The Routledge Handbook of Phenomenology and Phenomenological Philosophy

Daniele De Santis, Burt C. Hopkins, Claudio Majolino

Phenomenology and medicine

Publication details

https://www.routledgehandbooks.com/doi/10.4324/9781003084013-70
Valeria Bizzari
Published online on: 25 Aug 2020

https://www.routledgehandbooks.com/doi/10.4324/9781003084013-70

PLEASE SCROLL DOWN FOR DOCUMENT

Full terms and conditions of use: https://www.routledgehandbooks.com/legal-notices/terms

This Document PDF may be used for research, teaching and private study purposes. Any substantial or systematic reproductions, re-distribution, re-selling, loan or sub-licensing, systematic supply or distribution in any form to anyone is expressly forbidden.

The publisher does not give any warranty express or implied or make any representation that the contents will be complete or accurate or up to date. The publisher shall not be liable for an loss, actions, claims, proceedings, demand or costs or damages whatsoever or howsoever caused arising directly or indirectly in connection with or arising out of the use of this material.
Ontology of the body and epistemology of medicine

If we look closely at the history of medicine, we will notice an essential link between the reflection on the meaning of being (ontology) and the nature of scientific, medical knowledge (epistemology). Beginning with Socrates and Plato, Western culture has been characterized by a dichotomous vision of the human, fundamentally rooted in something whose deepest expression is found in Descartes’ division between res cogitans and res extensa. Behind this ontological assumption is a specific kind of medicine, constituted by those features that still characterize the classical image of the clinician: an essential fairness and a strong inductive capacity, thanks to which she can produce a diagnosis. On this view, illness is a sort of epiphenomenon, a merely contingent event, because it takes root in the res extensa. Accordingly, the gaze of the clinician is represented by an anatomical look on a depersonalized body: the emotional components of the lived body are completely rejected and the fulcrum of this medical practice is the opening of the corpse in order to better observe its disease.

It seems clear that, given such a vision of the body and medicine, the patient’s narrative is completely unnecessary and useless, and the hierarchy between doctor and patient shifts in favor of the former, leaving the latter completely inert: rather, it is the body (understood as mere matter) that talks through physical evidence. The removal of the lived body from the scientific ideal involves what Whitehead called “the fallacy of misplaced concreteness” (Whitehead 1929): an ideal of pure objectivity is identified with the reality itself, and the clinical reality is reflected in the analysis of the corpse and in experiments in the lab, rather than in the living sick person.

Beginning with Canguilhem the ontological-epistemological dichotomy starts to change. In fact, although he agreed with the Positivists concerning the usefulness of the pathophysiological analysis of the corpse, he shed light on a new and completely different dimension: lived experience.

This emphasis on the experiential aspects of pain put the author much closer to the phenomenological way of thinking: Canguilhem himself recognizes his debt to Merleau-Ponty in the text The Normal and the Pathological (Canguilhem 1991). He gives importance to the disease, and he claims that it is the sick individual, the living subject with its own body, that gives it meaning. The role of the embedded and embodied subject involved in an ongoing relation with the world is emphasized, and the idea of the clinician also faces a transformation: as a matter of fact, we can witness the passage from the body-corpse, the bearer of meanings
of the pathological perspective, to the revaluation of the body-subject and of the experiential dimension that may still play a role in the definition of the diagnosis. Influenced by a similar vision of the body, medicine itself is therefore likely to change, and to free itself from the dream of pure objectivity.

Accordingly, the experiential and qualitative dimension is emphasized as characterizing both the healthy subject and the pathology. In this context, the living body is not described as “a representable object but in the immediacy of its concreteness” (Jennings 1986, 1238). As a result, medical analysis should also focus not just on the individual symptoms, but on the existential meaning that each pathology represents to the sick subject.

