Health is not a condition that one introspectively feels in oneself. Rather it is a condition of being there (Da-sein), of being-in-the-world, of being together with other people, of being taken in by an active rewarding engagement with the things that matters in life. It is the rhythm of life, a permanent process in which equilibrium re-establishes itself.

Hans-Georg Gadamer

Chapter 4

Modern Medicine:
A Phenomenological Critique

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The growing philosophical interest in medicine within the last few years has yielded many discussions about concepts in medicine and the character of medicine in general. This last subject has its place in the attempt to elaborate a general philosophy of medicine, in which essential structures are explicated as the foundation of all medical activities. In this chapter, our attempt is not to provide a philosophy of medicine. Rather, we attempt to present a critique of modern medicine starting from phenomenology, especially of Merleau-Ponty.

As we have seen in the previous chapter, Merleau-Ponty’s thought provides a general philosophy about human existence which we consider to be indispensible for the above mentioned critique. Phenomenology in general and Merleau-Ponty’s concept of lived body in particular provide extraordinary insights into many of the issues that are directly addressed within the world of medicine. Most importantly, such issues include: The meaning of health, illness and disease, and the distinction between the patient’s immediate experience and the Physician’s scientific conceptualization of illness. We focus our attention on these issues.

The reductionist tendencies and lack of emphasis on preventive measures are certain recognized demerits in modern medicine. The reason behind such flaws is often been shown to be related to the exclusive use of Cartesian notion
of embodiment. We would discuss this problem centering on the above said issues. Then, in a speculative vein, we will suggest ways in which medical theory and practice might be transformed by attending more fully to lived-embodiment.

4.1. **Phenomenology and the question of health**

Health theory is not a new subject in the history of philosophy. Inversely, from time immemorial, the philosophies of health and medicine were important sub-disciplines to philosophy. Theorizing over health and medicine were contained in the philosophies of Plato, Aristotle and in many other Greek and Roman philosophical schools as well. A detailed survey of ancient health theories would be well beyond the scope of this chapter.

For philosophers like Descartes, Locke, Kant and Schelling, the subject ‘health’, was an important concern. Later, coming to modern era, it became a theme of empirical science rather than of philosophy. For majority of the doctors and medical scientists health is not a major concern in the time of modern medicine. Rather they have been interested in the factors which go against health such as diseases, impairments, injuries and other defects. The main tasks of modern medicine are identifying and classifying various diseases and defects
by means of studying their etiology to affect their remedy, palliation and prevention.

Fredrik Svenaeus in his work, *The Hermeneutics of Medicine and The Phenomenology of Health*, says that the main weakness of the western medicine’s theory of health is that, it looks upon human beings wholly as organisms- as sophisticated machines- and not as persons. Western medicine’s theory of health does not pay much attention to the surroundings of the organism and their effect on the physiology of the body. This is due to the inadequacy of the theory of health that modern medicine entertains. What is this inadequacy? Sveneaus argues that the inadequacy consists in theorizing health as the absence of illness. Let us try to make this point more clear.

According to Sveneaus modern medicine is grounded on what can be called a biological-statistical theory of health which is provided by Christopher Boorse. Boorse’s theory-just like the empirical theories of medical science-is based on the notion of disease. Boorse interprets disease in a very wide sense in order to include other maladies, such as congenital defects, injuries and impairments. The test for a state to be called a disease is whether it prevents a part of the body from functioning in a normal way. If the organism is not afflicted by any disease it is healthy. Health is accordingly the *absence* of disease.
The emphasis of Boorse’s theory is on biological functions. Normality, as it is shown in his theory, is a descriptive concept, based solely on empirical investigation and statistics. Biological functions are goal-directed, they have an aim: the goal of the kidneys is to remove some substances from the blood; the goal of the heart is to pump the blood through the vascular system, and so forth. Most parts and systems of the body have many different functions with different goals. All of the goals that Boorse refers to are functional goals; that is, they are the goals of biological processes and are not aimed at in any intentional, purposive way. They are, however, indeed purposeful in the sense of serving survival and reproduction, but they are not the conscious aims of any person.

The fundamental goals of the organism-survival and reproduction-can be achieved if the organism’s biological functions, the functions of its parts are normal with respect to its species. Svenaeus points out that this analysis is essentially based on the same type of reasoning as in physiology where body is looked upon as a complicated machine, the functions of which are analyzable in terms of the functions of its parts. It is precisely for this reason that the bio-statistical theory of health is been called the ‘machine model’ of health which is Cartesian in spirit. If the parts of the organism have the ability to function in a normal way then the organism is healthy. If not, the organism is diseased.
Health is consequently looked upon as the absence of disease, and diseases are defined as internal states reducing the ability of biological functioning below the normal value. For a person to be ill, it is necessary that some part of his organism function in a subnormal way. If the organism is not afflicted with any disease it is healthy, since it will have the ability to perform the biological functions of its parts in a normal way.

