PERSONS IN DIS-EASE: UNDERSTANDING MEDICINE THROUGH PHENOMENOLOGY

by

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Dedicated to my wife, Judy Kuan-Yu Liu

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ABSTRACT

Medicine is often referred to as both a science and an art. The scientific rigor of medicine has allowed for the advanced and effective treatment of disease whereas the humanistic art of medicine has allowed for clinicians to uncover how best to care for their patients in a compassionate manner. This dissertation hopes to discover how medicine can coordinate scientific expertise with compassionately focused care. The goal of this dissertation, then, is to uncover how medicine can begin to develop a more personalized medicine in which patient's values and life-plans are coordinated with a scientific understanding of the treatment of disease. First, this dissertation establishes how medicine can be split into two perspectival understandings of disease (a first-personal and second-personal understanding), then it argues how these two understands can be coordinated with one another to develop a more holistic understanding of patient care. Next, this dissertation illustrates how concepts from phenomenology hold relevance within clinical practice in order to show how clinicians can develop a more robust understand of their patients as persons. This understanding is then used to recapture an account of the clinical relevance of empathy so that clinicians are better able to imagine what it might be like to be a patient living through illness.

INTRODUCTION

The foundation of this project is personal, both in subject matter and in motivation. Shortly before the end of my third semester in graduate school, I was diagnosed with stage 2B classic Hodgkin's lymphoma. Luckily, Hodgkin's lymphoma is a highly treatable form of cancer. In fact, Hodgkin's lymphoma often respond so well to chemotherapies that some research on the treatment of Hodgkin's focuses on how to *reduce* the amount of chemo a Hodgkin's patient is given (Engert et al. 2010). It was this diagnosis that initially began my interest in investigating the philosophical roots of medicine. However, as I began to read articles under the umbrella of philosophy of medicine, I quickly realized that I was not interested in how philosophy can be used to describe pathology or disease. While I understood the importance and aptitude of philosophy to help carve out the normal from the pathological, I felt that this level of abstraction did not help me describe the experience of being 23-year-old, being pumped with highly toxic drugs, in order to rid my body of a disease that would have certainly killed me otherwise.

Fortunately, my hopes to discover a sect of academia that was interested in uncovering the lived experience of illness were not in vain. Shortly after receiving word from my oncologist that my tumors had all melted away from the caustic concoction of chemotherapeutics, I came across a few articles on a foreign-to-me branch of the humanities: medical humanities. Further scholarly digging brought me to a small, but lively branch of philosophy: the phenomenology of illness. It was engagement with this field that allowed me to uncover the ways in which philosophy could help me best *make sense of* or *describe* my lived experience with my illness. As I began my precursory writings on the subject, I constantly found myself having to make the decision of who my audience should be. Who is a project on the phenomenology of illness for? Philosophers? Doctors? Nurses? Patients? Caregivers? Medical humanities scholars?

My audience became clarified once I understood that my goal for this project was to provide modern medicine with an account of how certain aspects of philosophy (i.e., phenomenology) can be useful in allowing for a better understanding of a patient's experience. My audience was, as I call them, clinicians. I use the term clinician to refer to anyone who is tasked with providing care (formal or informal) to someone who is living through illness. Throughout the project, I often invoke this term so that I do not abstract away from the clinical care of patients. In doing this, I believe I have avoided unnecessary obfuscations and abstractions. However, all academic fields have their necessary and unavoidable bits of jargon. As a result, this project contains a great deal of explication in trying to show how key phenomenological concepts can be employed in gaining a better understanding a patient's experience. To philosophers who are well versed in phenomenology, this might result in frustration, as the reason for my analysis is not to provide philosophical depth but rather to show how the breadth of phenomenological concepts hold relevance to clinical practice.

As one can gather from all this, I consider this project to be an instance of applied philosophy. Historically, philosophical investigations have been undertaken mainly as a means to come up with solutions, critiques, or analyses of uniquely philosophical problems. A "pure" philosophical investigation will engage with arguments proposed by philosophers regarding a certain philosophical topic (i.e., metaphysics, epistemology, etc.). It was not until relatively recently that philosophers began to apply their philosophical training to problems that persist *external* to philosophy. While there are several conceptions of what it means to do applied philosophy (Lippert-Rasmussen 2017), I consider this project to be an instance of applied philosophy insofar as it maintains its relevance in and provides direction to an area outside of philosophy itself, namely, medicine.

With all this in mind, one still might wonder *why* this project holds any relevance to medicine. What does medicine have to gain by having philosophers investigate the nature of patient experience? What is the *practical* upshot in writing—or more importantly, reading—philosophical investigations on illness? Providing an answer to these questions requires us to consider a long-standing debate within medicine itself: medicine as science versus medicine as art (Francis 2020; Panda 2006). While it seems like common sense to conclude that medicine is *both* a science *and* an art, recent trends in medical education have left some clinicians wondering whether we are cultivating future clinicians that are up to the task of providing the humanistic care that is often necessary in sound and good medicine. Two senior radiologists express their worry with the track that medical schools are headed down concerning incoming students:

> Many of today's premedical students have amazing credentials. Their backgrounds include such challenging disciplines as biophysics, biomedical engineering, neurobiology, biochemistry, and molecular biology. Some have already completed highly sophisticated scientific research projects and could probably compete successfully with practicing physicians in the quest for research funding. Yet they differ from past generations of medical students and from the role models many of us learned to admire during our careers. Many operate from fundamentally different intellectual vantage points, lacking all but a rudimentary familiarity with the history of Western thought and culture in the preceding 4 millennia. Their outlook is a mile deep, but sometimes only an inch wide, a narrowness that does not bode well for the future of a profession facing challenges that require humanistic understanding (Gunderman and Lanzieri 2006).

It seems evident to me, that a key portion of a humanistic understanding comes from being able to give meaningful shape to the experience of illness, to be able to describe *what it is like to feel ill*. Phenomenology, with its focus on describing human experience in general, appears to be an ample candidate as a method for describing a specific facet of human experience: being ill.

As I discovered early on in my cursory research on the medical humanities, I am not the only one who believed that phenomenology may be a fruitful method for describing the experience of illness. S. Kay Toombs foundational work in the phenomenology of illness, *The Meaning of*

Illness, provides a concise and succinct account of how phenomenology can be applied to medicine. Equally foundational to the phenomenology of illness is Drew Leder's *The Absent Body*, Kevin Aho's *Bodily Matters*, and Havi Carel's *The Phenomenology of Illness*. Being the foundational works of the phenomenology of illness, the thoughts and ideas expressed in these works will be constantly referenced. As well, these works likely suffice as an ample reading list for teaching young clinicians about what it means to experience illness. However, as I read through these works, I noticed that an important humanistic concept within the practice of medicine seemed to have been left unclarified: personhood. That is, while it is evident and obvious that a phenomenology of illness will be about a *person's* experience of illness, it was not evident and obvious what it means to have a *personal experience of illness*. As such, this project provides an original and unique contribution to the literature by attempting to give shape and definition to what is meant by a "personal experience of illness".

It should be noted that phenomenology is not the *only* or *exclusive* way to uncover and better understand a patient's experience of illness. Narrative and literary accounts of illness provide a unique access to understanding the complex emotions and thoughts that make up an illness experience. Leo Tolstoy's *The Death of Ivan Ilyich* puts the reader at the window of the sick, dying man's soul and allows them to peer into and ponder what it is like to be terminally ill. Aleksandr Solzhentsyn's *Cancer Ward* leads the reader through the doors of Soviet healthcare and recounts how the brutal and often-ineffective early cancer treatments (i.e., surgeries and heavy-dose radiation) mimicked the brutal and often-ineffective Stalinist-era political persecutions. More recently, Margaret Edson's *Wit* reveals to the reader the absurdities of a modern medicine that attempts to treat patients as both the subjects of scientific discovery and the subjects of their own

personal tragedy. To put all of this more simply, stories are powerful teachers that provide us with a privileged access to a perspective that we might have otherwise never had access to.

The concept of a "narrative medicine" is perhaps as old as illness narratives themselves, but its formalization into a practiced academic discipline can largely be accredited to the work of the physician-scholar Rita Charon. In her work, *Narrative Medicine*, Charon describes how narrative theory can be applied to and practiced within medicine. Each patient's encounter with illness takes the shape of a narrative in which both the patient and their physician attempt to make sense of and develop some level of understanding. Charon argues that various elements of narrative theory can be helpful for clinicians and patients who hope to gain a better understanding of illness experiences. From all that has been said, it is evident that a phenomenology of illness and a narrative understanding of illness overlap in many respects. However, I do not think that these two frameworks for understanding illness experiences are equivalent or the same. The purpose of phenomenology is to provide an account of how someone understands, makes senses of, or uncovers meaning within the world from their unique and personal perspective of the world. The purpose of a narrative theory is to investigate the unfolding or development of a certain event or set of events. Narratives, in this sense, can feature many perspectives whereas in phenomenology the perspective is *necessarily* from a single standpoint within the world. It is in this sense that a phenomenological framework can be said to attend more to personal experience than a narrative framework.

Hence, for the most part, this project will not provide much commentary on narrative medicine. As the reader can now understand, this omission is not due to scholarly ignorance on my part, but rather because I believe solely focusing on phenomenology can develop a more robust understanding of the *personal* experience of illness than focusing on narrative medicine in

conjunction with phenomenology. However, while beyond the scope of this project, it would be greatly beneficial and enlightening to uncover and describe the relationship between illness narratives and phenomenological investigations of illness. It is evident that narrative medicine has much to learn from the phenomenology of illness and that the phenomenology of illness has much to learn from narrative medicine.

In summation, the promissory note that I offer to the reader is this: by the end of this project, you will gain a better understanding of how to engage in a more *personalized medicine*. While I do not offer a rigid framework for practicing personalized medicine—since such rigidity would likely result in a *less personalized* medicine—I acquaint the reader with concepts and terms that can be put to immediate use within medical practice. In addition to this, I provide the reader with an account of empathy from a phenomenological perspective that provides greater clarity into how clinicians can engage in empathic care. Each chapter of this project can be regarded as its own standalone work in that each chapter has its own purpose and argument. Yet, the concepts, ideas, and themes from these chapters can also be culminated together in order to give shape and definition to a personalized medicine. This being the case, I briefly summarize each chapter below, and then provide an account for how each of these chapters help develop an overarching concept of a personalized medicine.

Chapter One Precis:

In this chapter, I introduce the reader to the two key frameworks for understanding medicine. The first framework is the naturalistic framework, in which disease is described as a deviation from normal function. The second framework is the phenomenological framework, in which a person's loss of relative ease results in the experience of dis-ease. The purpose of this chapter is show how medicine contains a first and third-personal perspective. I argue that by

putting these perspectives in cooperation and coordination with each other, clinicians will be better suited to their task of healing persons.

Chapter Two Precis:

Building on the conclusion and arguments established in chapter one, this chapter uses key figures in the phenomenological tradition to develop an account of personhood that is useful for the clinical setting. Rather than attempt to use phenomenology to provide an abstract or generic account of personhood, I provide the reader with a clinical case and then use ideas and concepts from the phenomenological tradition to show how clinicians can use these ideas and concepts to better understand a patient as a person. I conclude this chapter by showing how the work of Charles Taylor ties together various concepts and ideas from phenomenology in order to develop a concept of personhood. Through invoking Taylor's conception of personhood, I invite clinicians to follow Taylor's lead by taking various pieces of phenomenological thought to present a mosaic-like picture of who a patient is as a person. In addition to this, I conclude this chapter by showing clinicians how understanding patients as persons can have a positive impact on patient care.

Chapter Three Precis:

In continuing with the theme of using phenomenology to uncover aspects of a more personalized care, this chapter focuses on a vitally important aspect of personalized and humanistic care—empathy. In this chapter, I survey some of the current literature regarding clinical empathy and uncover a set of problems that have been associated with clinical empathy. From this set of problems, I develop a set of desiderata for an account of clinical empathy. I then show how the account of empathy provided by the phenomenologist Edith Stein can serve as the foundation for an account of clinical empathy that fulfills all of the aforementioned desiderata. I conclude this

chapter by showing how this account of clinical empathy can help aid clinicians in practicing a more personalized medicine.

Towards a Personalized Medicine:

The conclusion of each of these chapters helps establish a framework for what can be referred to as a "personalized medicine". By considering medicine as the pursuit of healing persons, clinicians require a wide range of frameworks for uncovering aspects of a patient's personhood. I offer phenomenology as one such framework and show how phenomenology can be used to cultivate key humanistic skills—such as empathy—within clinical practice. In the conclusion of this project, I illustrate how the culmination of the ideas and concepts provided in the previous chapters can help clinicians envision practicing a personalized medicine in which clinicians make an intentional effort to better understand their patients as persons.

CHAPTER ONE: THE FRAMEWORKS OF MEDICINE

Introduction

This chapter investigates the division of medicine into two conceptual frameworks. These frameworks can be distinguished from one another based on the differing purposes they assign to medicine. For one of these frameworks, the purpose of medicine is to understand how a person's body expresses a physiological dysfunction within the body. For the other framework, the purpose of medicine is to understand how a person experiences a loss of ease (i.e., dis-ease). These differing purposes results in these two frameworks being portrayed to have two separate and distinct projects. That is, if one believes the purpose of medicine is to understand how a person's body expresses a physiological dysfunction, then the project of medicine will be to uncover ways to "correct" or "amend" such physiological dysfunction. Conversely, if one believes the purpose of medicine is to understand how a person experiences illness, then the project of medicine is to support a person through their illness.

These conceptual frameworks can be understood to be closely related to the distinction between medicine as a science and medicine as an art. Those who portray medicine as a science will likely adhere to the standards of an evidence-based medicine; they will practice medicine by "integrating individual clinical expertise with the best available external clinical evidence from systematic research" (Sackett 1997, p. 3). On the other hand, those who portray medicine as an art will consider how best to engage in the art of healing a patient and what it means to practice the art of *listening to patients and their illnesses* (Lown 1999). However, one might wonder whether it might be best to consider medicine *both* as an art *and* as a science (Kirkpatrick 2006; Groninger

2006). After all, it seems evident that treating medicine purely as a science or purely as an art will leave someone in an indefensible position; treating disease without healing a person seems equally as absurd as healing a person without treating their dis-ease. Yet, many clinicians seem at a loss when it comes to establishing a balance between the science of medicine and the art of medicine. It remains relatively unclear what it means to practice a more *balanced* sort of medicine.