The “phenomenological body”: from disease to illness

Considering pathology exclusively in a biological sense seems to be a very reductive and incomplete approach. For this reason, thanks to a change in the epistemological medical paradigm, in recent decades the sick person has started to be considered both in her “pure” biological dimension, both in her existential and psychological features, which have been revalued as constitutive for the experience of the illness. From such a perspective, the body of the patient cannot be intended anymore as a mere biological organism (Körper), but needs to be considered as a body necessarily linked to feelings, and influenced by anthropological, cultural and social elements that give it a specific shape.

On a theoretical level, the body of the patient starts to be intended as a “bio-psycho-social whole”, and consequently, according to our thesis for which the ontological definition of body defines the epistemological paradigm of reference, the clinical approach begins to study the body in a gestaltic and holistic manner. In other words, considering the subject a psycho-physical whole involves the shift from the disease (a vision of the pathology as something that affects the biological organism that medicine should rigorously and objectively study in detail, in its unlimited fragmentation that paradoxically makes the body “invisible”) to the illness: a pathology considered as a lived experience capable of changing the subject both somatically and psychically.

The vision of the body of the patient changes from a body as object of medical therapy and becomes a body-subject of the clinical relationship.

The necessity to enlarge the horizon of medicine, and to consider illness a complex personal experience, involves several issues, both ethical (the patient is a subject with her own autonomy) and of clinical efficacy (the patient has to supervise her own illness from a first-person perspective).

In this view, a phenomenological approach seems to be useful: as a matter of fact, considering the subject a Leib enables the overcoming of the Cartesian dualism and the understanding of the patient in her entirety, as a lived body.

Furthermore, the use of a phenomenological method is helpful for the understanding of the deepest structures and meanings of the clinical experience. By analyzing the modes of our experience of the world, phenomenology highlights its forms and its constitutive processes rather than its contents: it’s not only descriptive, but also explicative.¹

This tendency has started to be considered in the United States since the 1970s, thanks to the work of thinkers like Richard Zaner and Edmund Pellegrino.²

The richness of the phenomenological lexicon and its usefulness in the clinical area emerges from these authors’ thought, especially concerning the concepts of époché, reduction, lifeworld and intersubjectivity. Thanks to the époché and the reduction, we can reach the essence and the concreteness³ of the experience of illness, while the notion of lifeworld could be useful in contextualizing the clinical encounter. Zaner, in particular, utilizes the Husserlian insight that intellectual
Phenomenology and medicine

abstractions and mere theories can actually be true, but that these also can be irrelevant if we lose awareness of the concreteness. Following this thesis, the attention is focused on the stories of patients. On the other hand, bracketing the ethical paradigms of medical practice, Pellegrino wants to reach the *eidos* of the intersubjective experience between the patient and the clinician. In this view, analyzing the *lifeworld* through the *epoché* allows us to elaborate a clinical ethics that doesn’t involve either the total objectification of the intersubjective reality or the mere prevalence of transcendental subjectivity.

Adopting a phenomenological approach will be useful in order to reach those substructures of consciousness that are disrupted in the sick subject: in fact, it is important to realize that a situation of *dis-case* implies a “break” of well-being characterized by a constellation of changes in the world-of-life and in the lived body. These changes not only pose a danger to the physical integrity of the subject, but also threaten the personal identity: in this view, the disease

verges on an ontological assault on the self-body unity. We speak of the “war” against cancer, the “struggle” against a disease or pain or suffering … Alienation of the body from the self, *a true ontological disassociation occurs*. The person altered by illness asks if he is the same person who became ill. He does not know if he will ever be again that person.

(Pellegrino 2004, 193)

Interestingly, Merleau-Ponty also claimed that the experience of the sick body implies the coexistence of two different types of knowledge: on the one hand, the usual way that the subject has to join the world (her way of being and her capacity before the onset of illness) and on the other, the current way of relating to the environment, which is imposed by the limits of illness and of which the subject is not fully aware. The appropriate way of dealing with the subject is not, therefore, either to reduce her body to a physiological malfunctioning object nor to consider the disease only through a disembodied first-person perspective: rather, it is necessary to treat the patient as a dynamic consciousness intentionally related to the world, remembering that “The union of soul and body is not an amalgamation between two mutually external terms, subject and object, brought about by arbitrary decree. It is enacted at every instant in the movement of existence” (Merleau-Ponty 2005, 102).

