



# Medicine and the individual: is phenomenology the answer?

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## Abstract

The issue of how to incorporate the individual's first-hand experience of illness into broader medical understanding is a major question in medical theory and practice. In a philosophical context, phenomenology, with its emphasis on the subject's perception of phenomena as the basis for knowledge and its questioning of naturalism, seems an obvious candidate for addressing these issues. This is a review of current phenomenological approaches to medicine, looking at what has motivated this philosophical approach, the main problems it faces and suggesting how it might become a useful philosophical tool within medicine, with its own individual, but interrelated, contribution to make to current medical debates. After the general background, there is a brief summary of phenomenological ideas and their current usage in a medical context. Next is a critique of four key claims within current phenomenological medical works, concerning both the role phenomenology plays and the supposedly clear divide between phenomenology and other approaches. There are significant problems within these claims, largely because they overlook the complexity of the questions they consider. Finally, there is some more in-depth examination of phenomenology itself and the true complexity of phenomenological debate concerning subjectivity. The aim is to show that it will be both more productive and truer to phenomenology itself, if we use phenomenology as a philosophical method for explicating and gaining deeper understanding of complex and fundamental problems, which are central to medicine, rather than as providing simple, but flawed solutions.

## Introduction

One of the most savage ironies within the experience of illness and its treatment is that, at the very moment when we are perhaps most acutely aware of ourselves as an individual, medicine seeks to restore health through viewing and reducing the individual to classifiable membership of a category. It is hardly surprising that people are struck by this disjunction. Many, from diverse fields, have proposed that conventional medicine and the patient could benefit if clinicians take a more inclusive approach, paying increased attention to illness as experienced by the individual, as opposed to basing diagnosis and treatment exclusively on established medical categories. As the extensive movement towards 'patient-centred care' within contemporary medicine shows, these ideas are certainly not restricted to academic philosophy.<sup>1</sup>

For philosophers, phenomenology may well seem the obvious solution since it espouses the primacy of first-hand experience and takes the individual's experiences of phenomena as the foundation of our knowledge and understanding of the world. It is easy to see why phenomenology has become an influential approach within

philosophy of medicine. Carel, for example [1], proposes a 'phenomenology of illness': 'I mean the experience of being ill: illness as it is lived by the ill person' (p. 12).

My aim here is to review central ideas and show where problems emerge in existing phenomenological approaches to medicine. My critique revolves around three key and interrelated elements, which also have broader relevance for questions about the role of philosophy in medical thought. First and foremost is my suggestion that there are crucial underlying difficulties in the positions presented in many examples of medical phenomenology. Given that a major aspect of philosophy's potential contribution to medical thought must surely be the conceptual and analytic rigour it can offer, philosophers of medicine must ensure their own arguments stand up to scrutiny. As well as these difficulties comes what I have termed 'weak' phenomenology: the idea that only the most general and basic phenomenological ideas are being used to draw conclusions which could or have been reached via other approaches.<sup>2</sup> Finally, I will question the validity, but also the value, of the pervasive viewpoint that phenomenology is a radical depar-

<sup>1</sup> We might also see, for example, the recent resurgence of case studies in medical journals as indicative of increasing interest in the individuality of cases/patients among the medical community.

<sup>2</sup> Some proponents of phenomenology do suggest it has had a universal, even when indirect, foundational influence on 'contemporary moral issues' [1]. However, even if this is true, we need to show why it still has specific relevance.

ture from the concerns and views found in other approaches to medical thought. Philosophy must be careful to show that it makes a contribution, which is distinct, but also has a valid relation to concerns and issues which are central to medicine.

I am not suggesting that these difficulties should lead us to reject phenomenology and I will conclude by proposing possible ways for it to make a distinct and productive contribution to medical thought. However, to do so, phenomenology must let go of its sectarian polemic, engage in depth with the difficulties it brings to light and somehow enter into a more integrated debate.

## Background – the individual within medical diagnosis and treatment

Once an individual exhibits symptoms of illness, medicine diagnoses. Chiefly, illness is categorized and treatment based on symptoms most open to observation and measurement, and therefore amenable to what is seen as objective analysis and quantification. Along with these come more subjective symptoms, which patients can perhaps describe, but which cannot be observed or measured objectively, together with the patient's overall perception of how the illness impacts on their lives.

Although, for the ill individual, it is often these subjective factors, which seem to have the most substantial and recognizable effects, conventional medicine concentrates on the other, objective, symptoms. In the words of Toombs, a major figure in medical phenomenology, 'as a scientific object, a particular body is simply an exemplar of *the* human body' ([2], p. 8) and 'the patient is seen as a kind of "translucent screen" on which the disease is projected' and 'subjective experiencing of illness is ignored' ([3], p. 14). Moreover, it aims to help the greatest number of people in the simplest and most easily dispensable way. Accordingly, sidelining the individual could even be seen as an inherent general aim within medical practice, rather than simply a consequence of diagnosis [4,5]. While this may well be necessary, it can certainly lead the patient to feel that the medical profession has a bewildering lack of empathy or understanding for their personal experience.

