, autoimmune disease, dementia, and so forth. These categories are essential. They allow clinicians to identify mechanisms, estimate risk, choose treatments, communicate with colleagues, and organize care. Without them, medicine would lose much of its precision.

Yet the patient's lived experience rarely arrives in such neatly separated categories. A person does not experience "type 2 diabetes" only as hyperglycemia, insulin resistance, vascular risk, or HbA1c. They may experience it as fatigue, hunger, shame, fear, dietary confusion, medication cost, family pressure, cultural food practices, shift work, erectile dysfunction, visual disturbance, foot pain, loss of confidence, or dread of future complications. Similarly, a person does not experience heart failure only as reduced ejection fraction, fluid overload, natriuretic peptide elevation, or diuretic requirement. They experience it as breathlessness, interrupted sleep, fear of exertion, dependence on others, loss of mobility, and the shrinking of ordinary life.

Life-coherence medicine therefore asks medicine to hold two truths together. The first is that disease has real biological structure. Pathophysiology matters. Mechanisms matter. Evidence matters. Investigations, medications, procedures, and guidelines matter. The second is that disease is always lived by a person whose capacity is shaped by context, meaning, relationship, environment, time, resources, and possibility. A treatment that is biologically correct but practically impossible is not yet coherent care. A diagnosis that is accurate but disconnected from the patient's lived constraints is not yet a sufficient clinical understanding.

The word **coherence** does not mean perfection, harmony, or the absence of struggle. Living systems are never static. They survive through continuous regulation, adaptation, repair, and reorganization. Coherence refers instead to a sufficiently viable alignment among the processes that allow life to continue: metabolism, movement, sleep, immunity, circulation, cognition, emotion, relationship, work, meaning, safety, and ecological support. When these processes are sufficiently aligned, the person has margin. When they are persistently misaligned, adaptive capacity narrows.

Life-coherence medicine is concerned with this narrowing of margin. A person may still function, work, parent, comply, smile, and appear outwardly stable while their adaptive reserve is being steadily consumed. Sleep debt accumulates. Blood pressure rises. Glucose control worsens. Pain sensitizes. Inflammation persists. Relationships fray. Medications multiply. Movement declines. Debt increases. Hope contracts. Eventually, the body presents what the life-field has been carrying.

In this sense, illness can be understood as a pattern of **organism-niche miscoupling**. The organism is not a machine operating in isolation. It is a living being structurally coupled to a niche: food systems, family systems, work demands, housing, climate, culture, institutions, technologies, social expectations, and histories of care or harm. Maturana and Varela's account of autopoiesis and structural coupling provides one biological lineage for understanding living beings not as detached mechanisms, but as organisms continuously constituted in relation to their worlds (Maturana & Varela, 1980, 1992). When the niche supports regulation, the organism has room to recover. When the niche persistently overloads or deprives the organism, disease risk rises and healing becomes harder.

This does not mean that all disease is caused by social context, lifestyle, or psychology. Such a view would be both clinically false and morally dangerous. Genetic disease, infection, trauma, malignancy, autoimmune pathology, congenital disorders, and many other conditions cannot be reduced to context. Life-coherence medicine does not dissolve biology into biography. Rather, it asks how biology and biography meet in the living person. It asks how disease alters life, how life conditions disease, and how care can be organized to restore viable regulation where possible.

Nor does life-coherence medicine blame patients for illness. On the contrary, it resists the subtle moralism that often hides behind the language of "lifestyle." A patient who cannot exercise safely, cannot afford healthy food, cannot sleep because of shift work, cannot reduce stress because of caregiving burden, or cannot attend

appointments because of transport barriers is not simply non-compliant. The life-field itself may be constraining the possibility of change. To call for self-management without understanding the conditions of self-management is to misread the clinical situation.

Life-coherence medicine therefore shifts the clinical gaze from isolated behavior to feasible capacity. It does not ask only, "Why has this patient failed to change?" It asks, "What would have to become possible for change to occur?" This question protects both clinical realism and patient dignity. It recognizes that healing often requires the restoration of margin before the demand for transformation can be reasonable.

At the same time, life-coherence medicine is not passive. It does not romanticize suffering or accept constraint as destiny. Its purpose is repair. The clinician seeks points of leverage where small, precise, feasible interventions can restore regulation and capacity. Sometimes this will be a medication. Sometimes it will be deprescribing. Sometimes it will be urgent referral, surgery, antibiotics, insulin, oxygen, anticoagulation, steroids, or chemotherapy. Sometimes it will be sleep restoration, pain relief, food access, physiotherapy, social support, explanation, reassurance, safety planning, grief work, occupational adjustment, family dialogue, or continuity of care. Often it will be a combination.

The distinctive feature of life-coherence medicine is not that it uses entirely different tools, but that it orders them by a different question. The question is not merely, "How do we normalize this number?" The question is, "How do we restore this person's capacity to live?" Biomarkers remain important, but they are interpreted in relation to function, risk, burden, and possibility. A lower blood pressure is not an end in itself if the patient becomes dizzy, falls, fears movement, or loses confidence. A lower glucose is not coherent if achieved through hypoglycemia, anxiety, cost, or treatment burden that overwhelms the patient's life. Disease control must be placed in service of life-capacity.

Life-coherence medicine also reframes the meaning of clinical success. Success is not only improved laboratory values, resolved symptoms, or guideline adherence, though these may be essential. Success also includes restored sleep, safer movement, reduced fear, fewer falls, improved energy, clearer understanding, reduced medication burden, renewed trust, better participation, regained work capacity, strengthened family support, and the patient's sense that life has become more possible again. These are not soft outcomes. They are clinical outcomes when medicine is understood as care for living beings.

This approach has affinities with several established traditions. It resonates with person-centred care, which insists that patients must be seen as persons rather than disease carriers. It resonates with the social determinants of health, which show that health is shaped by conditions of living, working, aging, and belonging. It resonates with salutogenesis, which asks what generates health rather than only what causes disease (Antonovsky, 1979, 1987). It resonates with rehabilitation, geriatrics, family medicine, psychiatry, palliative care, narrative medicine, and systems medicine, all of which recognize that clinical reality exceeds disease classification alone.

Yet life-coherence medicine adds a unifying clinical grammar. It brings these insights into a practical question that can guide the encounter: what pattern is constraining this person's capacity for viable living, and what would restore it? This question is broad enough to include biology, psychology, society, environment, and meaning, but disciplined enough to remain clinical. It does not ask the physician to solve everything. It asks the physician to see enough of the pattern to act wisely.

The Life-Coherence Clinical Assessment is the clinical method that follows from this view. If life-coherence medicine is the broader paradigm, the Life-Coherence Clinical Assessment is its practical expression in the consultation. It changes how the clinician takes a history, performs an examination, orders investigations, interprets results, and constructs a care plan. The method does not add a separate layer of complexity to the clinical encounter. Rather, it reorganizes what is already present so that the clinician can see the relation between disease and life-capacity more clearly.

# 3. The Life-Coherence Clinical Assessment: Definition and Scope

The **Life-Coherence Clinical Assessment** is a person-in-world method of clinical evaluation that integrates history taking, physical examination, investigation, interpretation, and care planning around a central question:

> *What pattern is constraining this person's capacity to live, adapt, heal, and participate?*

This question does not replace the conventional diagnostic question: **What disease is present?** Rather, it situates that question within a wider clinical frame. A physician must still ask whether the patient has infection, malignancy, ischemia, inflammation, endocrine disease, renal failure, heart failure, neurological disease, psychiatric illness, medication toxicity, trauma, or another identifiable pathology. The Life-Coherence Clinical Assessment insists that such diagnostic rigor remains non-negotiable. But it also asks what the disease means in the patient's lived context, how it is reducing adaptive margin, and what conditions would make repair possible.

The method begins from the recognition that illness is never encountered as pathology alone. Illness is encountered as interruption. A patient seeks care because something in the continuity of living has become uncertain, painful, frightening, exhausting, limiting, or unmanageable. The body may be signaling danger. A disease process may be unfolding. But the patient's concern is also practical and existential: Can I breathe? Can I work? Can I sleep? Can I walk? Can I think clearly? Can I care for my family? Can I trust my body? Can I afford this treatment? Can I continue like this? Will I recover?

Clinical assessment must therefore be able to read both the pathology and the interruption. To read pathology, medicine uses the established tools of diagnosis: symptom analysis, examination, differential diagnosis, investigations, risk stratification, and evidence-based treatment. To read interruption, the clinician must examine the patient's life-capacity: function, reserve, agency, relationships, burdens, supports, meanings, constraints, and options. The Life-Coherence Clinical Assessment brings these two readings together.

Its purpose is not to create a longer consultation by adding endless social, psychological, or philosophical questions to an already pressured clinical encounter. Its purpose is to improve the quality of clinical attention. In many cases, one or two life-coherence questions may reveal the decisive missing piece: the medication cannot be afforded; the patient is not sleeping; the caregiver is overwhelmed; the diet plan is impossible; the dizziness began after intensification of treatment; the pain is disabling movement; the patient is afraid to disclose domestic violence; the appointment schedule is incompatible with work; the "non-compliance" is actually confusion, grief, cost, or mistrust.

The method can be summarized as follows:

| Clinical Step | Conventional Question | Life-Coherence Question |
|---|---|---|
| History taking | What symptoms are present? | What life has been interrupted? |
| Physical examination | What signs indicate disease? | What does the body reveal about reserve, regulation, and function? |
| Investigations | What tests clarify diagnosis? | What tests clarify danger, diagnosis, lost margin, modifiable causes, or meaningful trends? |
| Management | What treatment is indicated? | What feasible repair restores the most life-capacity? |

The Life-Coherence Clinical Assessment therefore operates as a **pattern-recognition method**. It asks the clinician to identify not only disease patterns, but constraint patterns. A disease pattern explains what is biologically wrong. A constraint pattern explains why adaptive capacity is narrowing, why treatment is failing, why symptoms persist, why risk is escalating, or why healing has not become possible. Good clinical care often depends on seeing both.

The scope of the method includes four interrelated domains. First, it includes the **Coherence History**. This is the patient's story of symptoms, illness, life-field, constraints, losses, rhythms, meanings, burdens, and possibilities. It preserves the structure of the conventional medical history while expanding its purpose. The clinician still clarifies the presenting complaint, chronology, associated symptoms, past medical history, medications,

allergies, family history, social history, and systems review. But the clinician also asks: What capacity has been lost? What has become harder to do? What was happening in the patient's life before the illness worsened? What pressures are accumulating? What supports are missing? What does the patient believe is driving the problem? What would make recovery feasible?

Second, it includes the **Regulatory-Functional Physical Examination**. This examination does not replace the conventional physical examination. It deepens it. The clinician continues to examine relevant systems, elicit diagnostic signs, assess vital signs, and search for evidence of disease. But the clinician also examines the body as a living system under constraint: posture, gait, frailty, muscle mass, breath pattern, edema, pain behavior, cognition, affect, autonomic strain, nutritional state, medication effects, skin integrity, sleep-related exhaustion, and functional reserve. The question becomes not only, "What signs indicate disease?" but also, "How much margin does this body have left?"

Third, it includes **Purposeful Investigation**. Investigations are not ordered simply because they are available, customary, or protocolized. They are ordered because they answer a clinically meaningful question. In life-coherence terms, investigations should clarify at least one of five purposes: danger, diagnosis, lost margin, modifiable causes, or meaningful trends. A test is coherent when its result can change care, reduce uncertainty, reveal risk, identify a reversible constraint, guide treatment intensity, or help monitor recovery. A test is less coherent when it adds data without changing the patient's pathway or increases anxiety, cost, burden, or fragmentation without proportional benefit.