Svenaeus points out that the Boorse’s notion of health is a theoretical concept, not a practical one. The question whether a person is diseased or not is a strictly empirical question and not a matter of evaluation. The terms used to specify normal functions are all terms from science—biology, chemistry and statistics—and so even the functions and goals of the whole organism are analyzable in these theoretical terms. The individual’s evaluation—his feelings and thoughts—about his state of health is not relevant in any final sense when we try to determine whether he is healthy or not. The evaluation might often be relevant in an instrumental sense, of course—guiding the physician in his search for a disease—but it is not the final word on the issue of health.

As it is obvious from this account, the inadequacy of the bio-statistical theory consists in looking upon human beings as machines, not as persons. Machines do not have an ‘existential’ environment. Person, from a
phenomenological perspective, is always already ‘in-the-world’. In Merleau-Ponty’s terminology, person is necessarily ‘embodied’; environment constitutes the structure of his lived body. The environment not only influences biological activity and function; it also influences the activities and goals of a person.

Actions are bodily and intentional; that is, they are directed towards goals in another sense than goal-directedness of biological functions; since they are executed by persons. Organisms do not act; rather they undergo processes that are the causal effects of other processes, and they move in response to stimuli. ‘The functioning of the organism is, of course, lived by the person, and it is therefore certainly essential to him; but to describe the life of the person one needs another language than the language of science’.

Phenomenology in general and Merleau-Ponty’s theory of motility, which we have already discussed in the previous chapter, provides us with such a language.

In the phenomenological context, the actions and goals of a person need to be specified in terms of his life-world or environment. Lived body is always already open towards an environment. The embodied person finds himself in constant interaction with the environment. As we have seen in Merleau-Ponty, environment is the necessary pre-requisite for the possibility of actions as well
as the possible obstacle for our plans. It represents the sphere in which our freedom is both realized and limited. It seems clear, however, that the things limiting our freedom are not to be found outside the body, since the design of our bodies prevent us from doing certain things that we might desire to do, such as flying (without the aid of any mechanical devises). Lived body, thus, is of the same stuff as its environs. What modern medicine and its theory of health fail to account for is precisely this aspect of ‘body-world pact’.

4.2. Towards a phenomenological account of health

As we have already seen, the concept of health implied in the bio-statistical theory is negative in nature. Modern medicine defines medicine via disease, or, as the absence of illness. Is it possible for us to have a positive characterization of health? We try to argue that phenomenology suggests a way in this direction.

Let us begin with some of Gadamer’s observations regarding the question of health. In his lectures on *Hegel, Husserl and Heidegger*, Gadamer gives some hints concerning how we could look up on the phenomenon of health. He says:

Health is not a condition that one introspectively feels in oneself. Rather it is a condition of being there (Da-sein), of being-in-the-world, of being together with other people, of being taken in by
an active rewarding engagement with the things that matters in life........It is the rhythm of life, a permanent process in which equilibrium re-establishes itself.\textsuperscript{3}

Gadamer’s point is to look upon health not as an introspective state, rather as a pattern of action of being-in-the-world. What he suggests is truly a phenomenological account of health. The terminology he is using is taken from the phenomenology of Heidegger. The terms that Gadamer uses to characterize health in the above quotation – ‘being there’, ‘being-in-the-world’, ‘being with people’, ‘to be busy with projects in life’ – indicate that health is something we live ‘through’ rather than ‘towards’.

Illness is obviously an obstruction to health and its smooth flow. Everything that goes on smoothly, quite unattended by the individual, when we are healthy now offers resistance, in the state of illness. The body, our thinking, the world, everything gets affected by feelings of pain, weakness and helplessness. For Svenaeus, “this way of being-in-the-world in illness is best understood as a form of homelessness”.\textsuperscript{4}

According to Svenaeus, the \textit{attunement} of our being-in-the-world is the phenomenon to focus upon, when we try to get hold of the difference between healthy and ill ways of being-in-the-world. That is, to be healthy or ill is not
identical with just having a good or a bad feeling. Attunement is not the quality of an isolated human subject. Using Merleau-Ponty’s terminology we may say that attunement is our body’s incarnated situation. It is the way our bodies are constituted. In other words, it is a condition of a ‘being delivered to the world’. Svenaeus’s point is that healthy being-in-the-world is to be understood a form of attunement, which is not a state that one feels in oneself, but which nevertheless has a ‘tune’.