Given all of this, the purpose of this chapter is to uncover how seemingly divergent projects within medicine can be reimagined to be in cooperation with one another. The question this chapter seeks to answer is how medicine can be *both* about the correcting and amending of physiological dysfunction *and* about uncovering how a person's experiences and understands their illness. I argue that these two frameworks can be found to *converge* with one another once one establishes that the goal of medicine is to heal persons. As such, the thesis I hope to defend here is that seemingly divergent frameworks within medicine can be found to cooperate with one another if the scope and purpose of medicine is reestablished as the healing of persons.

1.1: Medicalization and the How and Why of Medicine

Before I begin to show how the concept of personhood can help cooperate the projects of two separate frameworks of medicine, I find it important to inform the reader of the historical process that I suspect played a key role in splitting medicine into these two separate frameworks. This historical process, described by sociologists and philosophers of medicine alike, is referred to as "medicalization". My goal in this section is not to determine whether or not medicalization—in itself—is a beneficial or harmful practice. Rather, my goal in this section is to show how medicalization operates as a way to re-enforce the authority and legitimacy of medicine. Ultimately, this section concludes that this re-enforcement of authority and legitimacy has placed

a high demand on medicine to continue to operate as an established, respected, and irrefutable science. Importantly, this section does not conclude with the assumption that medicine is worse off because of the effects of medicalization. Rather, it concludes that medicalization does not address issues that may arise from a lack of humanistic and personalized care.

Luckily for us, the task of providing a historical analysis of medicalization has already been undertaken by the sociologist and philosopher Michel Foucault. Central to Foucault's historical and philosophical analysis is the idea that social institutions—such as medicine—seek to maintain *power*. Now, gaining an understanding of what Foucault ultimately means by power is beyond the scope of this project. For our purposes, the following passage regarding power from Foucault's essay "The Subject and Power" will suffice:

> In itself, the exercise of power is not a violence that sometimes hides, or an implicitly renewed consent. It operates on the field of possibilities in which the behavior of active subjects is able to inscribe itself. It is a set of actions on possible actions; it incites, it induces, it seduces, it makes easier or more difficult; it releases or contrives, makes more probable or less; in the extreme, it constrains or forbids absolutely, but it is always a way of acting upon one or more acting subjects by virtue of their acting or being capable of action. A set of actions upon other actions (Foucault 2002, p. 341).

Power, in the Foucauldian sense of the term, involves those actions that make other actions more or less possible or probable. To provide a simple example, a parent who places the frozen treats on the top shelf of freezer so that the small child cannot reach them is an instance of power; the parent's action removes a possible action (i.e., getting a frozen treat) away from the child. As this simple example shows, power should not be understood to be necessarily bad or coercive. Rather Foucault thinks that power is dangerous insofar as unchecked and unexamined power can result in a society of individuals that will lack power.

This discussion of power is important to medicine because Foucault will ultimately claim that medicine has a particularly special sort of power: the power to save someone from death or

illness. In his *Birth of the Clinic*, Foucault sets out to provide a brief history of institutionalized medicine within France with the ultimate goal of describing how medicine became invested with the power to provide salvation from disease. Foucault starts this brief history in the 18th century, when a nosology (i.e., the classification and taxonomy of diseases) was first beginning. Foucault explains how in the mid-to-late 18th century, medicine was becoming a state interest insofar it was given the task of managing epidemics and other geographic diseases. Early nation-states, such as France, sought to institutionalize (i.e., place power in) medicine in order to reduce outbreaks of communicable disease. At this time, it was becoming accepted for medical authorities to enact quarantines and prevent travel in an attempt to reduce the spread of various infectious disease outbreaks.

According to Foucault, this intertwining of medical interest with state interest was further strengthened by a common interest to reduce quackery; neither medicine nor the state found peddlers of miracle-cures to be furthering the interests of institutional power. So, in an effort to combat quackery, medicine sought to further legitimize itself as an institution. In order to achieve this legitimization, medicine began to establish itself as a *science*—as opposed to a craft—so that an established set of techniques and specialized knowledge could set it apart from the ultimately baseless salesmanship of the quack. This newly established set of techniques and specialized knowledge began what Foucault and other refer to as the "medical gaze" in which clinician is expected to look upon their patient *first and foremost* with the lens of medical knowledge. This gaze unified medicine insofar is it determined medicine to be a probabilistic science that was capable of saving persons from death and disease. Through this legitimization of medicine, it was believed that soon to be gone were the days of "physicians-salesmen" standing on street corners in Paris or Marseilles offering various bloodletting "therapies".

According to Foucault's historical analysis, the gaze first began as an observation of symptoms and then the classification of those symptoms into a diagnostic encyclopedia. Eventually, these symptoms became known as "signs" of a disease. As such, the gaze transfigured the patient from an individual sufferer of an ailment to a specific "case" of a disease. This transfiguration is to be understood as an early example of medical power, as clinicians could now assert what a patient's symptoms *mean*. Complaints about shallow, rapid and painful breathing in conjunction with fever and cough were no longer taken to be just complaints, but as *signs* of a particular disease: pleurisy. The clinician assigns meaning to patient's symptoms and, through this act of assigning meaning, the clinician prevents the patient from asserting a meaning beyond that of the clinician. The patient may say: "it feels like I have an ocean of fire in my chest" to which the clinician responds: "That's just your pleurisy". Through the medical gaze, the clinician is granted the ability to assert the scientific and medical meaning behind a patient's concerns and complaints, in doing so, the patient losses some of their ability to assert meaning to their illness.

According to Foucault, the medical gaze became more robust through scientific investigation and discovery. As human cadaver dissections became a common practice for early anatomists, it was soon discovered that certain lesions were associated with certain diseases. Through anatomy, the body was dissected into a geography of organs and organ systems. Evidence of damage in an organ or amongst an organ system became an indicator of disease. In this way, rather than assigning symptoms to a disease name, symptoms were instead assigned to an objectively observable and verifiable lesion. Medicine had now found even firmer scientific grounds; it could point to actual physical evidence of disease by showing a fatty liver or a scarred and hardened lung. This scientific knowledge resulted in more power for the medical gaze, as clinicians could now verify that particular symptoms mapped onto some abnormality within the

body itself. A case of a disease now meant a case of an anatomical abnormality. The patient's reporting of symptoms became less significant than the process of verifying those symptoms by recognizing the underlying lesion or abnormality that has caused them.

In this way, Foucault describes how these scientific investigations shifted the focus of medicine from the external, subjective reporting of symptoms to the internal, objectively observable marks of a pathology. Once the clinician developed a differential diagnosis by listening to the clinician's complaint, they could see the patient as a subject of medical investigation; abnormalities and lesions where to be discovered so that the clinician could describe the patient as a specific case of a certain pathology. As the science of medicine uncovered the specific physiological causes for diseases, so too did it develop more robust methods for the treatment of these diseases. Not only could the clinician uncover what ailed you, they could also provide the treatment for this ailment. Slowly, but surely, scientific investigation caused the legitimization of medicine. The legitimized clinician was one who *knew* a fair bit of anatomy and physiology. The actualization of this knowledge through medical treatment would separate them from the quack who only *claimed to know* a fair bit of anatomy and physiology.

Foucault thinks that scientific progress legitimizes medicine through a constant refining of the medical gaze. Each scientific advance within medicine refined the clinician's ability to diagnose and treat an instance of disease, thus reducing the clinicians need to depend upon a patient's reporting of symptoms alone in uncovering what *truly* ails them. Ultimately, the medical gaze allows the clinician to see past the patient and look at a disease alone. After all, a lesion amongst the viscera will likely not be discovered by the patient self-reporting it. The patient will not be able to report: "I have scar tissue forming within my kidneys due years of untreated hypertension", rather, they report: "I have a constant pain in my back". The gaze, aided by

technology and a highly technical level of anatomical and physiological understanding, allowed clinicians to see past the individual suffering of the patient and instead discover the anatomical and physiological reason for such suffering. This gaze is an instance of power because it proclaims that the relevant knowledge of medicine is not the patient's experience of suffering, but rather the indications of that suffering exhibited by the patient's body. In this way, the gaze has a silencing effect on patients, once the gaze has discovered the lesion amongst the viscera it no longer requires the patient's words or experience in order to verify a diagnosis or treat it.

Now, one should not get the impression that the power vested in the medical gaze is to be regarded as inherently bad or problematic. Life expectancy and general well-being increased substantially through advances in medicine and the subsequent practice of the medical gaze in treating disease. Allowing clinicians to assert their medical knowledge and expertise upon their patients saved an incalculable number of lives. As one Foucault scholar puts it, the power of medicine's gaze allowed "hospitals [to become] healing machines, to a certain extent, and cease to be only places where one would go to die" (Talcott 2014, p. 298). The medical gaze greatly enhanced a clinician's ability to save their patients from diseases that, prior to the gaze, would have meant an astonishing amount of misery, suffering, and death. This being the case, it is difficult to deny the positive benevolence that results from the medical gaze.

Foucault remarks that these positive effects of the medical gaze resulted in medicine being able to take up an almost religious power. Foucault describes this sort of power as being a "pastoral power" (Foucault 2002, p. 333). The ultimate goal of this pastoral power is salvation; as the goal of the pastor is to save their flock from evil, so it is the goal of the clinician to save their patients from disease. Now, as medicine wielded more pastoral power—as medicine bettered its ability to save people from disease—it began to establish its own legitimacy as an independent social

institution. This independence thereby placed medicine in a position to make demands of a state in order to retain its pastoral power; medicine could demand the state to enforce measures in order to mitigate preventable misery and death. However, social power is not a static entity. Just as easily as it is given, it can just as easily be taken away. In this way, medicine remains on an ever-quest to maintain its social power, medicine seeks to replicate and reconfirm its legitimacy. In this way, medicine was *and is* provided with the task of constantly envision new ways to save the body from the crises of death, pain, and dysfunction.

Foucault's account of the birth of the clinic, and the power expressed through the medical gaze, provides us important historical and conceptual context as to the wedge that split medicine into two separate frameworks. In order for medicine to establish itself as a legitimate social institution, it was required that medicine wield scientific advancements as a way to distinguish itself from quackery. The medical gaze resulted in a hyper-focus on cases of pathology rather than a focus on the patient in which such a pathology resides. By setting aside a patient's subjective complaints, the clinician could focus on what might be regarded as the objective elements of a disease (i.e., the physiological/anatomical abnormality or dysfunction) and determine how best to treat that particular instance of that disease. While Foucault's analysis is historical in nature, it is evident that medicalization persists into the present day. Medicine must continue to legitimize itself in order to maintain the pastoral power that has been bestowed upon it. Medicine must continue to use technological advances to ward off the threat of death for its flock. Hence, as we approach our current historic moment, we can become aware of how medicalization acts to perpetuate one framework and this has resulted in an underdevelopment of the other framework.

Before moving onto a close examination and explication of these two frameworks of medicine, it is worth considering the discourse surrounding medicalization post-Foucault. Perhaps

equally as influential as Foucault on the process of medicalization is the works of the philosopher Ivan Illich. According to Illich, not only were our bodies being increasingly defined by medicine, but also our lives. Illich aptly points out that our lives begin and end within the hands of medicine. The first hands that touch us are those a clinician and, for most of us, our last moments will be biomedically measured on the vital signs monitor at our bedside. The intimate and intense events of crises happen within hospitals, and the alleviation of our worries and stresses occur with the help of medical imaging and bi-annual check-ups. Illich's claims portray medicine as intruding upon our lives in an insidious sort of way; medicine is inserted into our lives such that it is almost impossible to imagine modern life without medicine. According to Illich, this is problematic insofar as medicine makes us less able to cope with and provide meaning to the natural phenomena of pain, illness, and death (Illich 1974, p. 919). For Illich, a medicalized society will regard these natural phenomena as problems to be corrected by medical intervention as opposed to something that one must, ultimately, need to accept and embrace. This is a point that has been echoed by physician-author Atul Gawande in his book *Being Mortal*:

> Being mortal is about the struggle to cope with the constraints of our biology, with the limits set by genes and cells and flesh and bone. Medical science has given us remarkable power to push against these limits, and the potential value of this power was a central reason I became a doctor. But again and again, I have seen the damage we in medicine do when we fail to acknowledge that such power is finite and always will be (Gawande 2014, p. 259).

As with Foucault, Illich's claim is not that we should regard all medical advancement and intervention as inherently problematic. Rather, Illich's claim is that an *over*emphasis or *over*dependence upon medical advancements and interventions can result in great harm for a society. Unfortunately, one need not look far in order to verify Illich's worry. It cannot be denied that a major contributing factor to America's ongoing opioid epidemic is the over-reaching of medicine in attempting to conquer the natural phenomenon of human pain. What Illich's analysis

of medicalization reveals is the necessity of having a framework for medicine that can counteract the possible harms that may result from the medicalization of our lives.

Today, medicalization establishes new frontiers as the institution of medicine expands within a neoliberal economic environment. The absence of market regulation has allowed non-traditional features of medicine to become essential features of medicine's ever-quest for legitimacy by establishing new and inventive ways to save patients from disease. As patients become thought of as "consumers", medicine has done quite well in appeasing consumer demands; medicine has adapted a good business model by using pharmaceutical science as "research and development" in order to drive up its profits. The sociologist Peter Conrad argues that pharmaceutical companies have obtained the ability to market diseases in order to sell treatments for them (Conrad 2005). Conrad argues that patients have been transformed into consumers that demand medical solutions to their common human problems: "individuals' self-medicalization is becoming increasingly common, with patients taking their troubles to physicians and often asking directly for a specific medical solution" (Conrad 2005). In the contemporary iteration of medicine's ever-quest for legitimacy, medicine has shifted its medical gaze from the "traditional" science of physiology and anatomy to the "new" science of pharmacology and its creation of medical products. These products now play the star role in medicine's salvation narrative. Increasingly, through the pressure of aggressive pharmacological marketing, clinicians themselves have been transformed into *prescriber* of a cure rather than an actual administer of a cure.

In summation, this discussion of medicalization is included here to show that the treatment of disease is not as clear-cut as most clinicians see it today. The clinical encounter centers around gathering a patient's history, establishing a differential diagnosis that is narrowed down via tests and imaging, and then performing a therapeutic course of action. However, engaging in this

clinical encounter reestablishes and reproduces social trust and power within institutionalized medicine. The patient whose life is saved by an emergency coronary artery bypass surgery assigns a great deal of trust and gratitude to the institution of medicine and its medical gaze. As such, the medical gaze and the reproducibility of legitimacy is often regarded as the most important feature of medicine due to its ability to both perpetuate its social power and effectively treat disease.