Fourth, it includes the **Life-Capacity Repair Plan**. This is the management plan reframed around restoration of adaptive margin and participation. The repair plan may include medication, procedures, referral, urgent treatment, monitoring, lifestyle change, rehabilitation, social support, education, deprescribing, psychological care, family engagement, environmental modification, or follow-up. Its distinctive question is: What is the least-forcing, most feasible intervention that would restore capacity? The plan is judged not only by whether it is medically correct, but by whether it can be lived.

The Life-Coherence Clinical Assessment can be used at different levels of depth. In acute care, it may be brief and focused: identify danger, stabilize physiology, and recognize immediate constraints to safe discharge or follow-up. In chronic disease care, it may become more longitudinal: track the interaction between disease control, treatment burden, function, emotional state, and life circumstances. In multimorbidity, it can help prioritize competing interventions by asking which action will most preserve or restore the patient's overall capacity. In palliative or end-of-life care, it can help clarify what matters most when cure is no longer the central aim. In preventive medicine, it can identify early loss of margin before overt disease escalation.

The method is especially useful when conventional care seems technically appropriate but clinically ineffective. These are the situations where the patient is "not improving," "not adhering," "not coping," "frequently attending," "difficult to manage," or "medically complex." Life-coherence medicine asks whether these labels may conceal an unrecognized miscoupling between the treatment plan and the patient's actual life. The patient may not be difficult. The pattern may be difficult. The care plan may be insufficiently coherent.

The Life-Coherence Clinical Assessment is also useful during transitions of care. When a patient is handed over from one physician to another, from hospital to community, from specialist to primary care, or from one country to another, a list of diagnoses and medications may not be enough. The receiving clinician needs to know the patient's capacity, risks, supports, barriers, treatment priorities, functional baseline, warning signs, and follow-up needs. A life-coherence handover therefore asks: What must be preserved for this person's life to remain viable? What is fragile? What should not be lost in transition?

The scope of the method is broad, but its boundaries are equally important. The Life-Coherence Clinical Assessment is **not** a substitute for emergency assessment, diagnostic reasoning, biomedical investigation, pharmacological treatment, surgery, psychiatry, public health, rehabilitation, palliative care, or specialist care. It must not delay urgent treatment. It must not encourage clinicians to explain away disease as stress, lifestyle, trauma, or social context. It must not become a vague language of "wholeness" that weakens clinical precision. It must not shift responsibility for structural constraints onto the patient.

Nor is the method a demand that every clinician solve every social, emotional, economic, or environmental problem. No individual clinician can repair all the conditions that shape health. The purpose is more modest and more practical: to see enough of the pattern to avoid miscoupled care, identify feasible leverage points, mobilize appropriate supports, and make clinical decisions that serve the patient's actual life.

The Life-Coherence Clinical Assessment therefore occupies a middle path. It is more expansive than a narrow disease checklist, but more disciplined than an unstructured holistic conversation. It is biomedical without being reductionist. It is person-centred without being vague. It is contextual without being blaming. It is practical without being merely technical. It asks the clinician to hold disease, person, and world in a single field of care.

## 4. Part I - The Coherence History

The clinical history is the first act of medicine. Before the clinician touches the patient, orders an investigation, writes a prescription, or names a disease, the patient speaks. The history is where suffering is translated into clinical meaning. It is where the physician learns what happened, when it happened, how it evolved, what it feels like, what worsens it, what relieves it, what came before, and what the patient fears may come next.

The conventional medical history remains indispensable. The presenting complaint, history of presenting illness, past medical history, medication history, allergies, family history, social history, and systems review provide the structure through which clinical reasoning begins. Without this structure, medicine becomes unsafe. A life-coherence approach does not replace the conventional history. It deepens it.

The **Coherence History** asks not only, "What symptoms are present?" but also, "What life has been interrupted?" It asks how the symptom has entered the patient's world, what capacity has been lost, what adaptive margin has narrowed, what burdens have accumulated, and what possibilities remain. The symptom is still analyzed medically, but it is also understood as a sign of disrupted viability.

A patient with breathlessness is not only asked about onset, exertional limitation, orthopnea, paroxysmal nocturnal dyspnea, wheeze, cough, chest pain, smoking, occupational exposure, and cardiac risk. They are also asked what breathlessness has made impossible. Can they climb the steps? Sleep lying flat? Walk to the bathroom? Work? Speak? Cook? Care for a spouse? Leave the house? Trust their body? The symptom becomes clinically meaningful not only through its pathophysiological implications, but through the life-capacity it has constrained.

Similarly, a patient with fatigue is not only assessed for anemia, endocrine disease, infection, malignancy, depression, sleep apnea, medication effects, inflammatory disease, and cardiopulmonary limitation. They are also asked how fatigue is shaping the day. What time does energy fail? What tasks are abandoned? What responsibilities remain unavoidable? What rest is possible? What demands exceed capacity? What forms of support exist? What does the patient fear the fatigue means? What has the fatigue taken from the person's sense of self?

The Coherence History therefore begins with the presenting complaint but does not end there. It moves from symptom to life-pattern. It asks how illness is embedded in rhythms of sleep, food, movement, work, relationship, environment, emotion, memory, meaning, access, and care. It seeks the pattern in which disease and life-world meet.

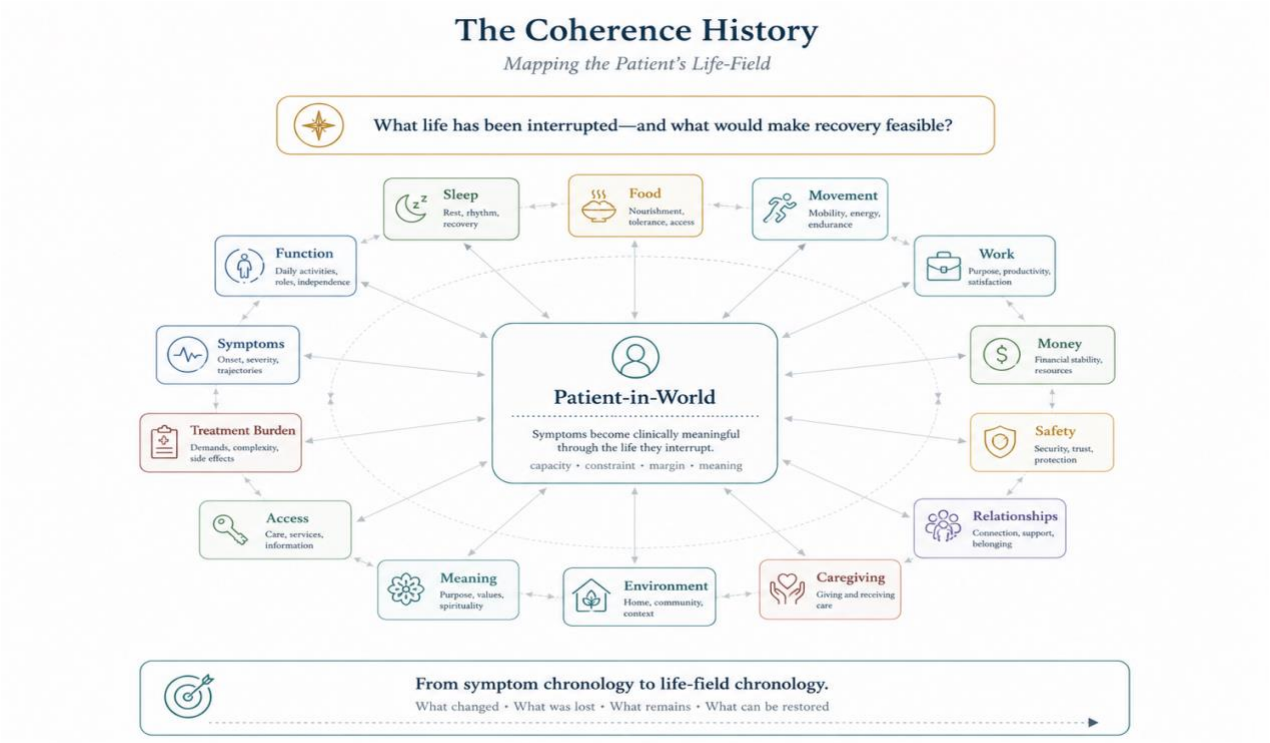


*Figure 2. The Coherence History. The Coherence History expands conventional history taking from symptom chronology to life-field chronology. It asks how illness affects function, what adaptive margin has been lost, what constraints limit healing, and what would make recovery feasible.*

A useful opening sequence may be: "Tell me what has been happening." "What has changed in your life since this began?" "What can you no longer do, or no longer do easily?" "Where do you feel you are losing ground?" "What do you think is keeping this from getting better?" "What would make recovery possible for you?"

These questions are not sentimental additions to clinical work. They are diagnostic. They reveal function, severity, burden, risk, feasibility, and priorities. They can uncover the difference between a disease that is biologically mild but life-disrupting and a disease that appears stable on paper while eroding the patient's capacity. They can also reveal why a treatment plan has failed despite being pharmacologically correct.

## 4.1 The Symptom as Loss of Capacity

Every presenting symptom should be translated into its effect on life-capacity. Pain, breathlessness, dizziness, weakness, fatigue, palpitations, nausea, insomnia, diarrhea, urinary symptoms, low mood, memory difficulty, and swelling are not only clinical data. They are interruptions in the patient's ability to live.

The clinician should ask: "What has this symptom stopped you from doing?" "What are you doing less of because of this?" "What are you avoiding?" "What has become frightening, exhausting, or uncertain?" "What matters most that this illness is interfering with?"

This does not dilute diagnostic reasoning. It sharpens it. Functional impact helps stratify severity. It helps distinguish mild disease from serious limitation. It helps identify urgency, risk of deterioration, need for support, and the patient's own treatment priorities.

For example, two patients may report knee pain. One has mild pain after long walks but remains active. Another has stopped leaving the house, gained weight, become depressed, developed poor glycemic control, and lost

social contact. The diagnostic label may be similar, but the life-coherence assessment is very different. In the second case, knee pain has become a gateway into systemic loss of capacity.

The same principle applies across clinical medicine. Chest pain is not only a possible marker of coronary disease; it may also create fear of movement, avoidance of work, and loss of bodily trust. Urinary frequency is not only a urological or metabolic symptom; it may disrupt sleep, travel, work, social life, and dignity. Insomnia is not merely a symptom to be recorded; it may be the nightly erosion of the body's ability to repair. The Coherence History asks the clinician to hear both the biomedical signal and the lived interruption.

## 4.2 The Life-Field Chronology

The conventional history asks when the symptom began. The Coherence History also asks what was happening in the patient's life before, during, and after the illness emerged or worsened. This does not mean assuming that life events caused the disease. Rather, it recognizes that disease expression, symptom burden, recovery, and self-management are shaped by context.

A flare of illness may follow infection, bereavement, financial crisis, relocation, caregiving strain, workplace conflict, medication interruption, environmental exposure, dietary change, sleep disruption, or loss of routine. Sometimes the link is causal. Sometimes it is contributory. Sometimes it is simply the context in which recovery must now occur.

The life-field chronology helps the clinician see patterns that a disease-only history may miss. It may reveal that blood pressure worsened after job loss, that glycemic control deteriorated after bereavement, that asthma worsened after mold exposure, that dizziness followed medication intensification, that depression deepened after retirement, that recurrent admissions reflect caregiver collapse, or that "poor compliance" began when the patient could no longer afford medication.