Relying on Gadamer’s account Svenaeus maintains that the phenomenon of illness seems to be easier to get hold of than the phenomenon of health. “When we are healthy everything ‘flows’, the mood we find ourselves in does not make itself heard or seen. It could possibly be felt as a certain form of rhythm in our being-in-the-world connected to time and to the way we are incarnated – of our breathing and to the beating of our hearts”.\(^5\) It should not, however, be confused with other positive moods like well-being or happiness. Such moods are expressed in a manifest way than health. ‘Health is a non-apparent attunement, a rhythmic, balancing mood that supports our understanding in a homelike way without calling for our attention’.\(^6\)

In short, the phenomenon of health and illness are not phenomena analyzable exclusively in terms of science. They are to be understood in
reference with the experiential realm of the human being. Human experience is necessarily embodied. Health and illness are evaluative concepts referring to the experiences, ambitions and abilities of lived body situated in certain contexts- life-worlds. The goal of medicine is to bring the patient back to home-likeness i.e. to health.

4.3. **Lived body, Pain and Disease**

The concept of body implied in modern medicine, as we have already seen, is Cartesian in nature. Body as corporeal substance constitutes the paradigm of the so called bio-statistical theory. When do we experience body to be corporeal? When does body become an object? From a phenomenological perspective, body becomes an object only when there is a break in the ‘attunement’, only when the ‘body-world pact’ gets disturbed. When we are healthy, body is ‘absent’; we do not experience its presence. Undoubtedly, body is the most abiding and inescapable presence in our lives. Yet, as Drew Leder says, “this bodily presence is of highly paradoxical nature”. The paradox is precisely that in our normal day to day living, body’s presence is not felt. Only in a crisis-situation body becomes present in our experience. As a matter of fact, pain and disease refer to these situations where body is felt as ‘corporeal
presence’. Let us try to have a close look on Drew Leder’s phenomenological analysis of the relation between the lived body and pain.

For discussing the problematic ‘presencing’ of the body, Drew Leder gives an example of a tennis player:

He is playing tennis. His attention dwells upon the ball flying toward him, the movements of his opponent, the corner of the court toward which he aims his return. He is already flexing in preparation for this shot and a subsequent charge to net. The closer the ball approaches, the more it acts to focus his attention and posture until at the exactly right movement, without the need of explicit thought or will, his body uncoils to meet it with force.

But as he swings he feels a sudden pain in the chest. His attention now shifts to the expanding focus of pain. The concerns with the game that a movement before were paramount – the perceptions of the ball, the court, the tricky wind, the attempt to intuit and outwit his opponent – all this recedes before the insistent ache. He raises and lowers his arms to see if the pain is muscular in origin, and flexes his torso in an attempt to reduce discomfort. But the pain hangs on, centered in the chest and spreading up the shoulder. He is distressed and a little fearful. He stops the game which, in an experiential sense, is already something far away”.

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As Drew Leder explains, pain is accompanied by an intentional disruption. The lived body of the tennis player was opened upon the world before the pain started. It is a center from which the rays of intentionality radiate outward. To use Leder’s language, “he lives from his body to the world”. This body-world relation in all its dimensions is disrupted by the call of pain. As pain comes the body gets prominence and its transitive use is disrupted. That is, the game comes to a stop. As the world of the game is disrupted, so is the connection with another. As Drew Leder puts it:

A moment before, the two players were bound together. They shared the court, the flight of the ball, the wind, the joy of effort and competition. Their thoughts intertwined around the goal of victory. But pain strikes one alone. Pain is marked by an interiority that another cannot share.

Such is not the case with pleasure. Pleasures as more tied to a common world also tend to maintain our intentional links with other people. We feast and drink with friends, making our enjoyment a common bond. In contrast, pain tends to induce self-reflection and isolation. Leder says that “pain effects a spatio-temporal constriction”.
As being-in-the-world, it is quite natural that we live in a spatio-temporal realm with certain projects and goals. But, as pain or distress begins we are taken into a new world which has an aspect of limitation. The tendency of pain to disrupt our intentionalities never leads to a complete collapse of the world. Through memory and imagination, it is possible for the body in well-being to explore the far reaches of time. But such possibilities are limited when we are in pain. Physical suffering constricts not only the spatial but the temporal sphere.

In Drew Leder’s understanding, a new relation to one’s body is developed as a result of the disruption and constriction of one’s habitual world. In pain, the body or a certain part of the body emerges as an alien presence. The painful body is often experienced as something foreign to the self.