When ill, we cannot even rely on our own self-perceptions to defend our sense of ourselves since we are robbed of the ability to function in all the ways that we associate with our self-identity. How to deal with this fundamental and enforced alteration, while trying to retain the essence of oneself, becomes one of the greatest challenges for both the ill person and those around them. Moreover, this disregard of individuality actually seems implicit, not just in medicine, but in illness itself. Environmental factors aside, illness is one true 'leveller', indiscriminate and regardless of what we might see as the most important aspects of ourselves as individuals. When *we* seek medical assistance, it is our *illness*, rather than *ourselves* which we ourselves prioritize.

Yet, even if medicine and illness seem stacked against the individual, there does seem to be an increasing contemporary awareness of the importance of paying more attention to the individual's own experience of illness. Nor is this being viewed purely as a means to improve the patient's emotional experience or sense of self, but as a strategy, which might actually increase the clinician's understanding of the illness and make a tangible difference to treatment decisions, efficacy and adherence.

## Phenomenology and its role within medicine

With its absolute prioritization of individual experience, phenomenology seems the obvious philosophical strategy for reinstating the individual within medicine. Before moving onto the medical context, it would be useful briefly to summarize some key phenomenological ideas, though with a certain *caveat*. Phenomenology is a broad and complex philosophical movement. Although there are various recurrent themes and features, phenomenology developed as an engagement between a number of different thinkers, responding to the difficulties and challenges within each others' ideas, so that it would be misleading to present it as a unified body of doctrine [6]. Nevertheless, the heterogeneity and unresolved conflicts within phenomenological thought are often overlooked or omitted from works of medical phenomenology and I would suggest that such blurring and omissions are a major reason for the problems within them.

Phenomenology was one of the most influential 20th century philosophical movements. Generally seen as emerging with the work of Husserl, it was further developed, most significantly, by Heidegger, Merleau-Ponty and, later, the French existentialists. Husserl's now famous call 'back to the things themselves!' can perhaps be interpreted as containing a central idea: that our investigations should focus on how phenomena appear within our own consciousness. In medicine, probably most influential is Merleau-Ponty, whose concept of 'embodied consciousness' entails the inseparability of consciousness or rationality from the body through which we perceive [2,3]. Perceptions are the foundations of subjectivity, personhood and all rationality, but also inseparable from the body and the world within which the body exists. The first-person nature of the whole experience is fundamental and fully 'embodied'.

A very influential distinction is between *Körper*, the 'corporeal body' and *Leib* 'how we experience this physical matter in our everyday lives' ([1], p. 1). Another key distinction is between transcendental and ontological phenomenology, and to what extent we can make any commitment about existence. Although one might assume that medical subject matter simply entails a commitment to existence, and, indeed, this debate is usually overlooked in medical phenomenological works, it was, nevertheless, foundational within the development of phenomenological thought and does, as I will later explain, have some relevance here.

Views on the role of phenomenology in medicine seem to range along a spectrum, from the idea that phenomenology will help us to focus more closely on the experience of the patient, to seeing it as a radical way to rewrite our distorted ideas of what constitutes health, illness and medical treatment.

Two key views emerge: (1) first-person conscious experience is the foundational constituent of our understanding; (2) the idea that *this* takes us back to a 'pre-theoretical' vantage point, from which to question our own assumptions. The second is the phenomenological *epoché* – the concept of reduction or 'bracketing' assumptions to attend to directly experienced phenomena without presuppositions [1–3]. In phenomenological works, these two points are represented, broadly, with the following claims: (1) phenomenology can give an account and help us understand illness as experienced by the ill individual themselves; (2) through attaching primary importance to the direct experiencing of phenomena

we suspend pre-existing assumptions and gain fresh understanding of illness (*epoché* or 'bracketing'), while certain key phenomenological ideas might also help facilitate this reconceptualization; and (3) perhaps implied in the first two claims is the idea that a phenomenological approach to illness can lessen or prevent the way in which illness and medical treatment compromise the integrity of the individual's sense of self. Along with these specific claims comes the idea of phenomenology as radically opposed to other medical approaches and an overarching sense that the phenomenological reconceptualization of health and illness can lead to improved medical treatment (although phenomenology has unsurprisingly been particularly influential within psychiatry, I will only touch on psychiatry as included within general accounts).

Problems with claim I: phenomenology can give an account and help us understand illness as it is experienced by the ill individual themselves.