## 4.3 Adaptive Margin

Adaptive margin is the reserve that allows a person to absorb disturbance without collapse. It includes biological reserve, emotional reserve, social reserve, financial reserve, cognitive reserve, and practical reserve. When margin is high, a person can tolerate illness, treatment, stress, and change. When margin is low, small disturbances can produce disproportionate deterioration.

The Coherence History therefore asks: "How much room does this person have left?" "What happens when something goes wrong?" "Can the patient absorb a new medication, appointment, dietary change, investigation, cost, or diagnosis?" "Is the care plan restoring margin or consuming it?"

The patient may reveal low margin through statements such as: "I am barely managing." "One more thing and I will break." "I cannot miss work." "I cannot afford another test." "I am too tired to cook." "I do not understand all these medications." "I have no one to help me." "I cannot keep coming back." These statements are not peripheral. They are clinical data. They determine what form of care is possible.

Adaptive margin is especially important in chronic disease, frailty, multimorbidity, mental distress, caregiving burden, and poverty. The same treatment plan may be feasible for a patient with strong support and high reserve, but impossible for a patient who is exhausted, isolated, confused, financially constrained, or physically fragile. To ignore margin is to risk prescribing beyond the patient's capacity.

## 4.4 Constraint History

A life-coherence assessment must identify the constraints that limit healing. These constraints may be biological, psychological, relational, social, economic, environmental, institutional, or cultural. They are the conditions that narrow the patient's options.

Important constraint domains include sleep and recovery, food and nutrition, movement and mobility, work and time, money and access, relationships and caregiving, safety and environment, meaning and agency, and treatment burden. The purpose is not to create an exhaustive social inventory at every visit. The purpose is to

identify the constraints most relevant to the clinical problem and the care plan. In a brief consultation, one constraint may be enough to change care. In complex care, a fuller constraint map may be necessary.

Sleep matters because without sleep, regulation fails. Food matters because dietary advice is not meaningful if the patient cannot access, prepare, chew, swallow, or afford food that supports health. Movement matters because pain, fear of falling, unsafe neighborhoods, breathlessness, neuropathy, depression, and deconditioning can all narrow participation. Work matters because irregular hours, toxic exposures, heat, violence, or inflexible schedules may directly shape disease and treatment feasibility. Money matters because unaffordable care is not care the patient can live. Relationships matter because support or isolation often determines whether treatment can be enacted. Treatment burden matters because care itself can become part of the constraint pattern.

## 4.5 The Patient's Explanatory Model

Patients usually have a theory of their illness, even if they do not state it in biomedical language. They may believe the problem is caused by stress, aging, food, medication, inheritance, spiritual distress, workplace exposure, grief, infection, climate, bad luck, punishment, or something more frightening. The clinician does not need to accept every explanation, but must understand it.

Useful questions include: "What do you think is causing this?" "What worries you most about it?" "What have you tried so far?" "What do you think would help?" "Is there anything you are afraid I might find?" "Is there anything you were hoping I would do today?"

These questions often reveal hidden fears, expectations, and barriers. A patient with headache may fear a brain tumor. A patient with chest pain may fear sudden death. A patient with diabetes may fear insulin because a relative started insulin before losing a limb. A patient with depression may fear being judged. A patient with cancer symptoms may delay care because they fear the diagnosis more than the illness. Unless these meanings are elicited, the care plan may fail.

## 4.6 Treatment Feasibility and Burden

A prescription is not complete when it is written. It becomes treatment only if it can enter the patient's life. The Coherence History therefore asks whether the plan is feasible. Can the patient get the medication? Can they afford it? Do they understand how to take it? What might make it hard to follow the plan? How many tablets are already being taken? Are any medicines causing problems? Would this plan fit the patient's day?

This is particularly important in multimorbidity, where multiple guidelines may produce an unlivable plan. Each condition may be treated correctly, while the patient as a whole becomes overburdened. A life-coherence approach asks whether the total care plan restores capacity or consumes it.

Treatment burden includes more than medications. It includes appointments, laboratory tests, imaging, referrals, monitoring devices, dietary rules, exercise instructions, self-measurement, paperwork, costs, transport, side effects, and the emotional work of being a patient. For patients with limited margin, care itself can become a source of overload.

## 4.7 From Non-Compliance to Miscoupling

One of the most important shifts in the Coherence History is the replacement of reflexive language of non-compliance with the more precise question of miscoupling. When a patient does not follow a treatment plan, the clinician should ask whether the plan is mismatched to the patient's life.

The patient may not understand the instructions. The medication may be unaffordable. Side effects may be intolerable. The timing may conflict with work. Depression may reduce motivation. Cognitive impairment may interfere with adherence. The patient may distrust the clinician. The treatment may conflict with cultural practices. The patient may be choosing between medication and food. The plan may be too complex.

The question is therefore not only: "Why is this patient not complying?" but: "Where is the care plan failing to couple with this patient's real conditions of living?" This shift reduces blame and improves care. It does not

remove patient responsibility; it makes responsibility possible by identifying the conditions under which action can actually occur.

### 4.8 The Coherence History in Practice

The Coherence History does not need to be long to be powerful. Even a brief consultation can include a life-coherence lens. After clarifying the biomedical complaint, the clinician may ask three practical questions: "What is this stopping you from doing?" "What is making it hard to get better?" "What would make the next step possible?"

These questions can transform the encounter. They reveal function, constraint, and feasibility. They help the clinician prioritize. They communicate respect. They invite partnership. They make the care plan more realistic.

### 4.9 Documentation of the Coherence History

If the Coherence History is not documented, it is easily lost. Clinical records often preserve diagnoses, medications, allergies, and results, but omit the conditions that determine whether care can work. A life-coherence note should include concise documentation of capacity, constraints, margin, and feasibility.

For example: "Lives alone; increasing exertional dyspnea now limiting shopping and cooking. Poor sleep due to orthopnea. Unable to afford previous inhaler. Daughter visits weekly. Main goal: to regain enough breath to walk to nearby shop."

Or: "Diabetes control worsened after spouse's death. Eating irregularly, low motivation to cook, stopped walking group. No hypoglycemia. Can afford medication. Priority today: restore routine and reduce overwhelm before intensifying therapy."

Such documentation helps future clinicians see the patient, not merely the disease. It also protects continuity. A receiving clinician can understand what has worked, what has failed, what matters to the patient, and what conditions must be considered for care to remain coherent.

### 4.10 Summary

The Coherence History is the first pillar of the Life-Coherence Clinical Assessment. It preserves the conventional history while widening its field of attention. It asks how symptoms affect life-capacity, how illness is embedded in the patient's life-field, where adaptive margin has been lost, what constraints limit healing, what meanings shape care, and whether treatment is feasible.

It does not make history taking less clinical. It makes it more clinically complete. The patient's life is not background information. It is the field in which disease emerges, treatment lands, and healing either becomes possible or fails to take hold.

## 5. Part II - The Regulatory-Functional Physical Examination

The physical examination is one of medicine's most disciplined forms of attention. Through observation, palpation, percussion, auscultation, measurement, and clinical interpretation, the physician reads the body for signs of disease. The examination can detect danger, confirm suspicion, challenge assumptions, reveal hidden pathology, and guide investigation. It remains indispensable.

A life-coherence approach does not replace the conventional physical examination. It preserves the examination's diagnostic function while widening its interpretive frame. The clinician still examines the cardiovascular, respiratory, abdominal, neurological, musculoskeletal, endocrine, dermatological, vascular, and other relevant systems according to the presenting problem. The clinician still assesses vital signs, looks for signs of acute illness, and searches for evidence that requires urgent action.

What changes is the question being asked of the body. The conventional examination asks: **What signs indicate disease?** The Regulatory-Functional Physical Examination also asks: **What does this body reveal about reserve, regulation, function, and adaptive margin?**

The body is not merely an anatomical object containing organs. It is the lived medium through which the person breathes, moves, works, sleeps, relates, perceives, remembers, and participates. When illness reduces life-capacity, the body often shows this not only through classical signs of disease, but through changes in posture, gait, muscle mass, breath pattern, facial expression, affect, cognition, balance, coordination, skin integrity, nutritional state, endurance, and the ability to move safely through ordinary tasks.

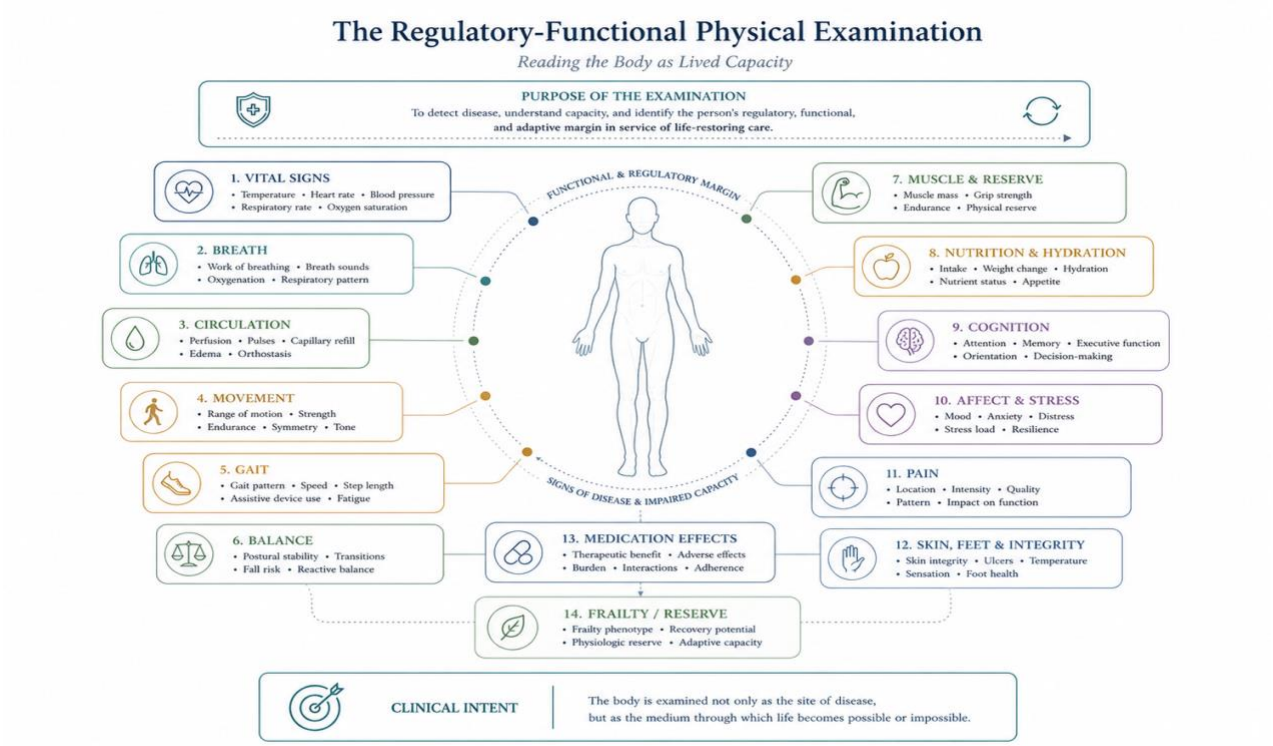


*Figure 3. The Regulatory-Functional Physical Examination. The physical examination remains diagnostic, but is widened to assess embodied regulation, reserve, function, frailty, treatment effects, and adaptive margin. The body is examined not only as the site of disease, but as the medium through which the person's life becomes possible or impossible.*

## 5.1 From Anatomical Signs to Embodied Regulation

Traditional physical examination is organized around anatomical systems. This organization remains necessary. A patient with chest pain requires cardiovascular and respiratory assessment. A patient with abdominal pain requires abdominal examination. A patient with weakness requires neurological and musculoskeletal examination. A patient with fever requires an examination oriented toward sources of infection and systemic instability.