This is often the same case in situation of disease. We will continue with previous example of Drew Leder borrowing his own terms. After his pain fails to subside, the tennis player pays a visit to the hospital, learning to his dismay that he has had a heart attack of moderate severity. For several days he is confined to a hospital bed and his movement is severely restricted. He is permitted to increase his activity upon returning home, but only gradually. A continued sense of restrictions remains with him. Many things he once did he no longer dares
risk. His attention often returns to his chest as he watches for the least sign of pain or irregularity. Even though there is no pain for long time, he always expects a distress. There is always a subliminal awareness of the heart that never fully disappears. He resumes playing tennis but now as much for the sake of rebuilding the heart as for enjoyment.

Finally, when a day comes with a more severe attack, the player’s activity is again restricted because of the weaker heart. He experiences a generalized heaviness and fatigue and cannot walk far because of shortness of breath. His appetite decreases for food and for life in general. The everyday concerns of others recede as he finds himself thinking more frequently about death.

As the above example suggests, disease, like pain also effects a spatio-temporal restriction and intentional links. This may first originate in the immediate call of pain and discomfort. Drew Leder says that “in disease, one is actively ‘dis-abled’. Abilities that were previously in one’s command and rightfully belong to the habitual body have now been lost”.12

As in the case of pain, this intentional disruption and spatio-temporal constriction correlates with an enhanced ‘thematization’ of body. The tennis player in congestive heart failure is aware of the body in everything he cannot
do. ‘It’ is what stops him from all physical activities. “It” then finds its position between the individual and all aspects of a normal life. The body can interfere in this way only because it is the power behind such acts, the locus of our sensor motor abilities. This body is a transparency through which we engage the world when it functions normally.

Drew Leder says that “the body ‘appears’ as thematic focus, but precisely as in a ‘dys-state’- dys-is a Greek prefix signifying ‘bad’ hard or ‘ill’. In the states of pain and disease, the person who suffers becomes more aware of his corporeality. Indeed the sick body partakes in all the modes of un-readiness-to-hand that Heidegger describes in relation to the tool. At times of illness one may experience one’s body as more or less unusable. It no longer can do what once it could. Certain possibilities of sensation and action, certain resources of energy are simply missing.

A sick body may be experienced as that which hinders, as a force that interfere our projects of normal life. These modes of un-readiness-to-hand increase as death approaches. And only when death approaches the body becomes a matter of concern. It is when I take care of my body to be cured or treated. Hence it becomes a subject of worry. In this sense it gets thematised.
The relationship of the individual with fellow beings or pleasurable sensation is undermined and everything at once comes under threat as disease occurs.

We have seen that, ‘dysfunction’ is the occasion in which we thematizes the body. Inversely, dysfunction can also be resulted out of thematizing the body. This can be clear from an example of a pianist, who shifts his attention from the piece he is playing to the observation of what he is doing with his finger while playing it. Then he gets confused and may have to stop. Dysfunction and body awareness produces one another. Body is often forgotten when there is health and life. Generally, everything is disclosed to the body-as-living and the body functions as a platform for this disclosure to happen. Yet, when illness emerges before us, this body is brought into sharp relief. As discussed before, one is seized in an immediate way by physical pain and dys-function.

Body, For Drew Leder, is at once a biological organism, a ground of personal identity and a social construct as well. Disruption and healing take place in all these levels, transmitted from one to another by complex exchange. Drew Leder says that “my awareness of my body is a profoundly social thing, arising out of experiences of the corporeality of other people and of their gaze directed back up on me”. Bodily objectification and alienation have often been understood to result primarily from the look of the ‘Other’. In Sartrean
understanding, the body is objectified within the encounter with the ‘other’.

“The body as being-for-itself is always the passed by in silence, a point of view upon the world that I exist without directly apprehending”.\(^\text{15}\) At this stage even our pains are experienced through the world, our illness suffered rather than known. When we are encountered by the ‘other’ all get transformed. Body becomes an object to study, a tool among other tools or a collection of organs.

Sartre gives an example of a man, who is looking through a keyhole.

Initially the voyeur is simply lost in the world he regards, without reflective self awareness. Suddenly he hears footsteps and apprehends his own position through the Other’s look. His own project is cut short; he now stands pinned to his place, exposed and ashamed. Insofar as the Other is a subjectivity, the voyeur’s own subjectivity is undermined.\(^\text{16}\)

For Drew Leder, the thematization of the body can arise independently of the ‘other’s gaze. There are physical experiences such as pain, exhaustion and illness that bring about the emergence of the body as explicit object. Sartre argues that the “Other’s gaze leads me to experience my own body as object”.\(^\text{17}\) Sartre’s example of a man looking through a keyhole illustrates that disappearance can be initiated by ethical distance or condemnation. Sartre’s voyeur
becomes aware of his own position by virtue of this disrupted co-subjectivity. We easily forget our body when it looks and acts just like everyone else.