However, as I have tried to enforce throughout this chapter, I do not believe that medicalization need be assigned a negative connotation. Medicalization *does* save people from almost certain deaths. Rather, my argument is that there exists an unnecessary trade-off for the success of the medical gaze and the resulting medicalization. This trade-off consists in medicine becoming an encounter that is a depersonalizing interaction amongst strangers. Clinicians are not trained to listen to suffering and make sense of how this suffering is significantly affecting the sufferer on a personal level. Rather, clinicians are trained to examine suffering and discover the location of the suffering within the body. I believe that philosophical concepts and frameworks can help clinicians enhance their human gaze in order to supplement their medical gaze. In the next section, I will provide two philosophical frameworks useful for understanding disease. One of these frameworks will provide insight into how to define a concept of disease whereas the other provides insight into how to define a concept of dis-ease.

1.2: Philosophical Frameworks for Clinical Medicine

In introducing these two frameworks for clinical medicine, I find it important to also introduce the reader to a way of conceptualizing divisions that does not necessarily depend upon dualistic or binary thinking. As my goal is not to assert that approaching medicine as a humanistic art is *preferrable* or *better than* approaching medicine as an evidence-based science, I find it important to provide a way for thinking about medicine in a non-hierarchical manner. In their work

A Thousand Plateaus the philosophers Gilles Deleuze and Félix Guattari develop a theory for interpreting multiplicity within the world that does not depend upon arborescent thinking. That is,

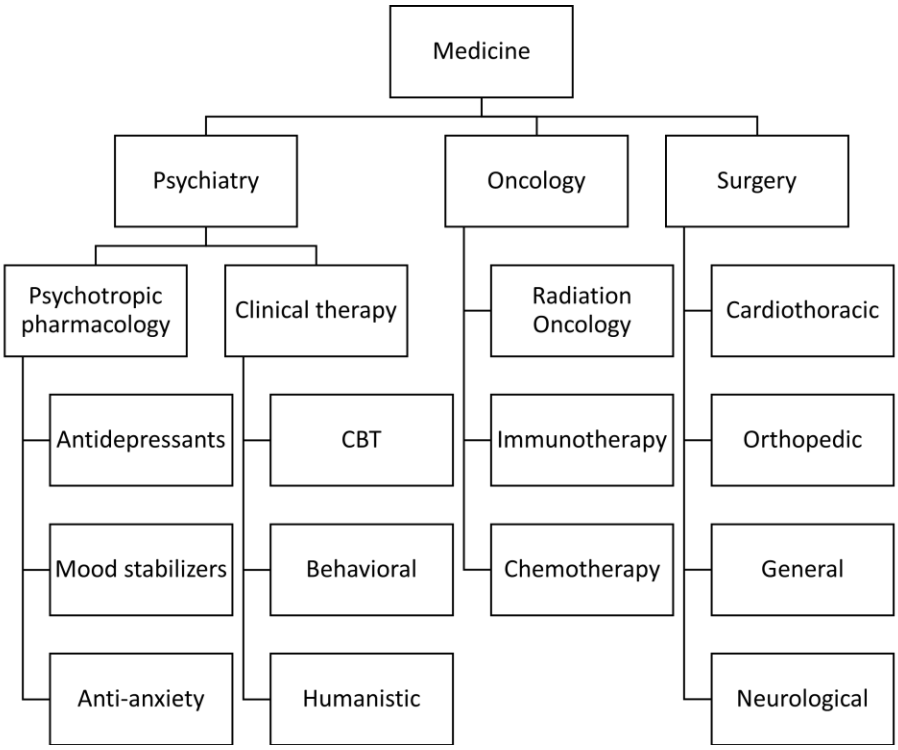


Figure 1: Example of an Arborescent Mapping of Medicine

a common way for dealing with multitudes or pluralities is to divide them into distinct branches that do not feature intersection. Below is an example of how "branches" of medicine could be displayed in an arborescent manner[1]:

In this tree-like figure, each category is subsumed under another category (e.g., chemotherapy is a subcategory of oncology). This sort of thinking about medicine implies, to some extent, a lack of intersection amongst subcategories. For instance, while cardiothoracic surgery and chemotherapy may *overlap*, they are never entirely entangled with one another. That is to say,

[1] This table is not meant to map out the entirety of medicine. Rather, it is merely meant to be an example of what an arborescent mapping would look like in the context of medicine.

I can separate cardiothoracic surgery from chemotherapy and the two subcategories could remain their own meaningful wholes.

Deleuze and Guattari refrain from appealing to arborescent interpretations of the world because they do not emphasize the connections that can be made amongst multitudes of heterogeneous things. For instance, an orchid and a wasp are not one and the same thing; an orchid is a sort of beautiful flower, belonging to the plant genus whereas a wasp is a sort of ant with wings, belonging to the insect genus. Yet, to uncover the world, we need to describe how the orchid mimics the female wasp and how the male wasp carries pollen from one orchid to another in its various attempts at copulation. But the arborescent model will not allow such a line to develop between the orchid and the wasp, because they are in no way alike; they cannot belong to the same subcategory of things.

So, Deleuze and Guattari contend that uncovering connections between heterogenous multiplicities depends on a "rhizomatic" way of thinking. In botany, a rhizome refers to a subterranean root structure that aligns itself horizontally. For Deleuze and Guattari, this horizontal nature supposes a lack of a hierarchy. To appeal to the orchid and wasp example, neither the orchid nor the wasp can be subsumed under or place over one another (conceptually speaking); their heterogeneous nature implies that they subsist only as multitudes that are different from one another. Yet, this difference, of course, does not imply a lack of interaction or connectability. If you cut culinary ginger or turmeric (two common examples of rhizomes), you will discover that they are comprised entirely of long strands of fibers enmeshed with one another. According to Deleuze and Guattari, rhizomes are comprised entirely of entanglement and connections. Each point of a rhizome can connect with another such that there exists a strand that can connect any set of points within a rhizome. However, rhizomes are not static and dead, they are growing forms of

life. New strands and new points are constantly coming into being. These new directions of growth are what Deleuze and Guattari call: “lines of flight”.

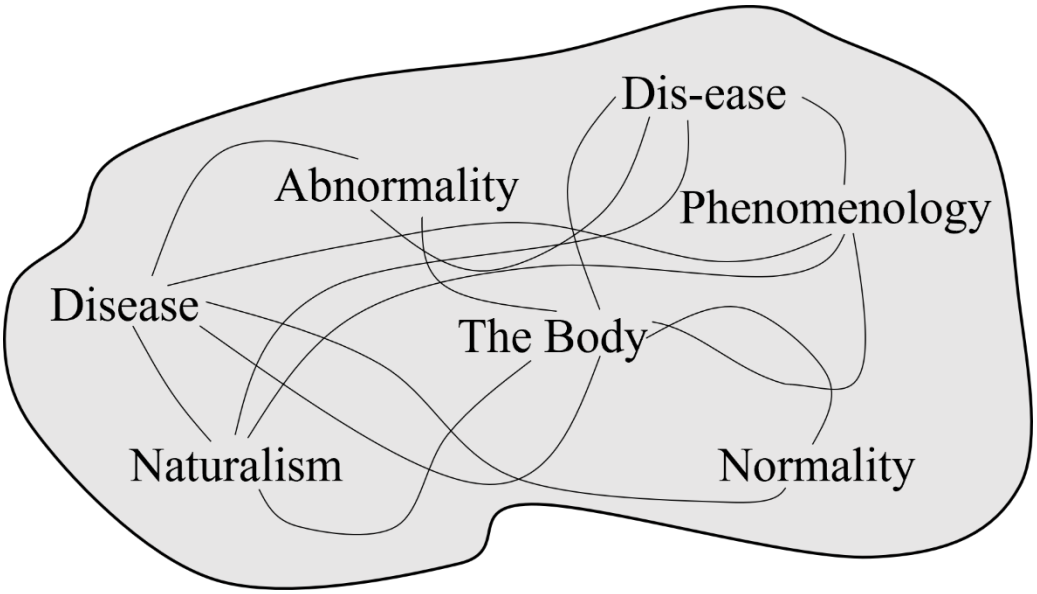
The reason of bring all of this to the reader’s attention is because the rhizomatic model can help us think about medicine in a novel way. For the most part, the process of medicalization described in the previous section has established medicine as consisting of a homogeneous gaze. In this sense, to be a practitioner of medicine is to practice the medical gaze. However, imagining medicine only through the lens of the medical gaze will only grant us access to that which is subsumed under that gaze. Two practicing radiologists, Benjamin Gray and Richard Gunderman, expertly illustrate how the medical gaze operates within the context of present-day clinic:

> The aspect of the patient that matters most is no longer the aspect that talks, thinks, and feels, the one that can be interviewed and examined, but the aspect that can be abstracted from the patient, such as a pathologic specimen or a radiologic image. What meets the eye in direct inspection, the ear in taking a history, and the hand in palpation gives way to a keen interest in the patient’s interior, the parts that cannot be directly interrogated by the senses. (Gray and Gunderman 2016, 775).

In this illustration, the medical gaze subsumes all aspects of the patient underneath it. A radiologist might never have any interaction with their patient, but they are certainly able—and required by their profession—to place them under the category of normal or abnormal.

Now, I do not think it is worthwhile to describe the medical gaze as undesirable. I, along with most people, truly hope that my radiologist looks upon my CT scans with the hopes of accurately categorizing me. I hope to be subjected to the medical gaze! Rather, I am arguing that the medical gaze is only one “line of flight” amongst many. Importantly, Deleuze and Guattari believe that we can develop rhizomatic maps in order to understand many possible lines of flight: “open and connectable in all of its dimensions: it is detachable, reversible, susceptible to constant modification. It can be reworked by an individual, group or social formation” (Deleuze and Guattari 1987, p. 2). As we now know, a rhizome is a living and growing thing; it is a messy mass

of connections that change and interweave within time. The benefit of creating rhizomatic maps, then, is uncovering the various ways seemingly unconnected things can connect with one another. To put this in the jargon of Deleuze and Guattari, when we develop rhizomatic maps, we uncover possible lines of flight and discover the various connecting-points within these lines of flight. In an effort to get the reader to move beyond the medical gaze, I provide the following rhizomatic map that uncovers another line of flight (i.e., phenomenology) within the rhizome of medicine.



This line of flight will be useful for understanding how medicine can also include a notion of abnormality that we can refer to as dis-ease:

First, I want to assure the reader that the messiness is part of the point. After all, the purpose of rhizomatic thinking is to uncover unexpected connections between seemingly incompatible sorts of things. Discovering these unexpected connections will be useful for medicine, as these unexpected connections can help show how the art of medicine can be enmeshed in the science of medicine and vice versa.

Figure 2: Rhizomatic Mapping of Medicine

As I mentioned at the beginning of this chapter, I contend that there are two frameworks for understanding the scope and purpose of medicine.[2] Using the rhizomatic map above, one of these frameworks is captured by the following line of flight:

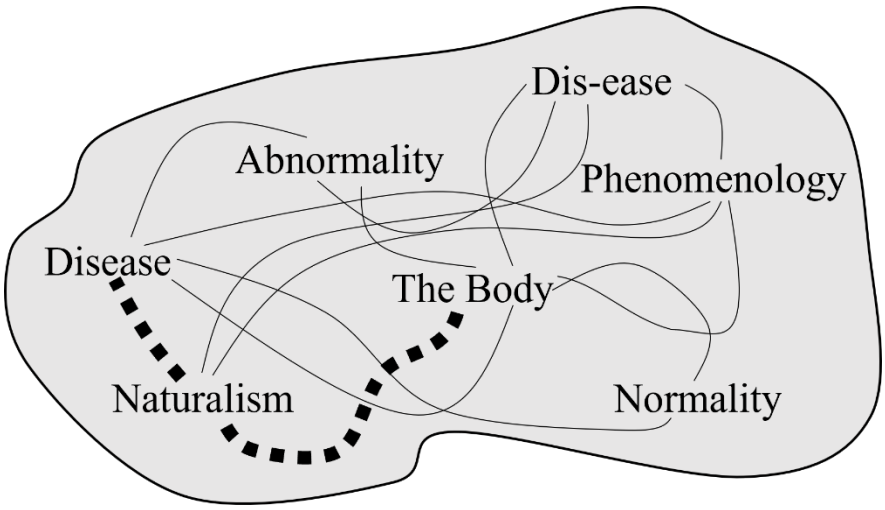


Figure 3: The Naturalism-Disease Line of Flight

Whereas the other framework can be captured by this line of flight:

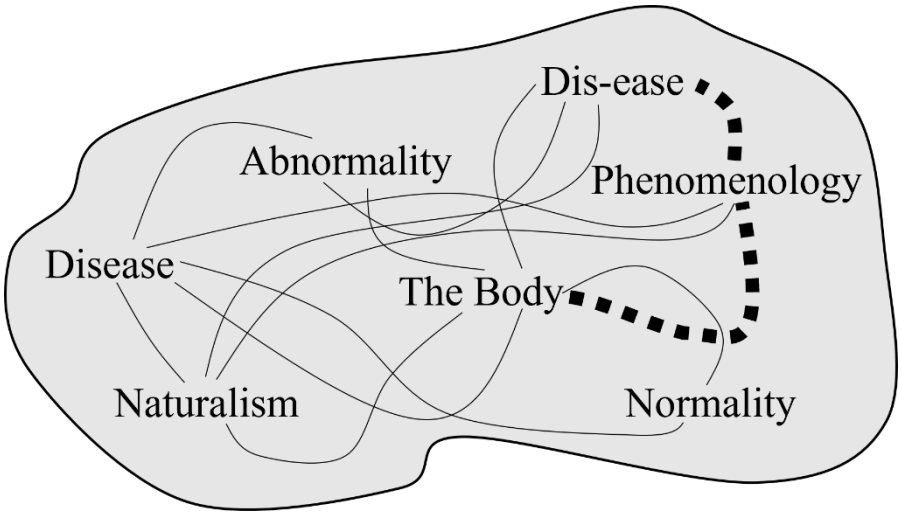


Figure 4: The Phenomenology-Dis-ease Line of Flight

[2] Importantly, I do not argue that these are the *only* frameworks for understanding the scope and purpose of medicine. For instance, narrative medicine, the practice of understanding a patient's journey using the elements of narrative theory, can also be understood as a framework for medicine. The reason I focus on the two frameworks that I do for this project is because they help capture the distinction between disease and dis-ease.

Now, in an effort to avoid the further use of jargon, I will depart from using the term "line of flight" in favor of using the term "framework". In the next section, I will further describe these frameworks and show how they have commonly been described to be antithetical to each other's projects. Understanding this perceived antithesis will then help us uncover another framework—line of flight, to use the jargon one last time—that can show how these two frameworks can cooperate with one another.