This implies a medical gestaltic analysis of the entire existence of the subject with particular attention to phenomenological structures, such as the intentions towards the world, the distortion of the potentialities (conceiving the body as an “I can”) and the world-of-life. The Schneider case is an example of the need for a *phenomenological-existential* analysis that has as its object the living body, whose complexity will never be fully described by a purely scientific approach.

In the wake of Merleau-Pontian philosophy, the patient’s body becomes an “expression of life”, and not just a biological support. The unity between the somatic region and the psychic one is indivisible, and, therefore, the therapeutic relationship is configured as a process that involves an enlargement of assistance interventions, which are transformed from an *organic cure* into a *holistic care*.

The result is an emphasis on the everyday world, on things and their function in the clinical encounter, which takes the form of an exchange of perspectives, a blend of two different *Leiber*, of two different *worlds of life*: the medical activity has found its own way in this intersection, in the complexity of shared perspectives. The phenomenological approach seems to be suitable to describe a similar encounter also because it emphasizes that this type of sharing will never be completed: the commonality goes hand in hand with individual uniqueness, so that first- and third-person perspectives will never be reduced to one another.
The clinical relationship: an empathic understanding

In the complex hermeneutic act of understanding the patient, the clinician should be aware that illness is “a disturbance within that most intimate sphere of relationships between self and its own body” (Zaner 2004, 240).

The existential aspect of the disease implies the necessity of compassion on the part of the doctor, who must not only understand the illness but also empathize with the patient. In this view, the clinical relationship could be considered an ethical relation between two subjectivities, a “form of affiliation” (ibid., 235).

Instead of focusing on the body-as-object (Körper), according to a “medical phenomenological approach” the encounter between the clinician and the patient should consider the body-as-subject (Leib), taking into account her double ontology, made up of dimensions irreducible to each other but articulated to one another.

This doesn’t involve a complete prevalence of the subjectivity on the objectivity: simply, both the clinician and the patient understand the multiple dimensions of the body, and the intertwining between the psychic side and the mere biological functions.

On the one hand, the clinician starts to consider the sick person as a subject; on the other hand, the patient, who usually lives her disease in an existential way, starts to attribute objective reasons to her illness and to accept it.

There is a balance between the clinician’s and the patient’s perspectives and an articulation between the Körper studied by medicine and the lived body of the patient; a collaboration where differences and mutual understanding coexist. The Husserlian “opacity” typical of the intersubjective relationship remains: there is still a sort of divergence and dialogical breakdown between the illness lived from within by the patient and the illness analyzed by the clinician. The doctor, simply as a human being, can empathize with the patient’s experience, knowing what it is to be in pain or be disabled and understanding the illness as a disruption that involves not a single organ, but a Self.

Speaking in Schutzian terms, this relation seems to be a Du-Einstellung, that is, an orientation towards otherness, a trend that may be unilateral or reciprocal. In the specific case of the medical report, the relationship between the two poles is undoubtedly an intense one, characterized, however, by the lack of a balance.

The method implied is to interview the patient in order to reveal her lived experience of the illness and to conduct qualitative research, prioritizing “the person and her experiences as the preeminent source of valid data” (Leder and Jacobson 2014, 1436). In other words, the clinician has to consider her a Leib, an intersection between transcendent and mundane, not reducible either to a mere objective thing or to an abstract ideality.

Concerning this theme, it is interesting to shed light on a distinction made by Husserl in Phantasy, Image Consciousness and Memory among “not two, but three objects, which, when one successively changes the direction of one’s regard, also come to the fore as separately meant: namely, the physical image, the presented mental image … and finally the image subject” (Husserl 2005, 131–132): Husserl made the example of looking at a painting. At the beginning, I consider the painting a mere physical thing (a canvas on a wall); then, I focus on the subject represented by the painting (image subject), and finally I re-consider it a picture representing something (image object). In the same way, we can affirm that the perception of the illness should be made up of these different but entangled dimensions: the physical image (for instance, the results of blood analysis, which represent a specific state of the patient), the image object (the Körper), and the image subject, a Leib, usually not studied by medicine. The distinction made by Husserl focuses on these different but necessarily intertwined dimensions, which have to be considered in a unitary apprehension.5
Phenomenology and medicine

The result is a new medical approach, based upon an empathic relation between two lived bodies: in this sense, we can consider medicine not a mere biological and scientific study, but an embodied ethics.