But in life-coherence medicine, anatomical findings are interpreted within the wider question of regulation. The clinician asks not only whether the lungs are clear, but whether the patient can breathe comfortably enough to sleep and move. Not only whether the heart rhythm is regular, but whether circulation supports exertion without

dizziness, falls, or fatigue. Not only whether joints are swollen, but whether pain has narrowed movement, independence, and participation. Not only whether cognition is impaired, but whether the patient can understand, remember, and enact the treatment plan.

The examination therefore becomes a bridge between disease and life-capacity. It reads the body for pathology and for the consequences of pathology. It asks how biological disturbance is being translated into limitation.

## 5.2 Vital Signs as Signals of Margin

Vital signs are often treated as routine measurements. In life-coherence medicine, they are read as signals of regulatory margin. Blood pressure, pulse, respiratory rate, oxygen saturation, temperature, weight, pain score, and orthostatic changes each provide information about the body's current capacity to maintain stability.

The life-coherence question is not simply whether the number is abnormal, but what the abnormality means for the person's capacity to remain viable. Is the patient compensating? Decompensating? Losing reserve? At risk of collapse? Living chronically near the edge of physiological tolerance?

Orthostatic blood pressure and pulse deserve particular attention in many patients, especially older adults, patients on multiple medications, those with diabetes, autonomic symptoms, dizziness, falls, dehydration, frailty, or recent treatment intensification. A seated blood pressure alone may not reveal the practical risk created by the care plan. A patient whose blood pressure looks "controlled" while standing poorly, falling, or fearing movement is not receiving coherent care.

## 5.3 General Appearance and the First Clinical Impression

Before formal examination begins, the clinician sees the patient enter the room. This first impression often contains important information: gait, breathlessness, effort, distress, posture, grooming, alertness, facial expression, weight change, odor, tremor, edema, pallor, jaundice, cyanosis, anxiety, agitation, psychomotor slowing, or exhaustion.

A life-coherence examination makes this observation deliberate. The clinician asks: Does the patient appear to have reserve? Are they using visible effort to breathe, move, sit, speak, or attend? Do they look depleted, overwhelmed, frightened, guarded, confused, or unsupported? Does the body appear to be carrying more than it can sustain?

These impressions must not be used carelessly. They can be biased by culture, age, disability, body habitus, dress, class, or clinician assumptions. But when disciplined and humble, observation can reveal early signs of lost margin.

## 5.4 Breath, Movement, and Effort

Breath is one of the clearest expressions of life-capacity. A person who cannot breathe comfortably cannot sleep, move, speak, work, or feel safe. The respiratory examination therefore includes more than auscultation. It includes observation of respiratory effort, posture, speech length, accessory muscle use, cough, wheeze, cyanosis, oxygen saturation, exercise tolerance, and the patient's confidence in exertion.

Movement reveals the relationship between body and world. Gait speed, balance, stride length, turning, rising from a chair, climbing onto the examination couch, reaching, gripping, bending, and transferring all show how illness has entered function. A patient's capacity to stand from a chair without using their arms may reveal more about future risk than a long list of stable diagnoses.

## 5.5 Frailty, Reserve, and Deconditioning

Frailty is a clinical expression of reduced adaptive reserve. It is not simply old age. It is a state in which the body becomes less able to absorb disturbance. Minor infections, medication changes, falls, dehydration, hospital admissions, bereavement, or social disruption can produce major deterioration (Clegg et al., 2013; Fried et al., 2001; Rockwood & Mitnitski, 2007).

A life-coherence examination therefore attends to signs of frailty and deconditioning: unintentional weight loss, reduced grip strength, slow gait, exhaustion, low activity, recurrent falls, sarcopenia, poor balance, cognitive vulnerability, and dependence in activities of daily living. These findings change how care should be planned. A treatment that is reasonable for a robust patient may be harmful or unrealistic for a frail patient.

## 5.6 Nutrition, Muscle, and Metabolic Coherence

The nutritional state of the patient is often visible before laboratory results return. Weight loss, central adiposity, muscle wasting, edema, poor dentition, glossitis, skin changes, hair thinning, poor wound healing, bruising, dehydration, and signs of micronutrient deficiency can all reveal disturbed metabolic coherence.

Life-coherence medicine treats nutrition not as a moral category but as a regulatory foundation. The question is not whether the patient is "good" or "bad" with diet. The question is whether the patient's body is being adequately supplied, metabolically overloaded, deprived, inflamed, or unable to use what is available. Obesity and malnutrition may coexist, especially in poverty, chronic disease, aging, and ultra-processed food environments.

## 5.7 Pain, Guarding, and Protective Patterns

Pain changes how the body moves through the world. The examination should identify location, tenderness, range of motion, swelling, neurological signs, inflammatory features, mechanical limitation, and red flags. But it should also observe how pain has reorganized the patient's body: guarding, bracing, fear of movement, altered gait, shallow breathing, muscle tension, avoidance, sleep disruption, and withdrawal.

Pain behavior should not be used to judge character or credibility. Guarding, distress, or limited movement are not evidence of exaggeration. They are signs that the body is protecting itself, sometimes adaptively and sometimes in ways that have become self-limiting. The task is to understand the pattern.

## 5.8 Cognition, Affect, and the Capacity to Participate in Care

The patient's ability to understand, remember, decide, and participate in care is central to treatment feasibility. Cognitive and affective observations therefore belong within the physical examination, not as optional extras. Orientation, attention, memory, language, psychomotor speed, facial expression, eye contact, tearfulness, anxiety, agitation, emotional flattening, hopelessness, and signs of delirium all affect clinical care.

A patient with mild cognitive impairment may appear to agree with a plan but be unable to implement it. A patient with depression may understand advice but lack energy, hope, or motivation. A patient with anxiety may repeatedly seek reassurance because the body feels unsafe. A patient with delirium may be misread as uncooperative. A patient with grief may be biologically stable but functionally collapsing.

## 5.9 Medication Effects Written on the Body

The physical examination often reveals the burden of treatment. Postural hypotension, bradycardia, edema, tremor, bruising, steroid changes, dry mouth, extrapyramidal signs, hypoglycemia symptoms, gait instability, confusion, constipation, dehydration, renal vulnerability, and falls may all reflect medication effects.

In conventional care, each medication may have been added for a valid reason. In the patient's body, however, the total effect may be incoherent. A life-coherence examination asks whether treatment is restoring life-capacity or eroding it.

## 5.10 Skin, Feet, Wounds, and the Periphery

The periphery often tells the truth about systemic care. Feet, skin, nails, wounds, pulses, sensation, edema, callus, ulcers, fungal infection, bruising, pressure areas, and footwear reveal circulation, neuropathy, mobility, self-care capacity, nutrition, inflammation, hygiene, access, and neglect.

In diabetes, vascular disease, frailty, kidney disease, heart failure, autoimmune disease, and immobility, careful examination of the periphery can prevent major harm. A foot ulcer is not merely a local lesion. It may express

neuropathy, vascular disease, poor footwear, visual impairment, poverty, limited mobility, inadequate education, and fragmented follow-up. To examine the foot is to examine the whole care system touching the patient.

### 5.11 Functional Micro-Tests

A life-coherence examination can include simple functional observations that require little equipment but yield significant information: Can the patient rise from a chair without using their arms? Can they walk safely across the room? Can they turn without instability? Can they remove and replace footwear? Can they speak in full sentences? Can they recall medication instructions? Can they demonstrate inhaler technique? Can they read the label?

These small observations often reveal why care succeeds or fails. A patient may be prescribed an inhaler but unable to use it correctly. A patient may be told to inspect their feet but unable to see or reach them. A patient may be given complex medication instructions but unable to read the label. A patient may be told to exercise but unable to stand safely.

### 5.12 Summary

The Regulatory-Functional Physical Examination is the second pillar of the Life-Coherence Clinical Assessment. It preserves the diagnostic rigor of the conventional examination while widening attention to reserve, regulation, function, treatment burden, and embodied loss of capacity.

## 6. Part III - Purposeful Investigation

Investigations are among the most powerful tools of modern medicine. Laboratory tests, imaging, physiological measurements, pathology, microbiology, endoscopy, electrocardiography, ultrasound, and advanced diagnostics allow clinicians to see what cannot be seen directly. They reveal hidden danger, confirm or refute diagnostic hypotheses, monitor disease, guide treatment, and prevent harm.

A life-coherence approach does not diminish the importance of investigation. It strengthens the discipline with which investigations are chosen and interpreted. The question is not whether medicine should investigate. The question is whether each investigation serves the patient's life.

The Life-Coherence Clinical Assessment proposes **Purposeful Investigation** as its third pillar. Investigations should be ordered and interpreted in relation to five clinical purposes: **danger, diagnosis, lost margin, modifiable causes, and meaningful trends.** These five purposes do not replace conventional diagnostic reasoning. They organize it around the restoration of life-capacity.


*Figure 4. Purposeful Investigation. In the Life-Coherence Clinical Assessment, investigations are ordered and interpreted according to five purposes: danger, diagnosis, lost margin, modifiable causes, and meaningful trends. A coherent test protects, clarifies, guides, or restores; an incoherent test adds data without improving care.*

## 6.1 Danger

The first purpose of investigation is to identify or exclude danger. This includes conditions that are life-threatening, time-sensitive, rapidly progressive, disabling, contagious, reversible if caught early, or unsafe to miss. If the patient may have myocardial infarction, stroke, sepsis, pulmonary embolism, meningitis, ectopic pregnancy, diabetic ketoacidosis, acute kidney injury, severe anemia, malignancy, cauda equina syndrome, temporal arteritis, acute abdomen, suicidal risk, or another serious condition, appropriate investigation and urgent action take priority.

The question is immediate: "Is there something dangerous happening that must be recognized now?" This purpose protects life-coherence medicine from becoming vague or falsely reassuring. A patient's life-field matters, but danger must be addressed.

## 6.2 Diagnosis

The second purpose is diagnosis. The clinician investigates to identify the disease process, mechanism, syndrome, or pathological category that best explains the patient's presentation. Breathlessness due to asthma, heart failure, anemia, pulmonary embolism, anxiety, pneumonia, deconditioning, or interstitial lung disease cannot be managed coherently without distinguishing among them. Fatigue due to depression, hypothyroidism, renal failure, malignancy, sleep apnea, medication toxicity, autoimmune disease, or caregiving exhaustion requires different forms of response.

In life-coherence medicine, diagnosis is not the end of assessment. It is a necessary stage in understanding the pattern. A diagnosis identifies what is biologically happening, but it does not fully explain how the disease is lived, why the patient is losing capacity, or what repair requires. The clinician must therefore move from diagnosis to coherence: from naming the condition to understanding its consequences, constraints, and feasible treatment pathway.

## 6.3 Lost Margin

The third purpose of investigation is to assess lost margin. Many tests matter not only because they diagnose disease, but because they reveal how much reserve remains. Renal function reveals filtration margin and medication safety. Electrolytes reveal regulatory stability. Hemoglobin reveals oxygen-carrying capacity. Albumin may suggest nutritional, inflammatory, hepatic, renal, or systemic vulnerability. HbA1c reflects longer-term glycemic exposure, but must also be interpreted in relation to hypoglycemia, frailty, anemia, and treatment burden.

