THE MEANING OF ILLNESS: A PHENOMENOLOGICAL APPROACH TO THE PHYSICIAN/PATIENT RELATIONSHIP

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ABSTRACT

It is my purpose in this thesis to explore the "reality" of illness, using philosophical phenomenology as a guide. In particular, I am concerned to show that the experience of illness, rather than representing a shared "reality" between physician and patient, represents in effect two quite distinct "realities" (the meaning of one "reality" being significantly different from the meaning of the other). Philosophical phenomenology focuses on the nature of experience, and particularly upon the manner in which all experience is structured by the activity of consciousness. In so doing phenomenology emphasizes the unique nature of experiencing and particularly the correlation between the perceiver and that which is perceived. Meaning is seen to be a function of the activity of individual consciousness. In the first chapter consideration is given to some basic concepts which are fundamental for phenomenology and a distinction is made between "own world" and "common world." In the second chapter these concepts are shown to provide insights into the nature of the discrepancy between the physician's and the patient's understanding of illness. Consideration is given to the manner in which the separate worlds of the

physician and patient are constituted. It is argued that it is through attentional focusing that the sense of illness is made explicit for the individual. An analysis is provided of the manner in which such attentional focusing is determined. In the third chapter consideration is given to the question of how it is possible to construct a shared world of meaning between patient and physician, given the unique nature of experiencing. An eidetic interpretation of illness is proposed and attention is directed towards some ways in which we do, in fact, come to some understanding of the Other. In the final chapter it is suggested that the notion of healing presupposes a shared world between physician and patient. A distinction is made between healing and curing disease. It is noted that the manner in which the "reality" of illness is defined directly influences the way in which the end of the patient/physician relationship is defined. It is argued that the end of the patient/physician relationship is healing and that healing is a mutual act which is accomplished within the context of a shared world between physician and patient.

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PREFACE

My interest in exploring the nature of the patient's and the physician's understanding of illness grew out of my own experience as a person living with multiple sclerosis.

It has often seemed to me, in discussing my illness with physicians, that we have been somehow talking at cross purposes, discussing different things, never quite reaching one another. It has also seemed to me that, for the most part, this inability to communicate has not been due to insensitivity or inattentiveness but to a fundamental disagreement in understanding about the nature of illness. In this thesis I have attempted to explore the nature of this disagreement using philosophical phenomenology as a guide.

Such insight as I have into the patient's situation is largely drawn from my own experience. Such insight as I have gained into the physician's situation has been possible because of the kindness of many physicians who have willingly discussed this topic with me.

The preparation of this thesis has been a unique personal learning experience. This experience has been greatly enhanced by the participation of the following

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the manner in which the physician and patient understand the experience of illness. Our stimulating dialogue has been a constant motivating factor in the preparation of this thesis.

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In addition, I would like to thank the faculty of the Philosophy Department at Baylor University for providing

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INTRODUCTION

The experience of illness represents an altered state of existence, a distinct mode of "being-in-the-world." The patient is isolated in this experience because of his inability to communicate the reality of his illness to others, and particularly to the one who is most intimately involved in sharing that reality - his physician.

The patient cannot meaningfully communicate with his physician because each is defining illness in a qualitatively distinct way. There is thus no mutual context of understanding between them. The experience of illness, rather than representing a shared "reality" between physician and patient represents, in effect, two quite distinct "realities" (the meaning of one "reality" being significantly different from the meaning of the other).

Philosophical phenomenology provides some insights into the nature of the discrepancy between the patient's and the physician's understanding of the "reality" of illness. Phenomenology also provides some insights into the manner in which a shared world of meaning may nevertheless be constructed between them.

One of the important insights to be gained from

phenomenology is the realization that all experience is, from the outset, structured by the implicit activity of individual consciousness; that there is, indeed, no such thing as "raw" experience, or objective "reality," apart from one's consciousness of and interpretation of that experience or "reality."

While such activity of consciousness may, upon reflection, be admitted, it is nevertheless largely ignored and to some extent discounted altogether in everyday life. For the most part it is assumed that the common sense world presents an objective "reality" which is available to all and which is simply there to be encountered. The manner in which this world is experienced is taken for granted or considered irrelevant. Thus, the complexity of the structure of "reality" is disregarded.

Phenomenology alerts one to the absolute primacy of the individual's unique experiencing-of the world. An analysis of the ways in which this experiencing is typically structured can provide significant insights into one's own understanding of "reality." Along with the recognition that each individual defines the "reality" he encounters, one is led to differentiate between the private, egoistical world ("the" world as it is transposed into "my" world) and the common world, the intersubjective world in which understanding with others has been established and about which one can communicate. It is in the exploration of the concepts

of "own world" and common world, in particular, that phenomenology can provide some insights which are most helpful when considering the experience of illness and the patient/physician relationship.[1]

In Chapter I I propose to identify some basic concepts which are fundamental for phenomenology. Such concepts will later be shown to be particularly relevant for an analysis of the patient/physician relationship.

In particular, I shall consider the phenomenological concepts of "own world" and the common world to show that there is a distinction between the two and to suggest some ways in which these separate worlds are constituted.

I shall discuss the phenomenological notion of the Life-world and show how such notions as intentionality, focusing, horizon, typification and biographical situation lead to the private, egoistical interpretation of the Life-world, that is, to a transposition of "the" world into "own world." I shall then consider how it is that a common world is possible, given the unique nature of experiencing, and how such a common world is constituted. Finally, I shall discuss

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[1]Edmund Husserl has distinguished between the private, egoistical world and the common world. See, Ideas: General Introduction to Pure Phenomenology, trans. W. R. Boyce Gibson (New York: Macmillan, 1931). Gerhard Bosch, following Husserl's notion of the private world has termed this world "own world." See, Infantile Autism: A Clinical and Phenomenological Investigation Taking Language as a Guide, trans. Derek and Inge Jordan (New York: Springer-Verlag, 1970).

the phenomenological method, with particular reference to Husserl's notion of "reduction" or "bracketing" and the notion of eidetic investigation.

In examining these concepts it is not my intention to provide a critical philosophical analysis of the work of any one phenomenologist, nor to explicate each concept in great detail; rather, I am concerned to convey something of the nature of philosophical phenomenology and to show how insights gained from phenomenology provide a means to identify and approach the problems inherent in the patient/physician relationship.

In Chapter II I propose to show how the phenomenological principles explicated provide some insight into the discrepancy between the physician's and the patient's understanding of the "reality" of illness. In particular, I shall consider how the separate worlds of the physician and patient are constituted. In this regard, I shall seek to show that it is through attentional focusing that the sense of the illness is made explicit for the individual, and I shall explore the manner in which such attentional focusing is determined. Such notions as "habits of mind," finite provinces of meaning, relevance, and context will be considered.

In Chapter III I shall consider how it is possible to construct a common world between physician and patient,

given the unique nature of experiencing. I shall offer an eidetic interpretation of illness and outline some ways in which we come to some understanding of the world of the Other. The following will be briefly considered: Herbert Spiegelberg's concept of "imaginative self-transposal," Richard Zaner's notion of "possibilizing," and Maurice Natanson's analysis of analogy and "extrapolative understanding."

In Chapter IV I shall consider the nature of healing and shall seek to show that the act of healing presupposes a shared world between physician and patient. A distinction will be made between healing and curing. It will be noted that the way in which the "reality" of illness is defined directly influences the manner in which the end of the patient/physician relationship is defined. It will be argued that the end of the patient/physician relationship is healing and that this end requires that the physician enter into a shared world with the patient.

CHAPTER I

THE PHENOMENOLOGICAL PERSPECTIVE

The Task of Phenomenology

The task of phenomenology is to explore the manner in which "reality" is experienced. Phenomenology seeks to explicate the nature of the common, everyday world in which we live and act, and about which we have certain taken-for-granted beliefs, and to reflect upon and elucidate the various elements which constitute our understanding of and experience of that world.

In so doing, phenomenology focuses on experiencing as an activity which is unique to the individual and seeks to make explicit the implicit structure of this experiencing.[1]

Phenomenology thus demands a radical shifting of attention from that of "engagement in to that of focal concern for the sense and strata of the very engagement itself."[2]

This crucial shift in attention results in a

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[1]Richard M. Zaner, The Way of Phenomenology: Criticism as a Philosophical Discipline (New York: Pegasus, 1970), p. 50.

[2]Ibid., p. 51.

focusing on the activity which structures experience. "Reality" is thus seen to be a function of consciousness and far more complex than had hitherto been supposed:

> . . . what had hitherto been simply accepted as "obvious" - so obvious, in fact, that it went beyond the barest notice or mention - is now recognized reflectively as a performance of consciousness and subjected to analysis. While that analysis goes on, the phenomenologist remains as much in the world as he ever was, retains all of his interests and knowledge, and persists in his human concerns. The only change (and it is a crucial one to be sure) is that he reflects selectively on what he had hitherto simply lived, though both the reflection and the living continue, side by side, in the life of consciousness.[3]

The shift in attention discloses a correlation between the one who is experiencing and that which is experienced, between myself-as-believer and the belief-as-believed by me.[4] In everyday life this correlation is, for the most part, rarely reflected upon:

> . . . our usual style of doing and thinking within the life-world is mainly characterized by (1) being attentive to, or being concerned and busied with, the things in the environs (and neither as experienced by us, nor our experiencing them as such) and (2) a suspension of the possibility of their being otherwise than they are experienced and believed to be . . .[5]

Only if something out of the ordinary occurs does one momentarily recognize that "reality" may be other than

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[3]Maurice Natanson, Edmund Husserl: Philosopher of Infinite Tasks (Evanston: Northwestern University Press, 1973), p. 59.

[4]Zaner, The Way of Phenomenology, p. 82.

[5]Ibid., p. 49.

was supposed, that what has hitherto simply been taken-for-granted is not indubitable:

> . . . the jolt of the uncommon, emerging in the midst of the common, awakens that in you of which until now you were not aware, and by so doing effects a subtle shift in you and a change in the world itself. You now see it for the first time, really. . . . With this shift there emerges the recognition of what before seemed so obvious and commonplace that it called no attention to itself. Now you find the obvious quite suddenly transformed. Having recognized it, "we have changed our world."[6]

By becoming "reflectively cognizant" rather than "straightforwardly cognizant" of the world,[7] that is, by reflecting upon the process of consciousness and the correlation between the one who is experiencing and that which is experienced, one becomes aware that experience is "manifestly richer and enormously more stratified and differentiated" than was previously assumed.[8]

The Familiar World, the "Lebenswelt" or "Life-World"

The familiar world, the "Lebenswelt" or "Life-World" is understood by the phenomenologist to be the world of concrete reality, of lived experience.

> My immediate living, being in the world, my awareness of what is about me now, my fresh or indistinct memories of my past, my lively or vague anticipations of my future, my existential relations to home and family and friends, my situation in life and its problems for me, my life and my death, are all

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[6]Ibid., p. 47.

[7]Ibid., p. 133.

[8]Ibid., p. 203.

> elements of the Lebenswelt. The phenomenologist believes that not only is the structure of this world as complex and rich in philosophical implications as the world of natural science but that the latter is ultimately founded on the experiences rooted in the former. The Lebenswelt is the underlying matrix of our lives . . .[9]

The individual lives and acts in the familiar world without, for the most part, any conscious awareness of the ways in which he structures and interprets his experience. The familiar world is simply taken for granted:

> I find continually present and standing over against me the one spatio-temporal fact-world to which I myself belong, as do all other men found in it and related in the same way to it. This "fact-world," as the word already tells us, I find to be out there, and also take it just as it gives itself to me as something that exists out there. All doubting and rejecting of the data of the natural world leaves standing the general thesis of the natural standpoint. "The" world is as fact-world always there; at the most it is at odd points "other" than I supposed, this or that under such names as "illusion," "hallucination," and the like, must be struck out of it, so to speak; but the "it" remains ever, in the sense of the general thesis, a world that has its being out there.[10]

Thus, for the most part, the individual lives in the familiar world in light of what Husserl has called "the natural attitude"; that is, in light of a naive unquestioned

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[9]Maurice Natanson, Literature, Philosophy and the Social Sciences: Essays in Existentialism and Phenomenology (The Hague: Martinus Nijhoff, 1968), p. 39.

[10]Edmund Husserl, Ideas: General Introduction to Pure Phenomenology, trans. W. R. Boyce Gibson (New York: Macmillan 1931), p. 106.

belief in the existence and validity of the world.[11]

In the "natural attitude" the world or "reality" is simply assumed to have an "objective" existence apart from one's consciousness of and experiencing of it.

> . . . when Husserl speaks of the natural standpoint, he is not claiming that some biological necessity forces a metaphysics upon us but simply that the ingrained habits of our common sense, without our even being aware of it, lead us into a metaphysics. Precisely because our common sense is habitual and quite free of self-conscious reflection, because it is preoccupied with the world it encounters as "out there," it assumes that reality itself is "out there," only passively recorded by the subject "in here." The shift is subtle but significant. As lived, reality is the experiencing of an object. As common sense interprets it, the reality is the object, the experience is incidental to it. That is no longer a datum; it is the unacknowledged theoretical postulate of common-sense knowledge. Husserl calls it the "thesis of the natural standpoint": the world is "out there," only its reflection is "in here," so that, if I am to understand what is "in here," I must look for an explanation "out there"; or, in sum, lived experience is what is to be explained, and the world is what explains it. To understand my experience, common sense assumes, I need to know what I am experiencing but must discover what in the world is causing it.[12]

Phenomenology is concerned to examine the "natural attitude" and to reflect upon the nature of this taken-for-granted believing in the world.[13] In so doing the

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[11]Natanson, Literature, Philosophy and the Social Sciences, p. 37.

[12]Erazim Kohak, Idea and Experience: Edmund Husserl's Project of Phenomenology in Ideas I (Chicago: University of Chicago Press, 1978), p. 32.

[13]Natanson, Literature, Philosophy and the Social Sciences, p. 37.

phenomenologist notes that the basic assumptions of daily life are distinctively different from the constructions or models utilized by natural scientists, and there is a radical distinction to be made between the life-world and the artificial world of scientific inquiry.[14] In particular, it is noted that the scientific world is founded on and presupposes the implicit acceptance of the life-world.

In this implicit acceptance of the existence of the familiar world the individual rarely recognizes that all experience of and knowledge of this "spatio-temporal fact world" is just as much the result of the structuring activity of consciousness as is the abstraction and conceptualization of the scientific world. In order to render the common-sense world intelligible, to transform it into a predictable, comprehensible universe, the individual interprets what he experiences in terms of some meaningful scheme which he imposes upon the "reality" which he encounters. It is by means of this activity of structuring that the individual is able to make sense of his experience:

> All our knowledge of the world, in common-sense as well as in scientific thinking, involves constructs, i.e. a set of abstractions, generalizations, formalizations, idealizations specific to the respective level of thought organization. Strictly speaking, there are no such things as facts, pure and simple. All facts are from the outset facts selected from a universal context by the activities of our mind. They are, therefore, always interpreted facts, either facts looked at

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[14] Ibid., p. 38.

> as detached from their context by an artificial abstraction or facts considered in their particular setting. In either case, they carry along their interpretational inner and outer horizon. This does not mean that, in daily life or in science, we are unable to grasp the reality of the world. It just means that we grasp merely certain aspects of it, namely those which are relevant to us either for carrying on our business of living or from the point of view of a body of accepted rules of procedures of thinking called the method of science.[15]

As Natanson has pointed out the common-sense world, the "life-world" is the "locus for man's construction of reality and the point of access to his comprehension of all knowledge."[16] All further abstraction and conceptualization is founded on and presupposes the implicit structuring and interpretation of the life-world.

How then is the familiar world ordered? What is it that enables the individual to adopt certain "taken-for-granted" attitudes.[17] How is one's knowledge of the world constructed?

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[15]Alfred Schutz, "Common Sense and Scientific Interpretation of Human Action," in Alfred Schutz: Collected Papers, ed. Maurice Natanson, vol. 1: The Problem of Social Reality (The Hague: Martinus Nijhoff, 1962), p. 5.

[16]Maurice Natanson, The Journeying Self: A Study in Philosophy and Social Role (Reading: Addison-Wesley Publishing Company, 1970), p. 97.

[17]Alfred Schutz has referred to the "taken-for-grantedness" of the familiar world in many of his works. See, Alfred Schutz: Collected Papers, ed. Maurice Natanson, vol. 1: The Problem of Social Reality (The Hague: Martinus Nijhoff, 1962).

Intentionality

Phenomenology, as has been noted, emphasizes that all experience is necessarily experience-of; that one cannot talk about consciousness without referring to the act of consciousing and the object of consciousness; that there is a crucial correlation between the perceiver and that which is perceived.

The phenomenologist is concerned to note that experience-of necessarily implies an act of consciousness which renders the experience possible. Such acts of consciousness are held to be directional in nature.