1.3: Two Frameworks of Medicine

As one may have noticed, the two frameworks feature the same point of departure: the body. The reason for these separate departures is the result of the perspectival viewpoint one has regarding a body. Put more clearly, there is a difference between having third-personally access to another's body (i.e., seeing, measuring, feeling) and having first-person access to one's own body (i.e., being a body/existing as a body). This difference, which I refer to as the "perspectival gap", sits at the heart of the antithesis between these two frameworks. As we will see, one framework—the framework of naturalism and disease—separates normality from abnormality from a third-personal perspective of the body; abnormality is recognized as a deviation from a perceivable norm. The other framework—the framework of phenomenology and dis-ease—separates normality from abnormality from a first-personal perspective of the body; abnormality is recognized as a loss or lack of how one would normally inhabit their world with their body. In what follows, I provide the reader with further insight into how these two frameworks perceive normality and abnormality differently.

The Framework of Naturalism and Disease

Within the philosophy of medicine, naturalism is associated with the appropriately named naturalistic theory of health. The most prominent proponent of this theory is the philosopher of health Christopher Boorse. Throughout his career Boorse has proposed that health should be understood as the natural state of a body that is free from disease. As Boorse himself put it: "the state of an organism is theoretically healthy, i.e. free of disease, insofar as its mode of functioning conforms to the natural design of that kind of organism" (Boorse 1975). We might wonder what Boorse means by: "conforms to the natural design of that kind of organism" since it seems apparent that understanding Boorsean *naturalism* will depend upon some explanation of what it means for something to have a *natural* design. I imagine what Boorse has in mind here is something along the lines of the 20th century school of thought referred to as "naturalism". Speaking broadly, the 20th century naturalists believed that to have knowledge of something required the application of a scientific method (Kim 2003, p. 88). So, the "natural design" of an organism most likely refers to what a scientific method reveals to us about an organism. To give an example, a scientific method has revealed to us that the heart operates as a pump in order to circulate oxygen enriched blood throughout a body. If a heart were to become less able to perform that task, then it would not conform to its natural design. From this, we can then assume that the natural design of an organism can be expected to be synonymous with the empirical evidence of cellular functions, organ functions, and biological functions. So, according to Boorse, in order to refer to someone as "healthy", we would need to possess no evidence of physiological dysfunction within that person.

In later works, Boorse makes his definition more precise: "a disease is a type of internal state which impairs health, i.e., reduces one or more functional abilities below typical efficiency" (Boorse 1977). Here, typical efficiency would be recognized by various clinical tests that places

one outside of reference class.[3] So, to establish an individual as a case of disease, there only needs to be an empirical and scientific investigation into the physiological functioning of their body and viscera. If an individual is found not to fit within the reference class, then that individual becomes a case of a disease.

Boorsean naturalism has many followers who have produced a robust account of health and disease. What all of these accounts have in common is an adherence to functionalism. Functionalism in relation to health usually centers around what is defined as etiological functionalism (EF). According to EF, to understand the function of something requires that we investigate the historical components of that function. Organs and organ systems are assigned proper functions based on what that particular organ is *for* rather than some other purpose (Griffiths 1993). To give an instance of this distinction; my kidneys are for filtering out wastes from my blood. Although my kidneys could also be used to make money on a dark-web organ market this is not their *proper* function, use, or purpose. According to EF, the *for*-ness or purposiveness of an organ can be discovered by uncovering the historical or evolutionary link in an organ's purpose. The body of a human being has an evolutionary history that provides a causal account that answers the question of why each organ has the proper function that it does. Somewhere in early in our evolutionary history, there existed a point in which those individual organisms that had proto-kidney-like structures fared better than those individuals that lacked such structures. As such, etiological functionalism contends that we can discuss the proper function of organs in terms of evolutionary fitness (Griffiths 1993).

[3] Regarding a reference class, Boorse states that: "the reference class is a natural class of organisms of uniform functional design; specifically, an age group of a sex of a species" (Boorse 1977). In later works, Boorse places an emphasis on biostatistical theory (BST) in order to give a "dynamic account of normal physiology" (Boorse 2014). The model proposes that medical measurements can place one within a reference range that is described either as normal or abnormal. For instance, the heart at rest should expand and contract anywhere from 60-100 times every minute. Once one's heart engage in more or less work than that, it would be considered abnormal as it is outside of the reference class.

EF often gets brought into a discussion of health through the work of the philosopher Jerome Wakefield. According to Wakefield, we can use EF to distinguish between normal inabilities and pathological dysfunctions (Wakefield 1997). Wakefield borrows from the framework established by Boorsean naturalism in order to propose that the body has a natural design. EF can provide an evolutionary account of the proper function of the organs and the human body and so dysfunctions would consist in the inability of the body to adhere to these natural or proper functions. In other words, we should consider something to be pathological if it prevents that natural function of the human body as established by EF. In recent years, it has become evident that some natural disorders have been passed off as pathological dysfunctions. Erectile dysfunction and male pattern baldness would not count as dysfunctions within Wakefield's conception of disease since they do not represent any dysfunction on an account of EF. That is, the inability to sustain a longer lasting erection or grow a full head of hair does not map onto any of the proper functions of the body as established by EF.

Thus far, this discussion of naturalism with respect to medicine should sound familiar to most clinicians. After all, it is expected that clinicians adhere to naturalism in order to reveal treatment options and narrow down a differential diagnosis. Put another way, a clinician is required to do the proper science in order to uncover a possible dysfunction in their patient's physiology. What these investigations uncover for the clinician, however, is a third-person perspective of a disease; by using a scientific method to uncover dysfunction within a patient, a clinician gains a third-person perspective of that dysfunction.

It is perhaps best to explain what I mean by this through examples. Let us consider common procedures within medicine, such as a biopsy or a routine blood draw for lab. These procedures represent a sort of scientific method within medicine insofar as some empirical data (i.e., a sample

taken from a patient) is analyzed in order to measure it against a standard. Suppose a patient relays to their primary care physician that they are having bouts of constipation, lower abdominal pain, and are passing bloody stools. After a colonoscopy and polypectomy, it is revealed that the patient has a colonic adenocarcinoma. The science of medicine has labelled this patient as a case of colorectal cancer. Through this labelling, the dysfunction that this patient experiences is now understood to be the result of an abnormal, cancerous growth within their colon. This leads to a third-person perspective of disease and dysfunction because anyone is now capable of understanding this dysfunction as an "it". Even a patient, who must experience the symptomatic effects of this dysfunction can still understand this dysfunction as an "it" that is revealed to them via the aid of a medical science.

If I may, I would like to relate this back to my own personal experience with Hodgkin's lymphoma. After having abnormal results come back for blood labs, my physician ordered a chest x-ray. I can recall my physician first informing me that I had cancer by revealing the cancer to me on the x-ray. A large, milky white mass could be seen within my chest. The deadly dysfunction presiding in me was revealed to me through the medical science of radiological imaging. In this way, the tumor became an "it" to me just as it became an "it" to my physician or an "it" to anyone who is able to interpret the x-ray.

Medical science reveals physiological and anatomical dysfunction. In doing so, it reveals to the patient that there is an "it" which can be identified as the cause of their suffering. This "it" is a diagnosis which can then be verified by any possible observe that could bear witness to this dysfunction. It is in this way that, the naturalistic account of medicine can be understood to a be a third-person perspective of disease.

Now, related to this third-person perspective of disease is the ability to view a disease in an *objective* manner. Medical science often times demands objectivity on behalf of the clinician who practices it. When the clinician looks upon the biopsied cells, they are aware that something from the physical world is impinging upon them; the cells are presented as an object for their gaze. However, the clinician recognizes that regardless of their gaze, the cells would still be there. More importantly, the clinician realizes that some of same cells are still in the body of the patient (i.e., they are a part of the physical world external to the perspective of the clinician). The clinician must make a judgement regarding the biopsied cells, but his judgement should be one that any other clinician in his position can converge upon. If the clinician declares the cells to be a malignancy, then it should be the case that any other clinician would come to the same conclusion.

To view disease as an "it", this "it" must be something that is objectifiable. That is, a naturalistic, third-person perspective of disease requires that a disease is to be understood an object that can be revealed through a scientific method. If a patient is declared to be a case of a disease, then any capable clinician should be able to verify this diagnosis; any capable clinician should be able to interpret the various tests, radiological reports, and biopsies that leads one to believe a patient is a case of a disease. To put this another way, since an objectifiable disease consists in either physical data (i.e. the presence of some lesion or abnormality) or quantitative data (i.e. falling outside of the statistically normal range on a test); this data will remain the same regardless of the clinician that interprets that data.

The naturalistic, third-person perspective of disease can be best construed as the diagnosis of disease. This framework transforms a patient's suffering into an "it" that can help explain this suffering. This transformation of suffering into an "it" can often provide clarity and assurance to patients. A recent scoping literature review regarding diagnostic labeling (i.e., being diagnosed as

a case of disease) found that 61% of studies "reported a positive psychological impact of being provided with a diagnostic label. For example, many individuals reported that receiving a diagnostic label produced feelings of relief, validation, legitimization, and empowerment" (Sims et al. 2021, p. 4). To speak again from personal experience, being able to view my cancer as something apart from me—as an "it" that was revealed by a medical science—helped demystify the presence of my disease. To know what exactly is wrong with you brings you out of the worrisome mystery that one lives in prior to a diagnosis; I no longer needed to ask myself: *what's wrong with me*, I now *knew* what was wrong with me. Similarly, in her *Illness as Metaphor*, the philosopher and essayist Susan Sontag argues that being able to understand disease in a way that is detached from the metaphors commonly used to describe disease (i.e., war, romantic struggle, punishment) can help patients "de-mythicize" their disease (Sontag 1978, Ch. 9). By portraying a disease as an "it" revealed by medical science, a patient is able to understand their disease through a detached perspective; they are able to view it just as their clinician would, through the lens of naturalism and science.

In summation, the naturalistic framework of medicine provides clinicians and patients with a third-person perspective of disease. This perspective is what we commonly refer to as "objective" insofar as it portrays dysfunction and abnormality as an "it" that can be understood and recognized by anyone that is willing to follow the science. In the next section, we will move on to a framework of medicine that illustrates the first-person perspective of a patient's illness and how patients must live through their illness.

The Framework of Phenomenology and Dis-Ease

Over the course of the last 30 years, there has been increased focus on what is referred to as the "phenomenology of medicine". To goal of a phenomenology is to uncover how persons

make meaning out of their first-personal experience of the world. Phenomenology, as we know it today, was developed by the 20th century philosopher Edmund Husserl who, amongst other things, saw phenomenology as a way to uncover what it meant for someone to experience the world from the standpoint of their own consciousness. To put this another way, Husserl saw phenomenology as a way to uncover how a person *attends* to their world from their own unique point-of-view and how a person carves out meaning in the world through their own point-of-view. Consider two people sitting across from each other both looking at a standard six-sided dice. Both persons are consciously experiencing the same dice, but one of these persons will interpret/experience the dice as reading "six" whereas the other will interpret/experience the dice as reading "one". Our position in the world—the point-of-view from which we attend to the world—has an effect on how we interpret it; it is phenomenology's goal to explain how our standpoint in the world has an effect on how we interpret the world and draw meaning from it.

While the naturalistic framework described in the previous section may have been familiar territory for most clinicians, I do not expect many clinicians to have great familiarity with the concepts of phenomenology. Outside of a philosophical audience, I do not expect the reader to have much acquaintance with phenomenology. So, I am supposing, on the behalf of many within a clinical audience, that the preceding paragraph was the first time the reader may have heard the term "phenomenology". For this reason, I see fit to provide the reader with a brief primer in phenomenology.

To begin this primer, I first want to introduce the reader to two important concepts within phenomenology: intentionality and embodiment. Intentionality, when used in context of phenomenology, refers to the *aboutness* of our thoughts. All of our thoughts have some content to them; all thoughts are about something. Phenomenology, being a study of one's perspective within

the world, seeks to describe how we are provided with the content for our thoughts. If you look up from your reading and face the world surrounding you, you will likely have some thoughts *about* the world. These thoughts, in some way, are unique to yourself. No one else can look up and see the world from the same perspective that you attend to it from—they might be able to have the same visual perspective as you, but not the same *personal* perspective as you. With a focus on intentionality, phenomenology hopes to elucidate how one's unique perspective results in unique understanding of the world.

The perspective from which our intentionality arises—our point-of-view within the world—is not a detached or theoretical sort of viewing of the world, but rather a living and participatory *engagement* with the world. A key aspect of phenomenology is a focus on embodiment. For phenomenologists, embodiment does not consist merely in having a body. Rather, embodiment consists in how we live, dwell, and inhabit the world around us. Consider what goes on when you suddenly meet a good friend in passing: you gesture in greeting—perhaps a smile or a wave, then you start to speak with them—perhaps a simple "hello" or an old joke the two of you share, and then you offer a friendly embrace—a handshake or a hug. The phenomenologist would argue that this ordinary and mundane experience arises from the standpoint of one's body. After all, the movements necessary to greet your friend, the words spoken through the coordination of your mouth and tongue, the conveying of warmth and comfort, and the sudden excitement that exudes from you are all actions and gesture that result from your being embodied within the world. However, the phenomenologist would be quick to assert that being embodied extends beyond the physicality of the body; being embodied is not just about having all the features that make up a body. Husserl—the forefather of modern phenomenology—distinguished between a *korper* and a *lieb*. In English, this distinction can be understood as the distinction between a corpse and a living

body. A corpse has all the anatomical and physiological features of a body but lacks the ability to engage with the world. A living body, then, can be understood to be the coordination and command of all the features of the body so as to engage with the world—to greet friends, go for walks, eat meals, rest, *et cetera*.

Now, phenomenologists diverge into two groups based on, amongst many other things, how to portray the relationship between intentionality and embodiment. Transcendental phenomenologists—such as Husserl—seek to explain how first-personal experience is possible whatsoever. Transcendental phenomenologists seek to uncover the conditions for the possibility of experience or consciousness. On the other hand, existential phenomenologists seek to provide and account of how we exist within the world. For the transcendental phenomenologist, the goal is to explain how our embodiment provides us with the *aboutness* of our thoughts. Our embodiment provides us with a lived perspective of the world, the goal of transcendental phenomenology, then, is to describe this lived perspective of the world. For the existential phenomenologist, the goal is to uncover how our embodiment effects the way we conceive of possibility and action within our world. Our embodiment is the place from which we act/inhabit/participate within our world, it is through our body that we navigate our existence within the world.