The life-coherence question is: "How much adaptive reserve has been lost, and where?" This is especially important in chronic disease, aging, multimorbidity, and complex care. A patient may have "stable" disease by one marker while losing margin elsewhere.

## 6.4 Modifiable Causes

The fourth purpose of investigation is to identify what can be changed. A test is clinically valuable when it reveals a reversible or treatable contributor to lost capacity. Iron deficiency, B12 deficiency, hypothyroidism, renal impairment, medication toxicity, infection, inflammatory activity, sleep apnea, poor glycemic control, hypoxia, arrhythmia, obstructive uropathy, occult bleeding, depression, alcohol-related harm, or environmental exposure may all represent modifiable contributors depending on the case.

The life-coherence question is: "What is driving this loss of capacity that we can actually do something about?" This question protects investigation from becoming merely descriptive. It asks whether the result will open a pathway of repair.

## 6.5 Meaningful Trends

The fifth purpose is trend. Many clinical values are more meaningful over time than in isolation. A creatinine level, hemoglobin, weight, HbA1c, blood pressure, albumin, inflammatory marker, eGFR, urine albumin-creatinine ratio, oxygen saturation, cognitive score, gait speed, or symptom score may be difficult to interpret as a single measurement but powerful as a trajectory.

Trends reveal direction. They show whether the patient is stabilizing, improving, deteriorating, fluctuating, or approaching a threshold of danger. They also show whether the care plan is working or creating harm. The life-coherence question is: "Is this person gaining margin, losing margin, or merely shifting burden from one domain to another?"

## 6.6 Coherence-Guided Testing

Coherence-guided testing asks the clinician to state the purpose of the investigation before ordering it: Am I looking for danger? Clarifying diagnosis? Assessing lost margin? Identifying a modifiable cause? Following a meaningful trend? If none of these purposes applies, the test may be unnecessary. If one applies clearly, the test is easier to justify and interpret.

This discipline also helps communicate with patients. Instead of saying, "I am ordering some routine bloods," the clinician can say, "I want to check whether your fatigue is related to anemia, thyroid disease, kidney function, inflammation, or another treatable cause." Such explanations convert testing into shared inquiry rather than impersonal extraction.

### 6.7 Under-Investigation and Over-Investigation

Purposeful investigation avoids two opposite errors. The first is under-investigation, when symptoms are dismissed, danger is missed, or treatable disease is not sought. The second is over-investigation, when tests accumulate without clear purpose, generating burden, confusion, false positives, incidental findings, and fragmented care. The middle path is disciplined inquiry: investigate enough to protect and restore life; do not investigate merely to generate information detached from action.

Choosing Wisely and related efforts to reduce unnecessary tests and treatments are aligned with this principle: avoiding overuse is not rationing care, but protecting patients from interventions that do not serve them (ABIM Foundation, n.d.; Morgan et al., 2015).

### 6.8 Summary

Purposeful Investigation is the third pillar of the Life-Coherence Clinical Assessment. It preserves the power of biomedical testing while placing investigation in service of life-capacity. Tests should clarify danger, diagnosis, lost margin, modifiable causes, or meaningful trends. They should be interpreted in relation to the patient's function, context, goals, burdens, and feasible options.

## 7. Part IV - The Life-Capacity Repair Plan

Assessment is incomplete until it becomes action. The purpose of the Life-Coherence Clinical Assessment is not merely to understand the patient more fully, but to guide care more wisely. The Coherence History, Regulatory-Functional Physical Examination, and Purposeful Investigation all converge on a practical question: **What would restore this person's capacity to live, adapt, heal, and participate?** The answer becomes the **Life-Capacity Repair Plan**.

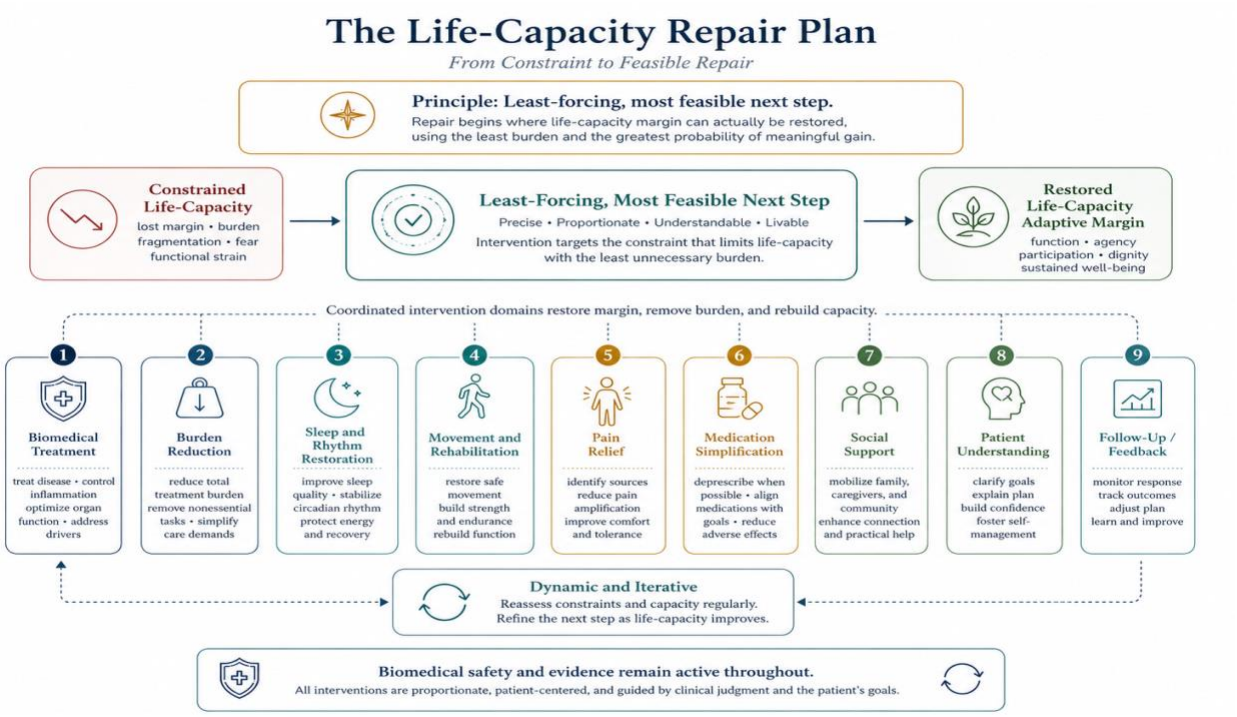


*Figure 5. The Life-Capacity Repair Plan. Management is reframed as the restoration of adaptive margin, function, agency, and participation. The repair plan asks what intervention will restore the most life-capacity with the least unnecessary burden, while preserving biomedical safety and evidence-based care.*

In conventional clinical practice, management is often framed around diagnosis and treatment: identify the disease, select the appropriate intervention, prescribe the medication, request the procedure, arrange the referral, monitor the response. This remains necessary. The Life-Capacity Repair Plan does not weaken this. It asks that treatment be placed in service of the living person rather than the isolated disease marker alone.

A plan is life-coherent when it is medically sound, proportionate to risk, feasible within the patient's life, understandable to the patient, responsive to constraints, and oriented toward restored margin. It is not enough for a plan to be correct in theory. It must be livable in practice.

## 7.1 From Disease Control to Capacity Restoration

Disease control remains important. Blood pressure, glucose, lipids, inflammation, pain, infection, fluid balance, oxygenation, renal function, mood symptoms, and other clinical targets matter because uncontrolled disease damages life. But life-coherence medicine insists that disease control is not the final end of care. The deeper aim is restored life-capacity.

The clinician therefore asks: What capacity are we trying to restore? What margin has been lost? What does the patient need to be able to do again? What would make this person's life more viable? How will we know that care is helping?

## 7.2 The Least-Forcing Intervention

A central principle of the Life-Capacity Repair Plan is the **least-forcing intervention**. This means choosing the smallest, most precise, feasible action that can restore margin without overwhelming the patient or destabilizing the system of care.

Least-forcing does not mean weak treatment. In an emergency, the least-forcing intervention may be immediate hospitalization, oxygen, antibiotics, insulin, anticoagulation, surgery, or intensive care. When danger is high, decisive treatment is life-serving. In chronic care, however, least-forcing often means avoiding unnecessary escalation, simplifying complexity, reducing burden, and identifying the intervention most likely to unlock recovery.

## 7.3 Restoring Margin Before Demanding Change

Many care plans fail because they demand change from a patient who has no margin left. The patient is told to exercise while exhausted, eat differently while food insecure, attend appointments while unable to miss work, monitor glucose while overwhelmed, reduce stress while unsafe, or adhere to complex medications while cognitively strained.

Life-coherence medicine reverses the sequence. Before demanding self-management, it asks whether the patient has enough margin to act. What must be relieved before this patient can participate in care? What burden is preventing change? What support would convert advice into possibility? What is the first repair that makes the next repair feasible?

## 7.4 Feasibility as a Clinical Criterion

In life-coherence medicine, feasibility is not an afterthought. It is a clinical criterion. A treatment plan should be evaluated by asking whether the patient can understand it, afford it, access it, remember it, tolerate it, fit it into daily life, return for monitoring, recognize danger signs, and survive contact with the patient's world.

A plan that fails these questions may still be medically correct, but it is not yet coherent. The clinician must then modify the plan, mobilize support, simplify instructions, prioritize fewer goals, involve others, or choose a more feasible pathway.

## 7.5 Prioritization in Multimorbidity

Multimorbidity is one of the strongest arguments for a life-coherence approach. When a patient has multiple conditions, each guideline may recommend its own targets, medications, tests, lifestyle advice, monitoring schedule, and specialist input. When combined, these recommendations can become burdensome, contradictory, or impossible (National Institute for Health and Care Excellence, 2016).

The Life-Capacity Repair Plan asks the clinician to prioritize according to whole-person capacity. Which problem most threatens this patient's life-capacity now? Which intervention will produce the greatest gain in margin? Which treatment is creating more burden than benefit? Which target should be relaxed because the patient is frail or vulnerable? Which condition is destabilizing the others? Which action would simplify the whole pattern?

## 7.6 Deprescribing and Burden Reduction

Sometimes repair requires adding treatment. Sometimes it requires removing what is harming, overwhelming, duplicating, or no longer serving the patient. Deprescribing is therefore a core life-coherence practice. It asks whether each medication still has a clear indication, benefit, tolerability, feasibility, and alignment with the patient's goals.

Burden reduction also includes simplifying appointments, reducing unnecessary monitoring, aligning follow-up visits, clarifying responsibility among specialists, and avoiding repeated instructions that the patient cannot implement. Sometimes the most life-restoring act is not another prescription, but the removal of avoidable complexity (May et al., 2009; Shippee et al., 2012).

## 7.7 Repair as Shared Work

The Life-Capacity Repair Plan is not something done to the patient. It is developed with the patient. Shared decision-making is not merely a communication style; it is necessary for coherence. The patient knows the lived field in which the plan must operate. The clinician knows the biomedical risks, options, and implications. Coherent care requires both forms of knowledge (Elwyn et al., 2012; Reuben & Tinetti, 2012).