Edmund Husserl has termed the directional character of consciousness "intentionality."[18] He notes that all perceptual acts point to, or "intend," some object. "All thinking is thinking of something; all willing is willing of something; all imagining is imagining of something."[19]

The object of consciousness, therefore, is to be understood not as a "thing" but rather as a correlate of the intentional act of consciousing, an intentional act which necessarily belongs to an experiencing ego.

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[18]Gilbert Ryle notes that the term "intentionality" is the revival of a scholastic term and is used only as a name for the fact that mental acts are of objects. See his article entitled "Phenomenology" in Collected Papers, vol. 1: Critical Essays (New York: Barnes and Noble, Inc., 1971) pp. 167-78.

[19]Natanson, Edmund Husserl: Philosopher of Infinite Tasks, p. 85.

Focusing

The manner in which an object is experienced is strictly correlative to the way in which the individual explicitly attends to, or focuses on, that object. In Husserl's terms, the activity of consciousness renders the object "thematic."[20]

In other words, there is a distinction to be made between the "object-which is intended" (the object X) and the "object-as it is intended" (the object in terms of the individual's explicit attentional focus).[21] One may, for example, focus on the color rather than the taste of a glass of wine. One may choose to attend to Napoleon AS husband of Josephine, or one may instead attend to Napoleon AS victor at Jena.[22] The attentional focus which renders the object "thematic" varies. Additionally, one may thematize in a variety of modes (cognitively, valuationally, emotively, and so forth).[23] It is through such attentional focusing that the sense of the object is made explicit.[24]

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[20]Edmund Husserl, The Crisis of European Sciences and Transcendental Phenomenology: An Introduction to Phenomenological Philosophy, trans. David Carr (Evanston: Northwestern University Press, 1970), p. 108.

[21]Zaner, The Way of Phenomenology, p. 165.

[22]Ibid.

[23]Ibid.

[24]Ibid., p. 166.

Thus, as Natanson points out, the primary "locus of meaning" of any objective state of affairs is grounded in the activity of intentional consciousness.[25]

What motivates the individual to attend to this object or that, or to focus on a certain aspect of a thing rather than another, depends upon his biographical situation generally and upon the particular project in which he is engaged at the time.[26]

Alfred Schutz has noted that ultimately what the individual attends to depends upon his "plan of life" and on the "complicated texture of choices, decisions, and projects" he makes every day in light of that plan and more immediate plans.[27]

Thus, experience is encountered, attended to, and rendered "thematic" in terms of the individual's unique situation. "The" world is valid for the individual according to the way it is defined in light of "specifically personal acts of perception, of remembering, of thinking, of valuing, of making plans . . ."[28]

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[25]Natanson, Edmund Husserl: Philosopher of Infinite Tasks, p. 95.

[26]Zaner, The Way of Phenomenology, p. 162.

[27]Ibid. See also: Alfred Schutz, Reflections on the Problem of Relevance, ed. Richard M. Zaner (New Haven: Yale University Press, 1970).

[28]Husserl, The Crisis, p. 317.

Horizon

The phenomenologist notes that everything that is encountered is encountered as a "being-in-a-context."[29]

> I see a tree as outside my window, next to the swings, behind the porch, in front of the hill - in short, as set off from a background of coperceived things (among them, my own body), and so on. More generally, I apprehend myself as located within a kind of zero-point, "Here" and "Now," my own living body, around which are concentric zones of "far" and "near." This is not only spatial and temporal, but also social, historical, economic, political, and so on.[30]

No object is perceived as insulated but rather is comprehended as an object within a "horizon of familiarity and preacquaintanceship."[31]

In Husserl's terms every act of consciousness presupposes an infinite horizon of "reactivatable validities" which have been acquired in previous acts of consciousness and which, together with the present act, make up "a single, indivisible, interrelated complex of life." The world's validities are always founded on other validities.[32]

As Schutz notes, the field of consciousness is structured into a "thematic kernel" which "stands out over

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[29]Zaner, The Way of Phenomenology, p. 154.

[30]Ibid.

[31]Schutz, "Common Sense and Scientific Interpretation of Human Action," p. 7.

[32]Husserl, The Crisis, pp. 148-51.

against a surrounding horizon."[33] What constitutes the thematic experience is that one voluntarily turns to it or reflects upon it.[34] The horizon is constituted not only by perceptual experiences (e.g. the background of coperceived things) but also by one's autobiographical situation which includes within it all one's former experiences which are preserved in memory or available within one's present stock of knowledge-at-hand.[35]

Thus, the "meaning" of a particular object cannot be separated from the global field of meaning of the individual's world.[36]

Typification

Schutz notes that the individual experiences and interprets his familiar world by means of what he has called "typifications." The individual encounters things always as examples of certain types (automobiles, trains, people, animals, and so forth).

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[33]Schutz, Reflections on the Problem of Relevance, p. 4.

[34]Ibid.

[35]Ibid., p. 2. For further discussion of the notions of "stock of knowledge-at-hand" and "biographical situation" see the following two sections of this work. See also, Schutz, "Common Sense and Scientific Interpretation of Human Action."

[36]John Wild, "Husserl's Life-World and the Lived Body," in Phenomenology: Pure and Applied, ed. Erwin W. Straus (Pittsburgh: Duquesne University Press, 1964), p. 37.

> The factual world of our experience . . . is experienced from the outset as a typical one. Objects are experienced as trees, animals, and the like, and more specifically as oaks, firs, maples, or rattlesnakes, sparrows, dogs. This table I am now perceiving is characterized as something recognized, as something foreknown and, nevertheless, novel. What is newly experienced is already known in the sense that it recalls similar or equal things formerly perceived. But what has been grasped once in its typicality carries with it a horizon of possible experience with corresponding references to familiarity, that is, a series of typical characteristics still not actually experienced but expected to be potentially experienced. If we see a dog, that is, if we recognize an object as being an animal and more precisely as a dog, we anticipate a certain behavior on the part of this dog, a typical (not individual) way of eating, of running, of playing, of jumping, and so on. Actually we do not see his teeth, but having experienced before what a dog's teeth typically look like, we may expect that the teeth of the dog before us will show the same typical features though with individual modifications. In other words, what has been experienced in the actual perception of one object is apperceptively transferred to any other similar object, perceived merely as to its type.[37]

Such "typifications" comprise the individual's stock of knowledge by means of which he is able to interpret the totality of his experience, and they bestow upon the world of everyday life its quality of "taken-for-grantedness."

> By way of culturally and socially inculcated typifications, we in the usual course of affairs simply and habitually learn to take hosts of things for granted, as going to be more or less as they have proven to be in the past - at least for all practical purposes. Only if something does not correspond or conform to our

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[37]Alfred Schutz, "Language, Language Disturbances and the Texture of Consciousness," in Alfred Schutz: Collected Papers, ed. Maurice Natanson, vol. 1: The Problem of Social Reality (The Hague: Martinus Nijhoff, 1962), pp. 281-82.

> social typifications are we at all alerted to it, called on to take notice of it - and then, our attention is typically directed to settling only what has been unsettled, in order then to proceed with whatever occupies us at the time.[38]

In other words, what is unfamiliar is recognized as being so because it is seen against the background of the familiar. Once the unfamiliar is encountered, the individual proceeds to adjust his stock of knowledge in such a way as to incorporate the novel into the typified schema.

> If we encounter in our experience something previously unknown and which therefore stands out of the ordinary order of our knowledge, we begin a process of inquiry. We first define the new fact; we try to catch its meaning; we then transform step by step our general scheme of interpretation of the world in such a way that the strange fact and its meaning become compatible and consistent with all the other facts of our experience and their meanings. If we succeed in this endeavor, then that which formerly was a strange fact and a puzzling problem to our mind is transformed into an additional element of our warranted knowledge. We have enlarged and adjusted our stock of experiences.[39]

The "typifications" which comprise the individual's knowledge of the world (what Schutz has termed his stock of "knowledge-at-hand") are derived either from his own previous experiences, or are handed down to him by others such as parents or teachers.[40] For the most part they are

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[38]Richard M. Zaner, "Chance and Morality: The Dialysis Phenomenon," in The Humanity of the Ill, ed. Victor Kestenbaum (Knoxville: The University of Tennessee Press, 1982), p. 48.

[39]Alfred Schutz, "The Stranger," in Alfred Schutz: Collected Papers, ed. Arvid Brodersen, vol. 2: Studies in Social Theory (The Hague: Martinus Nijhoff, 1964), p. 105.

[40]Schutz, "Common Sense and Scientific Interpretation of Human Action," p. 7.

culturally and socially inculcated. From childhood on the individual continues to add to his stockpile of "typifications." Thus, the world of everyday life assumes a familiar quality which makes the prediction and control of experience possible.[41]

However, although the "typifications" which comprise the individual's stock of "knowledge-at-hand" are, more often than not, socially derived, the way in which the individual ultimately interprets his common sense reality, given these "typifications," depends upon his own unique "biographical situation."[42]

Biographical Situation

Each individual finds himself in a unique biographical situation within the social world. His situation is unique not only in terms of his actual physical environment, but also in the manner in which he arrives at his carefully constructed definition of reality. From the outset things are handed down from parents and teachers in such a way that "typifications" carry along with them a "sedimented" meaning which is different for each individual.

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[41]Maurice Natanson, Introduction to Alfred Schutz: Collected Papers, ed. Maurice Natanson, vol. 1: The Problem of Social Reality (The Hague: Martinus Nijhoff, 1962), p. xxix.

[42]Alfred Schutz has used this term to refer to the unique biography of each individual. See, Alfred Schutz: Collected Papers, ed. Maurice Natanson, vol. 1: The Problem of Social Reality.

Additionally, as the individual lives and acts in the life-world he amasses a store of subjective experiences, compiles a unique stock of knowledge-at-hand which is necessarily his alone and upon which he builds his further interpretations of reality:

> . . . the actor's actual situation has its history; it is the sedimentation of all his previous subjective experiences. They are not experienced by the actor as being anonymous but as unique and subjectively given to him and to him alone.[43]

Thus, the way common-sense reality is defined depends on "the totality of the experience a person builds up in the course of his existence."[44] All that the individual encounters has significance for him in light of his own "special interests, motives, desires, aspirations, religious and ideological commitments."[45] Therefore, although his knowledge is comprised of "typifications" which are socially inculcated, the individuated expression of this knowledge, the interpretation of his experience, depends on the unique placement of the individual in the social world.[46]

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[43]Alfred Schutz, "Choosing Among Projects of Action," in Alfred Schutz: Collected Papers, ed. Maurice Natanson, vol. 1: The Problem of Social Reality (The Hague: Martinus Nijhoff, 1962), p. 77.

[44]Natanson, Introduction, p. xxviii.

[45]Ibid.

[46]Ibid., p. xxix.

"Own World"[47]

In summary, then, the individual finds himself always located within the Life-world, the world of lived experience. In order to render this world comprehensible, he interprets it in light of a meaningful structure which he imposes upon the "reality" he encounters. By means of intentionality and focusing he attends to certain aspects of his experience which are always perceived against a background or horizon which includes his unique biographical situation and stock of knowledge-at-hand.

Since all experience represents a correlation between the one who is experiencing and that which is experienced, and since the locus of meaning is grounded in the intentional activity of personal consciousness, the core of a person's experience cannot be immediately accessible to another. Everyone has exclusively his own phenomena which only he is capable of experiencing quite originally.[48] As Husserl notes the contents of the Other's world are therefore only available to me in an "appresent manner." I cannot experience them directly.[49]

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[47]Throughout this work I shall use Gerhard Bosch's designation of "own world" to refer to the private, egoistical world of the individual. See, Bosch, Infantile Autism: A Clinical and Phenomenological Investigation Taking Language as a Guide.

[48]Bosch, Infantile Autism, p. 55.

[49]Ibid.

Each individual retains the essential core of his experiencing as a constituted world which essentially transposes "the" world into "own world." In such a "world-for-me" things are:

> . . . not the in-themselves-existing things of nature - of the exact sciences with the definitive properties which alone are recognized by science as objective characteristics - instead they are experienced, thought, or otherwise posited things as such, intentional objectivities of the personal consciousness.[50]

Nevertheless, although the individual experiences his world directly in a unique way, he perceives himself to be located in an intersubjective world, that is, to be living in the familiar world as a man among fellow men who share a relationship to a common world. He perceives himself to be an experiencing subject (for whom objects exist as correlates of his experiencing of them) among other experiencing subjects for whom he, himself, exists as an object.[51] Thus, he is at once subject and object in the world. In addition, he is a self-conscious being in that he is reflectively conscious of being both subject and object in an intersubjective world.

How is the intersubjective world constituted? And, particularly, how is a shared relationship to a common world possible given the unique nature of experiencing?

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[50]Edmund Husserl, Ideen zu Einer Reinen Phanomenologie und Phanomenologischen Philosophie, Bd. 2, p. 186, quoted in Bosch, Infantile Autism, p. 54.

[51]Zaner, The Way of Phenomenology, pp. 119-20.

Common World

Alfred Schutz argues that the world is from the outset an intersubjective world of culture:

> It is intersubjective because we live in it as men among other men, bound to them through common influence and work, understanding others and being understood by them. It is a world of culture because, from the outset, the world of everyday life is a universe of significance to us, that is, a texture of meaning which we have to interpret in order to find our bearings within it and come to terms with it. This texture of meaning . . . originates in and has been instituted by human actions, our own and our fellow-men's, contemporaries and predecessors.[52]

For the most part the individual's stock of knowledge-at-hand is socially and culturally derived. "The" world is handed down as an interpreted world. This stock of knowledge-at-hand forms the frame of reference, interpretation and orientation for the individual's life in the world of daily experience.[53]

Included within his stock of knowledge-at-hand, and interpreted in light of his naive "typifications," is the individual's knowledge of other fellow human beings. Just as he takes the existence of the familiar world for granted, so the individual takes for granted the assumption that intelligent fellow men exist and presumes that the objects

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[52]Schutz, "Common Sense and Scientific Interpretation of Human Action," p. 10.

[53]Aron Gurwitsch, Introduction to Alfred Schutz: Collected Papers, ed. I. Schutz, vol. 3: Studies in Phenomenological Philosophy (The Hague: Martinus Nijhoff, 1966), p. xviii.

of the world are, as a matter of principle, accessible to their knowledge.[54] At the same time the individual takes for granted that the "same" object must mean something different to himself and his fellows in that each experiences the object from a different perspective spatially and in light of unique biographical situations, different purposes at hand and different systems of relevances.[55] Common sense thinking overcomes these differences in individual perspective by means of two typifying constructs which Schutz has called "the general thesis of reciprocal perspectives."[56]

This general thesis is comprised of two idealizations:

> . . . i) The idealization of the interchangeability of the standpoints: I take for granted - and assume my fellow-man does the same - that if I change places with him so that his "here" becomes mine, I shall be at the same distance from things and see them with the same typicality as he actually does; moreover, the same things would be in my reach which are actually in his. (The reverse is also true.)
> . . . ii) The idealization of the congruency of the system of relevances: Until counter evidence I take it for granted - and assume my fellow-man does the same - that the difference in perspectives originating in our unique biographical situations are irrelevant for the purpose at hand of either of us and that he and I, that "We" assume that both of us have selected and

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[54]Schutz, "Common Sense and Scientific Interpretation of Human Action," pp. 11-12.

[55]Ibid.

[56]Ibid., p. 12.

> interpreted the actually or potentially common objects and their features in an identical manner or at least an "empirically identical" manner, i.e., one sufficient for all practical purposes.[57]

Both idealizations are "typifying constructs of objects of thought which supersede the thought objects of my and my fellow-man's private experience."[58] It is through the operation of these constructs of common-sense thinking that the private world of immediate experiencing is rendered into a "common world" shared with other fellow men.

The "common world," therefore, is constituted in the encounter with other individuals through acts of reciprocal agreement. Such acts of reciprocal agreement are, for the most part, possible because the familiar world is interpreted by means of "typifications" and a stock of knowledge-at-hand which is socially and culturally derived, and in light of the "general thesis of reciprocal perspectives."

Through communication the individual erects a bridge between the world he essentially experiences as "own world" and the world of the Other. As Bosch points out, this communication is based on original experiences which "so long as they are not revealed by the act of communicating, remain a concrete part of the own world, and even when they are communicated they still retain an abstractable portion of own-world originality."[59]

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[57] Ibid., pp. 11-12 [58] Ibid.

[59] Bosch, Infantile Autism, p. 55.

It is by means of the constitution of the "common world" through the act of focusing on the Other, that the individual attempts to both grasp something of the Other's experience and to convey something of the meaning of his "own world"; that is, to create a shared "reality." That he is able to do so successfully in many instances is a result of the constructs of common-sense thinking.

But the individual's immediate experiencing of the life-world is always and inevitably unique and occurs prior to the construction of the "common world." It is, therefore, important to note that there is a distinction to be made between "own world" and "common world" and to reflect upon the manner in which each is constituted.