Thus ends our brief primer on phenomenology. As was alluded to at the beginning of this section, phenomenology has recently been viewed as a viable way to gain a better understanding of a patient's experience of illness. In his work, *The Absent Body*, the phenomenologist and physician Drew Leder argues that Western philosophy, culture, and medicine has largely neglected the significance of the body (Leder 1990). Leder's point is that while we are engaged in our daily life, our bodies play a sort of disappearing act, fading into the background as we engage with our

world.[4] This disappearing or fading into the background causes us to become alienated with our own existence because we fail to recognize the importance of our bodies within our existence. Leder's purpose here is to drive home the idea that embodiment—in the way that phenomenologist describe it—can help uncover *who* and *what* we are within our world.

Leder aptly points out that when we do become aware of our bodies—when we recognize them—it is because they "dys-appear" (i.e., appear badly) to us (Leder 1990, p. 83-92). This etymological flourish by Leder is meant to exemplify the fact that in Western cultures our bodies become apparent to us only in a negative (i.e., bad) sense. When we skip lunch, our bodies appear to us through hunger pangs. When we stub our toe, our body appears to us through pain. When we become temporarily ill due to a seasonal virus, our body appears to us through fatigue or discomfort. Related to the dys-appearance of the body is the loss of one's sense of ease. If one understands ease to be *the normal way someone participates-in/inhabits the world,* then a loss of this ease amounts to the *inability to participate-in/inhabit the world as one normally would*. To borrow Leder's etymological flourish, a loss of ease can be rendered as dys-ease, or more familiarly, dis-ease.

In pointing out the dys-appearance of the body, Leder's ultimate purpose is to propose a way to establish greater awareness of one's embodiment within the world, such that the body does not dys-appear to us, but also simply appears to us. For the purposes of a phenomenology of medicine, however, Leder's discussion of dys-appearance of the body is significant because captures the loss-of-ease, (i.e., dis-ease) that one experiences within illness. Building off of Leder, and establishing her own unique analysis, the phenomenologist S. Kay Toombs provides an

[4] Leder refers to this as: "the body's own tendency towards self-concealment" (Leder 1990, p. 69ff): Most of our physiological processes occur in a space that is hidden from our consciousness. For instance, we are able to become aware of our own breathing, but the natural tendency of our body is to make our own breathing something that we are unaware of.

account of illness from a phenomenological perspective. Toombs' concern is with the gap that persists between a physician's understanding of the body and a patient's understanding of the body. According to Toombs, patients experience their illness as a "loss of the familiar world" (Toombs 1993, p. 96). She carries on, saying of dis-ease: "in this altered state the sick person is unable routinely to carry on normal activities, to participate in the everyday world of work and play" (*ibid*). To experience dis-ease, according to Toombs, is to be unable to carry on within the world as one normally would due to a pathological disruption. The experience of dis-ease, from a patient's perspective is the experience of disruption in one's normal way of life: "the body-in-pain or the body-malfunctioning thwarts plans, impedes choices, renders actions impossible" (Toombs 1993, p. 90). Toombs argues that the gap that persists between a physician and their patient is experiential in nature. The physician uses a medical science to experience a patient's body (i.e., through imaging, testing, and physical examination) whereas the patient experiences their body immediately through their living acts (i.e., they participant-in/inhabit the world). Toombs argues that these different experiential standpoints result in a gap of meaning. For the physician, pathology means an expression of dysfunction or abnormality uncovered by medical science. For the patient, pathology means a disruption of their life-plans and their familiarity with the world.

Toombs argues that differences in meaning thereby result in different interpretation of what it means to heal (Toombs 1993, p. 110-118). For a physician, healing might mean the correction of some abnormality or the curing of some pathology. For the patient, on the other hand, healing might mean being able to recover some sense of familiarity or lived normality within their life. Toombs' account of a patient's meaning of dis-ease as disruption is echoed and expanded upon by Havi Carel in her *Phenomenology of Illness*. Carel, amongst other things, argues that illness represents that illness represents a sort of "uncanniness" (Carel 2016, p. 213ff). What Carel means

by this is that illness disrupts the taken-for-granted normality of our everyday existence. She refers to this disruption as an *epoché*, a term that generally means the cessation of one's belief or assumption. In health, we go about the world as we normally would, inhabiting the world and making sense and meaning out of it from the point-of-view of our healthy, normal bodies. In illness, the sense and meaning that we uncovered in the world is suddenly pulled out from under us. As Carel writes: "illness is a form of violent suspension of the natural attitude…" (Carel 2016, p. 216). This "natural attitude" that Carel is referring to here can be understood as the common, everyday way we experience the world: the taken-for-grantedness of our experiencing and interacting with the world.[5] Carel argues that illness makes the world uncanny—something foreign or alien to us—because our natural attitude is now suspended.

The framework of the phenomenology and dis-ease contends that normality and abnormality are inherently first-personal in nature and, as a result of this, illness is inherently first-personal in nature. Abnormality and normality within this framework are understood to be notions related to one's lived experience. We know what it is like to experience dis-ease because we are unable to go about life as we would when we inhabited the world with a sense of ease. Consider becoming acutely ill with a stomach flu: your body suddenly dys-appears to you, and you are forced to condense your life to closing the distance between you and the bathroom. This experience of dis-ease represents a disruption of your lived normality, it is not likely that the normal way you participate in your life is by lying on the cold, tiled floor of the bathroom eating ice chips. Rather,

[5] Carel is borrowing this term from Husserl who uses the term "natural attitude" to refer to the way in which we are commonly conscious of the surrounding natural and social world (Husserl 1982a, p. 51ff). If you look up from your reading and examine the world around you, it is likely you will be doing so from a natural attitude. That is, you will act, judge, sense, and feel from a perspective that believes "in the existence of a mind-, experience-, and theory-independent reality" (Zahavi 2003, p. 44). Husserl's phenomenological project begins by bracketing our natural attitude, we set it aside and in doing so we are able to study and investigate the structure of first-person experience (i.e., consciousness).

this dis-ease represents a deviation from a normal experience of living, a deviation from the everyday way in which you usually experienced and engage with the world.

This framework, then, can be said to provide a patient's first-person perspective of pathology. Insofar as medicine can be simplified into the relationship between clinicians and patients, the framework of dis-ease can be said to provide insight into the lived experience of a patient coping with abnormality. At the end of the previous section, I discussed how naturalism allowed for the transformation of disease into an "it": an object for a patient to view and decipher. The framework of phenomenology can be understood as the patient's attempt to make meaning and sense out of the "it", to deal and cope with "it" as best they can. The patient will makes sense and meaning out of "it" through a first-personal perspective, they will place "it" within the context of their own life and their own plans; they are uniquely conscious of "it" in the way that the clinician is not. All of this is just to say that the framework of dis-ease is focused on portraying *what it is like* to live through the disruption that is illness.

This focus upon the first-personal perspective of the disruption of dis-ease calls into question the notion of what it means for something to be considered pathological or abnormal. Emily Ladau, a disability rights activist, relays the importance of recognizing disability as an authentic part of one's lived experience:

> Without my lived experiences as a disabled person, I would be a completely different Emily. And as tough as certain aspects of my life have been, and though I know I will continue to face disability-related challenges throughout my life, I wouldn't trade my life for a minute. My disability has given me a place in a community and a culture; it has been the reason why I've had amazing adventures and unforgettable experiences. To walk freely up and down stairs for one day would *never* measure up to the things I've done *because* I have a disability ("The Complexities of 'Curing' Disabilities" 2013, emphasis in original).

For Ladau, living within the world in the usual and normal way amounts to living with Larsen syndrome, a physical disability. Given this, it will not be the case that being able to suddenly "cure"

Ladau of Larsen syndrome will result in a state of ease. In fact, given what Ladau has said, we should expect the opposite: "curing" Ladau of Larsen syndrome will likely result in a state of dis-ease for her. What it means to experience ease, to have a first-person perspective of normality, therefore varies based on the context of one's life.

To summarize, the framework of phenomenology and dis-ease understand normality and abnormality to be a matter of lived, first-personal experience. Each person has established for themselves a state of ease—a way of inhabiting the world as they normally would. A state of dis-ease is understood to be a departure from this state of normality. Generally, this departure occurs when our bodies dys-appear to us and force us to interact and experience the world in a way that is foreign to us, in a way that is abnormal to us. What this abnormality amounts to is a transformation or dissolution of sense and meaning, we are *forced* to reimagine what it means to interact with our world.

1.4: Bridging the Perspectival Gap

Earlier, I mentioned that what separates these two frameworks of medicine is a perspectival gap: one framework approaches medicine from a third-personal perspective whereas the other approaches medicine from a first-personal perspective. This perspectival gap has established different projects for each framework: the framework of naturalism and disease aims to conduct medical science in order to treat or cure abnormalities and pathologies using the leading edge of technological and pharmacological advance. The framework of phenomenology and dis-ease aims to give a qualitative rich and robust account of what it is like to experience illness. Now, there is no reason to assume that these projects run parallel or contrary to one another, there is no reason to assume that these projects cannot coordinate with one another. Rather, the tension between these

two frameworks is that they will diverge from one another unless an attempt is made to coordinate them.

I argue that this coordination can occur through the concept of personhood. That is, I argue that by recognizing the goal of medicine as *the healing of persons*, we can see how both frameworks *converge* on this goal. In establishing this argument, I would like to present the reader with a medical case and subsequent analysis that I think can elucidate how this convergence occurs.

Case: Sickle Cell Pain

M. is a 24-year-old African-American female who is admitted to the hospital emergency department (ED) while suffering from a sickle-cell crisis. In the past 6 years, M. has been admitted to the ED a total of 18 times for sickle-cell crises. Prior to her 18th birthday, M. was treated with the standard of care for sickle cell disease, which consisted of hydroxyurea as well as supplemental blood transfusion for anemia and other hematological deficiencies. After entering college, M. began taking her medication only episodically. After her 4th admission to the ED, M. began to take her hydroxyurea on a regular basis, but the pain became a chronic issue. After her 7th admission to the ED, M. met with a pain management specialist who prescribed tramadol which she could use to manage moderate pain without having to be admitted to the hospital. Unfortunately, the crises and ED visits continued. During this admission to the ED, M. expresses the concern that she will become dependent on the medical system for the rest of her life. She states that "it feels like pain is taking over my life".

Sickle cell crises (SCC) are often described by sufferers as the most intense pain they will ever experience. The pain is the result of blood clots caused from sickle-shaped red blood cells that clot and prevent blood flow within the various blood vessels all throughout the body. As a result, the pain featured in a sickle cell crisis is often an excruciating full body debilitation. Such

a vast amount of pain is difficult to treat in effective manner. From a pharmacological perspective, clinicians have a wide array of options to treat pain. However, the general expectation is that non-opioid painkillers are to be tried before the patient is provided with opioids that have an addiction potential (Lakkakula et al. 2018). This can result in a lengthy trail-and-error process in which different pain medications are tried prior to the implementation of opioid therapeutics. Further complicating pain management in SCC is the fact that a vast majority of persons with SCD are black. Research has shown that black patients are less likely to receive effective pain management than their white counterparts (Meghani, Byun, and Gallagher 2012a), (Sabin and Greenwald 2012). As well, research has also shown that many clinician may still harbor the racist belief that biological differences separate white patients from black patients in terms of pain tolerance (Hoffman et al. 2016a). As such, it is not surprising that some black patients experiencing SCC report inadequate pain management when they arrive at the ED (Begley 2017).

I believe that it can also be shown that once the two frameworks are coordinated and work in tandem with one another, clinicians are able to gain a better sense of what it means to heal *M.* as a person. However, when these frameworks act alone or diverge from one another, I do not think it can be the case that a clinician can gain an appreciating of what it means to heal *M.* as a person. Let us consider the framework of naturalism and disease in the context of *M.*'s case. If a clinician approaches *M.*'s condition from a third-personal perspective, they will be able to establish what is going on within *M.*'s physiology to cause her pain. After all, at base, physical pain is the result of a physiological process: nociceptors (i.e. pain receptors) are sensory neurons that respond to damaging or potentially damaging stimuli by sending an electrical impulse to our spinal cord or brainstem (Purves et al. 2001). Within a sickle cell crisis, a disruption of blood flow results in cells being deprived of oxygen and from this physiological disruption arises pain. As was stated above,

the general way to combat this pain from a naturalistic point-of-view is to use pharmacological solutions in order to block pain receptors. To put this in the terms from previous sections: from a third-person perspective, the pain is rendered as an "it" that can be silence using medication. Unfortunately, however, empirical studies show that clinicians often fail to adequately address physical pain (Deandrea et al. 2008), (van den Beuken-van Everdingen et al. 2007), (Russell et al. 2010), (Giordano and Schatman 2008). It appears that clinicians struggle to adequately recognize the depth and seriousness of their patient's pain. In addition to the problem of the under-treatment of pain, the overprescribing of opioids for pain has led to widespread opioid abuse and dependence (Compton, Boyle, and Wargo 2015), (Makary, Overton, and Wang 2017). Complicating matters further, and regarding SSC in particular, the worry amongst clinicians that they might be overprescribing opioids to their SSC patients has resulted in what patients feel to be the undertreatment of their pain (Sinha et al. 2019).

Understanding physical pain is central to medical treatment, our bodies dys-appear to us through pain, and we often know that something is wrong with us because we are in pain. Reducing pain to an "it" and then providing powerful medications to combat this "it" has largely failed to adequately address pain; either clinicians undertreat or overtreat pain. The problem with managing pain is not that pharmacological solutions do not work to alleviate pain—it is necessarily the case the opioids will bind to receptors in the brain and prevent pain signals. This fact ensure that pain medications will alleviate pain. Rather, the problem with pain management is the fact that pain is not just a physiological phenomenon, but also a subjective phenomenon that can only truly be felt by the person in pain. Without insight into a patient's subjective experience of pain, clinicians are left without of measure of what it means to overtreat or undertreat pain.

Yet, understanding pain from a phenomenological framework comes with its own set of problems and shortcomings. As was just stated prior, the experience of pain makes our body dys-appear to us. But this dys-appearance does not make evident what is causing normality and ease to escape us. Consider the person who accidently steps on a nail or a tack. They feel a sharp pain in their foot; it suddenly dys-appears to them. They look down and see what has caused this sudden dys-appearance and they find the culprit: the nail or tack. In this event, there is an almost immediate recognition of what has caused their body to dys-appear. This immediate recognition reveals the *meaning* of the pain; their foot is in pain because they have stepped on a sharp object. To state this another way, the person in pain can *interpret* their pain by understanding what has brought it about—they are able to realize that the reason why they suddenly felt pain in their foot.

Now, contrast this with a person who experiences sudden and intense chest pains. From their own first-personal experience of their pain, they are not able to immediately interpret the meaning of the pain. That is, this person will not be able to differentiate if this pain is indicative of a serious ailment—such as a heart attack—or a minor ailment—such as indigestion. They are unable to interpret whether their pain is life-threatening, or if it is something that does not require immediate attention. This is to say that while a phenomenology of pain can provide a description of a first personal account of pain, this description does not always provide a full interpretation of what this pain means.