## 7.8 Repair Pathways Across Domains

The Life-Capacity Repair Plan may include biomedical repair, regulatory repair, functional repair, cognitive-emotional repair, relational repair, practical repair, and environmental repair. Not every patient needs all domains. The clinician identifies the domains most relevant to the presenting pattern and chooses feasible leverage points.

The repair plan is therefore not a generic holistic list. It is a targeted clinical response to the specific pattern constraining the patient's life-capacity. The clinician asks: Which domain is most limiting recovery now? Which repair will unlock the next repair? Which action is both clinically meaningful and practically possible?

## 7.9 Follow-Up as Coherence Tracking

Follow-up is not merely a check on compliance or laboratory values. It is the process of tracking whether the patient is regaining margin. Is the patient safer? Functioning better? Are symptoms improving? Are test results moving in the right direction? Is treatment tolerable? Has burden increased or decreased? Does the patient understand the plan? What new constraint has appeared? What is the next feasible step?

A life-coherence follow-up is iterative. It does not assume that the first plan is final. It observes how the plan behaves in the patient's life and adjusts accordingly. Coherence is built through feedback.

## 7.10 Summary

The Life-Capacity Repair Plan is the fourth pillar of the Life-Coherence Clinical Assessment. It translates clinical understanding into feasible, life-serving action. It asks not only what treatment is indicated, but what intervention will restore adaptive margin, function, agency, and participation.

# 8. Clinical Applications

The Life-Coherence Clinical Assessment is not intended to remain a conceptual framework. Its value depends on whether it changes clinical seeing, clinical reasoning, and clinical action in ordinary practice. The method should help clinicians recognize disease more safely, understand patients more fully, reduce miscoupled care, and construct plans that restore adaptive margin and life-capacity.

## 8.1 Hypertension

Hypertension is often treated as a numerical problem: the blood pressure is elevated, risk is estimated, medications are prescribed, and targets are pursued. This approach is necessary because uncontrolled hypertension increases risk of stroke, heart disease, kidney disease, heart failure, and vascular injury. Yet a life-coherence approach asks what the blood pressure is expressing within the patient's whole regulatory field.

The Coherence History may reveal sleep deprivation, shift work, chronic pain, caregiving stress, grief, alcohol use, financial strain, food insecurity, medication cost, poor understanding, fear, or mistrust. The Regulatory-Functional Examination remains focused on cardiovascular and systemic risk, but also asks whether treatment has reduced adaptive margin. Purposeful Investigation may clarify renal function, electrolytes, urine albumin-creatinine ratio, glucose, lipids, ECG findings, and other risks. The Life-Capacity Repair Plan asks how to reduce vascular risk while restoring capacity.

## 8.2 Diabetes and Metabolic Syndrome

Diabetes is often managed through glucose metrics, medication escalation, nutrition advice, complication screening, and cardiovascular risk reduction. These are essential. But diabetes is also a disorder of daily rhythm, food environment, energy, movement, stress physiology, social conditions, medication burden, and long-term fear.

A life-coherence diabetes assessment asks what makes metabolic regulation possible or impossible in this person's life. It explores food access, meal timing, cultural food practices, cooking capacity, appetite, dental issues, alcohol, sleep, shift work, depression, grief, caregiving, health literacy, medication affordability, fear of insulin, fear of complications, previous family experiences, and the patient's actual daily routine. The aim is not simply to make the patient "compliant." The aim is to make metabolic care possible within the patient's real life.

## 8.3 Chronic Pain

Chronic pain is one of the most important domains for life-coherence medicine because pain is not only a sensation. It reorganizes the person's entire world. It changes movement, sleep, mood, work, relationships, identity, sexuality, confidence, and hope. It can narrow life even when tissue damage is not worsening.

Conventional assessment remains essential. The clinician must identify red flags and treatable or dangerous causes. A life-coherence approach does not dismiss pain as psychological. It takes pain seriously as embodied suffering and functional disruption. The Life-Capacity Repair Plan focuses on restoring safe function through medication where appropriate, explanation, reassurance, sleep restoration, graded movement, physiotherapy, treatment of mood disorders, occupational adjustment, reduction of fear, and careful medication review.

## 8.4 Depression and Anxiety

Depression and anxiety are often described as mental health conditions, but they are also whole-body and whole-life conditions. They affect sleep, appetite, energy, concentration, pain, immune function, relationships, work, self-care, medication adherence, and the ability to imagine a future.

A life-coherence approach begins by taking distress seriously while maintaining diagnostic discipline. The clinician must assess severity, suicidality, psychosis, bipolarity, substance use, medical contributors, medication effects, trauma, and risk. But the assessment must also ask what world the patient is living in. The Life-Capacity Repair Plan may include psychological therapy, medication, safety planning, sleep restoration, movement, social

support, grief work, reduction of alcohol or substances, family involvement, occupational adjustment, and close follow-up.

### 8.5 Multimorbidity and Frailty

Multimorbidity exposes the limits of disease-by-disease care. A patient may have diabetes, hypertension, chronic kidney disease, osteoarthritis, heart failure, depression, visual impairment, polypharmacy, and falls risk. Each condition may have guidelines. Each specialist may have recommendations. But the patient has one life, one body, one medication schedule, one income, one family system, one memory, and one finite reserve.

The Life-Coherence Clinical Assessment is particularly useful here because it asks the clinician to assess the whole pattern rather than simply accumulate disease plans. It helps convert multiple partial plans into one livable pathway.

### 8.6 Continuity Care and Clinical Handover

Continuity care is one of the most important applications of the Life-Coherence Clinical Assessment. When patients move between clinicians, institutions, countries, or stages of care, essential life-coherence information is often lost. Diagnoses and medication lists travel more easily than context, function, support, risk, and goals.

A life-coherence handover should include biomedical summary, functional baseline, adaptive margin, constraints, what has worked and failed, priority goals, and follow-up needs. This approach makes continuity more humane and safer.

### 8.7 Acute Care, Discharge Planning, and Prevention

Although life-coherence medicine is especially relevant to chronic disease, it also matters in acute care. Acute care must first identify danger and stabilize the patient. Once immediate danger has been addressed, the life-coherence lens becomes especially important during transition. A patient may be medically "fit for discharge" but practically unable to recover at home.

Preventive medicine often focuses on risk factors, screening, immunization, and early detection. These remain essential. A life-coherence approach adds the question of early margin loss. Before disease becomes overt, patients may show signs of narrowing viability: weight gain or weight loss, poor sleep, reduced movement, rising blood pressure, worsening glucose, loneliness, occupational strain, pain, alcohol escalation, depressive symptoms, caregiver exhaustion, or loss of routine. Prevention, in life-coherence terms, is not only risk-factor control. It is early restoration of adaptive margin.

## 9. Implications for Medical Education and Practice

If the Life-Coherence Clinical Assessment is to become clinically useful, it must be teachable, documentable, and practicable. It cannot remain a philosophical aspiration. It must change how clinicians are trained to listen, observe, investigate, prioritize, explain, document, and follow patients over time.

Medical education has traditionally emphasized the mastery of biomedical knowledge, diagnostic reasoning, physical examination, pharmacology, procedures, and evidence-based treatment. These remain foundational. What must be added is a more explicit education in **clinical seeing**. Students and clinicians must learn to see not only disease but also life-capacity.

### 9.1 Teaching the Clinical Gaze

The clinical gaze is shaped by what clinicians are trained to notice. A life-coherence curriculum would teach students to ask two questions side by side: "What disease process might explain this presentation?" and "What loss of life-capacity is this patient experiencing?" Students should learn to present patients not only as diagnostic puzzles, but as persons whose lives have been interrupted.

### 9.2 Teaching History Taking as Pattern Recognition

Students should learn to ask what the symptom has stopped the patient from doing, what was happening before deterioration, where the patient is losing margin, what makes the care plan difficult, what the patient thinks is happening, and what would make recovery possible. These questions should be taught as part of routine clinical history, not as optional extras.

### 9.3 Teaching Physical Examination as Embodied Capacity

Physical examination teaching often focuses on signs of disease. This is necessary, but incomplete. Students must also learn to examine for embodied capacity: gait, frailty, muscle mass, balance, breathlessness, fatigue, affect, cognition, pain behavior, orthostatic symptoms, medication effects, skin integrity, and functional performance.

### 9.4 Teaching Investigation as Disciplined Inquiry

Students and clinicians must learn to order investigations with purpose. The five purposes of investigation - danger, diagnosis, lost margin, modifiable causes, and meaningful trends - should become a teaching tool. Before ordering a test, the learner should be able to state which purpose it serves.

### 9.5 Teaching Management as Repair of Life-Capacity

Management plans are often assessed by whether they are guideline-concordant. This is important, but insufficient. A life-coherence approach asks whether the plan is feasible, proportionate, and life-serving. Students should learn to present management under four headings: biomedical priorities, capacity priorities, constraints, and next feasible step.

### 9.6 Documentation, Team Care, and Metrics

Records shape attention. What clinicians are required to document often becomes what they notice. A practical life-coherence note could include presenting problem, biomedical assessment, capacity impact, margin, constraints, investigations, repair plan, and patient goal. This need not be lengthy. In busy practice, even a few lines can preserve essential coherence.

Life-coherence medicine also requires team-based care. Nurses, pharmacists, social workers, physiotherapists, occupational therapists, psychologists, dietitians, community health workers, caregivers, and administrative staff all hold pieces of the patient's life-field. The Life-Coherence Clinical Assessment provides a shared language for team care.

Health systems should also measure whether patients are regaining capacity. Potential measures include functional status, falls, mobility, symptom burden, treatment burden, medication complexity, patient understanding, access barriers, care continuity, goal attainment, quality of life, ability to perform daily activities, caregiver strain, and patient-reported capacity.

## 10. Risks, Safeguards, and Boundaries

Every widened clinical method carries risk. A method that asks clinicians to see disease, person, and world together can enrich care, but it can also become vague, sentimental, overextended, or unsafe if not carefully bounded. The Life-Coherence Clinical Assessment must therefore be protected by clear safeguards. Its purpose is to deepen clinical rigor, not dilute it.

The central danger is that the language of wholeness may be used to weaken the discipline of diagnosis. A patient with fatigue may have grief, poor sleep, overwork, and social strain, but may also have anemia, renal failure, malignancy, hypothyroidism, infection, inflammatory disease, medication toxicity, or heart failure. To see the life-field must never mean failing to investigate disease.

A second danger is moralism. If life-coherence medicine attends to food, movement, sleep, relationships, work, alcohol, stress, environment, and social context, it may be misused to imply that patients are responsible for the conditions that constrain them. This would betray the method. A third danger is impracticality. A fourth is overreach. A fifth is therapeutic drift. These risks do not invalidate the method. They clarify its boundaries.

## 10.1 Preserve Diagnostic Discipline

Every life-coherence assessment must begin with the possibility of disease, danger, and treatable pathology. The rule is simple: **Life-field understanding must never be used to explain away danger.** Context enriches differential diagnosis; it does not replace it.

## 10.2 Keep Evidence-Based Treatment Central

The Life-Coherence Clinical Assessment is not an alternative to evidence-based medicine. It is a way of applying evidence more wisely to the person in context. Evidence identifies effective interventions, risks, benefits, diagnostic strategies, prognostic markers, and standards of care. Life-coherence reasoning asks how that evidence should be interpreted and implemented in this patient's life (Sackett et al., 1996; Greenhalgh et al., 2014).