Generally, this claim is represented in two different ways: as a more straightforward description of individual experiences; or a more complex philosophical discussion of how phenomenology is the approach best able to justify and support the centrality of the first-person perspective within medicine.

The first descriptive approach seems subject to what I call the problem of 'weak' phenomenology, being a very watered-down version of an extremely general idea, which could be seen to be derived from phenomenology, but might also have come from elsewhere. Although most people would probably agree that first-hand accounts are useful within medicine, we must surely be sceptical about the degree to which such accounts are truly enhanced by supposedly being philosophically underpinned with phenomenology.

Let's consider a few examples from the *Handbook of Phenomenology and Medicine* [2]. Bliton describes deliberations with pregnant women considering open-uterine foetal surgery. While this is fascinating and clearly shows the centrality of the first-person viewpoint, it is hard to see precisely how either case descriptions or ethical discussion are specifically phenomenological, in anything but the broadest sense. The same could be said for McWhinney's illuminating history and defence of the patient-centred clinical method within medicine. In Frank's piece on how phenomenologists can use illness narrative to study illness, he talks about 'applied' phenomenology, which is 'empirical and autobiographical'. However, much as he might argue that the underlying theoretical ideas of phenomenology inform his discussion of how such narratives provide unique insights into the individual's reality of illness, it is unclear what contribution specific doctrines really make, beyond broad connections, and how his 'applied' method is truly phenomenological in philosophical terms.<sup>3</sup>

Applied phenomenology is a practical research methodology based on phenomenological philosophical principles and has been a key qualitative methodology in nursing for understanding patient experience since the 1970s.<sup>4</sup> In this context too, we find similar difficulties. Earle describes the division that has emerged between phenomenological theory and its practical applications in nursing,

<sup>3</sup> See the pieces by Bliton, McWhinney and Frank in [2] and cf. also [30,31].

<sup>4</sup> Applied phenomenology stems mainly from the stems largely from the phenomenological research method of the Canadian Van Manen [32]. Interestingly, it is not mentioned much in the medical phenomenological literature.

with critics complaining that nurses' methods only draw on the 'simple basic assumptions' and espouse allegiance to the deep philosophical basis as a way to validate the rigour and seriousness of 'qualitative research streams' ([7], p. 293).

In nursing, then, as in philosophy of medicine in general, it seems that phenomenology risks being used to suggest a complex philosophical underpinning and justification for what is essentially quite a broad humanistic and patient-centred approach. The concern with such 'weak approaches' is that, either they are not really phenomenological or, if they are, phenomenology in this context has no special or unique relevance.

If we move on to the use of more complex phenomenological ideas, more complex problems emerge. A common claim is that phenomenology can both give us access *to* and justify the importance *of* the individual's own experience and account of illness. Illness is a set of phenomena experienced by an ill individual which gives them a privileged and unique perspective on what it entails. Phenomenology can then not only increase clinicians' empathy with patients, but can also provide insights into the nature of illness, which are unavailable through indirect observation or analysis. For example, Carel says:

When patient and clinician are discussing the patient's condition, there is often no shared set of assumptions or a common understanding of the object of discussion, the illness. Most significantly, phenomenology does not see the patient's experience as a subjective account of an abstract objective reality; rather it takes this experience to represent the reality of the patient's experience ([8], p. 236).

But if we follow through the consequences of this argument to its ultimate and ironic conclusion, we arrive at the problem of solipsism. Far from enabling empathy and understanding, if the true conception of illness resides in the ill individual's personal experience of the phenomena, we might well ask how it can ever be truly communicated and understood by another.

Far from just pushing an argument to its extreme consequences, this problem actually reveals fundamental difficulties in the idea that phenomenology aids communication and understanding. For communication requires some shared understanding, so that, even from the individual's non-observable and private experience, there is a need to extract and establish some common ground which can be successfully shared.<sup>5</sup>

Aware of this danger, phenomenologists bring in the notion of intersubjectivity to suggest possible solutions. Although the main purpose of their approach is to explicate different perspectives, Toombs says that 'phenomenological analysis also provides clues as to the manner in which a shared world of meaning may be constituted' ([3], p. xvi). Between doctor and patient is not only a first/third-person divide, but also a different system of contextual relevances. She argues that if the doctor reflects on their lived experience of when their own body felt alien to them, they will share a contextual framework or 'common communicative environment' with their patient and be more ready for empathy and shared understanding. Others also make similar suggestions [2,9].

However, these solutions themselves seem deeply question begging. How can we claim that 'the world is analytically acces-

<sup>5</sup> Cf. the widespread archetype of the 'wounded healer' or 'wounded physician', with its idea that personal experience of illness allows the insight, which enhances one's healing capacities [33].

sible only as it is present in a subject's experience' ([2], p. 68) so that the individual's own experience of their illness is unique and therefore of primary importance for medical understanding, but then go on to say that *another* person will be able to empathize and somehow have true access to these experiences through their experiences of *their own* states of body and health? Stated more simply, a true understanding of an illness resides in the unique experience of the ill individual, as opposed to a common understanding. But we others only gain access to this unique experience through the common understanding, which comes from reflecting on our own experiences.