Phenomenological Method

In order to explicate the implicit structure of experiencing, the phenomenologist engages in what Husserl has termed "the phenomenological reduction."[60] Through this procedure of "reduction" or "bracketing" the individual deliberately sets aside all ontological judgments about the nature of perceived objects in order to focus on the activity of experiencing or consciousness. In performing the "reduction" the individual does not deny (nor affirm) the "reality" of experienced objects. He is no longer interested

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[60]Alfred Schutz, "Some Leading Concepts of Phenomenology," in Alfred Schutz: Collected Papers, ed. Maurice Natanson, vol. 1: The Problem of Social Reality (The Hague: Martinus Nijhoff, 1962), p. 104.

in the object-as-such. His concern is rather for the object-as-it-is-perceived, or as-it-is-experienced, by him.

This suspension of belief in the ontological character of the familiar world (this epoché) enables the individual to focus upon the activity of consciousness:

> With the execution of the epoché, the world in no way vanishes from the field of experience of the philosophically reflecting ego. On the contrary, what is grasped in the epoché is the pure life of consciousness in which and through which the whole objective world exists for me, by virtue of the fact that I experience it, perceive it, remember it, etc. In the epoché, however, I abstain from belief in the being of this world, and I direct my view exclusively to my consciousness of the world.[61]

In order to perform the "reduction," the phenomenologist must disengage or distance himself from his ordinary, taken-for-granted believing-in the world, so that he can critically reflect upon the nature of his experiencing. This disengagement is nothing other than a shift in focus, an attempt to clarify what has hitherto been naively accepted as unquestioned.

> The radical "alteration" of the natural thesis requires a continuing procedure of disconnection or bracketing which transposes the naively experienced world into the intentional field of world-for-me. To bracket the world is neither to deny its reality nor to change its reality in any way; rather, it is to effect a change in my way of regarding the world, a change that turns my glance from the "real" object to the object as I take it, treat it, interpret it as real. Within the natural attitude I attend to the object; in the phenomenological attitude

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[61] Alfred Schutz, "Phenomenology and the Social Sciences," in Alfred Schutz: Collected Papers, ed. Maurice Natanson, vol. 1: The Problem of Social Reality (The Hague: Martinus Nijhoff, 1962), p. 123.

> I attend to the object as known, as meant, as intended. The reality of the object is bracketed only in the sense that I attend to what presents itself to me immediately, whether really real or not, and seize the reality of the object as the object of my intentional acts. The object continues to be in the real world, as I do, but what now interests me, phenomenologically, is my awareness, my sense of its being in the real world. The object I reflect upon in the reduced sphere is the real thing as I've taken it to be real. Thus, "the" world is replaced by "my" world, not in any solipsistic sense, but only in the sense that "mine" indicates an intentional realm constituted by my own acts of seeing, hearing, remembering, imagining, and so on.[62]

What remains after the performance of the "reduction" is "nothing less than the universe of our conscious life, the stream of thought in its integrity with all its activities and with all its cogitations and experiences."[63] "The" world is preserved in so far as, but only in so far as, it is the intentional correlate of my conscious life.[64]

Eidetic Approach

The eidetic approach, like the phenomenological reduction, is another methodological device of investigation. Through the eidetic approach the phenomenologist seeks to make explicit the essential characteristics of any perceivable object, in contrast to its varying empirical features.

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[62]Natanson, Literature, Philosophy and the Social Sciences, pp. 58-59.

[63]Schutz, "Some Leading Concepts of Phenomenology," p. 105.

[64]Ibid., p. 106.

As Schutz notes, the principle of the eidetic method is as follows:

> Let us assume that on the desk before me, illuminated by the lamp, stands a red wooden cube, of one-inch dimensions. In the natural attitude I perceive this thing as unquestionably real, having the qualities and characteristics I have mentioned. In the phenomenologically reduced sphere the phenomenon cube - the cube as it appears to me - keeps the same qualities as an intentional object of my perceiving act. But suppose I am interested in finding what are the qualities common to all cubes. I do not want to do so by the method of induction, which not only presupposes the existence of similar objects but also implies certain unwarranted logical assumptions. I have before me only this single concrete object perceived. I am free, however, to transform this perceived object in my fancy, by successively varying its features - its color, its size, the material of which it is made, its perspective, its illumination, its surroundings and background and so on. Thus I may imagine an infinite number of varied cubes. But these variations do not touch on a set of characteristics common to all imaginable cubes, such as rectangularity, limitation to six squares, corporeality. This set of characteristics, unchanged among all the imagined transformations of the concrete thing perceived - the kernel, so to speak, of all possibly imaginable cubes - I shall call the essential characteristics of the cube or, using a Greek term, the eidos of the cube. No cube can be thought of that would not have these essential features. All other qualities and characteristics of the concrete object under scrutiny are non-essential.[65]

Thus, through the use of imaginative variation the phenomenologist seeks to uncover the essential features which characterize an object, and thus to discover its meaning.[66]

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[65] Ibid., p. 114.

[66] It is not my purpose here to explicate Husserl's specific method of apprehending essences, i.e. the method of free phantasy variation. Rather I am simply concerned to emphasize the distinction between the eidetic features of an object and its varying empirical features. For an interesting

Summary

Phenomenology focuses on the nature of experiencing, and particularly upon the correlation between the perceiver and that which is perceived. All experience is seen to be structured by the activity of individual consciousness.

Phenomenology notes that the individual finds himself always located within the familiar world, a world which is simply taken for granted. For the most part the individual is unaware of the manner in which he structures his experience.

In order to explicate the implicit structure of experiencing, it is necessary for the individual to engage in the "phenomenological reduction." The "reduction" involves a suspension of belief in the ontological character of the familiar world and an explicit focusing on the activity of consciousness.

This shift in focus provides a clue to the complexity of the structure of experiencing and an awareness that the primary "locus of meaning" of any "objective" state of affairs is grounded in the activity of consciousness.

The individual interprets his world in light of a meaningful structure which he imposes upon the "reality" he

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discussion on this topic see, Richard M. Zaner, "The Art of Free Phantasy in Rigorous Phenomenological Science," in Phenomenology: Continuation and Criticism. Essays in Memory of Dorian Cairns, eds. Fred Kersten and Richard M. Zaner (The Hague: Martinus Nijhoff, 1973), pp. 192-219; and Richard M. Zaner, "Examples and Possibles: A Criticism of Husserl's Theory of Free-Phantasy Variation," in Research in Phenomenology 3 (1973): 29-43.

encounters. By means of intentionality and focusing he attends to certain aspects of his experience which are always perceived against a background or horizon which includes his unique biographical situation and stock of knowledge-at-hand. Thus, the individual effectively transposes "the" world into "my" world.

Nevertheless, in spite of the unique nature of experiencing, the individual finds himself to be located in an intersubjective world. That is, he finds himself living in the familiar world as a man among fellow men who share a relationship to a common world. This common world is constituted through acts of reciprocal agreement. Such acts are possible because the familiar world is interpreted in light of the "general thesis of reciprocal perspectives" and by means of "typifications" which are socially and culturally derived.

CHAPTER II

THE SEPARATE WORLDS OF PHYSICIAN AND PATIENT

> To Ivan Ilych only one question was important: Was his case serious or not? But the doctor ignored that inappropriate question. From his point of view it was not the one under consideration, the real question was to decide between a floating kidney, chronic catarrh, or appendicitis. And that question the doctor solved brilliantly, as it seemed to Ivan Ilych, in favour of the appendix . . .
>
> Leo Tolstoy
> The Death of Ivan Ilych

When the patient and physician meet in the experience of illness they enter into a shared world. Each presumes that this "common world" is perceived in essentially the same manner by the Other, that there is a mutual context of understanding by means of which they can communicate and reach reciprocal agreement. Each is mystified when it becomes apparent that this "common world" is an illusion; that what was believed to be a shared "reality" is, in effect, two quite distinct "realities"; that the meaning of one world is significantly different from the meaning of the other.

In analyzing the structure of experiencing, phenomenology provides insights into the constitution of the separate worlds of the physician and patient, and addresses the question of how it is possible to bridge the gap between

them; that is, to arrive at a shared "reality."

The phenomenological reduction (i.e. the suspension of belief in the ontological character of the familiar world) may, in itself, have little practical application for either the physician or patient with regard to the construction of a shared world between them. However, the phenomenological notion of disengagement, of critically evaluating one's hitherto taken-for-granted presuppositions, can provide significant insights into the manner in which such presuppositions are formulated. The shift in focus which causes one to reflect upon the activity of consciousness in structuring all experience, requires that one pay primary attention to the object-as-it-is-experienced and to the correlation between the perceiver and that which is perceived - a correlation which cannot be discounted. "Reality" is seen to be the experiencing-of the object.

Thus, when considering the phenomenon of illness, one is motivated to focus upon the illness-as-it-is-experienced prior to the formalizations of science and, further, to attend to the manner in which the individual (both physician and patient) structures or constitutes this experience.

Phenomenology notes that the manner in which an object is experienced is strictly correlative to the way in which an individual attends to it. The activity of consciousness renders the object "thematic." It is through

such attentional focusing that the sense of an object is made explicit.[1]

The motivation for attending to particular aspects of an object (and thus rendering it "thematic") is determined by the individual's biographical situation and upon the particular project in which he is engaged at the time.[2] Everything that the individual encounters has significance for him in light of his own "special interests, motives, desires, aspirations, religious and ideological commitments."[3]

The recognition that focusing renders the object "thematic" and that focusing is, in turn, determined by one's motivation provides some insight into the discrepancy between the patient's understanding and the physician's understanding of the "reality" of disease. Each has rendered the disease "thematic" in a qualitatively distinct manner. Each is attending to different aspects of the experience of illness according to their dissimilar motivations.

Habits of Mind

The motivation for focalizing is intimately related to the individual's placement within the familiar world. In the practice of an occupation or profession certain "habits

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[1]This is in no way to suggest that "reality" consists of objects "out there." Rather it emphasizes that there is no meaning to "reality" apart from experiencing. The locus of meaning of all experience is grounded in the activity of individual consciousness.

[2]Zaner, The Way of Phenomenology, p. 162.

[3]Natanson, Introduction, p. xxviii.

of mind" emerge or develop which provide a horizon of meaning by means of which "reality" is interpreted. Such "habits of mind" are in many ways peculiar to the profession which utilizes them. They represent a distinct approach to the world and compose the "culture" of a profession.[4]

"Habits of mind" in a real way determine the manner in which an object is rendered "thematic." For example, the individual who is a professional art critic will attend to a painting in a significantly different manner than will the person who has no training in art criticism. The art critic will be influenced by certain "habits of mind" which are a function of his profession and these "habits of mind" will, to a large extent, determine what he will "see" and the way in which the sense of the object is made explicit. Thus, the experiencing of the art critic will be qualitatively distinct from the experiencing of the untrained individual. Indeed, it may be difficult for them to converse together about the same painting in a meaningful way.

The scientific "habit of mind" likewise determines the manner in which an object is rendered "thematic." It provides a horizon of meaning, a motivation for focalizing and a means of interpreting or structuring "reality." However, this particular interpretation is quite distinct

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[4]Victor Kestenbaum, "The Experience of Illness," in The Humanity of the Ill, ed. Victor Kestenbaum (Knoxville: The University of Tennessee Press, 1982), pp. 6-7.

from other interpretations of "reality."

Phenomenologists are concerned to make a radical distinction between the life-world, the world of immediate experience, and the artificial world of scientific inquiry, and it is perhaps often the case that these two distinctly different worlds clash in the experience of illness. The patient encounters and interprets his illness in its immediacy and fundamentally in terms of the basic assumptions of daily life, whereas the physician may categorize the disease solely in terms of scientific constructs (i.e. according to the prevailing "habits of mind" of the medical profession which render the disease "thematic" in terms of "objective," quantifiable data). Indeed, it is often assumed that the physical, anatomical, pathological view of disease exclusively represents the "reality" of the patient's illness.[5]

Nevertheless, it should be noted that the models of

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[5]In his article, "The Clinical Application of the Biopsychosocial Model," The Journal of Medicine and Philosophy 6 (May 1981): 101-23, George Engel notes:

> "How physicians approach patients and the problems they present is very much influenced by the conceptual models around which their knowledge and experience are organized. Commonly, however, physicians are largely unaware of the power that such models exert on their thought and behavior. This is because the dominant models are not necessarily made explicit. Rather they become part of the fabric of education that is taken for granted, the cultural background against which they learn to become physicians. . . . The dominant model in medicine today is called the biomedical model. . . . the crippling flaw of the model is that it does not include the patient and his attributes as a person, a human being."

science are constructions which represent a constantly changing interpretation of "reality" and which presuppose and are superimposed upon the immediate experiencing of that "reality" - such experience being primary and prior to conceptualization.[6]

> A study of Helmholtz's Physiological Optics tells me nothing about the visual experience I have in its qualitative immediacy. Nor will a more recent treatise help. There is a decisive gap between my color experience and a scientific account of its causal structure. My color world is first of all mine; it is not mediated by expert knowledge of its conditions, nor is the theory of vision in any way relevant to its presentational validity. It is only in a derivative sense that the case of my color experience falls under the general scientific category of visual perception. In one sense, then, my color world is a privileged one; the total scope and content given in it possess an experiential depth that is independent of subsequent theoretical explanation. What holds for vision holds for my entire world. The particulars of my existence are not decided on by some conceptual apparatus of the discipline of history or sociology or psychology; they are primordially given states of affairs uniquely and irrevocably mine. To say that they are mine means first of all that they are given to me through a certain vantage point, a certain location. My body, in fact, is the point of reference in terms of which perceptual phenomena achieve location and placement. And once again, my body is an immediately intuited reality, not the product of a sophisticated knowledge of physiology. To say that I possess a qualitatively given, privileged domain of immediate experience is to suggest that this primordial given has precedence of a certain order over the derivative world of science.[7]

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[6]It is, of course, recognized that all experience, including immediate experience, is to some extent structured by the individual. However, the constructs of science are models or abstractions which are quite different from the constructs of common sense.

[7]Natanson, Literature, Philosophy and the Social Sciences, p. 95.

In other words, the models of science are simply one way in which "reality" is rendered "thematic." They represent a set of abstractions, generalizations, formalizations specific to one level of thought organization.

> Strictly speaking there are no such things as facts, pure and simple. All facts are from the outset facts selected from a universal context by the activities of our mind. They are, therefore, always interpreted facts, either facts looked at as detached from their context by an artificial abstraction or facts considered in their particular setting. In either case, they carry along their interpretational inner and outer horizon. This does not mean that, in daily life, or in science, we are unable to grasp the reality of the world. It just means that we grasp merely certain aspects of it, namely those which are relevant to us either for carrying on our business of living or from the point of view of a body of accepted rules of procedure of thinking called the method of science.[8]

Non-scientists tend to believe, however, that the "facts" of science are immutable, unambiguous and, in some way, fundamentally representative of the essence of "reality." Similarly, it is often assumed that the quantitative, scientific, "objective" model of disease renders scientific medicine free of ambiguity and, further, that it exclusively represents the "reality" of illness.

As Lewis Thomas has noted, "of course, it is not like this at all."[9] Rather, scientific "facts" represent a constantly shifting, abstract model, an ongoing interpretation of "reality" which is subject to change at any time.

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[8]Schutz, "Common Sense and Scientific Interpretation of Human Action," p. 5.

[9]Lewis Thomas, "The Art of Teaching Science," New York Times Magazine, March 14, 1982, p. 89.

> . . . in real life, every field of science is incomplete, and most of them - whatever the record of accomplishment during the last 200 years - are still in their very earliest stages. In the fields I know best, among the life sciences, it is required that the most expert and sophisticated minds be capable of changing course - often with a great lurch - every few years. In some branches of biology the mind-changing is occurring with accelerating velocity. Next week's issue of any scientific journal can turn a whole field upside down, shaking out any number of immutable ideas and installing new bodies of dogma. This is an almost everyday event in physics, in chemistry, in materials research, in neurobiology, in genetics, in immunology.[10]

Furthermore, the way in which a disease is conceptualized does not simply represent a progressive refinement in the understanding of a set of facts; rather it represents the intersection of a series of changing human "realities" dealing with how the world is organized socially, intellectually, emotionally.

> Where Galen might have understood pain in the stomach as a poor mixing of humors (a bad complexion), a nineteenth century German physician would see it as an anatomic fact of ulcer, while a later nineteenth century French physician might see it as a functional disturbance in acid output and a twentieth century American physician might see it as a physiologic correlate of a psychological state - a "psychosomatic" complaint.[11]

All facts, including medical facts, contain ideological components:

> Facts contain ideological components, older views which have vanished from sight or were perhaps never formulated in an explicit manner. These components are

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[10]Ibid., pp. 89-90.

[11]Richard Baron, M.D., personal letter, December 14, 1983.