## 10.3 Avoid Blame

A life-coherence history may reveal smoking, alcohol use, inactivity, dietary patterns, missed medication, poor sleep, or delayed presentation. These must be addressed clinically, but without blame. Behaviors are often adaptations to constraint, distress, habit, culture, addiction, environment, poverty, trauma, or lack of support. Even when patient choice is involved, shame rarely restores capacity.

## 10.4 Distinguish Constraint from Excuse

Avoiding blame does not mean abandoning agency. A life-coherence approach recognizes real constraints while still asking what action is possible. The clinician must neither moralize nor collude with helplessness. The task is to identify the next feasible step.

## 10.5 Be Scalable and Document Only What Matters

The Life-Coherence Clinical Assessment must fit the realities of practice. In a brief visit, three questions may be enough: What is this stopping you from doing? What is making it hard to get better? What next step feels possible? In complex care, the assessment can be more comprehensive. Documentation should preserve the information that changes care: the main capacity affected, the major constraint, the patient's priority, evidence of margin or fragility, treatment feasibility, the purpose of investigations, and the next repair step.

## 10.6 Respect Scope, Protect Against Bias, Avoid Infinite Responsibility

The method may reveal issues beyond the physician's direct expertise: trauma, domestic violence, addiction, legal insecurity, food insecurity, housing instability, occupational exploitation, caregiving collapse, or spiritual distress. The clinician should respond with seriousness and compassion, but also with appropriate boundaries. Life-coherence medicine must also be practiced with humility, asking rather than assuming. The clinician is not responsible for solving every determinant of health, but is responsible for not designing care as if those determinants did not exist.

## 10.7 Maintain Clinical Humility

The clinician never fully knows the patient's life. The patient may withhold information because of shame, fear, mistrust, trauma, privacy, or lack of time. The clinician's interpretation may be wrong. The apparent constraint may not be the real one. The first plan may fail. A coherent clinician remains provisional: "This is how I understand

the pattern so far." "Tell me if I have missed something." "Let us try this and see whether it restores some margin." "If this does not work, we will revise the plan."

## 11. Conclusion: Clinical Medicine as the Restoration of Life-Capacity

Medicine begins when a person's capacity to live is threatened. The threat may be sudden or gradual, obvious or hidden, biological or relational, acute or chronic, reversible or progressive. Whatever its form, illness is not only a pathological process. It is an interruption in the continuity of living.

The great achievement of modern clinical medicine has been its ability to make such interruption intelligible. Through history taking, physical examination, investigation, diagnosis, and treatment, clinicians have learned to recognize disease, detect danger, stratify risk, and intervene with increasing precision. This achievement must be preserved.

Yet clinical medicine is incomplete when disease recognition is separated from life recognition. A patient is not merely a bearer of pathology, a cluster of risk factors, a medication list, or a set of abnormal values. A patient is a living person whose body, history, relationships, environment, burdens, meanings, and possibilities are inseparable from the way illness is suffered and healing becomes possible.

The **Life-Coherence Clinical Assessment** has been proposed as one response to this problem. Its central question - what pattern is constraining this person's capacity to live, adapt, heal, and participate? - does not displace the conventional clinical question, "What disease is present?" It completes it.

The four pillars of the method follow from this question. The **Coherence History** widens history taking from symptom chronology to life-field chronology. The **Regulatory-Functional Physical Examination** preserves the diagnostic discipline of the conventional examination while reading the body as embodied viability. **Purposeful Investigation** places testing in service of life-capacity. The **Life-Capacity Repair Plan** translates assessment into action.

Together, these four pillars renew the clinical method without abandoning it. They ask clinicians to see more clearly what was always present in the encounter: the relation between disease and the life it interrupts. This is not a call for vague holism. It is a call for disciplined wholeness. The Life-Coherence Clinical Assessment remains biomedical, but not reductionist; person-centred, but not sentimental; contextual, but not blaming; practical, but not merely technical.

The deeper claim of this paper is that medicine does not have to choose between rigor and wholeness. The best medicine requires both. Rigor without wholeness can become fragmented, burdensome, and miscoupled from the patient's life. Wholeness without rigor can become unsafe. Life-coherence medicine seeks their integration: precise enough to recognize disease, wide enough to understand suffering, humble enough to learn from the patient's world, and practical enough to restore what has been lost.

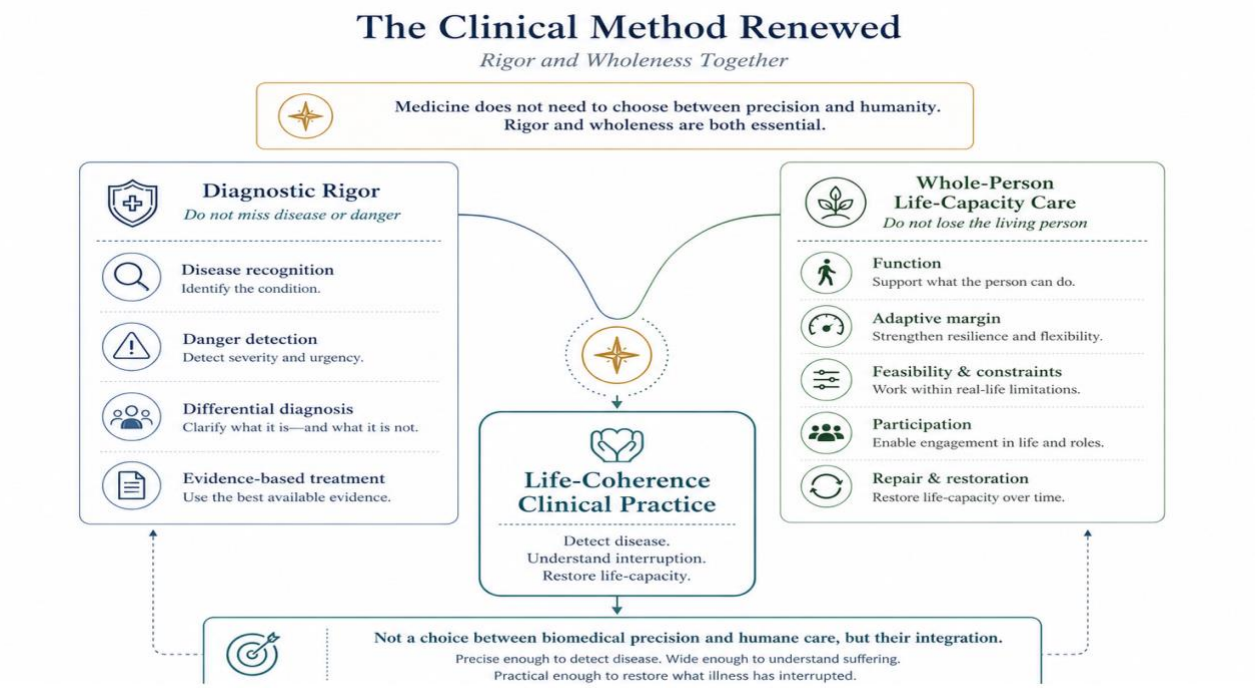


*Figure 6. The Clinical Method Renewed. The Life-Coherence Clinical Assessment integrates diagnostic rigor with disciplined attention to life-capacity. It seeks a medicine that is precise enough to detect disease, wide enough to understand suffering, and practical enough to restore what illness has interrupted.*

Clinical medicine, at its most complete, is the disciplined restoration of life-capacity.

## Glossary of Key Terms

**Adaptive Margin:** The reserve that allows a person to absorb disturbance without collapse. Adaptive margin may be biological, emotional, cognitive, social, financial, relational, or practical.

**Biological Regulation:** The ongoing processes by which the living body maintains viable function, including circulation, respiration, metabolism, immunity, endocrine signaling, neurological integration, sleep, appetite, movement, repair, and stress response.

**Burden of Treatment:** The total work imposed on the patient by health care itself, including medications, appointments, investigations, monitoring, lifestyle instructions, dietary rules, costs, transport, side effects, and administrative demands.

**Clinical Coherence:** The alignment between diagnosis, treatment, patient capacity, context, feasibility, and meaningful goals.

**Coherence History:** The first pillar of the Life-Coherence Clinical Assessment. It preserves the conventional medical history while widening attention to the patient's life-field.

**Constraint:** Any condition that narrows the patient's capacity to regulate, act, adapt, heal, or participate.

**Constraint Pattern:** The recurring arrangement of factors that keeps illness, dysfunction, or lost capacity in place.

**Embodied Viability:** The body's visible and functional capacity to support the person's life.

**Feasibility:** The practical possibility that a patient can understand, access, afford, tolerate, remember, and enact a care plan.

**Life-Capacity:** The person's practical ability to live, regulate, adapt, heal, relate, act, work, care, move, understand, and participate in meaningful life.

**Life-Capacity Repair Plan:** The fourth pillar of the Life-Coherence Clinical Assessment. It reframes management around restoration of adaptive margin, function, agency, and participation.

**Life-Coherence:** The sufficiently viable alignment of biological regulation, functional capacity, relational participation, environmental support, and meaningful agency in ways that sustain life.

**Life-Field:** The lived context in which the patient's body, relationships, environment, history, burdens, supports, institutions, meanings, and options come together.

**Lost Margin:** The erosion of reserve that makes the patient more vulnerable to disturbance.

**Meaningful Trend:** A change over time that reveals whether the patient is gaining or losing margin.

**Miscoupled Care:** Care that is medically reasonable in theory but poorly matched to the patient's actual life.

**Organism-Niche Coupling:** The relationship between the living person and the world that sustains or constrains them.

**Purposeful Investigation:** The third pillar of the Life-Coherence Clinical Assessment, ordering and interpreting tests according to danger, diagnosis, lost margin, modifiable causes, and meaningful trends.

**Regulatory-Functional Physical Examination:** The second pillar of the Life-Coherence Clinical Assessment. It preserves the conventional physical examination while widening attention to embodied regulation, reserve, function, frailty, mobility, cognition, affect, pain, treatment effects, and adaptive margin.

**Repair:** The restoration of conditions that allow the patient to regain margin, function, agency, and participation.

# Appendix A - The Life-Coherence Clinical Assessment Template

## A.1 Core Clinical Question

What pattern is constraining this person's capacity to live, adapt, heal, and participate? This question should be held alongside the conventional clinical question: What disease, danger, or pathological process is present?

## A.2 Brief Consultation Version

1. What is this problem stopping you from doing?
2. What is making it hard to get better?
3. What next step feels possible?

## A.3 Standard Clinical Template

**Presenting Problem:** main concern, symptom or issue, patient's priority.

**Biomedical Assessment:** likely diagnosis or problem list, differential diagnosis, danger signs, relevant background.

**Capacity Impact:** what has been interrupted; functional domains affected; patient's own words.

**Coherence History:** life-field chronology, recent changes, explanatory model.

**Adaptive Margin:** evidence of preserved margin, evidence of lost margin, and whether the person is gaining margin, losing margin, or living close to collapse.

**Constraint Pattern:** biological, practical, relational, environmental, emotional, and meaning constraints.

**Regulatory-Functional Physical Examination:** vital regulation, general appearance, movement and function, reserve and nutrition, cognition and affect, medication effects.

**Purposeful Investigation:** danger, diagnosis, lost margin, modifiable cause, meaningful trend; tests ordered and why.

**Life-Capacity Repair Plan:** biomedical priorities, capacity priorities, constraint repair, least-forcing next step, support needed, patient agreement, safety-netting.

**Follow-Up and Coherence Tracking:** Has the patient gained or lost margin? Is function improving? Is treatment tolerable? Has the main constraint changed? What is the next feasible step?