This view that we can understand others' experiences by analogy with our own is a version of the argument from analogy, a principle that was actually heavily criticized within the historical phenomenological development of the notion of intersubjectivity itself. Phenomenologists suggest that to experience another is in fact to experience their very inaccessibility and otherness. Undoubtedly, the issue of how the individual can communicate unique experiences so as to give another maximal understanding and allow them to help is of great significance for medicine. Yet, while phenomenology itself may well offer penetrating insights here, the existing medical phenomenological literature seems to concentrate on simply promoting the importance of considering the individual perspective, at the expense of providing satisfactory philosophical discussions of the difficulties involved. In doing so, it even suggests notions of intersubjectivity and empathy based on principles whose rejection is central to the classical phenomenological formulation of these very same notions ([10], p. 153).

Problems with claim II: Through attaching primary importance to the direct experiencing of phenomena we suspend pre-existing assumptions and gain fresh understanding of illness (*epoché*).

The idea of reconceptualization, of neutral re-examination and the casting aside of established preconceptions is a dominant and recurrent theme in medical phenomenology. Through examining how we arrive at what we understand as constitutive of reality, it is said that phenomenology enables us to set aside preconceptions and gain fresh understanding of illness and treatment through 'systematic neutrality' ([2], p. 2).

The first question here concerns this very notion of 'systematic neutrality'. As phenomenology itself has been so instrumental in showing, we are contextualized beings. Indeed, one of the deepest problems with which phenomenology has grappled is how to deal with our ultimate inability to step completely outside of our contextual circle.<sup>6</sup> Just as with the solipsism objection, this constitutes an essential difficulty. Any meaningful discussion about reconceptualizing illness or medicine will rely on some degree of consensus about what they involve. The concept of 'alterity', so fundamental to much phenomenological writing, with its idea that illness makes us something 'other' than what we are, presupposes a 'norm' of health from which illness is a departure. Similarly to the solipsism difficulty, it seems that to generate meaningful ideas and communication, we need something else: in this case, something stable and external to a pre-theoretical experience of phenomena.

We can see these difficulties quite clearly by looking, for example, at Waksler's article on 'medicine and the phenomenological method' [2]. He espouses *epoché* or 'bracketing' – putting

aside existing knowledge until we have gone back to a pre-theoretical level and examined the preconceptions on which it is based. Medicine is, he claims, 'grounded in cultural/historical contexts. If we explore these through phenomenology, we can grasp the underlying subjectivity of science ([2], p. 73).' Through acknowledging the primacy of the subject's perspective and suspending belief and doubt, he proposes that we will become aware, for example, of the socio-political context of scientific theory and the way that both diagnostic categories and notions of health are social constructions – worthwhile and plausible general points, though hardly original, not only in phenomenological critiques. But when we look, though, at how he expands them into actual practical examples we can see problems starting to emerge.

His selected examples – the validity of alternative medicine; problems with the Diagnostic and Statistical Manual, fourth edition (DSM-IV) and the concept of disability – are themselves staples of critiques of conventional medicine and therefore already betray his own embeddedness in a certain academic context.<sup>7</sup> Waksler claims that Western medicine and alternative medicine both reject each other, because the former relies on 'scientific' evidence (extracting quantifiable data), the latter on 'experiential' (observing effects through experience). Not only in this opposition itself questionable,<sup>8</sup> but Waksler certainly does not seem, in conceptual terms, truly to have bracketed assumptions and fixed views. He still measures success in both alternative and conventional medicine in terms of alleviation or healing of a condition, and implicit within this are deeply entrenched ideas about alleviation, cure, illness and success criteria.

This difficulty of liberating oneself completely from appeal to external/fixed or objective ideas can be seen perhaps most clearly in his DSM example. After some fairly standard general objections,<sup>9</sup> he moves to a more specific example, where the more penetrating philosophical difficulties perhaps emerge. To defend the view that we should place epistemological value on the individual's own experience of non-observable factors, he cites the case of a schizophrenic patient. Believing a rat was stuck in his throat, he 'was told *sardonically* by his doctors that the rat was too far down to see'. After recovering from this episode, the patient recalled that he would have been grateful if 'they had stated quite plainly that they did not believe that there was a rat in my throat'.

While this incident might well raise various questions about the doctors' behaviour, it is difficult to see why it would constitute a

<sup>7</sup> Waksler's view of, for example, 'deafness' not as disability, but as an alternative mode of existence is, without doubt, valuable. However, it has also been at the heart of disability rights movements for at least 30 years and this could be seen as an example of 'weak' phenomenology (pp. 80–82) ([34], p. 225). For the use of 'deafness' as a controversial example of 'disease', Papadimitriou, C ([2], pp. 475–492) on 'ableist assumptions'.