Conclusions

In the last few years, we have witnessed the development of several attempts to use phenomenological notions in areas very far from the “pure transcendental” domain of eidetic experience. Medical phenomenology is a paradigmatic example, and it surprisingly reveals many epistemic and moral consequences.

Firstly, considering the patient as a Leib has completely changed the epistemic definition of medicine: in fact, stressing the importance of Erlebnis and of the psyche of the patient involves a holistic and gestaltic understanding of the disease and healing. In this view, the mind–body dichotomy seems senseless, and phenomenological notions are helpful in order to understand the essential meaning of illness. Overcoming qualitative or narrative approaches, phenomenology highlights the centrality of the lived dimensions, helping not only the clinician, but also the patient, who could be aware of the psycho-physical changes caused by the disease, which represent a danger to her self-identity and integrity.

Narrowing the gap between the objectifying gaze of science and the subjective experience and modifying the clinical relationship in a dimension shared by two lived bodies, a medical phenomenological approach could bring out the variations caused by illness, and medicine could acquire an ethical-moral value.

Notes

1 We should notice that phenomenology has always been characterized as a purely descriptive enterprise, focusing on the eidos of things. Following the thought of Sass, it seems to us that, especially in the analysis of psychiatric pathologies, the descriptive aim could be helpful also in the explanation of such pathologies. In other words, the eidetic description could contribute to explaining both the genesis and the structure of human experience.

2 Richard Zaner (1933–) was Professor of Ethics and Philosophy of Medicine at Vanderbilt University Medical Center, while Edmund Pellegrino (1920–2013) was a bioethicist and president of the Catholic University of America.

3 We should notice the contradiction present in this sentence: in fact, “essence” and “concreteness” usually stand in opposition to each other. What we would like to underline is that, as for its relationship with medicine, we should not speak about a use of phenomenology in the strict sense, but rather of what Natanson defines a “phenomenological orientation”. Natanson distinguishes between a phenomenological attitude, more formal and closer to Husserl’s method, and a phenomenological orientation characterized by “an insistence on a return to what is basic to science, its grounding in a reality taken for granted by the learned and the vulgar” (Natanson 1973, 115). In the same way, we think that medical phenomenology is of course an evidence of the richness and the modernity of phenomenology, but at the same time it is a “metaphenomenological approach” not totally reducible to the “classical” one. This idea can be placed inside of the debate about the naturalization of phenomenology, or the possibility of bringing phenomenology close to the empirical sciences. In fact, despite the several attempts of “naturalizing phenomenology”, we should remember the strong Husserlian anti-naturalism, according to which naturalism is an essentially flawed tendency because we cannot reduce issues like idealism, normativity and consciousness objectively. Naturalism and the empirical sciences are incorrect because they do not recognize the double ontology of consciousness, which is both subject and object of the world. Today, we can observe a practical use of phenomenological notions in several kinds of study. Nevertheless, we should be careful to recognize the “phenomenologization” of disciplines like medicine (or psychiatry), which are benefiting from the phenomenological method and concepts.
Remembering the “Natansonian” distinction could be helpful to appreciate these tendencies without forgetting the real meaning of phenomenology.

To cure is synonymous with healing by means of specialized medical technologies, which refer to the body like an organic Körper; on the contrary, to care means taking care of the sick person in a global sense, with an emphasis on the educational and relational dimensions of the clinical process. Considering the patient a Leib, whereby the disease afflicts not only the single organs, but the body in its whole existence, implies a sense of cure that stresses the complexity of the person and reveals the necessity of a holistic and not merely biological therapy.

See also Legrand 2013.

References