Placing this into the context of *M*., it is likely that when *M*. experiences a SCC, she is able to recognize it as a SCC. Since *M*. has had an SCC before, she is able to recognize the pathology that is causing her pain. However, what is not available to *M*. through her first-personal experience of pain is an understanding of what is to be done to help alleviate this pain. *M*.'s experience of pain does not make it immediately clear what the various possibilities are for *M*. to address her

pain. Hence, *M*. requires her pain to be interpreted by another in order for the various possible treatments to be revealed to her. While the framework of phenomenology reveals how *M*.'s dis-ease causes her to deviate from her normal inhabitation of the world, this framework alone does not provide a full account of what can be done to help *M*. establish a renewed sense of normality.

As we can see, then, both frameworks have their shortcomings when considered in isolation from one another. By not considering the first-personal aspects of a pathology, the naturalistic framework can be seen to fail to account for the elements of disease that can only be revealed through subjective experience—such as pain. On the other hand, by not considering the third-personal aspects of a pathology, the phenomenological framework misses out on establishing a fuller interpretation of the meaning behind one's dis-ease. I believe these shortcomings can be overcome once these frameworks are coordinated together.

This coordination occurs via a clinician consider the concept of personhood. A clinician that is tasked with treating *M.* and her pain must place some thought in what it means to heal *M.* as a person. Certainly, this contains a physiological component; pain must be addressed using whatever pharmacological means are available. As well, physiological dysfunction expressed through blood tests must be amended through various treatments. However, healing requires more than simply correcting or addressing the most immediate physiological concerns. Rather, healing requires that a clinician examines how their patients navigate their dis-ease through a first-personal perspective. In other words, healing requires a clinical framework that supplements the naturalistic paradigm within medicine. To heal *M.* requires investigation into her personhood, and this personhood cannot be found merely amongst her physiology.

Pain is a personal phenomenon. What this means is that in order to understand and appreciate pain, we must understand and appreciate the person in which such pain is located. In

order to treat *M.*'s pain, we must begin to understand *M.* as a person. According the philosopher Charles Taylor, "a person is a being who has a sense of self, a notion of the future and the past, can hold values, make choices; in short, can adopt life-plans" (Taylor 1985a). We can see that *M.*'s pain has a clear effect on her life-plans; she expresses the worry that she will need to depend on hospitals and medications for the rest of her life. Given that a person's mood has an effect on their tolerance of pain (Tang et al. 2008), it may be clinically relevant to consider how best to address *M.*'s personal feelings of hopelessness. Such considerations, however, require more than just a physiological treatment of disease. Rather, they require that we investigate *M.*'s dis-ease.

Most clinicians have a folk understanding of personhood. That is, most clinicians understand the concept of personhood when it is brought up within certain medical contexts. For instance, if a clinician hears "this *person* will die without an emergency bypass", they will be able to understand the gravity and importance behind performing the emergency bypass. Yet, most clinicians will likely have trouble describe their patients as persons; most clinicians will not be able to report on their patient's life-plans, their values, or their patient's sense of self. This illuminates the fact medicine may lack a cogent way to understand a patient's *personal* experience of dis-ease. One cause of this might be what the philosopher Ian Hacking refers to as neo-Cartesianism. Hacking describes an on-going revolution within medicine and culture that once again accepts the Cartesian notion that our bodies can be conceptually reduced to machinery (Hacking 2007). According to Descartes, our physical bodies can be reduced to an assemblage of parts with each of these parts serving a particular purpose in maintaining a state of health.[6] As such,

[6] Descartes moves beyond the descriptive elements of anatomy (i.e. the heart has four chambers) and into the normative elements that can be established via relations between parts (i.e. the normal functioning heart will circulate blood throughout the parts of the body). We can catch a glimpse of Descartes in his full physiological mode in a somewhat forgotten work: *Descriptions of the Human Body and All of Its Functions*. In the *Descriptions*, Descartes uses his substance dualism to distinguish between the functions of the body and the functions of the soul (CSM 1.314-5). Descartes' dualism allows him to move past the assumption that a bodily function is in some way linked with the soul (i.e. our thoughts). This is a significant intellectual turn in physiology considering that the

Descartes can be seen as offering up a proto-naturalistic account of health and disease in which the health of the whole body consists merely in the proper functioning of all its parts. However, Descartes took his account of health further by arguing that the bodies of humans and animals were automata (i.e. machines). Hacking argues that the rapid development of biomedical engineering and the normalization of organ transplantation is reflective of the belief that we consider our physical bodies merely as machinery. In other words, medicine now considers our bodies to be made up of parts that can be replaced or engineered in the same way that parts of a car or a bicycle can be replaced or engineered.

This way of thinking influences how we think about personhood. Hacking points out that this engineering and replacing may affect more than just our physiological well-being; according to Hacking, having our body altered in some way will greatly affect the way we come to engage with "a world full of peoples, things, and events" (Hacking 2007). Having a different or altered embodiment means inhabiting the world in a different way. If a clinician merely considers surgical transplantation as a physiological cure to some ailment, they fail to recognize the first-personal experience of the patient that undergoes such an ordeal. It is not uncommon for a transplant patients to feel a sense of guilt (Griva et al. 2002), or to feel a sense of disrupted personal identity (Sharp 1995).

Hacking's critique allows us to recognize the conceptual framework undergirding the naturalistic view on disease. This conceptual framework involves separating the body into sets of organ groups specified by their proper functions. The cardiovascular system includes all the organs

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vestiges of transcendental anatomy still played a role in the major physiological works of Descartes' day. Descartes' substance dualism allows him to treat body *qua* body and soul *qua* soul. In his mereological physiology, the body is broken down into parts with each part playing an important role in causing the well-functioning of another part. This can be seen mostly clearly in Descartes' analysis of the heart. According to Descartes, the heart changes the nature of the blood that enters it and therefore makes the blood better suited to nourish the body and all its parts (CSM 1.318).

and bodily material that is responsible for the circulation of blood cells. The respiratory system includes all the organs and bodily material that is responsible for oxygenation of blood cells and the expulsion of carbon dioxide. All of these groups consist of parts—the organs, tissues, and cells that make them up. If one of these parts goes awry, we can either remove it, replace it, fix it, or destroy it. The problem with this conceptual framework is that it does not provide insight into how to understand a patient's personal experience. Where amongst the constellation of organs, tissues, and bodily cells does the clinician locate the person? At what point does a collection of organs, tissues, and bodily cells constitute a person? These are particularly important questions for clinicians because medicine is defined by its healing capabilities. That is, medicine is defined by its ability to heal *persons*, not by its ability to *alter* or *enhance* the bodily parts of a person.

Healing *M*., then, requires that a clinician attend to both her underlying physiological disruption—her disease—as well as her phenomenological disruption—her dis-ease. A clinician that coordinates both of the frameworks of medicine will be able to uncover how best to heal *M*. as a person. In the next chapter, I will provide the reader with deeper insight into how phenomenology can provide us with a more robust understanding of personhood. While I expect that most clinicians have an established grasp on physiology, it is not likely that clinicians share the same grasp on phenomenology. Hence, the goal of the next chapter is to establish the relevance of phenomenology within clinical practice so that clinicians can better understand how to coordinate a first-personal and third-personal perspective of illness.

CHAPTER TWO: PHENOMENOLOGY AND EMBODIED PERSONS

Introduction:

The concept of personhood is uniquely important to the practice of medicine. The person—a patient—serves as a lodestar for medical practice in that the clinician's task is to attend to and heal a *person*. When the 47-year-old woman experiencing profound pain from a migraine-like headaches presents to the emergency department, it is not necessarily the case that she is looking for someone to "cure" her condition. It might not be that she is looking for some magic bullet that might instantaneously relieve the vice-grip that is causing her head to throb with a pounding, unrelenting pain. Rather, it might be the case that she is experiencing sudden distress—an experience of debilitating dis-ease—and knows no other place to turn to other than the ED. What does it mean to help this *person*? Tests can be ordered: The CT and MRI scans come back with no abnormalities, blood tests reveal nothing aside from dehydration—she appears relatively healthy aside from the obvious pain she is experiencing. The best that can be done is to administer I.V. fluids and the standard-of-care cocktail of various NSAIDs (Gupta, Oosthuizen, and Pulfrey 2014). A treatment plan is then created; monitor her for a few hours and then discharge her when the headache passes with instructions to follow up with her primary care physician regarding a referral to a neurologist.

In the above case, the framework of naturalism and disease could not provide a complete understanding of what it meant to attend to the patient. Medical imagining and testing could not offer a greater understanding of the patient's physiological distress—no physiological dysfunction was discovered.[7] Pharmacological treatments helped alleviate some of the patient's pain but did

[7] This does not mean that there is not a physiological cause for migraines. Medical researchers know that a migraine is the result of dysfunction in how different areas of the brain interact with one another (Flatow, 2020). However,

not entirely resolve the issue at hand; the patient was still in a state of dis-ease insofar as they faced ample disruption for their headache. In this case, understanding the patient as a *person in distress* was key to developing a plan in alleviating this distress. Only time and attentive care could support the patient through her distress. The patient's self-report: "I'm feeling better" signals to the clinician that their task has been completed, that they have helped alleviate her *personal distress*.

Yet, in the above case, while it may be evident that the concept of a person helped guide medical practice, it is not evident what it meant for the patient to be understood as a person. In the acute care setting, where interaction with patients is limited by time, relative patient load, and the rotation of attending physicians, an underdeveloped definition of the term "person" might suffice. That is, when an unresponsive patient identified only by their driver's license presents to the ED on advanced life support after suffering a heart attack, perhaps all that needs to be considered is that this *person* will die or face irreparable damage if they are not given proper and immediate care. But after an emergency is abated and the chaos of a severe acute disease resolves itself into relative stability, decisions will need to be made regarding how best to balance a patient's own, personal values with the medical treatments that can help mitigate both their physiological disease and lived dis-ease.

Taking all this into account, my goal in this chapter is to argue that disease and dis-ease can be better navigated in a clinical setting if clinicians establish a more robust understanding of personhood. In the previous chapter, I established that medicine can be divided into third personal and first personal perspectives on normality and abnormality. In this chapter, I aim to show how these perspectives coincide with one another insofar as clinicians consider who a patient is *as a*

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aside from the subjective reporting of symptoms, there is not an empirical way to narrow down a differential diagnosis to the definite diagnosis of a migraine headache.

person. Now, while this chapter will engage with philosophical concepts, it is not my goal to establish a theoretical definition of personhood that can then be employed to settle philosophical debates regarding whether or not some form of life qualifies as a person. My treatment of personhood in this chapter is not meant to establish a set of criteria for personhood. Rather, my goal is to establish a practical examination of personhood from a phenomenological perspective so that useful elements of phenomenology can find relevance within clinical practice.

My reason for focusing on phenomenology in this chapter is due to the fact that clinicians often lack a first-personal understanding of illness. While it will be that case that clinicians have a great amount of aptitude in understanding the physiological and anatomical disruption that results from pathological disease, it is not likely that clinicians will have much, if any, familiarity with what it might be like to live through the personal and lived disrupting that is dis-ease. So, to coordinate an understanding of disease with dis-ease in our current clinical setting, it is required that a balancing act be performed; clinicians must balance their physiological and anatomical expertise with the patient's lived aspects of dis-ease. Hence, the focus on phenomenology in this chapter is not to assert that clinicians need to gain a deep understand of phenomenology in order to adequately practice humanistic medicine. Rather, my focus is to elucidate how phenomenology can be used in conjunction with standard medical practice in order to establish a more personalized medicine that allows medicine to better pursue its task of healing persons.

This practical understanding of personhood will develop throughout the chapter. It will draw heavily from traditional phenomenological theory. As well, I will show how these phenomenological concepts can be found to cohere together within works of Charles Taylor who has written on the topic of personhood from the phenomenological perspective. The addition of Taylor is meant to show the reader how to piece together a phenomenological mosaic using the

concepts of phenomenology. An essential component of this practical understanding of personhood is that it will support the idea that one's embodiment plays a foundational role in what it means for someone to be a person. Hence, it will be well suited to understanding how a physiological disease has an impact on one's *personal* dis-ease.

In order to ensure that this highly conceptual chapter retains some importance to clinical practice, I will focus this discussion of personhood around a clinical case which is presented below. This case is fictional, but I have made an attempt to present the reader a case that could be constructed through a review of a patient's electronic medical record and a 15-20 minute discussion with the patient and their family. In addition to this, in the next section I will provide the reader with a reference chart in order to help show what the reader should take from each major phenomenological thinker and how they have relevance to clinical practice.

Case:

G. is a 73-year-old man who was recently diagnosed with chronic heart failure (CHF). He reports that his symptoms started around three months ago, when he experienced dyspnea while doing landscaping around his daughter's home. Shortly after that incident, G. started to experience the dyspnea while laying down, often awaking suddenly throughout the night to catch his breath. Recently, G. dyspnea has become more severe, making it difficult to climb stairs or walk around the neighborhood.

G. is retired and lives with his wife. Prior to his retirement, G. worked as a carpenter for a construction firm. He enjoys working on various handyman/do-it-yourself projects around his house as well as the home of his daughter, who lives nearby. Prior to experiencing the symptoms of CHF, G. was building a screened-in patio addition for his daughter's house. G. is also an avid

fisherman; he often takes many weekend trips to a local reservoir to fish on his boat. The symptoms of his CHF have since prevented him from engaging in his projects and hobbies.

G. was prescribed various medications to help treat and manage his CHF. While the medications do help relieve his dyspnea and fluid retention, he experiences some difficulty managing and adjusting to the side-effects of these medications. He often feels constantly fatigued and will experience bouts of dizziness throughout the day.

2.1: The Lived Body and Personhood

We all experience and lead our lives as persons. Aside from death or irreparable catastrophic brain damage (i.e., brain death) our status as living persons is not placed into question. At base, we all have access to the lived experience of a person due to the fact that all our experience is *personal experience*. Being persons, we are not able to perform some trick to remove ourselves from personhood, we cannot suddenly attend to the world as an amoeba or fungus. This being the case, the sheer fact of our existence demand that we live and persist as persons within our world. This fact of our existence establishes a connection between personhood and phenomenology since what it means to be a person—in the sense that human beings are persons—requires having some understanding of the features and conditions that establishes a personal experience. Phenomenology, as a philosophical method, aims to provide us with insight into such features and conditions so as to elucidate how we experience and live within our personal world.

In this section, I will show how ideas and concepts found in the works of key figures within phenomenology allow us to better understand what it means to be a person. In the next section, I will synthesize these ideas together and put them into conversation with a conception of personhood offered by the philosopher Charles Taylor.