According to Husserl, the way in which an individual explicitly attends to or focuses on an object does have a sharp correlation to the way an object is experienced. In Husserl’s terms, the activity of consciousness renders the object ‘thematic’. An object becomes explicit through such attentional focus of consciousness. The attentional focus could vary. For example, one may focus on the color rather than the taste of a glass of wine. The variance of this attentional focus could be based on variety of modes. Or in other words, thematization happens in variety of modes - cognitively, valuationally, emotively and so forth. The meaning of the object-as-experienced changes as the attentional focus varies.

Ultimately, the priority of the individual determines the way he looks at or focuses on an object. The focus of the individual to an object depends on his situation and upon the complex emotional structures of choices, decisions and projects that make up his life. The focus of one’s experience is made through one’s personal interests, motives, wishes, ideological and religious commitments. Experience is rendered thematic based on these biographical factors of an individual. “The world is valid according to the way it is defined
in “specifically personal acts of perception, of remembering, of thinking, of valuing, of making plans. .”.

4.4 Patient and Physician

Such attentional focusing determines the meaning of illness. Different aspects of experience are attended by both the patient and the physician. So, attending differently both of them renders experience thematic in a qualitatively distinct manner. To a physician, illness is a state defined by a collection of symptoms and signs which affects a body. Assessing or focusing on the signs or symptoms he thematizes the illness as being a particular case of diabetes or peptic ulcer or so. But the patient focuses on differently. A patient does not see it in terms of signs and symptoms of a particular disease state. Rather it is experienced as his inability to do his regular activities. He experiences it essentially in terms of its effects upon his everyday life. Thus, whereas the physician sees the patient’s illness as a typical example of disease, the patient attends to 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 insofar as it exemplifies something other than the affair itself.
The individual’s situation in a world familiar to him is a motivational factor in his act of focusing. There are certain ‘habits of mind’ developed as part of practicing a profession. Actually, these habits of mind provide a bundle of meanings by which certain state of affairs is interpreted. And these habits of mind are in many ways peculiar to the profession that utilizes them. They represent a distinct approach to the world and compose the culture of a profession.

An object becoming a theme is determined by the habits of mind. This is best exemplified by the instance of a critic and lay man looking at a painting. The way critic looks at the painting and that of a lay man is different. The art critic will be influenced by certain habits of mind that are a function of his profession. The art critic may see the school to which the painting belongs, explicit use of color pattern, the tools employed for painting etc. To a great extent, these habits of mind determine what he sees and the way in which the sense of the object is made explicit. The lay man might enjoy the beauty of the painting in its quite common sense. His experiencing will, therefore, be quite different from that of the untrained individual. Indeed, both of them may find difficulty in talking each other about the painting since both of them take things differently and employ different parameters to see the painting.
These professional habits of mind are quite scientific in nature. 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 focusing, and a means of constituting reality. However, the scientific interpretation is quite distinct from other interpretations of reality. In particular, it is quite different from the immediate experiencing of that reality in the everyday world.

From a phenomenological perspective, the world of immediate experience has certain precedence over the world of science which derives it constituents out of reflection. At first, we experience the world, and then only through reflection and abstraction we may then thematize our experience in terms of theoretical, scientific constructs. Even then, as Maurice Natanson notes, there is a ‘decisive gap’ between one’s immediate experiencing of the world and the theoretical, scientific account of the causal structure of such experiencing.20

It is in experiencing illness, this ‘decisive gap’ between the world of immediate experience and the world of science manifests itself concretely. A patient experiences illness in its qualitative immediacy. Unlike physician, a patient employs different categories which are related to everyday life and functioning to define illness. On the other hand, a physician uses scientific findings or constructs, arrived at as per existing habits of mind, to categorize
illness. Being scientific, habits of mind understand illness objectively and render it thematic in terms of quantifiable data. Naturally, these clinical data are the sole basis of physician’s understanding of the reality and they exclusively represent the reality of illness.