<sup>8</sup> Conventional Western medicine is increasingly open to alternative practices, such as referrals for acupuncture, exercise, hypnotherapy, chiropractors, to name but a few. In terms of the experiential/scientific opposition, multiple processes are used within conventional medicine where a complete biochemical account of causation cannot be given and evidence is, so to speak, either wholly or partially 'experiential'. Cf. Munson [13], on the idea that medicine's way of measuring success in terms of practical application, rather than complete causative understanding, is a key reason why it should not be classified as a science.

<sup>9</sup> Waksler, 77, first introduces a widespread critique of psychiatric diagnosis as socially constructed and cites the increasing 'proliferation of categories' in each new version of the manual.

<sup>6</sup> Deconstruction was founded on these very difficulties.

good example of justification, either for placing equal value on all individual experiences of phenomena, or for questioning the value of having fixed diagnostic criteria. In fact, it would seem to militate against this view. For both Waksler and patient accept that there really was no rat. The patient himself, with hindsight, was actually disappointed that his belief had not been questioned with recourse to what he subsequently saw as the objective truth of the matter. Certainly, there are valid questions to be asked about psychiatric diagnosis and causation, and about how best to engage with an individual whose condition produces delusional beliefs. Nevertheless, while phenomenology may well offer some help with understanding the philosophical difficulties involved in these issues, it cannot do this without seeing the problems involved in trying to attribute exclusive 'epistemological' value to individual human experience of phenomena. This might also stand as a good example of phenomenology being sidetracked by its polemical and radical agenda, with Waksler's presentation perhaps reflecting badly on psychiatrists, but doing little to justify the use of phenomenology in medicine.

The recurrent idea that certain specific topics within phenomenology are useful for reconceptualization is subject to similar difficulties when we try to dismiss any idea of stable or common conceptions. In brief, along with my earlier example of how alterity or 'otherness' seem to presuppose some stable norm,<sup>10</sup> another example could be phenomenological 'temporality'. Brough, for example, explains how the 'formal' phenomenology of temporality could help counteract the way our changing sense of time within illness impinges on our sense of self. However, as with 'otherness', we can only understand how illness affects temporality in the context of a more ordinary and conventional sense of time. Brough says 'the now becomes extended, the past is radically separated' ([2], p. 39) and here we could compare Shriver's observation on cancer: 'Five minutes of lying here in the dark passes as fast as the Paleozoic era' ([11], p. 178). This elongation of the present and the impact it has on the experience of illness, so that 5 minutes becomes an eternity, must presuppose some ordinary notion of time and how it is experienced by others or oneself in different circumstances.

Problems with claim III: a phenomenological approach to illness can lessen or prevent the way in which illness and medical treatment compromise the integrity of the individual's sense of self.

The threat posed to an individual's sense of self by illness and its effects, is heightened by medical diagnosis, with its reduction of the individual to a featureless instantiation of a condition. Phenomenology counters this threat, both by focusing on the individual's own experience of illness and, in doing this, by suggesting we 'bracket' naturalist medical assumptions about the body as a scientific object and the ill individual as a bodily exemplar of disease.

According to Toombs, if we follow Merleau-Ponty's notion of embodiment and the lived body, there is 'no perceived separation between body and self'. Our bodies are not perceived as separate instruments through which we experience the world, but are identical with ourselves and *constitute* our 'point of view on the world'. When ill, we experience a sense of alienation from our bodies. We

<sup>10</sup> Levinas' concept of alterity has been very influential within phenomenology in medicine and is often alluded to, together with adaptations of Heidegger's concept of the 'uncanny', in discussions of how illness distances us from our ordinary or 'healthy' understanding of ourselves [35,36].

become explicitly aware of our body's mechanistic and corporeal nature and experience a sense of distance from it, at the very same time as we are also most acutely aware of its inescapability. This inseparability and identity combined with alienation means, as Toombs says, that 'illness necessarily incorporates not only a threat to the body but a threat to one's very self'. This threat is reinforced in the usual clinical encounter where the patient becomes the 'body-as-object' for examination and their subjective experiences are also sidelined, as they become a 'being-for-the-other' ([3], pp. 51–57; pp. 67–76).