> highly suspicious, first, because of their age, because of their antedeluvian origin; second, because their very nature protects them from critical examination and always has protected them from such an examination.[12]

In his essay, "On the Question of the Foundations of Medical Knowledge," Ludwik Fleck argues that a fact is not something objectively given but that it is socially conditioned. He suggests that what an individual observes is conditioned by a socially-mediated thought style.[13] That is, the way in which an individual attends to an object is largely determined by prevailing "habits of mind."

Fleck applied to medicine a philosophical analysis that had previously been applied to the natural sciences, in which it is noted that observation can no longer be assumed to be a process which takes place between a passive knowing subject and an object to be known, the object being basically uninfluenced by the observing subject.[14]

He noted that Heisenberg's uncertainty principle had "established an inherent coupling between the observer and the observed."[15] The subject-observer and the object

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[12]Paul Feyerabend, "Against Method: Outline of an Anarchistic Theory of Knowledge," in Studies in Metaphysics, Minnesota Studies in the Philosophy of Science, vol. 4, eds. Herbert H. Feigl and Grover Maxwell (Minneapolis: University of Minnesota Press, 1979), p. 52.

[13]Thaddeus J. Trenn, "Ludwik Fleck's 'On the Question of the Foundations of Medical Knowledge'," The Journal of Medicine and Philosophy 6 (August 1981): 237-56.

[14]Ibid., p. 238.

[15]Ibid.

observed were now understood to be in an intimate relationship, neither having its being independently of the other.[16]

Fleck argued that cultural contexts (thought styles) not only made certain observations possible but likewise made other observations impossible.[17] For example, he noted that in the Middle Ages people observed many things that we do not observe today - such as miraculous signs in the sky, devils incarnate, bizarre animals and plants.[18]

He suggested that the history of anatomical observation demonstrates the influence of thought style on observation and noted that the earliest anatomical illustrations are "ideograms corresponding to the then-current ideas, not the form which is true to nature as we construe it."[19]

An ideogram is a graphic illustration of a certain idea, and Fleck noted that the anatomical illustrations drawn by Vesalius have emotive as well as anatomical content. Vesalius' illustration of a skeleton, for example, symbolizes death through its posture.

Fleck also noted that modern anatomical illustration is similarly "ideographic and not purely 'true to nature'"

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[16]Laurence B. McCullough, "Thought-Styles, Diagnosis and Concepts of Disease: Commentary on Ludwik Fleck," The Journal of Medicine and Philosophy 6 (August 1981): 257.

[17]Trenn, "Foundations of Medical Knowledge," p. 248.

[18]Ibid., p. 241.

[19]Ibid., p. 245.

and argued that it is not possible to free the illustration of an observed object from ideographic elements. "Indeed without these elements the illustration, a picture in its own right, a definite form, cannot be created."[20]

Fleck identified historical differences in the significance of numbers and names of bones, as well as differences in other features of the human anatomy. He noted that depending on the cultural setting the numbers and names took on a variety of meanings becoming ideograms as much as attempts at reliable observation.[21]

He was concerned to note, however, that difference between thought styles is not simply a question of greater knowledge:

> The ancients have actually more to say about that which in their particular reality has a greater value than it does in ours. Bartholin wrote a chapter on the sesamoid bones . . . which exceeds by a factor of nearly thirty what little a modern anatomist would have to say about these bones.[22]

As the thought style changes, so does the object observed:

> . . . the boundaries of an object under anatomical consideration have changed and are continually shifting. Not only the bounds, but also the content of every anatomical observation has changed according to the style. The knee joint of today (a mechanical device) has almost nothing in common with the "genu" of the

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[20]Ibid., p. 247.

[21]McCullough, "Thought-Styles, Diagnosis and Concepts of Disease," p. 258.

[22]Trenn, "Foundations of Medical Knowledge," p. 249.

> ancient anatomists (the seat of mercy). . . . It is possible to imagine changes in thought-style as a result of which the object of observation on the one hand disappears completely, on the other hand is thereby revealed or "discovered."[23]

McCullough has suggested that two features of Fleck's analysis are particularly worth noting. The first is that observations are culture-laden, "thought-style is a social progeny: it is fashioned within a collective as a result of social forces."[24]

Secondly, thought styles are "cultural matrixes under whose sanction observation occurs." By their very nature thought styles, or "habits of mind," make certain observations possible. In addition, they also make it difficult, if not impossible, for other observations to gain standing for the observer.[25]

Eric Cassell has noted that our way of conceiving disease, our rational scientific basis of medicine, is part of our Western cultural heritage and that it may not be the only "correct" picture.[26] He notes that we have always believed that our explanations are correct but that "if there is one thing the history of science should have taught

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[23]Ibid., p. 251.

[24]McCullough, "Thought-Styles, Diagnosis and Concepts of Disease," p. 257.

[25]Ibid., p. 258.

[26]Eric Cassell, The Healer's Art (New York: J. B. Lippincott, 1966), p. 52.

us, it is that our most dearly beloved scientific beliefs are fragile in the face of time."[27]

He emphasizes that we tend to confuse the question we are asking with the method we are using to arrive at the answer - and yet the method we are using determines the nature of the answer:

> Our science is based on the measurement of the finite, the rendering of the phenomena into numbers. It is common to confuse the question we are asking with the method we use to get the answer. Yet, the method used determines the nature of the answer. If we were asked to describe a rose and we were given only a ruler to do it, the picture of the rose that emerged would be solely in terms of inches. The picture would be true but incomplete. If a ruler were our only way of describing things, we would not know that the picture was incomplete. Our knowledge of the universe is a function of our technology, and technology is a function of our philosophical view of the universe.[28]

Thus, our "habits of mind" to a large extent determine what we will "see."

Fleck noted that as a result of our culture-laden beliefs certain observations are not readily entertained. Cassell makes a similar point about the resistance in scientific medicine to accepting as evidence of disease anything that cannot be quantified; that is, the prevailing "habits of mind" of the medical profession are such that disease is interpreted or defined exclusively in terms of objective, quantifiable data. Cassell notes that the

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[27] Ibid.

[28] Ibid., p. 64.

philosophy and methodology of scientific medicine tend to deny the existence of that which cannot be measured but:

> . . . the rise of psychiatry in the twentieth century established that there is a validity in what we cannot measure. Certainly the growth of psychiatry during this century and the contribution of Freud must be counted as a major medical advance . . . he introduced a mode of therapy comparable to no previous way of making people better. . . . These concepts cannot be quantified; there is no structure to examine under a microscope and, with few exceptions, no chemical to find altered in a blood test . . . they do not, in short, fit a philosophy of disease that took a long time to evolve.[29]

Cassell has noted that the form healing takes in any society (primitive, as well as modern) is intimately related to the central beliefs of that particular culture. Such beliefs are "concepts of reality" but not necessarily, of course, "the Truth." He argues that our modern concept of disease is similarly not "the Truth" but "simply a useful way of organizing observations of reality."[30]

> The constructs of disease, as physicians learn them, are as surely a belief system as are the constructs of yin and yang found in classical Chinese medicine. They are ways of organizing and thinking about the amorphous manifestations of illness that patients bring to the doctor. Judging from the results of therapy, our belief system of disease is very successful, but it is not the only way of viewing the sick. The ancient Chinese system must also be quite successful, as evidenced by its durability . . .[31]

Thus, in utilizing the models of scientific medicine the physician renders the experience of illness thematic in

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[29]Ibid., pp. 68-69

[30]Ibid., p. 15

[31]Ibid.

a distinct way according to the prevailing "habits of mind" of the medical profession - "habits of mind" which to a large extent determine the scientific definition of the "reality" of disease.[32] In so doing he is focusing on certain aspects of "reality," those which are relevant from the "point of view of a body of accepted rules of procedure of thinking called the method of science."[33]

Finite Provinces of Meaning

Schutz has suggested that in structuring experience the individual organizes his world in terms of "sub-universes of reality" or "finite provinces of meaning."[34] Schutz defines a "finite province of meaning" as a certain set of experiences, all of which show a "specific cognitive style and are - with respect to this style - not only consistent in themselves but also compatible with one another."[35] Thus, these finite provinces of meaning represent different worlds consistent within themselves but distinct from each other.

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[32]For an enlightening discussion on the manner in which the prevailing epistemology influences the concept of disease see, George L. Spaeth and G. Winston Barber, "Homocystinuria and the Passing of the One Gene-One Enzyme Concept of Disease," The Journal of Medicine and Philosophy 5 (March 1980): 8-22.

[33]Schutz, "Common Sense and Scientific Interpretation of Human Action," p. 5.

[34]Alfred Schutz, "On Multiple Realities," in Alfred Schutz: Collected Papers, ed. Maurice Natanson, vol. 1: The Problem of Social Reality (The Hague: Martinus Nijhoff, 1962), pp. 226-59.

[35]Ibid., p. 230.

Such worlds include the world of dreams, the world of religious experience, the world of scientific contemplation, and so forth.[36]

Schutz is concerned to note that in speaking of finite provinces of meaning what is emphasized is that it is the meaning of our experiences rather than the ontological structure of the objects which constitutes reality.[37]

The constructions of science represent a finite province of meaning, a sub-universe of reality, which is quite distinct from the naively experienced, immediately perceived reality of everyday life.

> By the "life-world" is meant the naively experienced, immediately perceived reality of everyday life as grasped and understood by men in the midst of their ordinary activities. Within the life-world, for example, the panorama of colors seen by the unassisted eye is appreciated and responded to quite apart from any scientific understanding of the theory of vision, the principles of optics, or the physiology of perception. In fact, it is the distinctive character of naive experience that its basis and framework remain outside the realm of technical theory. Most common-sense men live and die without the vaguest knowledge of the anatomy and function of the retina, yet they manage to find their way in the hectic richness of visual reality. Very often it is a matter of chance that brings to their attention the nature of the complex organization of their bodies: accidents, emergencies, the unexpected moment which introduces them to a new vocabulary and a new domain of problems. In the common run of events, however, the ground for understanding the workings of the world is not the apparatus of science but models of quite modest character, typical of the mundane sphere.[38]

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[36]Ibid., p. 232.

[37]Ibid., p. 230.

[38]Natanson, The Journeying Self, p. 95.

The patient encounters his illness in the context of the life-world; the physician, however, may conceptualize the disease solely within the context of the universe of science, utilizing the "habits of mind" of his profession. Each understands HIS interpretation to disclose and represent the fundamental meaning of illness.

Eric Cassell suggests that the patient and physician are often, in fact, using different categories to define the "reality" of illness:

> . . . when doctors are presented with a sick person they do not attempt to find out what is the matter, but rather attempt to make a diagnosis. Both patients and doctors believe that making a diagnosis IS discovering what is the matter, but that is not the case. Diagnoses are (usually) relatively sharply defined name diseases that are believed to exist when certain criteria are met by the patient's history, physical examination, or laboratory or other tests. When such criteria are not met, and unless the patient has certain objective manifestations, such as fever or weight loss, then from the doctor's point of view nothing is the matter. But patients whose illnesses fail to meet the criteria are mystified, after all they still do not feel well, etc.[39]

The categories that the patient uses to define the "reality" of illness are concerned with everyday life and function, and not primarily with "objective" clinical data. Illness as it is lived-through in its immediacy is responded to quite apart from any scientific explanation of disease.

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[39]Eric Cassell, M.D., personal letter, April 27, 1983.

Relevance

Schutz has emphasized that what the individual attends to depends upon his purpose at hand and the system of relevances which are a function of his plan of life.

> By resolving to adopt the disinterested attitude of a scientific observer - in our language, by establishing the life-plan for scientific work - (the scientist) detaches himself from his biographical situation within the social world. What is taken for granted in the biographical situation of daily life may become questionable for the scientist, and vice versa; what seems to be of highest relevance on one level may become entirely irrelevant on the other. The center of orientation has been radically shifted and so has the hierarchy of plans and projects. By making up his mind to carry out a plan for scientific work governed by the disinterested quest for truth in accordance with preestablished rules, called the scientific method, the scientist has entered a field of preorganized knowledge called the corpus of science.[40]

In attending to the experience of illness the physician does so in light of the "disinterested attitude" of the scientific observer. What is of primary relevance to the physician at this level, however, is often significantly different from that which is of primary relevance to the patient.

The patient is not able to define his illness in terms of abstract scientific principles. To do so would require him to adopt the disinterested attitude of the scientific observer and to detach himself from his biographical situation. What is of primary relevance to him can never be

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[40]Schutz, "Common Sense and Scientific Interpretation of Human Action," p. 37.

the scientific explanation of his disease; rather, what is necessarily of primary relevance to him is the meaning that his illness has in terms of his unique life situation.

Although the clinical data are, obviously, of relevance to the patient, this information is not of PRIMARY relevance. What is of primary relevance to him is what the information means in terms of its effect upon his plan of life. The physician, however, may assume incorrectly that the clinical data are necessarily of primary relevance both to himself and to the patient.

Walker Percy has elaborated on this distinction by suggesting that one may differentiate between "knowledge sub specie aeternitatis" (knowledge which can be arrived at anywhere by anyone at any time) and "news" which expresses a "contingent and nonrecurring event or state of affairs which . . . is peculiarly relevant to the concrete predicament of the hearer of the news."[41]

The significance of a statement for an individual will depend upon his mode of existence in the world.

> To say this is to say nothing about the truth of sentences. Assuming that they are all true, they will have a qualitatively different significance for the reader according to his own placement in the world.[42]

For example, Percy notes that a statement such as

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[41]Walker Percy, The Message in the Bottle (New York: Farrar, Straus and Giroux, 1954), pp. 125-26.

[42]Ibid., p. 128.

"there is water over the next hill" will have a qualitatively different significance for the castaway on a desert island deprived of water, than it will for the individual in the midst of civilization who is experiencing no shortage of water. Whether such a statement is actually true or not is irrelevant to the consideration of the manner in which it will be attended to by the hearer, or reader.

The scientist has abstracted from his own predicament in order to achieve his objectivity. His objectivity is indeed "nothing else than his removal from his own concrete situation."[43] What is significant or relevant to him as a piece of "knowledge" may be significant to another as a piece of "news"; that is, the information may have a peculiar relevance for the other's concrete predicament in the life-world.

The patient defines his illness in terms of his concrete predicament. What is relevant to the physician as a piece of "knowledge" (i.e. the clinical data) will represent for the patient a piece of "news." The significance of the information, and the manner in which it is attended to, therefore, will be qualitatively and distinctly different for the physician and the patient.

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[43] Ibid., p. 130.

Being-in-a-Context

In reflecting upon the manner in which the individual "thematizes" his experience, it is helpful to consider the phenomenological insight that everything that is encountered is encountered as a "being-in-a-context."[44] Thus, the field of consciousness is structured into a "thematic kernel" which "stands out over against a surrounding horizon."[45] This horizon is constituted not only by perceptual experiences (e.g. the background of coperceived things) but also by one's autobiographical situation which includes within it all one's former experiences which are preserved in memory or available within one's present stock of knowledge-at-hand. The "thematic kernel" and the surrounding horizon together constitute the meaning of experience.

For both physician and patient, then, illness is encountered not as an isolated entity but as a "being-in-a-context" and it is usually the case that this context, or horizon, is significantly different for the patient and the physician.

In the case of the patient the surrounding horizon against which the illness is "thematized" is obviously the world of everyday life and function. The illness is encountered and located within the context of the individual's

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[44] Zaner, The Way of Phenomenology, p. 154.

[45] Schutz, Reflections on the Problem of Relevance, p. 4.

familiar world.[46]

In the case of the physician, disease is encountered within a context that, in effect, dislocates the illness from the individual patient's familiar world and locates it as an abstract entity which is perceived against a surrounding horizon of scientific laws and principles.[47]

In summary then, in endeavoring to understand the meaning of illness and the discrepancy between the physician's and the patient's understanding of the experience, it is helpful to note that the attentional focus of the physician and patient is such that each is rendering the experience "thematic" in a qualitatively distinct way. It is through

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[46]Eric Cassell notes that the meaning of illness to a particular patient will depend upon the "collectivity of his meanings" - a collectivity which is necessarily a function of his autobiographical situation and the contextual horizon of his world. Cassell notes that the person who is ill is both the experiencer and the "assigner of understandings." See, "The Subjective in Clinical Judgement," in Clinical Judgement: A Critical Appraisal, Philosophy and Medicine Series, vol. 6, eds. H. T. Engelhardt, Jr., S. F. Spicker and B. Towers (Dordrecht, Holland: D. Reidel Publishing Company, 1979), pp. 199-215.

[47]For an interesting discussion relating to the manner in which traditional medical views of illness abstract the disease from the particular patient see, Richard J. Baron, "Bridging Clinical Distance: An Empathic Rediscovery of the Known," The Journal of Medicine and Philosophy 6 (February 1981): 5-23. For a historical perspective see, Stanley Reiser, Medicine and the Reign of Technology (Cambridge: Cambridge University Press, 1978). See also, Stephen Toulmin, "On the Nature of the Physician's Understanding," The Journal of Medicine and Philosophy 1 (March 1976): 32-50. Toulmin notes that the growth of biomedical science has created a new image of the physician as biomedical scientist. This has contributed to the tendency for physicians to view their patients less as people than as cases; not "Here comes Betty Jones," but "Here comes an interesting carcinoma."

this attentional focus that the sense of the illness is made explicit for the individual.