Husserl, Meaning, and the Lifeworld

Husserl, who was mentioned in the previous chapter, was the first philosopher to attempt to develop a systematic account of a new science he referred to as "phenomenology". He regarded phenomenology as a new sort of science whose goal was to provide a greater understanding of consciousness from a first-personal perspective. Rather than examine consciousness as the result of some physiological process described by neurobiology through the functioning and processes of the brain, Husserl tried to fill in what it means to *be conscious*, to exist as a *being with consciousness*. Essential to Husserl's description of consciousness is his analysis of intentionality. As we know from the previous chapter, intentionality is concerned with the "aboutness" of our thoughts. Insofar as we are conscious, we are conscious of *something* and this *something* helps establish what we generally refer to as experience. When *G.* becomes aware of his dyspnea, he must focus upon his breathing; his breathing is something he is suddenly *conscious of*. During this experience of dyspnea, he will think *about* how heavy his chest feels, *about* the sudden sensation of being starved for air, or *about* the demand by his body to pause whatever he is doing to catch his breath. The entirety of this aboutness will determine what it is like for *G.* to experience breathlessness from his first-personal perspective.

According to Husserl, our consciousness can be distinguished from "Nature".[8] In other words, the science that describes our consciousness (i.e., phenomenology) can be distinguished from the sciences that provide a description of material bodies within the natural world (i.e., physics, biology, chemistry, etc.). Husserl establishes the method of "bracketing" to ensure that when we are examining our experiences, we set aside—or bracket—questions that have to do with

[8] As one Husserl scholar puts it: "On Husserl's account, each concrete experience falls under two high-level essences or species, called Consciousness and Nature respectively, so that the mental and physical sides of experience are two aspects of a single event" (Smith 1995, 323).

the natural sciences so that we do not mistake or confuse an account of our specific experience of the world with an account of the world in general (Husserl 1982, §32). F.C. Waksler, a sociologists who writes on the intersection of phenomenology and illness, points to the method of bracketing as a way to understand illness in a way that stands apart from a physiological description of a disease. Waksler argues that if the clinician is able to suspend their "medical knowledge" then "this suspension makes available to medical theorists and practitioners a different vantage point from which to view a rich world or otherwise obscured experiences" (Waksler 2001, 73). According to Waksler, a clinician who is able to suspend their medical knowledge and belief will be provided with a better understand a patient's experience of their illness. However, I hold reservations in accepting Waksler's characterization of Husserl's method of bracketing. Rather than imagining bracketing as a suspension of medical knowledge, I propose that clinicians engage in bracketing to establish *a balance* between their scientific expertise and their understanding of a patient as a person. By bracketing certain questions regarding an undergirding physiological dysfunction within a patient's body, a clinician is able to *refocus* their attention and line of inquiry upon how a patient is personally experiencing dis-ease.

Regarding our case, bracketing helps us understand that describing *G.*'s personal experience of starving for air is different from describing the physiological causes of *G.*'s dyspnea. Describing how a reduction in *G.*'s ejection fraction results in reduced pulmonary diffusion is separate from a description of what it *feels like* to have a hunger for air. Engaging in bracketing will assist the clinician in attending to *G.* with the goal of trying to understand how *G.*'s experience of breathlessness has an impact on his lived, everyday experience. Bracketing, then, can be understood as a way to *reimagine* a goal of medicine. Setting aside (i.e., bracketing) lines of inquiry that pertain to physiological abnormality does not mean that these questions are of less importance

or value, but rather that these questions will not bring us closer to the goal of establishing some understanding how *G.* personally experiences his dis-ease.

In addition to bracketing, understanding Husserl's distinction between Consciousness and Nature is crucial to grasping his account of human personhood because important aspects of personhood will of course arise from our consciousness and conscious experience of the world. A major reason why this is the case is because, according to Husserl, the meaning of some object will depend upon someone's consciousness of it. Because we attend to the world through the standpoint of our own consciousness, we thematize (i.e., make sense of) the world through our own perspectival standpoint within the world.[9] *G.*'s fishing boat, in itself, is just a molded aluminum frame with a small trolling motor attached to its back end. However, through *G.*'s stream-of-consciousness, the molded aluminum frame with a small trolling motor is understood by *G*. to mean: *a place of relaxation and recreation*. This assignment of meaning allows for the world to be made sense of in a way that establishes an order to one's experience. When *G.* experiences dis-ease, the meaning of objects is transformed. For instance, the fishing boat might be transformed from *a place of relaxation and recreation* into *an object that triggers profound longing and nostalgia*. Briefly, consciousness makes sense of the world by assigning meaning to the things that we encounter within our surrounding world.

According to Husserl, we experience our surrounding world and make sense of it through our personal and cultural contexts. As a result, the world that we consciously experience is a *personal* world that features objects whose meanings are assigned by ourselves and our culture.

[9] Husserl remarks that: "Speaking quite universally, the surrounding world is not a world 'in itself' but rather a world 'for me,' precisely the surrounding world of *its* Ego-subject, a world experienced by the subject or grasped consciously in some other way and posited by the subject in his intentional lived experiences with the sense-content of the moment" (Husserl 2000, 196). Husserl is here pointing out that the world that we are situated in (i.e., the world that we live within) is grasped by us as the world to/for me. The various meanings I uncover within my surrounding world will be my own since this world will be provided to me from my own standpoint within it.

This personal experience of the world is what Husserl refer to as one's lifeworld.[10] Living as a person within a lifeworld consists in engaging in the habits, practices, and activities that we find meaningful either to ourselves and/or our culture. On an ordinary day before experiencing dis-ease, *G.* would begin his day by eating a small breakfast with his wife and then he would go to his daughter's home to work on the screened-in porch addition. In the early afternoon he would pick his granddaughter up and school and watch afternoon cartoons with her. Once his daughter got home from work, he would return home and have dinner with his wife. Finally, he would end his evening by watching a movie or sporting event before going to bed. All of this is just to say that *G.* participated within his lifeworld, and this participation in the lifeworld determines his personal experience of the day (i.e., a day in the life of *G.*). So, to *be* (i.e., act as) a person, in the everyday and ordinary sense, is to participate within the lifeworld. Being a person consists in going about your day as you ordinarily or normally would.

This ability to participate in our lifeworld is closely linked with the ability of our bodies to engage in such everyday and ordinary habits, practices, and activities. As we know from the previous chapter, Husserl thinks that our bodies can be described in two senses. The first sense is as a material body that can be defined through its physical characteristics uncovered by the natural sciences—as a physiological and anatomical object.[11] The second sense is as a medium between

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[10] In his book, *The Crisis of European Sciences and Transcendental Phenomenology*, Husserl elucidates his conception of the lifeworld as it relates to scientific inquiry (understood here not to mean just the natural sciences, but rather how human beings come to have knowledge of anything whatsoever). §33-4 of the *Crisis* provides a general account of Husserl's theorizing regarding the lifeworld. In short, the major question becomes how we can move from our subjective understanding of our surrounding lifeworld to an intersubjective (e.g., objective) and shared understanding of objects within the lifeworld. In philosophical parlance: how can subjectivity be a condition for the possibility of an objective understanding of the world?

[11] Husserl refers to the body in this sense as a "körper"—which, in German, is a cognate of the English "corpse". For Husserl, we understand our body as körper when we conceive of it as a material object within the natural world (Smith 1995, 324-7; Carman 1999, 210; Zahavi 2003, 101-9; Husserl 2000, §41). Understand the body in this sense is to understand it as a possession within physical space (i.e., recognize it as *my body* as I would recognize *my desk* or *my pen*).

our consciousness and our lived experience within the lifeworld. This second sense of the body is what Husserl refers to as the "lived body". Through our lived body, we move through and engage with the lifeworld, providing the content of our stream-of-consciousness.[12] Being consciousness means to be conscious of something, and being conscious of something will require some bodily interaction with things in the world. The conscious, personal experience that *G.* has of his dyspnea will include *the feeling* of desperately trying to draw air into his lungs. It will include frantically trying to find somewhere to rest his body in order to catch his breath. As we can notice, *G.*'s experience of dyspnea is bodily not just in the sense that there is an underlining physical dysfunction that is causing his shortness of breath, but also because it is through his body that *G.* uncovers what it is like to *feel* being short of breath. The content of our conscious experience will be provided to us from our living bodies *living* (i.e., moving, feeling, sensing) within the world.

Since Husserl believes that meaning is developed and assigned through our consciousness, he places a unique emphasis on the role that our bodies play in establishing meanings within a lifeworld. Prior to Husserl, it was common to discuss the body only in terms of mechanical or physiological explanations; the body was thought of as being merely a sensory machine or assemblage of organs that moved and operated according to a will dictated by the mind. In this view, all aspects of personhood would be located within the mind, since only the activity of thinking would be deemed important for what it means to be a human being. This is expressed more powerfully in Rene Descartes' *cogito ergo sum* (I think, therefore I am). Husserl disagrees with this Cartesian notion, and this is important because this disagreement affords him the

[12] In *Ideas II* Husserl regards the body as the "organ of the will" (Husserl 2000, §38). We have access to an "I can" through our body insofar as we can freely move our body in the manner that we wish. The embodied activities that we engage in—living within the everyday—consists in our subjectivity ability to engage within the everyday through an "I can". To function within the everyday is to engage with this "I can"—to have a subjective will that one can enact. This point will become crucial to Merleau-Ponty's own reflections on the importance of realizing an "I can" through the body.

opportunity to claim that our consciousness—previously thought to be a mental activity—is an embodied affair insofar as our perspective of the world is limited by the perspective of our bodies within the world.[13] What I can do and what I can experience within the world will depend upon my living body and its possible interactions within the world. If this is the case, then understanding someone's personhood does not require some privileged access to someone's "soul", but rather understanding how they come to engage within their world through their body. To begin to understand *G.* as a person, then, does not require an extensive and exhaustive understanding of a disembodied soul. Rather, understanding *G.* as a person requires knowing how he establishes and grasps meaning within the lifeworld through his body. *G.* goes about his day doing the things that matter to him—he works on various projects, talks with the people he cares for, and participates in his hobbies—these activities retain their meaning because *G.* is able to interact with the world through his body.

To put this all of this another way, *G.* is able to *live a life* because his body is able to take part in the activities that matter to him. When *G.* experiences the symptoms of CHF, the meaning of things become estranged and alien to him. The tools *G.* used to fix sinks, install cabinets, and replace windows are transformed from things vital to *G.*'s personality as a jack-of-all-trades handyman to things that now only exasperate his dis-ease. We can now appreciate that Husserl's notion of the lived body maintains that our bodies function not just physiological entities, but also—and more importantly—meaning making entities.

[13] As one Husserl scholar remarks: "Meanings are, like essences, ideal, i.e., not in space or time…they are contents of intentional experiences, embodying ways in which objects are presented in consciousness" (Smith 1995, 330). However, it should be noted that objects are presented to our consciousness through the way our body senses the world. According to Husserl, our perspective of the world is embodied—we come to know our world by sensing it through the body (Husserl 2000, §36).

As we can see then, what it means to experience the world as a person depends upon how one's lived body interacts with their lifeworld. This living in the world communicates and establishes the meaning of things within our consciousness. What things mean to us, on a personal and experiential level, will depend upon our bodily connection to a lifeworld. Leading a life within a lifeworld is a central theme for all subsequent phenomenology following Husserl. The major goal of most phenomenologists following Husserl was to provide an account of what it means to *exist* within the world as a human being. For our purpose of gaining a better understanding of personhood in medicine through a phenomenological lens, we can begin to appreciate how phenomenological investigations and analysis of living within a lifeworld can help provide an account of what it means *to be a living person within the world*.

Table 1: Core Concepts from Husserl's Phenomenology

Key Concept / Short definition	**Clinical Example**	**Clinical Importance**
Bracketing: Setting aside theoretical/scientific assumptions in order to better understand aspects of one's lived experience.	*G.*'s physician temporarily sets aside questions pertaining to *G.*'s heart function (i.e., ejection fraction, etc.) in order to inquire about how *G.*'s symptoms have had an impact on his daily life.	Understanding a patient's illness in terms of lived dis-ease allows a clinician to better understand how to make realistic and informed recommendations regarding lifestyle changes and adaptations.
Meaning: The meaning of something is established through someone's conscious interaction with an object and its context.	*G.* remarks to his physician that he has not been able to be as active as he used to be due to his symptoms making it difficult to do things he used to enjoy (i.e., fishing, working around the house, etc.).	Discovering that dis-ease is often a crisis of meaning allows a clinician to consider what ways they can help guide a patient through this crisis of meaning.
Lifeworld: The world in which we interact and engage with persons, artifacts, and our culture.	*G.*'s physician is able to gather that engaging in family relationships is how *G.* spends a majority of his time.	Realizing how a patient engages within their world provides a greater understanding of and insight into a patient's values. This understanding and insight can help inform judgement regarding a patient's quality of life.
Lived Body: Our embodied existence through which we experience and participate within the lifeworld.	*G.* offers a report of how his symptoms have impacted his everyday functioning. His shortness of breath has often prevented him from working on various handyman projects.	Determining the impact of an illness on a patient's life will require an account of how their dis-ease impacts how they participate within the world. Understanding this impact can help inform what it means *to heal* a person.

Heidegger, Being, and Worldliness

Martin Heidegger, a student of Husserl who is sometimes regarded as his successor, was greatly influenced by Husserl's comments on how human beings persist within their lifeworld. However, Heidegger would take a different methodological approach to understanding human being. As we now know, Husserl's phenomenology centered around the concept of intentionality and how meaning is assigned to entities found within our conscious experience. Ultimately, the goal of Husserl's phenomenology was to describe how we can have knowledge and acquaintance of the things encountered through our consciousness (e.g., people, trees, tables, rocks, etc.). However, Heidegger's concern was not with how we develop a repertoire of knowledge and meaning through our consciousness. Rather, Heidegger was concerned with providing an account of *being* and what human *being* amounts to. In philosophical parlance, we can say that Husserl's project was an *epistemological* one (i.e., concerning how human beings can know things) whereas Heidegger's project was an *ontological* one (i.e., concerning how we can provide an account of what it means *to be*).

In regard to developing a practical concept of personhood, we can understand Heidegger as providing an account of what it means *to be* a person within the world. Since Heidegger's focus is ontological, his method centers around establishing the various ways human beings can be. These ways of being are understood through practical activities since all human being is found in a world that it must constantly interact and engage with. *To be*, according to Heidegger, is also *to act*; through our activity we engage in our being and further it. Heidegger elucidates this point through his discussion of existence. Human being is always undergoing an interpretation of itself.[14]

[14] "Its ownmost Being is such that it has an understanding of that Being, and already maintains itself in each case as it its Being has been interpreted in some manner" (Heidegger 2007, 36 [15]).