Also echoed in many phenomenological works is the idea that the clinician should somehow aim for a more empathic understanding, which can 'heal', as opposed to simply 'cure' the patient, by helping with this 'existential predicament' ([3], pp. 112–9). But, as elsewhere, it seems that these phenomenological approaches are, in part, explicating the nature of the problem, rather than offering viable solutions. If we focus first on the individual's own experience as an 'embodied' self, all bodily activity is embedded in the contextual networks of its 'being-in-the-world'. Yet surely, this implies that the bodily changes which take place within illness constitute fundamental changes to one's self. If we *are* our bodies and our bodies are inextricable from our experiencing of the world, then it follows that, when ill, we *become* our ill selves. Where can we hang onto our notion of self-identity, if everything is in dramatic flux? Rather than helping the ill individual preserve their sense of self, the phenomenological view might almost be seen as instrumental in eradicating it.

Once again, it seems that what phenomenology is offering is a profound and rich explication of the problem of the loss of identity, which comes with illness. However, once again, it also appears that something external to the individual's experience of phenomena needs to be drawn upon if we are looking for a grounds for continuity. In the very broadest terms, illness is a complex process of balance and readjustment, of realizing and accepting changes, while retaining a sense of self. Some ways this might be achieved are through analysis of our own experience, but also comparison with the experience of others who share the condition; through contemplation of how our capabilities now differ from healthy 'norms'; through our own memories of our capabilities and expectations; through other peoples' sense of who we are and how things have changed; through putting all these ideas together and seeing what changes and what remains. Some come from focusing on immediate individual experiences. Yet, equally, some derive from external elements.

Illness changes us. Medicine starkly points this out and medical professionals do not always have the time or ability to deal with this experience as well as they could. Even if, as it stands, phenomenology cannot eradicate this problem and might even seem to compound it, it can offer a way to understand how and why illness threatens the integrity of the individual's sense of self to such an extent.

What I want to retain, then, is this idea of phenomenology as the means to explicate major problems. However, before expanding on this idea, we must first consider the interrelation of phenomenology and other medical approaches.

Problems with claim IV: phenomenology is radically different from other medical approaches.

I have suggested that phenomenological approaches, sidetracked by their own polemic, become so preoccupied with showing

how conventional medicine omits certain issues that they fail to engage in depth with the implicit difficulties of their own proposed solutions. Yet even this polemic itself is questionable, as there is actually significant overlap between the issues considered within phenomenological medical works and alternative approaches.

Most generally, phenomenology presents itself as standing in opposition to what we might broadly term the naturalist or biomedical model of illness as disease or biological dysfunction [1,3]. In many ways, it comes across as a broad movement, which questions and examines the assumptions of scientism. It is often grouped or even conflated with subjective, humanistic epistemology [12] or with continental philosophy and all the associated stereotypes of the continental/analytic divide: subjective, idiographic, qualitative, humanistic, as opposed to positivistic scientism and purported abstract objectivity.

However, throughout its development, philosophy of medicine has presented numerous critiques of prescriptive and restrictively naturalistic models. For example, in 1977, Engel attacked the idea of medicine as purely somatic and based on biochemical factors, calling for a new biopsychosocial medical model [5]. In 1981, in another influential article, Munson explained why medicine cannot be reduced to a science, trying to challenge both a simplistic naturalist and normativist view [13]. Normativism represents perhaps the most dominant alternative to naturalism, its central idea being that our whole understanding of illness has been constructed in accordance with social norms and values, as opposed to an objective measure of biological dysfunction. It is also true that many texts, which have influenced phenomenological works on medicine, are not explicitly phenomenological, such as Michael Balint's seminal 1957 psychoanalytic work *The Doctor, His Patient and the Illness*.

The prioritization of patients' perspectives is also widespread, most notably perhaps in the growth of patient-centred care, which centres on listening to and understanding the patient [14]. Nor is this a new concern: the surrounding controversies can be traced back to antiquity. For the use of qualitative data to question theoretical assumptions, we can see strong parallels in grounded theory, a 'family of methods' dominant in qualitative medical research since the 1980s, whose central tenet is 'primacy of grounded observation over preconceptions' [15].

This is not to say that phenomenology within medicine did not have a radicalizing role and a major influence on any of these ideas. However, like other radical movements and ideas, phenomenology has become, to a certain extent, the victim of its own success. With its ideas now more widely accepted, its current challenge is perhaps to retain their force and significance while integrating them more broadly.

While such approaches might naturally be expected to yield similarities, this is perhaps more surprising when we look at those most directly associated with the quantitative biomedical objective idea, to which phenomenology presents itself as opposed. The most obvious candidate here is evidence-based medicine (EBM), not only the dominant model in contemporary mainstream medical practice and research, but with an evidence hierarchy, which attributes utmost priority to randomized, quantitative and objective data. Might EBM, with its so-called 'gold standard' of the 'randomized control trial' as the most valid indicator of a treatment's efficacy, be a viable opponent for phenomenology?