In attending to the experience of illness, the physician and patient are influenced by different "habits of mind" and systems of relevances, and they are defining the "reality" of illness from within the context of different "worlds" (each "world" providing a horizon of meaning).

The Personal Attitude

Husserl has noted that one may distinguish between the thematic attitude directed at the "objective" world as scientific theme (the "scientific attitude") and the "personal attitude." The "personal attitude" focuses not on an abstract "objective" "reality" but rather on the way in which the individual encounters and interprets "reality." In the "personal attitude" attention is directed to the meaning that an individual's experience has for him personally:

> . . . in the personal attitude, interest is directed toward the persons and their comportment toward the world, toward the ways in which the thematic persons have consciousness of whatever they are conscious of as existing for them, and also toward the particular objective sense the latter has in their consciousness of it. In this sense what is in question is not the world as it actually is but the particular world which is valid for the persons, the world appearing to them with the particular properties it has in appearing to them; the question is how they, as persons, comport themselves in action and passion - how they are motivated to their specifically personal acts of perception, of remembering, of thinking, of valuing, of making plans, of being frightened and automatically starting, of defending themselves,

> of attacking, etc. Persons are motivated only by what they are conscious of and in virtue of the way in which this (object of consciousness) exists for them in their consciousness of it, in virtue of its sense - how it is valid or not valid for them, etc.[48]

In the patient/physician encounter the "scientific attitude" and the "personal attitude" are often assumed by the physician to be mutually exclusive; that is, the "reality" of illness is presumed to be given exclusively in the "scientific attitude." The "personal attitude" is thus disparaged.

However, THE meaning of illness - given the "thematic" nature of experiencing - can never be captured solely by means of scientific paradigms or models. In attempting to construct a shared world with the patient it is, therefore, helpful for the physician to reflect upon the way in which the individual has "thematized" his experience of illness and thus to adopt the "personal attitude" in addition to the "scientific attitude."

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[48]Husserl, The Crisis, p. 317.

CHAPTER III

THE SHARED WORLD OF PHYSICIAN AND PATIENT

> In a sense, sickness is a place more instructive than a long trip to Europe. And it's always a place where there's no company, where nobody can follow.
>
> Flannery O'Connor

> Our health, diseases, and reactions cannot be understood in vitro, in themselves; they can only be understood with reference to us, as expressions of our nature, our living, our being-here (da-sein) in the world.
>
> Oliver Sacks
> Awakenings

How then is it possible to grasp the meaning of the Other's experience given the unique nature of experiencing? And particularly how is it possible to understand the experience of illness?

It should be noted that it is impossible to directly penetrate another's experience in such a way as to grasp it in the immediate manner in which it is originally encountered. It is the nature of experience that there will always remain an "abstractable portion of own-world originality" which cannot be communicated. Nevertheless, individuals do understand one another and Schutz has suggested that they do so in light of their stock of knowledge-at-hand and in light

of the general thesis of reciprocal perspectives.

It is interesting to note that the experience of illness is such that the factors which Schutz has identified as integral to a common understanding no longer provide the means to constitute a "common world." The patient and physician are unable to communicate about the experience of illness on the basis of a shared set of assumptions.

As Schutz notes, the individual ordinarily interprets his daily life in light of "typifications" which make up his stock of knowledge-at-hand and which render the experience predictable and controllable. By means of such naive "typifications" the familiar world assumes a quality of taken-for-grantedness such that one expects things will continue more or less as they have proven to be in the past. This taken-for-grantedness permeates the fabric of daily life and it is on the basis of a "typified" stock of knowledge-at-hand that a shared world of experience is possible.

In the experience of illness the taken-for-granted quality of daily life is irrevocably shattered. What is primarily threatened is the integrity of the self (one's own self) - and this most fundamental loss of wholeness, this ontological threat, cannot readily be interpreted in terms of the individual's existing stock of knowledge-at-hand; that is, in terms of his "typifications." The most deeply held taken-for-granted assumption of his daily life is the assumption that he, personally, will continue to be alive and

it is in light of this assumption that he engages in his daily life. In illness the individual suddenly finds himself concretely face-to-face with his personal vulnerability. The loss of control that is intrinsic to the experience of illness is accompanied by an acute awareness of the unpredictability of the familiar world. It can no longer be assumed that things will continue much the same as they have in the past. Thus, the person who is ill finds his prior assumptions about the familiar world, his stock of knowledge-at-hand, to be strangely inadequate for interpreting his existential crisis. He is unable to fit his illness into the typified schema he uses to organize and interpret his experience.[1]

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[1]Consider, for example, the distinction between death as a typified event and death as a personal, concrete, awareness that I, myself, will no longer continue to be alive (as portrayed in the following quote from Martin Heidegger, Being and Time, trans. John Macquarrie and Edward Robinson (New York: Harper & Bros., 1962), pp. 296-97).

> "In the publicness with which we are with one another in our everyday manner, death is 'known' as a mishap which is constantly occurring - as a 'case of death.' Someone or other 'dies,' be he neighbor or stranger . . . People who are no acquaintances of ours are 'dying' daily and hourly. 'Death' is encountered as a well-known event occurring within-the-world. As such it remains in the inconspicuousness characteristic of what is encountered in an everyday fashion. . . . The analysis of the phrase 'one dies' reveals unambiguously the kind of Being which belongs to everyday Being-towards-Death. In such a way of talking, death is understood as an indefinite something which, above all, must duly arrive from somewhere or other, but which is proximally not yet present-at-hand for oneself, and is therefore no threat. The expression 'one dies' spreads abroad the opinion that what gets reached, as it were, by death, is the 'they.' In Dasein's public way of interpreting, it is said that 'one dies,' because everyone else and oneself can talk himself into saying that 'in no case is it I myself' . . ."

Since communication with others is founded on the shared "typifications" of the familiar world, the person who is imprisoned within the chaos of the experience of illness finds himself unable to successfully communicate his experience to others.[2]

The physician, on the other hand, IS able to

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[2]For an interesting analogy to the patient's experience see Alfred Schutz's essay, "The Homecomer," in Alfred Schutz: Collected Papers, ed. Arvid Brodersen, vol. 2: Studies in Social Theory (The Hague: Martinus Nijhoff, 1964), pp. 107-19. Schutz notes that the person who returns home after spending a period of time away in a different environment finds himself unable to successfully communicate his experience to those who have remained at home. He is unable to do so because he can no longer communicate on the basis of a shared set of typifications. As an example Schutz quotes the case of the returning veteran:

> "When the soldier returns and starts to speak . . . he is bewildered to see that his listeners, even the sympathetic ones, do not understand the uniqueness of these individual experiences which have rendered him another man. They try to find familiar traits in what he reports by subsuming it under THEIR preformed types of the soldier's life at the front. To them there are only small details in which his recital deviates from what every homecomer has told and what they have read in magazines and seen in the movies. So it may happen that many acts which seem to the people at home the highest expression of courage are to the soldier in battle merely the struggle for survival or the fulfilment of a duty, whereas many instances of real endurance, sacrifice, and heroism remain unnoticed or unappreciated by people at home."

The soldier's experience is personal and unique and he will never allow it to be typified. For the people at home, however, it represents a typification.

For a vivid description of the breakdown in communication between the one who is ill and those who surround him see also Leo Tolstoy's short story, "The Death of Ivan Ilych," in Story and Structure, 5th ed., edited by Laurence Perrine (New York: Harcourt Brace Jovanovich, Inc., 1978), pp. 502-44.

interpret the illness of the patient in terms of his own stock of knowledge-at-hand and he may be unaware that the patient is unable to conceive of the illness as a "typification." In this instance the patient and physician are unable to communicate on the basis of a shared stock of knowledge-at-hand. It is not simply that the patient does not possess the knowledge that the physician uses to typify the illness (although this is almost certainly the case), but it is rather that the physician conceives of the illness as a typified instance of a particular disease, whereas the patient encounters the illness as a fundamental threat to his being - a threat which cannot be interpreted by reference to his stock of knowledge-at-hand.

To put it in different terms, the physician is attending to the illness as an example, whereas the patient is focusing on the illness "for its own sake." This is an explicitly different focus. Whenever one considers something as an example it is not considered "for its own sake" but only in so far as it exemplifies something other than the affair itself.[3]

In communicating with one another the patient and physician assume that they do so in the context of a shared "reality," a "common world." This assumption is made on the

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[3] For an enlightening discussion elucidating this shift in attention see Richard M. Zaner, "Examples and Possibles: A Criticism of Husserl's Theory of Free-Phantasy Variation".

basis of the two idealizations of the "general thesis of reciprocal perspectives."

Through the idealization of the "interchangeability of the standpoints" the individual takes for granted - and assumes that his fellow man does the same - that if they were to change places then each would see essentially what the other now sees. Through the idealization of the "congruency of the system of relevances," the individual takes for granted that the difference in perspectives originating in the unique biographical situation of himself and his fellow man is irrelevant for the purpose at hand, and that both he and his fellow have selected and interpreted common objects in an identical manner or, at least, an "empirically identical" manner sufficient for all practical purposes.[4]

Thus, the patient and physician both assume that, in communicating about the illness, they are doing so on the basis of a shared understanding; that they are interpreting illness in an "empirically identical" manner. The patient takes for granted that the physician recognizes his illness, as he does, as primarily and essentially a threat to his being. The physician assumes that the patient understands the disease (albeit incompletely) in terms of the "objective" clinical data.

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[4]For a more detailed explication of Schutz's notion of the "general thesis of reciprocal perspectives" see Chapter I of this work, pp. 24-26.

Thus, the constructs of common sense thinking, rather than enabling the patient and physician to share a common "reality," tend to deepen the chasm between their separate worlds.

Paradoxically, it is only by focusing on the unique experiencing of the Other, and by consciously disregarding the taken-for-granted assumptions of the "general thesis of reciprocal perspectives" (by performing an epoché of sorts) that the physician can communicate with the patient on the basis of a shared understanding of the meaning of illness.

The Eidetic Approach

In attempting to focus on the experience of the one who is ill, it is helpful to try to identify the eidetic features of illness which transcend the peculiarities and particularities of different disease states.

The eidetic approach, as has been noted, is a means of investigation in which the phenomenologist seeks to make explicit the essential characteristics of a perceived object, as opposed to its varying empirical features.

In the case of illness this suggests temporarily setting aside the conglomeration of clinical symptoms and signs which interpret the experience of illness as a manifestation of a particular disease, in order to focus upon and make explicit those characteristics which are fundamental to the experience of illness itself - in all its manifestations. Such characteristics include the perception

of loss of wholeness, loss of certainty, loss of control, loss of freedom to act in a variety of ways, and loss of the familiar world.

Illness is primarily experienced as a fundamental loss of wholeness, a loss of wholeness which manifests itself in several forms.

Fundamentally, of course, it is the perception of bodily impairment - a perception which is not so much a simple recognition of specific impairment (e.g. shortness of breath) as it is a profound sense of the loss of total bodily integrity. The body can no longer be trusted, relied upon, taken for granted, or ignored. It has seemingly assumed an opposing will of its own, beyond the control of the self. Rather than functioning effectively at the bidding of the self, the body-in-pain, or the body-disabled, or the body-malfunctioning thwarts plans, impedes choices, renders actions impossible. Illness disrupts the fundamental unity between the body and self.

> Disease can so alter the relation (with one's body) that the body is no longer seen as a friend but, rather, as an untrustworthy enemy. This is intensified if the illness comes on without warning, and as illness persists, the person may feel increasingly vulnerable.[5]

In illness the body is experienced as at once intimately mine but also other-than-me, in that there is a sense in which I am at its disposal or mercy.

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[5]Eric Cassell, "The Nature of Suffering and the Goals of Medicine," The New England Journal of Medicine 306 (March 1982): 640.

> If there is a sense in which my own-body is "intimately mine," there is, furthermore, an equally decisive sense in which I belong to it - in which I am at its disposal or mercy, if you will. My body, like the world in which I live, has its own nature, functions, structures, and biological conditions; since it embodies me, I thus experience myself as implicated by my body and these various conditions, functions, etc. I am exposed to whatever can influence, threaten, inhibit, alter, or benefit my biological organism. Under certain conditions, it can fail me (more or less), not be capable of fulfilling my wants or desires, or even thoughts, forcing me to turn away from what I may want to do and attend to my own body: because of fatigue, hunger, thirst, disease, injury, pain, or even itches, I am forced at times to tend and attend to it, regardless, it may be, of what may well seem more urgent at the moment.[6]

This sense of "otherness" of body is acutely felt by the patient in his discussions with the physician. The biological, pathological sense of the body is of the body as other-than-me, of the body in opposition to the self, and it is this sense that is now iterated.

Even if the body is eventually restored to health the perceived loss of bodily integrity remains. For the individual who has experienced illness recognizes that he has only a limited control over the functioning of his body; that at some future date it may again come into opposition with the self and that he can no longer take its compliance for granted.

In this regard, incidentally, it is interesting to

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[6]Richard M. Zaner, The Context of Self: A Phenomenological Inquiry Using Medicine as a Clue (Ohio: Ohio University Press, 1981), p. 52.

note that the dichotomy between self/body and self/not-self directly influences the individual's perception of control or loss of control in the experience of illness. The way in which "self" is defined in a real way determines whether or not the individual perceives himself to be totally at the mercy of external elements, decisively at the disposal of his body.

If "self" is equated with physical embodiment or with role - rather than being defined as that collection of qualities (intellectual, emotional, moral, and so forth) which render the individual a unique "person" - then in the event that physical embodiment is assaulted or the role disrupted, the individual loses not only bodily integrity but also the integrity of "self." He perceives himself to be no longer a "whole person." He thinks himself "less of a person." In this event, physical impairment results not only in the destruction of body but also in the loss of "self." On the other hand if "self" is recognized in a fundamental way as something quite distinct from physical embodiment, the integrity of "self" can be preserved.

This is particularly important with regard to the response to "incurable" illness. The patient comes to the physician seeking to regain control. A strengthening of the "self" results in a concurrent reduction in the perception of loss of control. Thus, anything the physician can do to bring this about will be of benefit to

the patient in dealing with his predicament.

The loss of wholeness experienced in illness not only incorporates a perception of bodily impairment and loss of integrity but also includes the loss of certainty in its most profound form. In the experience of illness the individual is forced to surrender his most cherished assumption, that of his personal indestructibility. And if this most deeply held assumption is no more than an illusion, what else in his hitherto taken-for-granted existence can remain inviolable?

The person who is ill comes face-to-face with his own inherent vulnerability. "It could happen to ME" is felt in the experience of illness as a concrete actuality, and not as an amorphous possibility. Once shattered, the illusion of personal indestructibility can rarely be regenerated.

The radical loss of certainty which accompanies illness is cause for great personal anxiety and fear. Although acutely conscious of his fear, the ill person nevertheless finds it difficult to communicate his deep apprehension to others. Paradoxically, he often deems such apprehension to be inappropriate even though it is ineluctably part of his experience. In attempting to minimize the anxiety of the patient, the physician may make an effort to discuss the illness or therapeutic intervention in such a way as to imply that there is no real cause for concern.

The patient, however, may interpret this simply to mean that the profound anxiety he feels is, therefore, irrational and inadmissible.

Illness is perceived as an assault on the person, an assault which is completely beyond the control of the one who is afflicted. And thus, accompanying the profound sense of loss of wholeness and loss of certainty, is an acute awareness of loss of control. The familiar world, including the self, is suddenly perceived as inherently unpredictable and uncontrollable. Illness, as Pellegrino has noted, "moves us . . . toward the absorption of man by circumstance."[7]

Illness is experienced as a capricious interruption, an unexpected happening, in an otherwise more or less carefully formulated life-plan. The disease is perceived as "befalling the person, as an unasked-for and unanticipated 'happening-to-me,' falling outside the person's range of possible choice and plans."[8] Thus, the person who is ill experiences a profound sense of loss of control, of helplessness in the face of circumstance.

The capriciousness of illness and the loss of control is acutely felt by modern man in light of the

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[7]Edmund D. Pellegrino, "Being Ill and Being Healed: Some Reflections on the Grounding of Medical Morality," in The Humanity of the Ill, ed. Victor Kestenbaum (Knoxville: University of Tennessee Press, 1981), p. 159.

[8]Zaner, "Chance and Morality: The Dialysis Phenomenon," p. 50.

illusions he harbors about the power of technology and the capabilities of modern science. Since technology and science have been extremely successful in eradicating or ameliorating many diseases, not only is illness perceived as an unwarranted intrusion but the person who is ill expects medical intervention to provide him with nothing less than a complete restoration of health. The patient thus comes to the physician with the unrealistic expectation that such a complete restoration of health will be forthcoming. If the physician is unable to fulfill this expectation, the patient is overwhelmed by his apparent helplessness and perceives his situation to be totally and irrevocably out of control.