As Eric Cassell notes, on being presented with a sick person doctors do not attempt to find out what is the matter but, rather, attempt to make a diagnosis. Diagnoses are strictly drawn lines and have clear criteria for inference. A patient has some illness if certain criteria are met by the patient’s history, physical examination, or laboratory or other tests. In the event that such objective criteria are not met, from the physician’s point of view there is no illness. But the patient nevertheless still feels ill.²¹

It is worth noting that when physicians themselves become patients they immediately become aware of the ‘decisive gap’ between the qualitative immediacy of their own experience of illness and any subsequent scientific explanation in terms of disease. Physicians who speak of their experience as patients note this change in experiencing and say they have great difficulty discussing their illness with colleagues. Here, a difference in thematisation is happening. When a physician sees the illness of another person he thematises
it as per certain habits of mind. But when the physician himself becomes ill, he responds to the illness as lived, rather he does not thematizes illness at all.

Schutz has suggested that in structuring experience the individual organizes his world in terms of ‘sub-universes of reality’ or ‘finite provinces of meaning’. According to Schutz, set of experiences which are resulted out of reflection or cognition forms the ‘finite province of meaning’. Schutz represents different worlds existing with that of these finite provinces of meaning. These different worlds are consistent within themselves but distinct from each other. Such worlds include the world of dreams, the world of religious experience, the world of scientific contemplation, and so on. In identifying these finite provinces of meaning, Schutz is concerned to show that it is the meaning of our experiences rather than the ontological structure of the objects that constitutes ‘reality’.

The world of science or science as a separate finite province of meaning is quite distinct from the truly experienced and immediately perceived reality of everyday life. The physician fixes diseases as per the scientific categories whereas the patient uses those categories that are relevant to everyday life and function. The way a patient lives through the diseases are entirely different from any scientific theoretical explanation of disease.
An individual engages world according to the plan and aspiration of the individual, or, in Schutz’s terms, what the individual attends to depends upon the project in which he is engaged and the system of relevance that are a function of his life-plan. But, while engaging in the scientific project, the scientist detaches himself from his life-situation. So the system of relevance of the scientist is different. Things which are important in one’s life may be quite unimportant or irrelevant in his scientific work. By stating the ‘problem at hand’ the scientist defines what is considered relevant and guides the process of inquiry.24

In attending to the experience of illness the physician does so in light of the ‘disinterested attitude’ of the scientist. A scientist or a physician does not have any personal or emotional interest towards illness or theme of inquiry. At this level he focuses upon the disease process itself. Consequently, the clinical data are of highest relevance to him. However, the patient is less concerned with the clinical data. What is most relevant to him is the effect the illness will have upon his life.

To achieve objectivity a scientist abstains from his own biographical situation and existential realm. The existence of a category may be significant in the sense of ‘knowledge’ to a scientist. But to another it may be significant in
sense of a piece of ‘news’. Such is the case in the patient-physician encounter. The clinical data is ‘news’ to the patient and ‘knowledge’ to the physician. And the way each responds to the piece of information is different.

In this regard Cassell notes that the patient is both ‘experiencer’ and ‘assigner of understandings’. The meaning of illness to a particular patient depends upon ‘the collectivity of his meanings’. This collectivity of meaning is necessarily a function of his autobiographical situation. As one’s autobiographical situation changes the experience also changes, rather an experience is differently interpreted based on one’s collectivity of meaning. So an experience of pain might be interpreted by one patient as a possible heart attack and by another as merely indigestion.

We have seen that a particular patient experiences pain as per his life history. In the same way, the significance of the clinical data to the particular patient depends upon his unique biographical situation. A patient may experience clinical diagnosis as terrible and another patient may regard it as merely ‘inconvenient’. Each reacts to the ‘news’ of the diagnosis according to its peculiar relevance to his concrete situation within the world. A patient is both ‘experciencer’ and assigner of meaning whereas a physician is only an assigner of meanings. A physician becomes an assigner of meaning in the sense that he
takes the patient’s subjective report of illness and reinterprets it in terms of his own understanding of disease processes. This assignment of meaning on the part of the physician will be quite different from the patient’s assignment of meaning.

The physician defines the ‘problem at hand’ in light of certain goals of medicine namely diagnosis, treatment and prognosis. These goals appear to be shared with the patient. However, the patient defines the problem at hand in terms of different goals which are quite personal. What the patient seeks is explanation and cure.

These two experiential goals are not the same. The patient’s goals relate to the qualitative immediacy of his illness. They represent an attempt to integrate the experience into his daily life. In seeking explanation, the patient seeks a validation of his experience, a means to reasonably account for his feeling that something is wrong. (“you have a pain because you have gall stones.”) If no explanation is forthcoming (“your tests are negative. I can’t find anything wrong with you”), the patient is at a loss as to how to make sense of his illness. In seeking a cure, the patient expects a perfect restoration of health, a return to the way things were before he became ill. In asking for a prognosis, the patient expects a prediction of what is going to happen to him personally.
According to goals that relate to their separate worlds the ‘problem at hand’ is defined differently by patient and physician. Hence they do not share a system of relevance with respect to these goals. What is relevant to one is irrelevant to the other.