### A.4 Concise Documentation Format

Disease / danger: Capacity affected: Main constraint: Margin / fragility: Purpose of tests: Repair plan: Follow-up signal:

### A.5 Life-Coherence Handover Format

4. Biomedical summary
5. Functional baseline
6. Current capacity threat
7. Main constraints
8. What has worked
9. What has failed or caused harm
10. Patient goals
11. Follow-up priorities

## Appendix B - Sample Life-Coherence Clinical Notes

### B.1 Hypertension With Dizziness and Falls Risk

**Disease / danger:** Known hypertension. No chest pain, focal neurological symptoms, syncope, or acute heart failure symptoms. Concern for overtreatment or orthostatic hypotension.

**Capacity affected:** Patient has stopped walking to the nearby shop because of fear of falling.

**Main constraint:** Medication schedule confusing. Patient unsure whether morning and evening tablets are both for blood pressure. Lives alone.

**Margin / fragility:** Recent near-fall. Slow gait. Orthostatic blood pressure drop present.

**Purpose of investigations:** Renal function and electrolytes to assess medication safety and dehydration risk. ECG to assess rhythm.

**Repair plan:** Simplify antihypertensive regimen, provide written medication list, involve daughter with pillbox, review BP and symptoms in two weeks.

### B.2 Diabetes After Bereavement

**Disease / danger:** Type 2 diabetes. No symptoms of acute hyperglycemic crisis. No hypoglycemia.

**Capacity affected:** Loss of routine after spouse's death. Stopped cooking regularly and stopped morning walks.

**Main constraint:** Bereavement, low mood, poor sleep, irregular meals.

**Purpose of investigations:** HbA1c, renal function, urine albumin-creatinine ratio, lipids, B12.

**Repair plan:** Restore meal rhythm, enlist daughter for weekly shopping, restart short walks with neighbor, screen mood, review in four weeks before intensification.

### B.3 Multimorbidity and Polypharmacy

**Disease / danger:** Hypertension, type 2 diabetes, chronic kidney disease, osteoarthritis, depression, and hyperlipidemia. No acute red flags today.

**Capacity affected:** Patient no longer leaves home alone because of dizziness and knee pain.

**Main constraint:** Polypharmacy, unclear indications, orthostatic symptoms, pain-limited mobility.

**Repair plan:** Medication reconciliation, stop duplicate antihypertensive, review sedating medication, simplify regimen, involve daughter and pharmacist, prioritize fall prevention and pain management before tighter chronic disease targets.

## Appendix C - The Life-Coherence Clinical Assessment Checklist

### C.1 Initial Orientation

What has brought the patient today? What is the patient most worried about? What does the patient most want restored? Is there immediate danger? Is this acute, chronic, preventive, transitional, or complex care?

### C.2 Coherence History Checklist

Presenting problem; capacity impact; life-field chronology; adaptive margin; constraint pattern; patient understanding; treatment feasibility.

### C.3 Regulatory-Functional Physical Examination Checklist

Vital regulation; general appearance; breath and circulation; movement and mobility; frailty and reserve; nutrition and metabolic signs; cognition and affect; medication effects; skin, feet, and periphery.

### C.4 Purposeful Investigation Checklist

Danger; diagnosis; lost margin; modifiable cause; meaningful trend; burden of testing.

### C.5 Life-Capacity Repair Plan Checklist

Biomedical priorities; capacity priorities; constraint repair; least-forcing next step; feasibility; shared decision-making; follow-up.

### C.6 Red Flags for Incoherent Care

Repeated missed appointments; poor medication adherence without explanation; symptoms persist despite technically appropriate treatment; more medications are added but function worsens; blood pressure or glucose improves while dizziness, falls, hypoglycemia, or fear increases; the patient is labeled "non-compliant" without assessment of feasibility; multiple specialists give conflicting instructions; the patient's main concern is not reflected in the plan.

## Appendix D - Comparison With Existing Clinical Frameworks

The Life-Coherence Clinical Assessment stands in continuity with the biomedical model, biopsychosocial model, person-centred care, social determinants of health, salutogenesis, narrative medicine, functional assessment, geriatrics, rehabilitation, palliative care, family medicine, minimally disruptive medicine, trauma-informed care, systems thinking, and goal-oriented care. Its contribution is not that it invents concern for the whole person, but

that it organizes these concerns around a single clinical grammar: life-capacity, adaptive margin, constraint, organism-niche coupling, feasibility, and repair.

| Framework | Main Contribution | Life-Coherence Extension |
|---|---|---|
| Biomedical model | Disease mechanism, diagnosis, treatment | Places disease control in service of life-capacity |
| Biopsychosocial model | Biological, psychological, social integration | Organizes these domains as constraint patterns and repair pathways |
| Person-centred care | Dignity, preference, shared decision-making | Links what matters to adaptive margin and feasible clinical action |
| Social determinants of health | Conditions shaping health | Translates determinants into treatment feasibility and organism-niche coupling |
| Salutogenesis | Sources of health | Focuses on restoration of capacity under real constraints |
| Narrative medicine | Patient story and meaning | Uses story to identify constraint, margin, and repair |
| Geriatrics / rehabilitation | Function, frailty, independence | Generalizes functional assessment across clinical care |
| Palliative care | Goals, dignity, burden, proportionality | Applies proportional, capacity-oriented care earlier and more broadly |
| Minimally disruptive medicine | Treatment burden | Adds organism-niche coherence and life-capacity restoration |
| Systems medicine | Feedback loops and complexity | Translates systems thinking into bedside pattern recognition |
| Trauma-informed care | Safety, trust, avoidance of harm | Integrates trauma awareness into feasibility and agency |
| Precision medicine | Biological tailoring | Expands precision to include contextual and practical fit |

The distinctive contribution of the Life-Coherence Clinical Assessment lies in five moves: it makes life-capacity the central clinical concern; treats adaptive margin as clinically visible; identifies constraint patterns rather than isolated factors; treats feasibility as part of clinical correctness; and defines management as repair.

# Appendix E - Suggested Figure Suite and Captions

## Figure 1. The Life-Coherence Clinical Assessment

**Caption:** The method preserves conventional biomedical diagnosis while widening clinical attention to life-capacity, adaptive margin, constraint patterns, feasibility, and repair. The clinician asks not only what disease is present, but what pattern is constraining the patient's capacity to live, adapt, heal, and participate.

## Figure 2. The Coherence History

**Caption:** The Coherence History expands conventional history taking from symptom chronology to life-field chronology. It asks how illness affects function, what adaptive margin has been lost, what constraints limit healing, and what would make recovery feasible.

## Figure 3. The Regulatory-Functional Physical Examination

**Caption:** The physical examination remains diagnostic, but is widened to assess embodied regulation, reserve, function, frailty, treatment effects, and adaptive margin. The body is examined not only as the site of disease, but as the medium through which the person's life becomes possible or impossible.

### Figure 4. Purposeful Investigation

**Caption:** In the Life-Coherence Clinical Assessment, investigations are ordered and interpreted according to five purposes: danger, diagnosis, lost margin, modifiable causes, and meaningful trends. A coherent test protects, clarifies, guides, or restores; an incoherent test adds data without improving care.

### Figure 5. The Life-Capacity Repair Plan

**Caption:** Management is reframed as the restoration of adaptive margin, function, agency, and participation. The repair plan asks what intervention will restore the most life-capacity with the least unnecessary burden, while preserving biomedical safety and evidence-based care.

### Figure 6. The Clinical Method Renewed

**Caption:** The Life-Coherence Clinical Assessment integrates diagnostic rigor with disciplined attention to life-capacity. It seeks a medicine that is precise enough to detect disease, wide enough to understand suffering, and practical enough to restore what illness has interrupted.

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This white paper has emerged from many years of clinical practice, reflection, and dialogue at the boundary between medicine, biology, ethics, systems thinking, and the lived realities of patients. Its deepest source is the clinical encounter itself: the repeated recognition that patients do not come to medicine merely as diagnoses, but as lives interrupted, capacities constrained, and worlds made fragile by illness.

I acknowledge with gratitude the patients, families, colleagues, nurses, allied health professionals, and caregivers whose experiences have shaped my understanding of what medicine is called to serve. Their stories, struggles, resilience, and practical wisdom have made clear that good clinical care requires both diagnostic rigor and attention to the real conditions under which healing becomes possible.

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This manuscript was developed with the assistance of ChatGPT, an AI language model created by OpenAI, used as a reflective drafting, structuring, and editorial tool under my direction. The conceptual framing, clinical judgment, ethical responsibility, final interpretation, and authorship remain my own. AI assistance was used to support clarity, organization, synthesis, and accessibility, not to replace professional responsibility or clinical discernment.

## Clinical and Publication Disclaimer

This white paper is intended for scholarly, educational, and reflective clinical purposes. It does not provide individualized medical advice, diagnosis, or treatment for any specific patient. Clinical decisions must always be made by appropriately qualified health professionals in relation to the patient's presenting condition, examination findings, investigation results, local standards of care, available resources, and clinical context.

The Life-Coherence Clinical Assessment is proposed as a complementary clinical method. It does not replace emergency assessment, biomedical diagnosis, evidence-based treatment, specialist consultation, public health guidance, pharmacotherapy, surgery, psychiatry, rehabilitation, palliative care, or local clinical protocols. Its purpose is to help clinicians integrate disease recognition with disciplined attention to life-capacity, adaptive margin, functional status, treatment burden, feasibility, and the patient's lived field.

Where urgent or serious illness is suspected, conventional emergency and diagnostic pathways must take priority. A life-coherence approach must never be used to delay necessary investigation, explain away danger, or substitute contextual understanding for clinical action.

## Back Cover Synopsis

Modern medicine is powerful at detecting disease, stratifying risk, and applying evidence-based treatment. Yet patients do not come to clinicians merely as diagnoses, laboratory values, or problem lists. They come as lives interrupted.

**The Life-Coherence Clinical Assessment** proposes a renewal of the clinical method. It preserves biomedical rigor while widening clinical attention to the patient's lived field: function, adaptive margin, treatment burden, social constraint, emotional meaning, feasibility, and participation in life.

The central question is simple: **What pattern is constraining this person's capacity to live, adapt, heal, and participate?**

From this question, the paper develops four pillars: the Coherence History, the Regulatory-Functional Physical Examination, Purposeful Investigation, and the Life-Capacity Repair Plan. Together, these form a practical method for reading disease not only as biological disorder, but also as loss of life-capacity within a lived world.

Clinical medicine, at its most complete, is the disciplined restoration of life-capacity.

## Author Bio

**Dr. Bichara Sahely, BSc, MBBS, DM (Internal Medicine)** is a physician, systems thinker, and writer from St. Kitts and Nevis. He trained in biology at Dalhousie University and in medicine and internal medicine at the University of the West Indies, Mona. His clinical background includes more than two decades of practice in internal medicine, with experience across hospital-based and community-based care.

His work explores the intersection of medicine, living systems, health, ethics, ecology, and social repair. Across his writings, Dr. Sahely develops the concept of life-coherence as a way of understanding health not merely as disease control, but as the preserved and restored capacity of living beings to regulate, relate, adapt, participate, and flourish within the worlds that sustain them.

In this white paper, Dr. Sahely proposes the Life-Coherence Clinical Assessment as a practical renewal of the clinical method: a way to preserve diagnostic rigor while restoring medicine's attention to the living person whose life illness has interrupted.

**Final framing statement:** Clinical medicine, at its most complete, is not only the detection and treatment of disease. It is the disciplined restoration of life-capacity.