The technology which promises redemption concurrently intensifies the loss of control experienced in illness. The one who is ill feels himself at the mercy of faceless machines, whose function he barely understands yet whose dictates he must obey. He perceives himself to be an object of investigation, rather than a suffering subject. He is acutely aware of the disparity between his experiencing-as-a-subject and his being-experienced-as-an-object. In his transformation to objecthood, he feels himself no longer able effectively to control what happens to him.

The loss of control also manifests itself concretely in the experience of having to rely on others to do what one has formerly been able to do for oneself. Illness, in its

various forms, always impedes the ability to be self-reliant, to act on one's own behalf. The ill person must not only seek the help of others for physical assistance but he must also rely upon the help of a trained healer, a physician. This relationship is an inherently unequal relationship in that the physician "professes to possess precisely what the patient lacks: the knowledge and power to heal."[9] The inequality of the relationship accentuates the loss of control felt by the ill person.

Such loss of control obviously represents a concurrent loss of freedom to act. Illness obstructs plans, limits choices and renders some actions impossible.

Illness also impedes the freedom and capacity to make rational choices regarding one's personal situation because the one who is ill:

> . . . does not understand what is wrong, how it can be cured, if at all, what the future holds, or whether the one who professes to heal can in fact do so. The ill person has not the knowledge or skills requisite for curing his own bodily or mental illness or to gain relief from his pain or anxiety. His freedom to act as a person is severely compromised. He may not even be free to reject medicine when he is the victim of overwhelming trauma, pain, shock or coma.[10]

Clinical decisions must ultimately be made by the patient, if he is able. Although such decisions are usually made after appropriate advice and consultation with the physician, the patient always feels inadequate to the task.

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[9] Pellegrino, "Being Ill and Being Healed," p. 159.

[10] Ibid.

The decision is uniquely his, not only in that he must make it but in that it will ultimately affect his plan of life. The responsibility is his, yet he feels that he does not possess the knowledge or the capacity to make the decision in a rational manner. Sometimes he may intuitively feel that the course of action recommended by his physician is not in his best interests, and yet - more often than not - the patient does not feel free to reject the advice of the physician. To do so would seem to be irrational in the face of the inadequate knowledge he feels himself to possess. To do so would also be to risk alienating himself from the one who promises to alleviate his distress.

In reflecting upon what is in his own best interest, the individual does so in light of his life plan and his unique system of values. Each person lives his life according to certain fundamental principles which have meaning for him personally, and it is in light of these principles that he makes his choices and acts in the world of everyday life. In the existential crisis of illness these fundamental personal values are often made explicit. The individual encounters and interprets the threat to the self by reference to and in light of the principles which render his life meaningful.

Invariably the patient assumes (often incorrectly and certainly unreasonably) that the physician knows and understands what his personal value system is and, further,

that in making the clinical decision the physician is doing so not only in light of the clinical data but additionally with regard to this personal value system. He, therefore, rarely explicitly communicates his value desiderata to his physician.

The physician on the other hand may deem it inappropriate, irrelevant or intrusive to inquire of the patient what his value system is and he may judge the clinical data alone to be sufficient to determine what is in the patient's best interest.

Thus, the patient not only loses the freedom to make a rational choice regarding his personal situation but additionally he loses or abrogates the freedom to make the choice in light of his uniquely personal system of values.

The person who is ill, therefore, finds himself to be in a peculiarly vulnerable state. He perceives himself to be impaired in a variety of ways, unable effectively to interpret, predict and control his experience.

Illness is a state of disharmony, disequilibrium, dis-ability, and dis-ease in which the individual finds himself separated from his familiar world. It is, as Pellegrino has noted, an "altered state of existence," a distinct mode of "being-in-the-world."

The person who is ill is preoccupied with the demands and dictates of his altered mode of existence. He is isolated from the familiar world in that he is no longer

able routinely to carry on his normal activities, to participate in the everyday world of work and play. His isolation is all the more acute because the familiar world revolves around him. His associates continue to pursue their activities much as they have in the past, and although his illness affects the totality of HIS experiencing, it is a "fact" which is necessarily only in the periphery of the experience of others.[11]

Illness not only causes a disruption in present functioning but also effects a change in the individual's perception of the future. In health the individual takes for granted that the future will be available to him to accomplish those goals which are an integral element of his life plan. Few people live their lives solely in terms of

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[11]This point is powerfully illustrated in Leo Tolstoy's story, "The Death of Ivan Ilych." Ivan Ilych arrived home from the doctor's office and "began to tell his wife about it."

> "She listened, but in the middle of his account his daughter came in with her hat on, ready to go out with her mother. She sat down reluctantly to listen to his tedious story, but could not stand it long, and her mother too did not hear him to the end. . . .
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> . . . There was no deceiving himself: something terrible, new, and more important than anything before in his life was taking place within him of which he alone was aware. Those about him did not understand or would not understand it, but thought everything in the world was going on as usual. That tormented Ivan Ilych more than anything. He saw that his household, especially his wife and daughter who were in a perfect whirl of visiting, did not understand anything of it and were annoyed that he was so depressed and so exacting, as if he were to blame for it. Though they tried to disguise it he saw that he was an obstacle in their path . . ." (pp. 521, 524).

the present. Most act in the present in light of specific goals which relate to future possibilities. Illness truncates the experiencing of the individual. It imprisons him within the present moment. The future is suddenly disabled, rendered impotent and inaccessible.[12] This loss of the future serves to further isolate the one who is ill and separate him from his hitherto familiar world.

Thus, the experience of illness is such that there are certain eidetic characteristics which are fundamental to the experience and which pertain regardless of its idiosyncratic manifestation in terms of a particular disease state. Such characteristics include the perception of loss of wholeness and bodily integrity, loss of certainty and concurrent apprehension or fear, loss of control, loss of freedom to act in a variety of ways, and awareness of the loss of the hitherto familiar world.[13]

The patient suffers, therefore, not merely in terms of physical discomfort but in light of the awareness of a fundamental change in his existential state. Thus, the

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[12]This point is well illustrated in Jean-Paul Sartre's story, "The Wall." Sartre shows how the dying man is confined to the present moment, no longer able to project mentally into the future. See, "The Wall," in Existentialism from Dostoevsky to Sartre, ed. Walter Kaufmann (Cleveland: Meridian Books, 1956), pp. 223-40.

[13]It is recognized, of course, that although such characteristics are eidetic in that they represent essential features of illness, nevertheless the manner in which they are experienced is unique to the individual experiencer.

patient is a person preoccupied with and encapsulated within his experience of dis-ease. He is not a disease personified. Nor is his distress limited to the medically defined symptoms which provide the means to label his illness in terms of a particular disease process.

The patient's dis-ease, therefore, cannot be alleviated solely by attending to the particular physiological symptoms which accompany his experience of illness. It is also necessary to attend to the patient's preoccupation with the fundamental change in his existential state; that is, it is necessary to focus upon the eidetic characteristics of illness as they are manifested in this particular patient's existential situation.

In this regard, Cassell has distinguished between "suffering" and "clinical distress." He notes that suffering is experienced by persons, not merely by bodies. It can include physical pain but is not limited to it.[14]

> Suffering occurs when an impending destruction of the person is perceived; it continues until the threat of disintegration has passed or until the integrity of the person can be restored in some other manner. It follows, then, that although suffering often occurs in the presence of acute pain, shortness of breath, or other bodily symptoms, suffering extends beyond the physical. Most generally, suffering can be defined as the state of severe distress associated with events that threaten the intactness of the person.[15]

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[14]Cassell, "The Nature of Suffering and the Goals of Medicine," pp. 639-45.

[15]Ibid., p. 640.

Cassell notes that an awareness of the relation of meaning to the way in which illness is experienced is essential to an understanding of the suffering of sick persons.

> The importance of things is always personal and individual, even though meaning in this sense may be shared by others or by society as a whole. What something signifies and how important it is relative to the whole array of a person's concerns contribute to its personal meaning. . . . Personal meaning is a fundamental dimension of personhood, and there can be no understanding of human illness or suffering without taking it into account.[16]

Thus, if suffering is to be relieved, along with clinical distress, the physician must focus upon the patient's experience of illness and the personal meaning that is inherent in that experience.[17]

The act of focusing on the Other's experiencing requires a shift in attention, a disengagement or distancing of oneself from one's own hitherto taken-for-granted presuppositions about the world. In order to become conscious of the Other's world, one must perform an epoché of sorts; that is, one must temporarily suspend, or set aside, or place in abeyance, one's own understanding of "reality." In so doing one attempts to enter into the world

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[16] Ibid., p. 641.

[17] To understand the illness-as-lived the physician must, says Richard Baron, "go beyond questions such as 'When did it begin? Do you have black, tarry stool? Does it get worse when you walk?' and develop such questions as 'What is it like?' or 'How is it for you?'" See his article, "An Empathic Rediscovery of the Known," p. 19.

of the Other in order to grasp something of its meaning.

In the physician/patient encounter this suggests that the physician shift attention from the "scientific attitude" to the "personal attitude" in the endeavor to construct a mutual context of understanding, a shared world, with the patient. This is no way implies that the physician abandon altogether his "objective," theoretical understanding of illness in terms of particular disease states. Rather, it is to suggest that he temporarily place this interpretation of disease in abeyance in order to explicitly focus on the illness-as-it-is-experienced by this particular patient. He is always at liberty to return to the "objective" scientific attitude. But it is vital, if he is to construct a shared world with the patient, that he not limit himself to, and remain solely within, the scientific attitude - especially since this does not, in and of itself, constitute the "reality" of illness.

In reflecting upon the act of setting aside one's own world in order to focus upon or enter into another's world, it is perhaps helpful to consider a similar act of "suspension" or abstention which occurs in the encounter with literature.

The Encounter with Literature

Natanson has explored the relationship between the reader of the novel and the world he encounters in his

reading.[18] He notes that the world of the novel represents a microcosm with its own contextual horizon. To enter the world of the novel requires a decision on the part of the reader to "set aside the ordinary flow of daily life, by attending only to the horizon given . . . in the literary work."[19] That is, the reader temporarily suspends the presuppositions of his own world in order to focus upon the meaning inherent in the world of the novel (such meaning being grounded in the contextual horizon of the literary work).

Natanson notes, for example, that in The Brothers Karamazov "the holiness of Father Zossima, the lust and buffoonery of Feodor Karamazov, and the divergent styles of being of his sons are comprehensible only as they unfold within the horizon of the world they project."[20]

In effecting this shift of attention the reader does not deny nor negate the validity of his own world. Rather he simply suspends one attitude in order to bring into focus another. In sharing the experience of the characters of a novel, the reader temporarily sees through THEIR eyes within the context of THEIR world. That is, the reader enters a

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[18]Natanson, Literature, Philosophy and the Social Sciences, pp. 96-100.

[19]Ibid., p. 97.

[20]Ibid., p. 92.

world which is pre-interpreted by its fictive inhabitants.

> Our analysis of their actions is therefore necessarily a second order translation. We interpret their interpretations; we encounter their encounters; we subscribe to or deny their faith.[21]

That the reader is able to do this in some measure is due to the fact that he has consciously set aside the presuppositions of his own world to make possible his transposition into another world.

The reader is always at liberty to move back within the context of his own world, to set aside the world of the novel. However, invariably the experience of another world made possible in the encounter with literature, illuminates or modifies the hitherto taken-for-granted presuppositions of his common-sense world. Having temporarily experienced or attended to the world of another, the reader's own world is changed, HIS experience enlarged.[22]

In focusing upon the experience of the patient the physician attempts in a similar way to place himself within the contextual horizons of the patient's world. Such an act requires that he temporarily set aside the contextual

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[21] Ibid., p. 91.

[22] Through vicarious experience the reader expands the horizons of his own world and grasps how his familiar world might possibly be otherwise. Something of the meaning of the experience of illness may be grasped through the encounter with illness as it is revealed in literary works.

horizons of his own world.[23]

The construction of a shared world of meaning is made possible through this shift in focus. In attending to the contextual horizons of the patient's world, in an attempt to grasp something of its inherent meaning, the physician focuses on the illness-as-it-is-experienced by this particular patient apart from and prior to the conceptualizations of scientific medicine.

Imaginative Self-Transposal

This attempt to grasp something of the meaning of another's world through the act of placing oneself within the context of that world involves what Herbert Spiegelberg has called "imaginative self-transposal."[24] Through the act of "imaginative self-transposal" one imagines oneself as occupying the place of the Other and seeing through his eyes.

Spiegelberg is concerned to emphasize that such acts of imagination are not simply "appeals to wild fiction" but that they involve the use of "disciplined" imagination. That is, the world of the Other is constructed on the basis

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[23]For an excellent analysis of the notion of contexture see Zaner, The Context of Self. Zaner clearly shows that every situation is contextual "constituted by and as a system of mutually referring constituents, each of which receives its particular significance, weight, and placement by reference to every other one." (p. 177).

[24]Herbert Spiegelberg, "Phenomenology Through Vicarious Experience," in Phenomenology: Pure and Applied, ed. Erwin W. Straus (Pittsburgh: Duquesne University Press, 1964), pp. 119-20.

of clues derived from one's perception of him and utilizing facts which are available concerning his biography.[25]

This self-transposal involves more than simply imagining ONESELF "in the Other's shoes." It involves an epoché, a radical setting aside of the contextual horizons of one's own world, in order to make the transposition not only into the world of the Other but as nearly as possible into the frame of mind of the other person.[26]

This is crucial if one is to arrive at some understanding of the particular world which is valid for the other person. A self-transposal in which one imagined oneself in the Other's shoes by asking "what would this mean to ME if I was in these circumstances" would result merely in an interpretation derived from within the contextual horizons of one's own world (a contextual horizon which provides its own inherent meaning).

In the patient/physician encounter this suggests that the act of "imaginative self-transposal" is not to be equated with "identifying with the patient." While the attempt to understand the meaning that the patient's experience has FOR HIM necessitates the physician abstracting from his own predicament, this does not mean that he thereby places his actual self in the patient's situation. To do so would lead to the misunderstanding of seeing the patient's

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[25] Ibid., p. 120.

[26] Ibid., pp. 120-22.

world through his own eyes.

What must always be remembered is that what is of primary relevance to one individual in the context of his life situation may not be of primary relevance to another individual in the context of HIS life situation. It is only by explicitly focusing on the meaning inherent in the contextual horizons of the Other's world that one can understand something of the Other's existential predicament.

Spiegelberg notes that the act of "imaginative self-transposal" is not such that one's own world is thereby permanently denied or invalidated. Indeed, the act allows us "to shuttle back and forth between our own understanding self and that of the Other whom we want to understand."[27] Such "shuttling back and forth" is vital if one is to construct a shared world of meaning with the Other.

Thus "imaginative self-transposal" does not require that the physician negate the validity of his own world. He is always at liberty to step back or withdraw from the patient's predicament in order to make a scientific judgment. However, having focused on the patient's world and on the meaning inherent within the contextual horizons of that world, the physician is able to communicate with the patient on the basis of a shared context of understanding and, more importantly, to fit the scientific judgment to the peculiar

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[27] Ibid.

and special needs of the particular patient.

Possibilizing

The ability to vary oneself in imagination is related to what Richard Zaner has called "possibilizing."[28] It is the ability to "realize" or make real a situation other than the immediate one in which one finds oneself. To "possibilize" is to move from immediate experience to the reflection of how such experience might possibly be other than it appears to be. It is to move outside of the "immediate zone of actuality" in order to "simulate affairs other than what lies actually at hand."[29]

A crucial element in "possibilizing" is the freeing of the self from the bounds of immediate experience and a concurrent "freeing-for."[30] That is, in order to free oneself for the possibly-otherwise, one must first free oneself from the actual.

Thus, the act of "possibilizing" requires that one abstract from, or step outside of, the situation as it presents itself in its concrete immediacy. Only then can one reflect upon the nature of this immediate experience and grasp how it might possibly be otherwise.

> This complex act is at once a freeing-from the actual and a freeing-for the possible; it is a leap out of the actually present and into the region of the possibly

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[28]Zaner, The Context of Self, pp. 175-80.

[29]Ibid., p. 176.

[30]Ibid., p. 179.

> otherwise, or the as-if. . . . Human freedom . . . is expressed most fundamentally - or even comes to be - by this imaginative leap: it is what may be called the act of possibilizing. A creature locked to the actual, the immediate praxis, is a creature capable neither of history, culture, education, nor thinking.[31]

What is hereby emphasized is that it is only through an act of disengagement that one can free oneself for the possibly-otherwise. Without such disengagement one is confined within the bounds of immediate experience.

> Being able to apprehend alternatives to situations, relationships, connections, and so on, positively requires being able to apprehend the "possibly-otherwise" as opposed to what is "actually present."[32]

To enter the world of another requires just such an act of disengagement. Through the act of abstracting from the immediacy of one's own experiencing one is able to "realize" (make real for oneself) the experience of the Other.[33]

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[31]Richard Zaner, "The Leap of Freedom: Education and the Possible," Main Currents in Modern Thought 28 (May 1972): 178.