Yet, stereotypes aside, within the development and literature on EBM itself, we can find numerous challenges to this orthodoxy. Even its most commonly used definition contains an emphasis on considering the individual patient and the integration of clinical expertise, and these issues are widely debated:

The conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients. The practice of EBM means integrating individual clinical expertise with the best available external clinical evidence from systematic research [16].

To name a few: in a 2004 issue of the *British Medical Journal* devoted to EBM, the editorial warns against the over-generalization and scientization of medicine [17], while Guyatt *et al.* [18] exhort us to make absorption of patients' views a practical reality, echoed in Lockwood's article "Evidence of me" in evidence based medicine? [19]. Elsewhere, Cartwright [20] and John Worrall [21] both discuss the limitations of prioritizing randomization, while Ashcroft questions the underlying epistemological assumptions [22].

Many also question how sharp the division is between EBM and alternative methods. Sehon suggests a close interrelationship [23] while Greenhalgh argues that the opposition between the 'hard science' and 'clinical epidemiology' of EBM and the 'traditional values' of personal, compassionate and 'patient-centred medicine' is 'largely a false dichotomy'. She proposes a third model of EBM, 'context-sensitive medicine', which analyses the medical decision-making process and is far more sensitive to the variants of the individual context [24]. Clearly, there is widespread discussion of how to integrate patient perspectives with clinical observation and external evidence, as well as questions about its true objectivity or neutrality.

Even a recent *Handbook of Analytic Philosophy of Medicine* [25] suggests that the qualitative approach provided by fuzzy logic could be a useful tool for explicating the vagueness within medicine, while elsewhere Pannesse [12] suggests that cross-disciplinary research, between neuroscience and humanism, can contribute to medical understanding, as does Thompson [26]. Emerging from various directions is a trend towards a more synthesized and integrated approach. The poles of the opposition, however we wish to name it – biomedical and humanistic, orthodox and radical, are not nearly so clear or entrenched as phenomenologists might suggest. Phenomenology should perhaps be seen as one of a network of distinct, but interrelated, approaches, which could productively share ideas on the various issues concerning subjectivity within medicine.

## Towards a suggested role for phenomenology

Two main points clearly emerge from considering the crossover between phenomenological and other medical approaches: phenomenology deals with issues central to contemporary medical debate and, within this debate, there is a growing move towards integrating and combining methods and approaches. This in itself suggests that there may well be a valid, even if not radicalizing, role for phenomenology in medicine. Nevertheless, this role must be both distinct and offer solutions not themselves readily dismantled through philosophical analysis.

Rather than searching for undiscoverable watertight solutions as the source for philosophy's contribution to medicine, what we

need perhaps is to approach the question from an alternative angle and acknowledge that there are no simple answers here. Existing medical phenomenological works are falling down by failing to recognize the difficulty and intractability of certain problems, even when, ironically, such difficulties have been foundational in the major developments in phenomenological debate.

Phenomenology itself and the critical engagement with it over the years represents probably the most in-depth philosophical discussion of subjectivity and how to reconcile this with some sense of objective or general understanding. Given that so much of medicine is tied up with questions of how to integrate the context and values of individual perspectives into general conceptions of illness and treatment, perhaps we should see medical phenomenology as presenting a philosophical arena for considering these questions and explicating their complexities and difficulties. Phenomenology cannot provide us with neat and simple answers to questions that remain deeply problematic and controversial. Nevertheless, what it can give us is a clearer understanding of the nature of the questions themselves, alternative ways to address them and the problems that face these alternatives. This in itself is deeply valuable.

As we have seen, existing medical phenomenology has proposed simplified, but also flawed, solutions to the problems of empathy and reconceptualization within medicine. By contrast, the approach I am proposing, of using phenomenology as a means to explicate the true complexity of the problems, might not only be more productive, but is also perhaps truer to the phenomenological movement itself. For, if we look at the development of phenomenological thought, it is very clear that the difficulties surrounding *epoché* or 'bracketing' assumptions and empathy/intersubjectivity are foundational within phenomenological debate and remained as controversial motivating questions throughout.

Let us start with the notion of *epoché* or 'bracketing', which has been seized upon by medical phenomenologists as a standard phenomenological idea and a model for the idea that we dispense with our theoretical assumptions to arrive at new 'pre-theoretical' understandings. Far from *epoché* being a universally accepted feature of phenomenology, there is no explicit mention in Heidegger, while Merleau-Ponty, seen as so significant for medical phenomenology, actually gives central importance to demonstrating its intrinsic problems and even how complete *epoché* is self-defeating. In very simple terms, Husserl's original notion of *epoché*, involves suspending and examining not just certain assumptions, but suspending our basic commitment to the actual existence of the world and goes hand in hand with his philosophical rejection of science because of its basis in unexamined naturalist theoretical assumptions [6,27]. By contrast, Heidegger and Merleau-Ponty's rejection, or possibly revision, of *epoché* is usually seen as crucial to the development of their ideas because they see phenomenology as revolving around our actual interrelationship with the world.<sup>11</sup> While the controversies surrounding this notion are far too detailed and complex to expand upon in detail here, one thing, which is very clear and uncontroversial, is that the phenomenological *epoché*, 'bracketing' or 'reduction' is not, as the

medical literature suggests, a unified or straightforward phenomenological method or principle.<sup>12</sup>