To summarize, both the physician and patient encounter the experience of illness from within the context of different worlds. So, each renders the experience thematic accordingly. Though illness is shared between physician and patient but it is quite a differently they experience the ‘reality’ of illness or they actually represent two quite distinct ‘realities’. In particular, it is noted that the attentional focusing of the physician is largely determined by the ‘habits of mind’ of his profession. The scientific ‘habits of mind’ provides a horizon of meaning and a means of structuring ‘reality’. Within the context of the universe of science, illness is rendered thematic in terms of “objective”, quantifiable data. Disease is thus reified as a distinct entity residing in, but in some way separated from, the one who is ill. The patient, however, encounters illness in its immediacy in the context of the world of everyday life, as opposed to the universe of science. Thus, he renders the experience thematic according to different ‘reality’. Since the patient and physician define the ‘problem at hand’ in light of different goals, they do not share a system of relevance.
4.4. **Illness-as-lived**

Phenomenology can provide important insights into the patient-physician relationship. Phenomenology discloses the manner in which the individual actively constitutes the meaning of his experience. S. Kay Toombs says that “a phenomenological description of illness-as-lived reveals certain characteristics that pertain to the experience of illness itself regardless of its differing manifestations in particular disease states”.

So, phenomenological description of illness provides a wider platform of illness to the physician wherein the physician also experiences his patient’s world of experience. This description enables him to narrow the gap between his own ‘world’ and that of his patient.

The lived experience of illness is a complex phenomenon that exhibits a typical way of being. A phenomenological description of illness-as-lived reveals certain essential features that characterize this way of being and that is relevant to phenomenon of illness. These essential features are what Toombs calls “the eidetic characteristics of illness”.

‘Eidetic’ characteristics are simply the essential characters which remain unchanged even if empirical factors change. They are the essential characteristics to the thing-itself. For example, the eidetic characteristics of
The cube would include rectangularity, limitation to six squares, and corporeality. The eidetic characteristics of illness transcend the peculiarities and particularities of different disease states and constitute the meaning of illness-as-lived. They represent the experience of illness in its qualitative immediacy. The physician is an expert to understand certain unchanging characteristics that define particular disease states. Or, in other words, the physician learns to understand explicitly the eidetic characteristics of illness.

We have mentioned about Maurice Natanson’s notion of ‘decisive gap’ between experiential world and world of science. Indeed, this decisive gap between the patient’s world—the world of immediate experience and the world of science is bridged up as the physician treats illness-as-lived. The eidetic approach makes possible a shared world of meaning between physician and patient. Such an approach requires that the physician temporally set aside his interpretation of illness in terms of theoretical disease constructs. This approach enables him to focus upon and make explicit those characteristic that are fundamental to the experience of illness itself.

As we have seen, illness is primarily experienced as a fundamental loss of wholeness. Fundamentally it is the perception of bodily impairment. Rather than functioning effectively at the bidding of the self, the body in pain or the
body-malfunctioning thwarts plans, impedes choices, renders actions impossible. In short, illness disrupts the fundamental unity between the body and self.

For Toombs “in illness the body 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”.28 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 emphasized.

With the treatment of illness, the perceived loss of bodily integrity remains even if the body is finally restored to health. The patient feels that he has only a limited control over the function of his body in illness. So the patient loses not only bodily integrity but also integrity of self. He perceives himself to be no longer a whole person. It is important for the physician to recognize the primacy of this loss of self. The patient needs support in his effort to establish the integrity of a newly defined self.

In this way great personal anxiety and fear is generated as a result of the loss of certainty that accompanies illness. Although acutely conscious of his
fear, the ill person finds it difficult to communicate his deep fearful expectation to others. Paradoxically, the patient often considers such fear and anxiety to be inappropriate even though it is inevitably the part of his experience. The physician may do his best to minimize the anxiety of the patient and make an effort to discuss the illness or therapeutic intervention. He may explain with diagnostic results that there would be no real cause for concern. The patient however may interpret this simply to mean that the profound anxiety he feels is therefore irrational and in-admissible.

A person who is ill expects complete restoration of health in this modern time in which technological advancement has reached its height. The patient has unrealistic expectation that such a complete restoration of health will be forthcoming through medical intervention. If the physician is unable to fulfill this expectation, the patient is worried by his apparent helplessness and perceives his situation to be totally and permanently out of control.