[32]Ibid., p. 179.

[33]Richard Zaner has suggested in a personal letter, dated July 29, 1983, that the ability to undertake an "imaginative self-transposal" is directly related to the ability to possibilize. He suggests that those who have cultivated the ability to "possibilize" are much more likely to be able to make the "imaginative self-transposal." Zaner notes:

> ". . . anyone who has not cultivated his imagination seems less likely to be able to undertake this kind of self-transposal. I am increasingly convinced that actual long-term involvement in the creative arts, in whatever form, is a crucial component of the development of the ability to possibilize. Hence it is a key ingredient to the training of health care professionals."

Analogy and Extrapolative Understanding

Maurice Natanson suggests that one way in which we have knowledge of the Other's experience is through analogy.[34] The Other is presumed to be "like me." There are thus analogical counterparts in my own experience which may provide me with some understanding of his experience. For example, I can appreciate something of the pain of another's toothache because I have gone through the same sort of thing myself when my tooth ached.[35] I can grasp something of the distress suffered in losing a loved one because I have experienced a similar loss.

Natanson notes that there are obviously instances when it is impossible to have an analogical counterpart in one's own experience. As an example he cites the impossibility of a man experiencing the labor pains of a woman.[36] Nevertheless, even in such instances there may still be an analogical basis for appreciating something of the Other's situation. There may, for example, be other forms of pain (such as abdominal cramps) which approximate and provide some understanding of the Other's experience.[37]

Natanson suggests that there are, therefore, two forms of the analogical mode: a strong and a weak form of

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[34]Natanson, The Journeying Self, p. 36.

[35]Ibid.

[36]Ibid.

[37]Ibid.

experience, "the first moving from 'same' to 'same,' the second from 'similar' to 'similar'."[38]

He further notes that there are instances in which a sort of analogical leap occurs. Such a leap characterizes what Natanson has called "extrapolative understanding."[39] "Extrapolative understanding" is the "sympathetic grasp of the Other's experience when even approximations are too weak to give any real sense of what is at issue."[40] Through "extrapolative understanding" the individual grasps the Other's experience in its essence not by reference to his own actual historical experience but in light of an intuitive awareness of what is involved in the Other's experience.

Natanson suggests that "the alien, the strange, the pathological, the demonic, the freakish, and the hellish may be analogical possibilities we come to by way of the outskirts of the familiar."[41] Although we may have no actual personal experience which is comparable to the experience of the Other, yet we can imaginatively grasp what such experience might be like. We can empathize with the Other.

In applying Natanson's analysis to the patient/ physician relationship, it is revealing to do so in light of

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[38]Ibid.

[39]Ibid., p. 37.

[40]Ibid.

[41]Ibid.

the following comments by Edmund Pellegrino regarding the notion of empathy in the experience of illness.[42]

Pellegrino suggests that it is difficult to understand the experience of illness without having been ill. (That is, in Natanson's terms, without any analogical basis of understanding.) He further notes that even if one is ill:

> . . . one's own experience of illness is unique and cannot be transferred point by point to another person's experience of illness. There is no question that having been ill and ideally with the same illness and the same set of circumstances would increase the probabilities of an empathetic match. Nonetheless, the probabilities of such a match are complicated by the very different circumstances in which illness strikes different people at different times in their lives.[43]

Pellegrino thus suggests that there are three levels of understanding the Other's experience of illness:

> Ideally, I suppose, we would say that first the closest approach to an ideal notion of compassion would eventuate when the experiences of illnesses match as closely as possible. The second level would be an experience of illness, perhaps not the same illness as the patient, but with the general phenomenon of illness, and this would give a closer match than the third, which is the more general problem, namely trying to penetrate another person's experience of illness when one is not or has not been ill.[44]

The first level of understanding would thus be akin to Natanson's "strong" analogical mode; the second would be akin to the "weak" analogical mode; and the third would seem

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[42]Edmund D. Pellegrino, personal letter, dated July 29, 1983.

[43]Ibid.

[44]Ibid.

to involve "extrapolative understanding" or "possibilizing."

In those instances where one is trying to penetrate another person's experience of illness when one is not or has not been ill, it may be helpful to draw upon analogical counterparts which are available through the encounter with literature. One may be able to develop some understanding of illness-as-lived through sharing such experience in the world of literature.

Consider, for example, the following passages from John Updike's short story, "From the Journal of a Leper."[45]

> Oct. 31. I have long been a potter, a bachelor, and a leper. Leprosy is not exactly what I have, but what in the Bible is called leprosy (see Leviticus 13, Exodus 4:6, Luke 5:12-13) was probably this thing, which has a twisty Greek name it pains me to write. The form of the disease is as follows: spots, plaques, and avalanches of excess skin, manufactured by the dermis through some trifling but persistent error in its metabolic instructions, expand and slowly migrate across the body like lichen on a tombstone. I am silvery, scaly. Puddles of flakes form wherever I rest my flesh. Each morning, I vacuum my bed. My torture is skin deep: there is no pain, not even itching; we lepers live a long time, and are ironically healthy in other respects. Lusty, though we are loathsome to love. Keen-sighted, though we hate to look upon ourselves. The name of the disease, spiritually speaking, is Humiliation.
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> . . . Nov. 1. The doctor whistles when I take off my clothes. "Quite a case." . . . The floor of his office, I notice, is sprinkled with flakes. There are other lepers. At last, I am not alone. . . . As I drag my clothes on, a shower of silver falls to the floor. He calls it, professionally, "scale." I call it, inwardly, filth.[46]

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[45]John Updike, "From the Journal of a Leper," The New Yorker, July 19, 1976, pp. 28-33.

[46]Ibid., p. 28.

Or consider the experience of cancer as it is powerfully evoked in the following description by Helen Yglesias:

> . . . Something I remembered being shouted at me in the recovery room: precancerous tissue. A bright little flame licked away at the edge of remembering. It lit up and charred as it burned, so that I remembered and forgot, remembered and forgot, in split instants. They took off my breast. No. They took off my breast. No. I fell asleep.
> . . . Precancerous tissue. I had never heard of that before. Like coming attractions. Next week cancer of the lung. Someone must have said it to me. Dr. Altman must have said it in his loud, fast voice - yes, in that crazy baker's outfit they wear when they operate. Was it in the operating room? Didn't I remember Matt there, too, with lying, frightened eyes, holding my hand in his trembling one? It couldn't have been in the operating room. It must have been in the recovery room, after they had done it.
> . . . As if I had rung a bell, the pretty nurse came in with an injection for me. . . . It had the unexpected result of allowing me a straightforward view of the landscape burning in my head. I am dying of cancer at twenty-eight, leaving my little boy and my newborn baby girl and my invalid mother in the hands of a scared and childish man who will run right out and get himself a beautiful two-breasted new wife to replace me. To REPLACE me? She will spoil all my work. She will put my mother in a home and mess up my children's lives and allow Matt to slip into his worst self. No. She will adore him and do whatever he wishes and rear the children perfectly and bake her own bread. He will be happy for the first time. No. I will be fine. I will finish all the work of my life. They have removed the precancerous tissue and I will be well. Matt will love me with only one breast. He will be here soon. He will look into my eyes with steady love. We will have a real Ladies' Home Journal scene. The bitterness between us will evaporate like magic.[47]

As Ronald Carson has noted:

> Cancer is unlike any other disease in the 20th century taxonomy of diseases. Defining it in dictionary terms

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[47]Helen Yglesias, "Semi-Private," The New Yorker, February 5, 1972, pp. 35-36.

> as a "general term frequently used to indicate any of various types of malignant neoplasms," though technically accurate, does not begin to tell the tale.[48]

However, such descriptions in literature can evoke the experience of the person who is ill, and may provide a clue to the meaning of such experience.

Summary

The experience of illness is necessarily unique to the individual sufferer. The attempt to penetrate another's experience of illness thus necessitates a conscious effort to enter into the world of the Other and a concurrent setting aside of one's own world.

In this chapter consideration has been given to the question of how it is possible to construct a shared world of meaning between physician and patient. It has been noted that there are certain fundamental characteristics (eidetic features) which are intrinsic to the experience of illness and it has been suggested that it is necessary to focus upon such characteristics in order to grasp something of the meaning of illness.

In particular, it has been noted that there is a distinction between suffering and clinical distress, suffering being grounded in the unique experiencing of the

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[48]Ronald A. Carson, "Care and Research: Antinomy or Complement," paper presented at a seminar, "The Common Bond: Ethics for a Categorical Institution," M. D. Anderson Hospital and Tumor Institute, Houston, Texas, April 26-27, 1984, p. 2.

individual.

It is suggested that the construction of a shared world of meaning between individuals is made possible through the acts of "imaginative self-transposal" and "possibilizing," and by means of analogy and "extrapolative understanding." The encounter with literature may also provide a basis of analogical understanding for penetrating the experience of illness.

CHAPTER IV

THE HEALING RELATIONSHIP

> Medicine is a special moral enterprise because it is grounded in a special personal relationship between one who is ill and another who professes to heal. Illness is an altered state of existence arising out of an ontological assault on the humanity of the person who is ill. Healing is a mutual act that aims to repair the defects created by the experience of illness.
>
> Edmund D. Pellegrino

It has been noted that the experience of illness represents much more to the person who is ill than simply a collection of physical symptoms which define a particular disease state.

Illness is fundamentally experienced in terms of disharmony, disequilibrium, dis-ability and dis-ease. It represents an altered state of existence characterized by loss of wholeness, loss of certainty, loss of control, loss of freedom to act, and isolation through the individual's separation from the familiar world.

The experience of illness is unique to the individual and the meaning of that experience is derived from within the contextual horizons of his particular world.

Healing aims at a restoration of wholeness, of

harmony, at an alleviation of the dis-ability and dis-ease that illness projects into the life of the one who is ill.

Such a restoration of wholeness can only be successfully accomplished if the healer's attention is focused on the experience of the one who is ill and particularly upon the meaning that in inherent in that experience.

As Pellegrino notes:

> Genuine healing must be based on an authentic perception of the experience of illness in THIS person. It must aim at a repair of the particular assaults which illness makes on the humanity of the one who is ill.[1]

Genuine healing thus requires some measure of compassion, an endeavor on the part of the healer to understand something of the experience of the one who is ill.

In the patient/physician relationship:

> "Com-passion" means co-suffering, the capacity and the willingness of the physician somehow to share in the pain and anguish of those who seek help from him. It connotes some understanding of what sickness means to another person together with a readiness to help and see the situation as the patient does. Compassion demands that the physician be so disposed that his every action and word will be rooted in respect for the person he is serving. Compassion is reflected in a disposition to "feel" along with the patient.[2]

"Com-passion" arises within the context of a "common

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[1]Edmund Pellegrino, "Being Ill and Being Healed: Some Reflections on the Grounding of Medical Morality," Bulletin of the New York Academy of Medicine 57 (January 1981): 73-74.

[2]Edmund D. Pellegrino, Humanism and the Physician (Knoxville: University of Tennessee Press, 1979), p. 158.

world" through an appreciation of the meaning that the Other's experience has for him. In the act of placing himself within the contextual horizons of the patient's world, in an effort to grasp something of its meaning, the physician expresses his willingness to "somehow share in the pain and anguish of those who seek help from him."[3]

"Com-passion" means to "feel genuinely the existential situation of the person who is bearing the burden . . . and who has undergone the insult of sickness to his whole being."[4] Thus, compassion requires a setting aside of one's own world and an entering-into the existential situation of the Other.

"We can never," notes Pellegrino, "enter wholly into the state of being of another human, but we must strive with all our might to feel it to the fullest extent our sensibilities will allow."[5]

The attempt to feel genuinely the existential situation of the person "who has undergone the insult of sickness to his whole being" necessitates an explicit focusing on the illness-as-it-is-experienced by this particular patient. "The only way," says Cassell, "to learn . . . whether suffering is present is to ask the sufferer."[6]

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[3]Ibid.

[4]Ibid., p. 226.

[5]Ibid.

[6]Cassell, "The Nature of Suffering and the Goals of Medicine," p. 643.

> We all recognize certain injuries that almost invariably cause suffering: the death or distress of loved ones, powerlessness, helplessness, hopelessness, torture, the loss of a life's work, betrayal, physical agony, isolation, homelessness, memory failure, and fear. Each is both universal and individual. Each touches features common to all of us, yet each contains features that must be defined in terms of a specific person at a specific time.[7]

"Com-passion" arises within the context of what Schutz has termed the "face-to-face" relationship. Only in the "face-to-face" relationship is:

> . . . another's body within my actual reach and mine within his; only in it do we experience one another in our individual uniqueness. While the face-to-face relationship lasts we are mutually involved in one another's biographical situation: we are growing older together.[8]

In the "face-to-face" relationship we are aware of the Other as a "co-subject" who experiences a shared world of time and space.[9]

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[7]Ibid., pp. 643-44.

[8]Alfred Schutz, "Symbol, Reality, and Society," in Alfred Schutz: Collected Papers, ed. Maurice Natanson, vol. 1: The Problem of Social Reality (The Hague: Martinus Nijhoff, 1962), p. 317.

[9]Edmund Husserl uses the term "co-subject." He notes:

> ". . . (on the one hand) persons . . . are thematic as objects - as objects belonging to the surrounding world which is already pregiven to the practical ego, practical in the broadest sense, i.e., concrete, living wakefully into the world - and are thus thematic as being of the surrounding world in the full sense, as objects to which something happens, objects which one finds existing in the surrounding world, which one sees but has nothing to do with: they are here and over there like mere things; perhaps what is especially in question here is the external seeing and understanding of the other without becoming intimately familiar with him,

This awareness of the Other as a "co-subject" suggests that the "face-to-face" relationship, if it is to be a genuine relationship, is what Martin Buber has called an "I-Thou" relationship.[10]

Buber makes the distinction between two kinds of human relationship: the "I-Thou" relationship in which the Other is encountered as a co-equal, as a unique individual, and the "I-It" relationship in which the Other is treated as an object. The "I-Thou" relationship is one of reciprocity; the "I-It" relationship is one of depersonalization.[11]

In the "face-to-face" relationship of the patient/physician encounter, compassion arises within the context of the "I-Thou" relationship, in the awareness of the Other as a thinking, feeling, suffering "Thou." If the physician focuses solely on the disease process, rather than on the particular person who is ill, then the patient becomes an object and the relationship becomes an "I-It" relationship. The "I-It" relationship is one of depersonalization and one

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living with him. On the other hand, (there are) the other subjects as co-subjects, with whom one forms a community in experiencing, in thinking, in acting, with whom one has common praxis in the surrounding world even though each one still also has his own. We already have a certain 'community' in being mutually 'there' for one another in the surrounding world (the other in my surrounding world) - and this always means being physically, bodily 'there'." The Crisis, p. 328.

[10]Martin Buber, I and Thou, trans. Walter Kaufmann (New York: Charles Scribner's Sons, 1970).

[11]Ibid.

that contributes to the feelings of isolation and helplessness experienced by the one who is ill.[12]

The patient/physician relationship is a unique kind of "face-to-face" relationship in that the "mutual involvement in one another's biographical situation," the shared world, is grounded in the patient's experience of illness.

Additionally, the patient/physician relationship has a specific end - the healing of the patient - and the relationship is entered into and perpetuated with this end in sight. The person who is ill comes to the physician (the healer) seeking a restoration of wholeness, or a means of alleviating or ameliorating his suffering or distress.

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[12]James Sellers has suggested that there is another type of relationship, an "I-You" relationship, which is not at the level of intimacy of the "I-Thou" relationship, but in which the Other is not treated as a thing. As an example he cites his relationship with his mailman - a casual friendly relationship which is not intimate but which is not impersonal either. Sellers, "Tensions in the Ethics of Interdependence," paper presented at a seminar, "The Common Bond: Ethics for a Categorical Institution," M. D. Anderson Hospital and Tumor Institute, Houston, Texas, April 26-27, 1984, pp. 10-11.

In a personal letter, dated May 4, 1984, Sellers suggests that the patient/physician relationship may be more properly characterized in terms of "I-You" rather than "I-Thou." However, it seems to me that the act of suffering together forges a level of intimacy which goes beyond the casual intimacy of the "I-You" relation. It may be that a distinction can be made regarding the level of illness. If the experience of illness is short-lived with minimal distress, then perhaps the patient/physician relationship may be at the level of an "I-You" relation. However, if the experience of illness is profound, then in the mutual exploration of the patient's existential predicament the physician and patient encounter one another in an "I-Thou" relationship.

The one who is ill also comes to the healer seeking a means to communicate his dis-ease and thereby to make sense of his particular experience of illness. What he seeks is not simply an explanation of his physical symptoms, but some measure of understanding on the part of another of the fear and anxiety and uncertainty that the experience of illness represents. In communicating with his physician he seeks to convey the meaning of his illness in the context of his particular biographical situation.