Moreover, these are not just pedantic objections about philosophical accuracy. This debate concerns the very question of whether we can ever truly step outside of our theoretical situatedness in the world and how this varies according to how we understand the nature of human existence, understanding and the relationship between our bodies, selves and the world. These questions and the intractability of the problems surrounding them must surely be relevant when we come to examine the difficulties and interrelations in understanding medical science, the individual, the body and the world in which all of these are situated.

The case is similar if we look at phenomenological debates about empathy and intersubjectivity, where any suggestion that there is an uncontroversial or unified account is deeply misleading ([10], p. 164). As I pointed out earlier, current medical phenomenology tends to omit or even conflict with many of the key ideas in this complex and extensive debate. While I cannot detail the debate here, I can point very briefly to a few ideas, which might be relevant in the medical context. There is the idea that empathy involves experiencing another person as a unified whole, and is a special form of 'intentionality' – the mind's capacity to be directed towards other things. We might reach a deeper understanding of how to achieve understanding of another's experience of illness, through coming to understand the process of empathy and how it can be differentiated from other forms of intentionality, such as 'perception, imagination and recollection' ([10], p. 153). Then there is Merleau-Ponty's view that intersubjectivity can only be possible if our own experience of ourselves involves an experience of otherness, as well as the varied phenomenological debate on solipsism [28].

As we have seen, there are deep and intrinsic difficulties in the question of how to reconcile the uniqueness of individual experience with accessing these and creating shared general understanding. Some suggest that phenomenology, taken as 'a study of how we experience', should be seen as a *core field* within philosophy, integrally interrelated to all the other more 'traditional' branches [29]. Perhaps this is how we can see its role within medicine. For, clearly phenomenological ideas are extremely pertinent here, as long as we resist condensing and unifying them into supposedly straightforward, but actually flawed, solutions.

To put all this in more specific contexts, with patient-centred care, although it has been accepted into medical orthodoxy, many remain sceptical, both about its true value and how best to integrate and implement it within health care. Though espoused in policy, it is certainly not always practised within clinical settings. Similarly, debates about EBM and medical practice are mired in controversy over how to reconcile the qualitative, subjective and individual aspects of patient/clinical experience with the quantitative objective ideal of scientific evidence and analysis. Numerous questions are asked, for example, about how the emphasis on finding validly randomized controlled trials means that population samples are not truly representative and general applicability is compromised. Medicine has to deal with all the difficulties of trying to assemble general scientific principles from very different real examples. With phenomenology, perhaps we have the

<sup>11</sup> Many take this further and suggest that Husserl rejects commitment to existence of world altogether. However, this is controversial. Even the terms *epoché*, reduction and bracketing are not straightforward and one cannot simply assume that they are interchangeable [27,37].

<sup>12</sup> See Smith [27] on the compatibility of externalism with the reduction for Merleau-Ponty.

starting point for really getting to the heart of these difficulties. For example, Merleau-Ponty's discussions of science and objectivity, with his aspirations to maintain scientific endeavours, despite the variability, individuality and contextual situatedness of examples, may well be of use here.

As further examples, phenomenological discussions of temporality could very likely be helpful in understanding how the individual patient experiences time and how this contributes to their assessment of treatment efficacy, by comparison with assessments based on ordinary chronology. Similarly, phenomenological debate may well be able to help enhance our understanding of measuring pain, assessing the true impact of side effects, understanding warning signs and triggers – all of these factors, and many more, which play a crucial role in determining diagnosis and suitability of particular treatments ([26], p. 16).

In the words of William Osler, a key figure in the development of modern medicine, 'he who studies medicine without books sails an uncharted sea, but he who studies medicine without patients does not go to sea at all.' While we need general ideas and theories, medicine can never be taken in isolation from all the variable factors of the individuals, which it has been constructed to treat. Reconciling the general and objective with the individual and subjective is, then, a key factor within medical enterprise and, as I said at the outset, few would argue that taking greater account of the ill individual's viewpoint and experience of illness is important. However, if phenomenology is to play a valuable role in deepening our conceptual understanding of how to integrate subjectivity into the theory and practice of medicine, it cannot sweep aside its complexities and act as a simple system or tool kit to make clinicians more empathic or understanding. Not only is this disingenuous to phenomenology itself, but it will not offer substantial innovations, nor stand up itself to any of the philosophical rigour or scrutiny that it supposedly imports.

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