The technology promises recovery from illness. At the same time, technology intensifies the loss of control experienced in illness. The patient feels himself at the mercy of faceless machine. He hardly understands its function. And yet he must obey whatever that machine dictates or finds out. He perceives himself to be an object of investigation rather than a suffering subject.
The patient is both a subject as well as an object. He is extremely aware of the difference between his experiencing as a subject and his being experienced as an object. Becoming an object, the patient himself feels that he is losing his complete control over what happens to him.

An ill person has to seek the help not only of others for physical assistance but also 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”.

The inequality of relationship emphasizes the loss of control felt by the ill person.

As Pellegrino says, the capacity of the individual to make rational choices regarding one’s personal situation is also affected adversely by illness. Clinical decisions must be ultimately 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. The decision is the decision of the individual alone in the sense that he is the person to take that decision as it is going to affect his life alone. But the individual is no longer able to make rational decision as he feels that he does not possess the knowledge for the same, though it is his responsibility. 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 that have meaning for him personally. 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 but he is no longer able to fulfill those values. The principles which render his life meaningful are referred when the individual encounters and interprets the threat to the self.

The patient always believes that the physician treats him knowing what his personal value system is. So, it is assumed that in addition to clinical data, the patient’s personal value system is also considered by the physician in making the clinical decision. That’s why in most cases patients do not explicitly communicate his values to his physician. The physician, on the other hand, may view it inappropriate or irrelevant. He may judge the clinical data alone to be sufficient to determine what is in the patient’s best interest. Thus the patient loses the freedom to make a rational choice regarding his personal situation.
So, the experience of illness is such that there are certain characteristics that are fundamental to the experience and that pertain regardless of its individual manifestation in terms of a particular disease state. Such characteristic include the perception of loss of wholeness, bodily integrity, loss of certainty, loss of control, loss of freedom etc. These characteristics represent the ‘reality of illness-as-lived’. They reveal what illness means to the patient.

The approach which considers fundamental characteristics of illness provides the physician with a new means to examine the experience of illness and to expand his traditional scientific paradigm of disease. A new paradigm will include not only an understanding of illness in terms of clinically definable disease state, but also an understanding in terms of the existential crisis of the patient. Such a paradigm will enable the physician to bridge the gulf that exists between himself and his patient, between the human experience of illness and the scientific explanation of disease.

In recent years medicine has been criticized for de-emphasizing the patient as person. We have already discussed the philosophical dimensions of this criticism. While advancements in medical technology have resulted in significant gains with regard to the treatment of disease, patients feel
increasingly alienated from their physicians. Much effort has been made to make medicine more humanistic. Such an enterprise can only truly succeed if the anatomical/pathological model of illness is superseded by a paradigm which incorporates an understanding of illness-as-lived. The traditional model focuses on the disease as process. Illness is conceptualized as an objective, abstract entity, in some way separated from the one who is ill. Most simply, it could be said that ‘the patient presents the lived-body for treatment while the doctor treats the Cartesian or object body’.  

In the previous chapter, we have discussed the phenomenological perspective of embodiment which is diametrically opposed to the Cartesian paradigm. Particularly, our attempt was to show how Merleau-Ponty’s notion of lived-body reveals the fundamental aspects of our being-in-the world – the aspects which are being repressed within the Cartesian scheme. Merleau-Ponty’s concepts of motility, operative intentionality, embodied perception, space and time were shown to be providing us with a radically new direction in conceptualizing the way we are in the world.  

In the present chapter we have seen how modern medicine reinforces the Cartesian paradigm, more specifically, its repression of the fundamental aspects of our being-in-the world. As a matter of fact, what is wrong with
Descartes is not exactly his perspective of mind-body dualism, but its implication that duality expresses the basic mode of our living in the world. The crucial thesis that can be derived from Merleau-Ponty’s account is that dualism is more suited to describing pathological situation than normal situation. That is, only in disease-state that body becomes separated from our being and becomes an object.

Modern medicine, as we have seen, takes disease as its starting point. It begins with the presupposition of object-body. At the level of this presupposition, it is grounded on the Cartesian belief that duality is the fundamental expression of our living in the world. What we have attempted in the present chapter is to show that various demerits of modern medicine and practice, such as the absence of an adequate theory of health, difficulties in conceptualizing pain, disease, illness, patient – physician relation and so on, are rooted in this basic philosophical presupposition. In the next chapter, we will mainly try to see some of the crucial, practical implications of this discussion.