The manner in which the "reality" of illness is defined has a profound impact on the notion of "healing," and thus on the way in which the end of the patient/physician relationship is defined.

If illness is attended to (and thus defined) solely in terms of "objective" pathophysiology (i.e. in terms of "disease"), the end of the medical encounter is understood to be primarily diagnosis and cure. The emphasis is on treating the "disease" rather than treating the person who has the disease.

If, however, the central experience of illness is understood to represent an altered state of existence, an ontological assault on the humanity of the one who is ill, then attention is focused on the dis-ease of the patient (rather than solely the "disease" of the patient) and the goal becomes to restore to him his integrity as a human being. This restoration of wholeness includes, but is not

limited to, the restoration of bodily integrity.

This qualitative shift in emphasis (a shift which moves from a stance of confrontation with an abstract disease entity to a stance of addressing the existential needs of the person who is ill) has profound implications in particular for the response to those individuals facing chronic or incurable illness, where the restoration of health is not an attainable end.

If the medical encounter is defined solely in terms of diagnosis and cure of "disease," those who cannot be cured stand outside medicine, outside the realm of "healing" and, therefore, as unable to participate in the healing relationship. The focus on "cure" suggests that the physician has nothing to offer the person who is incurably ill (or whose illness does not meet the "objective" criteria for "disease").

Such is the implication of the following statement made by a clinical professor and quoted approvingly as an example of how the "good" clinician will give prior attention to "disorders for which effective therapy is available."[13]

> I do not care if I make a diagnosis of multiple sclerosis; there is little I can do about it anyway. I want to make sure that this patient does not have

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[13]J. D. Myers, "The Process of Clinical Diagnosis and its Adaptation to the Computer," quoted in Ernan McMullin, "Diagnosis by Computer," The Journal of Medicine and Philosophy 8 (February 1983): 21.

> a tumor of the spinal cord which can be removed surgically and cure the patient.[14]

Likewise, such is the emphasis of the following statement appearing in Harrison's Principles of Internal Medicine (Thorn, 1977), a textbook which is described as "probably the single most respected textbook of medicine."[15]

> The discovery and cure of potentially serious disease represents a far greater service to one's patients than ministrations in the course of an incurable condition.[16]

If "cure" is perceived to be the only goal, disease is the enemy and the patient's body the battlefield. The emphasis is on winning the war, whatever the cost. The "disease" is confronted as an abstract entity residing in, but in some way separated from, the one who is ill.

This emphasis on confrontation with a disease entity, rather than addressing the existential predicament of the one who is ill, is reflected in the following description by Martin Netsky, a professor of medicine. He describes the treatment received by his dying mother in a large teaching hospital that prides itself on the excellence of patient care:

> What happened was a nightmare of depersonalized institutionalization, of rote management presumably related to science and based on the team approach of

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[14] Ibid.

[15] Baron, "Bridging Clinical Distance: An Empathic Rediscovery of the Known," p. 6.

[16] G. W. Thorn, et. al., Harrisons's Principles of Internal Medicine, 8th ed. (New York: McGraw Hill, 1977), p. 2.

> subdivision of work. . . . Different nurses wandered in and out of my mother's room each hour, each shift, each day, calling for additional help over a two-way radio. . . . They were trained as part of a team "covering the floor" rather than aiding a sick human being. . . . Laboratory studies of blood and urine continued to be performed, fluids were given, oxygen was bubbled in, antibiotics were administered; the days went by but seemed to be years. The patient was seen occasionally by large groups of physicians making rounds, presumably learning the art of practicing medicine properly. . . . The chart was enlarged regularly with "progress notes." These hastily scrawled writings always dealt with laboratory data, never about the feelings of the patient or her family. . . . One report stated that occult blood had been found in the stool. Someone responded by writing in the chart that, in view of this finding sigmoidoscopic examination and a barium enema were indicated. I suggested to the author that his conditioned reflexive act was not warranted in the care of an unconscious 80-year old woman who wanted to die gracefully.[17]

If cure is the only goal, inability to cure is equated with failure. Thus, the patient whose "disease" cannot be cured is often avoided as an uncomfortable reminder of failure.

> "It was so strange," said a patient entering a London hospice recently, after being discharged from an ordinary hospital. In other places, she explained, "no one seemed to want to look at me." She was dying of cancer, and to look at her might have meant to see, in a place where only successful cure was acceptable, that she was incapable of being cured. To look at her might have meant to see failure, and with it the terror of one's own inescapable death. To look at her, in fact, might have meant to see HER.[18]

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[17]Martin D. Netsky, "Dying in a System of 'Good Care': Case Report and Analysis," Pharos, April 1976, pp. 57-61.

[18]Sandol Stoddard, The Hospice Movement: A Better Way of Caring for the Dying (New York: Stein and Day Publishers, 1978), p. 21.

In particular, the dying patient is abandoned as beyond help. Medicine is assumed to be powerless in the face of impending death. The dying person often becomes faceless, nameless, a diseased body rather than a dying person. In this event the person who is dying loses his humanity even before he loses his life.

> . . . The person in question, a female aged thirty-seven, Caucasian, single, had not been giving birth; she had been dying. She had no business to be in the maternity department. She was cancer, terminal.
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> The patient had been in the hospital many times before, they told me. There was nothing more anyone could do for her. They had already cut out her breasts, her ovaries, her uterus. She had lost her eyesight, her fingernails, her hair. She was incontinent, and even when fully conscious, she was not altogether in her right mind. She belonged in medical-surgical, obviously.
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> For nine days before the birth of my child, they had been trying to get her moved. At first her papers had been misfiled, and then there had been a problem about insurance. After that, there had simply been no other place for her to go. Under ordinary circumstances they would have put her, when she was being so noisy, into the little isolation cubicle behind the nursery. As it happened, even that room at the time had been filled.
>
> They were terribly sorry. The whole thing had been very unfortunate. They apologized to me for the inconvenience I had suffered, having to lie awake next door to her and, due to the poor quality of the sound-proofing of that wing, having to listen to her die.
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> The faces of the individuals who said these things to me were somewhat puzzled and distracted, but they were not cruel or even unkind. In fact, I have rarely found medical people - or people of any sort - to be deliberately stupid or consciously mean and enjoying it. Still, it is hard to reply to well-intentioned people who are, in matters of life and death, so very far off the mark.[19]

If cure of "disease" is taken to be the sole end of the medical encounter, there is indeed "little" the

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[19]Ibid., p. xvi.

physician can do in the face of intractable illness. But if alleviation of dis-ease and suffering is perceived to be the end of the healing relationship, there is much the physician can do. Indeed, he is perhaps the most effective ally that the patient can have in the struggle to deal with the limitations imposed by his illness.[20]

Eric Cassell has distinguished between the "healing function" as opposed to the "curing function" of the physician.[21] The "curing function" is, of course, limited to the cure of disease states. However, the "healing function" is directed at addressing and resolving the existential predicament of the person who is ill.

Cassell notes that, in fact, "in this day of cancer, chronic disease and the problems of the aging," the healing function of the physician is primary. Patients with incurable disease far outnumber those with curable disease.[22]

In the case of chronic or incurable illness the healing function of the physician is crucial. As Cassell notes, the healing function is not to be equated simply with

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[20]As a person living with incurable illness, and more particularly with multiple sclerosis, I can attest to the fact that the physician's participation is crucial in assisting the patient to retain control and cope with the realities of his illness. Without such participation on the part of the physician, the patient often feels helpless in the face of circumstance.

[21]Cassell, The Healer's Art, p. 149.

[22]Ibid.

giving reassurance, acceptance and patience.[23] In a real way, through the healing relationship, the physician can restore to the patient his integrity as a person. To do this the physician must address those factors which are fundamental to the experience of illness (the eidetic characteristics of illness), such as loss of control, isolation, helplessness and loss of freedom to act. Whereas the restoration of wholeness may be limited in terms of restoring bodily integrity or eradicating "disease," the physician can assist the patient in regaining control (even if it is only limited control), overcoming helplessness and thus retaining the freedom to act. Although the freedom to act may be severely circumscribed by physical impairment, nevertheless the physician can assist the patient in continuing to live his life to the fullest extent possible.

The healing function of the physician extends even to the dying patient. As Cassell notes, the physician is only helpless in the battle against death if he sees his role solely in terms of curing "disease."[24]

> . . . the physician who knows that his function is to help the sick to the limit of his ability is almost always able to offer something. In his care the sick are protected from helplessness, fear, and loneliness, agonies that are worse than death.[25]

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[23] Ibid.

[24] Ibid., p. 200.

[25] Ibid.

"Healing a person does not always mean curing a disease," says Cicely Saunders, founder of St. Christopher's Hospice in London.[26]

> Sometimes healing means learning to care for others, finding new wholeness as a family - being reconciled. Or it can mean easing the pain of dying or allowing someone to die when the time comes. There is a difference between prolonging life and prolonging the act of dying until the patient lives a travesty of life.[27]

It may be objected that healing, so defined, is not limited to medicine. Pellegrino suggests, however, that although "psychologists, ministers, friends and families" can provide healing relationships, they do so "over a limited range of human need."[28]

The person who seeks healing from a physician does so specifically because he regards himself as sick, whereas the person who seeks healing from those outside medicine does not consider himself to be ill.[29]

> Sickness implies embodiment, the distinctly human phenomenon of a conscious self in a lived-body. When a person experiences some disturbance in his accustomed state of balance between body, psyche and self he counts

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[26]Cicely Saunders, quoted in Sandol Stoddard, The Hospice Movement, p. 75.

[27]Ibid.

[28]Edmund D. Pellegrino, "The Healing Relationship: The Architectonics of Clinical Medicine," paper presented in part as the Second Annual Grant Taylor Lecture, University of Texas Health Science Center, Houston, Texas, April 1982, p. 21.

[29]Ibid.

himself as sick.

> It is the fact of embodiment that creates the need for the physician. Only he can unravel the connections between the subjective experience of illness and its linkage to bodily function. Without denying the part others may play, the physician comes closest to what healing means - to restore wholeness or, if this is not possible, to assist in striking some new balance between what the body imposes and the self aspires to.[30]

The special relationship between physician and patient, the healing relationship, distinguishes clinical medicine from biomedical science, per se. In the healing relationship attention is focused on the experience of the one who is ill, rather than simply on the disease process itself.[31]

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[30] Ibid., pp. 21-22.

[31] As Stephen Toulmin notes, the nature of the physician's understanding differs according to whether he is engaged in clinical medicine or whether his role is primarily that of biomedical scientist. In his traditional role of healer the physician's understanding is:

> ". . . typically particular rather than general, individual rather than collective, even (so far as is practicable) empathic rather than intuitive. He will focus his attention entirely on the particular problems of individual patients, whatever these turn out to be, rather than view patients merely as 'nice cases of x-itis'."

In contrast, as biomedical scientist, the physician's understanding, like all scientific understanding, will remain entirely general:

> "His questions - qua scientific - are entirely general questions about THE brain, THE liver, etc. . . . This being so, his interest in particular patients will be minimal and accidental: the more of his research he can do with laboratory animals or in vitro, the better. And to say this is in no way to criticize the biomedical scientist, still less to denigrate him. These attitudes are a proper reflection of his role in the professional division of labor." Toulmin, "On the Nature of the Physician's Understanding," pp. 46-47.

It is the explicit focusing on the particular problems of the individual patient that enables the physician to fulfill his role of healer. Healing includes the relief of suffering, of dis-ease, as well as the cure of "disease."

Healing requires an understanding of illness-as-lived - a perception of the meaning inherent in the experience of illness. Such an understanding can only be reached if the physician explicitly focuses on the illness as it is experienced by a particular patient. The act of focusing on the Other's experience requires that the physician temporarily set aside his own presuppositions about the world, in order to attend to the meaning inherent in the world of the Other.

Healing is a mutual act which presupposes a shared world between physician and patient. In focusing on the eidetic features of illness, the physician sets aside his own interpretation of illness in terms of "disease" and thereby endeavors to constitute a mutual context of understanding (a shared world of meaning) with the patient.

Through the acts of "imaginative self-transposal" and "possibilizing," and by means of analogical understanding, the physician "realizes" (makes real for himself) a shared world with the patient. It is in the context of this common world, through the mutual exploration of the patient's

existential predicament, that the act of healing is accomplished.

CONCLUSION

It has been my purpose in this thesis to explore the "reality" of illness, using philosophical phenomenology as a guide. In particular, I have been concerned to show that the experience of illness, rather than representing a shared "reality" between physician and patient, represents in effect two quite distinct "realities" (the meaning of one "reality" being significantly different from the meaning of the other).

I have also endeavored to show that phenomenology may provide a clue to the manner in which a shared world may be constructed between physician and patient. Such a shared world is presupposed in, and is vital to, the notion of healing.

Philosophical phenomenology focuses on the nature of experience, and particularly upon the manner in which all experience is structured by the activity of consciousness.

In analyzing the complexity of the structure of "reality," phenomenology emphasizes the unique nature of experiencing, and particularly the correlation between the one who is experiencing and that which is experienced. Meaning is seen to be a function of the activity of individual consciousness.

In particular, it is noted that the manner in which an object is experienced is strictly correlative to the way in which the individual explicitly attends to, or focuses on, that object. The activity of consciousness renders the object "thematic." Such attentional focusing is influenced by the individual's biographical situation which provides a horizon of meaning in terms of which "reality" is interpreted.

Thus, the individual interprets his world in light of a meaningful structure which he imposes upon the "reality" he encounters. In so doing he effectively transposes "the" world into "my" world.

In encountering the experience of illness the physician and patient do so from within the context of different worlds. Each renders the experience "thematic" in a qualitatively distinct manner. Although the "reality" of illness is presumed to be a shared "reality" between them it is evident that, in fact, it represents two quite distinct "realities."

Phenomenology provides some insight into the manner in which the separate worlds of physician and patient are constituted. In particular, it is noted that the way in which the experience of illness is attended to by the physician is largely determined by the "habits of mind" of his profession. The scientific "habit of mind" provides a horizon of meaning, a motivation for focalizing and a means

of interpreting or structuring "reality." This interpretation is, however, quite distinct from other interpretations of "reality." The experience of illness is rendered "thematic" by the physician in terms of "objective," quantifiable data which transform illness into "disease." Illness is thus reified as a distinct entity residing in, but in some way separated from, the one who is ill.

The patient, however, encounters the experience of illness in its immediacy in the context of the familiar world, as opposed to the context of the universe of science. Thus, he interprets his experience within a different contextual horizon from that of the physician, and according to a different system of relevances. The meaning of his immediate experience of illness is, therefore, qualitatively distinct from the meaning superimposed upon the experience by the physician.

In addition to providing insight into the separate worlds of physician and patient, phenomenology offers a clue as to the way in which a shared world may nevertheless be constructed between them.

The phenomenological notion of disengagement involves a setting aside of one's hitherto taken-for-granted presuppositions about the world, in order to critically evaluate those presuppositions. This shift in focus requires that one pay primary attention to the object as it is experienced and to the correlation between the perceiver and that which is perceived.

It is through a similar act of disengagement and shift in focus that the physician may construct a shared world with the patient. In setting aside his own hitherto taken-for-granted presuppositions about the "reality" of illness, he focuses on the unique experiencing-of the patient (and the meaning inherent in that experiencing). What is thereby rendered "thematic" is the experience itself, in terms of those eidetic characteristics which convey the essence of illness in all its various manifestations.

In the act of setting aside his own world, the physician explicitly focuses on the patient's world. In order to grasp something of its inherent meaning, the physician must attempt to place himself within the contextual horizons of the patient's world. Such a transposal is possible through the acts of "imaginative self-transposal" and "possibilizing," and through the use of analogy and "extrapolative understanding." The encounter with literature may also provide an analogical basis of understanding for the physician.

The notion of healing presupposes a shared world between physician and patient. Healing aims at a restoration of wholeness. Such a restoration of wholeness can only be successfully accomplished if the healer's attention is focused on the experience of the one who is ill and particularly upon the meaning inherent in that experience.

"Healing" is not to be equated with, nor is it

limited to, "curing disease." The healing function of the physician extends to those persons facing chronic or incurable illness. In the act of healing the physician explicitly addresses the existential predicament of the one who is ill. Healing thus requires some measure of compassion, an endeavor on the part of the healer to understand something of the experience of the one who is ill.

The manner in which the "reality" of illness is defined directly influences the way in which the end of the patient/physician relationship is defined. If the "reality" of illness is interpreted in terms of "disease," then the end of the patient/physician relationship is seen to be diagnosis and cure. Those whose "disease" cannot be cured thus stand outside medicine and outside the healing relationship.

If the experience of illness is rendered "thematic" in terms of the eidetic characteristics which convey the essence of illness, the end of the patient/physician relationship is seen to be healing. Healing is a mutual act which takes place within the context of a shared world between physician and patient.

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