What this means is that human being must always deal with or address the fact that it *is*. Since I am a human being, I must be concerned with (or at the very least, respond to) the fact that I *am*. I cannot take a day off from my being; I cannot suddenly void my human being and return to it later. Rather, I must have a response to that fact that I *am*. This response will be what is referred to as "comportment"—a behavior or activity—that determines the way we *are* within the world.[15] Heidegger refers to this response to being, our comportment, as existence.[16]

Heidegger, like Husserl, thinks that phenomenology is a fruitful philosophical method; Heidegger thinks that we can make progress in understanding *being* by using phenomenology. However, Heidegger's approach to phenomenology is vastly different from Husserl since it focuses on the act of *interpretation* rather than on intentionality. Heidegger is more concerned with human *being* rather than human *consciousness*. Human being consists in interpretive acts since we must always, as one Heidegger scholar says, "cope" with our being.[17] As was said in the previous paragraph, we cannot absolve ourselves from being. We cannot simply phase out of existence in order to avoid a tough day ahead of us. Rather, we must respond to the fact that we are human beings with responsibilities, skills, habits, and culture. Our coping reflects our interpretation of our being; in other terms, it reflects what it means to exist. Since human beings are always interpreting their existence, Heidegger thinks that the best approach to study what it means *to be* is what is now referred to as hermeneutic (i.e., the study of interpretation) phenomenology. Essentially, Heidegger proposes that the best way to study human being is to examine how human beings

[15] "These entities, in their Being, comport themselves towards their Being" (Heidegger 2007, 67 [41]).
[16] "That kind of Being towards which Dasein can comport itself in one way or another, and always does comport itself somehow, we call 'existence'" (Heidegger 2007, 32 [12]).
[17] Throughout his book, *Being-in-the-World: A Commentary on Heidegger's Being and Time, Division I*, Hubert Dreyfus refers to Dasein's persistent self-interpretation within the world as "everyday coping".

interpret themselves.[18] In simpler terms, Heidegger thinks that the best way to study human being is to examine and describe what sorts of practical activities human beings engage in. Heidegger transforms phenomenology from the study of consciousness to the study of how human beings cope with/interpret their being.

According to Heidegger, our interpretation/coping of being is not uncovered by theoretical activity. We do not gain a sense of who we are simply by pondering the question: *who am I?*. Rather, Heidegger thinks that a fundamental understanding of who we are starts with an investigation of one's involvement with the world. Each and every human being partakes in what Heidegger calls the "everyday"; we go about our world completing tasks and engaging in activities that requires little or no theoretical effort.[19] In coping with the everyday, *G.* wakes up, takes his medication, brushes his teeth, eats breakfast, takes a light walk around his neighborhood, rests and reads the newspaper, watches TV, goes to visit his daughter, has dinner, watches a movie, and then goes to bed. All of this represents involvement with the world, but Heidegger does not think that this involvement is indicative of consciousness alone. That is, Heidegger does not think that these activities describe what it is like to be conscious but rather what it is like *to be* in the world. This being the case, Heidegger does not discuss our involvement with the world in terms of thinking or being conscious of things (i.e., intentionality) but rather in terms of interacting or using things within our world. Those things that we interact with and use in our world is what Heidegger refers to as "equipment". The world that we are involved in is made up of equipment that we make use

[18] "We must rather choose such a way of access and such a kind of interpretation that this entity can show itself in itself and from itself. And this means that it is to be shown as it is proximally *and for the most part*—in its average everydayness" (Heidegger 2007, 37-8 [16]).

[19] Regarding our use of things found within our world, Heidegger states: "The kind of dealing which is closest to us is as we have shown, *not a bare perceptual cognition*, but rather that kind of concern which manipulates things and puts them to use; and this has its own kind of 'knowledge'" (Heidegger 2007, 95 [67], emphasis added). While not referring to consciousness directly, we can understand Heidegger as stating that our understanding of our everyday consists in our activity within the everyday as opposed to a conscious reflection on the everyday.

of. The toothbrush is a piece of equipment that we use for brushing our teeth, the car is used for getting us to and from somewhere, the mail app on the smartphone is for sending emails. By being involved in the world, we use make use equipment, but our use of equipment does not qualify as consciousness. I do not *think about* the toothbrush when brushing, the car when driving, or the smartphone when emailing. In coping with my being, I simply partake in worldly involvement without paying it a moment of thought. I am bound up in my everyday tasks, and so I thoughtlessly make use of the equipment is available to me to complete the task at hand.

Our involvement in the world through our use of equipment is also how we develop a sense of meaning within our lives and our world. This development of meaning can be expressed most clearly when the equipment that we use suddenly breaks down or malfunctions. Suppose that *G*. has promised his daughter that he would pick his granddaughter up from school. *G*. enters his truck, presses on the brake, and turns the key in the ignition. Rather than hearing the familiar and gentle roar of the engine starting, *G*. instead hears a rapid clicking sound. The battery in *G*.'s truck is dead. *G*., understandably exasperated, slams his palms against the wheel and curses. He thinks to himself: *how am I supposed to pick her up from school? Some grandpa I am!* Through the breakdown of his truck, *G*. realizes not just the importance and meaning of his truck (i.e., that it is a transportation tool that allows them to get from one place to another), but also the various plans, duties, and responsibilities that he has. In other words, the breakdown of *G*.'s truck makes evident his place and situation within the world. In this way, *G*. is able to realize *what* things matter for them and *why* they matter for them. Currently, the truck matters to *G*. because he promised his daughter that he would pick his granddaughter up from school—without his truck, he cannot fulfill this promise.

As we can now see, our involvement with equipment allows us to maintain some aspects of our personhood within the world. These aspects—our responsibilities, plans, habits—are revealed to us when this equipment breaks down and we suddenly have to face who we are in our worlds. Much of our involvement in the world, then, goes unnoticed by us, but is still essential to who we are. If things are going well for me, I do not need to think much—if at all—about any of the equipment I will use today. Yet, if all of this familiar equipment were unable to be used by me in the way I previously was able to interact with it, I would find myself in a state of existential shock. Needless to say, I would need to cope and interpret my being in an entirely different manner than I had before. This new way of coping and interpreting would affect who I am since as I would now need to involve myself in the world in a manner that is entirely different from the way I did previously.

G. experience of his dis-ease will affect the way he involves himself in the world through various equipment. Fredrik Svenaeus, a philosopher who studies the phenomenology of health and illness, aptly points out that Heidegger refers to our everyday, effortless existence as being homelike (i.e., familiar). When we experience dis-ease, Svenaeus contends that our existence becomes unhomelike, and a sense of alienation pervades our being (Svenaeus 2001, 92-4). This is to say that when *G*. experiences his dis-ease, he will not be able to interact with equipment in that manner that he did previously. If *G*. attempts to involve himself in the world as he previously did—using equipment in the manner that he did prior to his dis-ease—he will be prevented from doing so by his dyspnea, other symptoms of his CHF, and medication side effects.

We can discover our personhood through the breakdown of equipment; a breakdown forces us to take a step back from the everyday to realize *who we are* within the everyday. In addition to this, our personhood is revealed to us through the directional nature of our everyday use of

equipment. This statement will require some unpacking. As we know, human beings must cope with their being through interpretation; this means that they must exist as *someone* who does *something*. According to Heidegger, the something that one does will be defined by a world that is shared amongst other human beings.[20] When performing certain handyman projects around the house, *G.* will employ various carpentry techniques that he learned from other carpenters. So, while *G.* might be the person who puts these techniques to use, he did not invent or create them. Rather, *G.* follows a certain set of norms or directions that allows him to properly employ a certain woodworking technique. What this shows is that *G.*'s use of equipment and various techniques in performing carpentry is not an individualistic affair. In cruder terms, *G.* does not interpret themselves as a carpenter by "winging it". Rather, *G.* involves themselves in the various activities of a carpenter by knowing the proper way to carry out the tasks of a carpenter, and these proper activities will be shared by all carpenters. Through this example, we can see that the various social identities that are prescribed to us in our world follow from our adherence and performance of the various norms established within our world. To be a carpenter, a fisherman, a husband, and a grandfather means being able to participate in the world in such a manner that reflects these social identities.

Interestingly and related to our purposes, Heidegger's emphasis on social identities maps on to a sociological perspective of personhood. The English term "person" comes from the Latin *persona* which refers to the mask that an actor would wear in order to play the part of a certain character. In the history of the theatre, as masks were exchanged for costumes and make-up,

[20] As Dreyfus notes, Heidegger is careful to distinguish Dasein *having* a world from Dasein *being in* the world. Heidegger does not think that Dasein possesses the world as its own—we cannot rightly say "well, in my world, this is how things are done". Rather Heidegger is explicit that Dasein should be conceived of as being in *a* world. This world is presented to us in terms of possibilities constructed through norms, culture, and available equipment construed by both norms and culture. See (Dreyfus 1991, Chapter 11).

persona was replaced with the term "dramaturgy" which meant performing a certain dramatic role. The sociologist Erving Goffman, in his book, *The Presentation of Self in Everyday Life*, argues that dramaturgy has application beyond the theatre. He proposes that our social life consists in presenting ourselves (i.e., playing/performing a part/role) in order to reflect who we understand ourselves to be as persons within a particular society. We can understand this sociology of personhood to be in-line with Heidegger's claim that our everyday use of equipment presents to the world who we interpret ourselves to be. We can understand Heidegger's discussion of our directional and purposeful use of equipment—how human beings interpret themselves—to provide us insight into someone's various personal identities.

Through Heidegger, we can understand that the experience of dis-ease is to also experience a sense of frustration with enacting one's personal identities within the world. *G*.'s symptoms prevent him from involving himself in the world as he previously had, and this has an effect on how *G*. interprets himself. Prior to dis-ease, being a handyman, a carpenter, a fisherman, a husband, a father, a grandfather were all roles that *G*. could fulfill with some sense of ease. Prior to dis-ease, these roles were familiar to *G*. and he involved himself in the world by taking part in them. This involvement in the world presented who *G*. is as a person, it reflected what it meant for *G*. to be at home within the world. When this involvement in the world becomes frustrated through the effects of CHF, *G*. is forced to renegotiate his personal identities. This renegotiation must take into consideration to what extent he can continue to participate (i.e., cope) within the world as he previously had.

The influence and legacy of Heidegger's phenomenology can be realized by an increased focus on existence within phenomenological circles. After Heidegger, phenomenology shifted from describing how we can know things from a first-person perspective (i.e., the phenomenology

of Husserl) to describing how the kind of beings that we have an impact on how we engage with and interact with our world. However, while Heidegger's philosophical system was both rich and extensive, it did not comment on *all* aspect of our being. One common complaint that subsequent phenomenologists have of Heidegger's system is that it lacks a robust account of the role of the human body in describing human being and existence. Numerous reasons for why Heidegger neglects the body have been provided in scholarly literature, and various defenses of Heidegger's neglect of the human body have come up in recent years. However, Heidegger's decision to forgo a detailed analysis of the human body was seen by some philosophers as an opportunity to enrich phenomenological inquiry by considering the question: *what is it like to be a body in the world?* In the next section, we will cover one such philosopher whose focus on this question provided us with a better understanding of how we participate in the world via our embodiment.

Table 2: Core Concepts from Heidegger's Phenomenology

Key Concept / Short definition	**Clinical Example**	**Clinical Importance**
Existence: Human being is always discovered in a particular context that represents a person's condition or situation within the world.	*G.*'s expresses that he feels "trapped" by his illness. He remarks that his illness has taken over his life.	Realizing that illness is the context through which a patient lives within the world allows clinicians to understand how disruptive an illness can be on a patient's life.
Comportment: Human beings are always in the process of interpreting themselves and acting in a manner that reflects this interpretation of themselves.	*G.*'s physician reflects on their previous visits with *G.* and notices that *G.* often talks about his family and how his illness has sometimes made him feel distant from his wife and daughter.	Uncovering how a patient interprets themselves can help a clinician discover how a patient's illness disrupts this interpretation of themselves (i.e., their illness may prevent them from engaging in meaningful social/familial/professional roles)
Equipment/Tools: A person's everyday life will be determined by how they put various objects to use. By using the various equipment one encounters in everyday life, a person reflects who they interpret themselves to be.	*G.* expresses frustration at how the symptoms of his illness have prevented him from engaging in various activities that he previously enjoyed.	Determining how illness can affect how a patient interacts with the world can provide a clinician with insight into how improving/restoring levels of functioning can have a drastic, positive impact on a patient's quality of life.
Breakdown/Disruption: Given that a person's everyday life is constructed through their use of tools found within the world, the breakdown of a tool can disrupt a person's interpretation of themselves.	*G.* remarks that he feels "lost" as a result of his dis-ease. He states that he spends many afternoons mindlessly watching T.V. because he has become disinterested in trying to attempt the activities that he previously enjoyed.	Reframing a patient's illness as a disruption will allow a clinician to determine what recommendations regarding lifestyle changes/adaptation are realistic. By understanding how a patient's life is disrupted by illness, a clinician can better understand a patient's level of functioning and how they can take incremental steps to help improve this level of functioning.

Merleau-Ponty, The Body, and Inhabitation

Merleau-Ponty's is a phenomenologist who makes human embodiment essential to their overall philosophical project. His phenomenology can be understood as a unique commentary on both Husserl's and Heidegger's phenomenological analyses with a central focus on how human embodiment affects the way that human persons exist within their world. In simple terms, we can understand Merleau-Ponty as synthesizing Husserl's concept of the lived body with Heidegger's analysis of how human beings cope with and interpret themselves within world. In doing so, Merleau-Ponty places a unique emphasis on the role that embodiment plays on developing our sense of personhood. This emphasis is expressed in his ideas and thoughts regarding the activity of perception.

For Merleau-Ponty perception is not a purely mental activity (i.e., the result of our computational mental powers). Similarly, perception is not an intellectual activity (i.e., the result of making judgements and inferences about things). Rather, perception is a pre-conscious and pre-intellectual activity; it is our immediate grasp the world and the things found within it. Merleau-Ponty argues that such a pre-conscious and pre-intellectual grasp on the world must be the result of our embodiment in the world; it is not our mind's engagement with the world but rather our body's engagement with the world that gives rise to our perceptual understanding of the world.

According to Merleau-Ponty, our perceptual access to the world through our bodies allow us to inhabit our world. Our human *being*—our existence within a world—depends upon our embodiment within the world. Consider *G*. reaching out to grab his hammer on the floor beside him. To complete this action, *G*. needed to (1) identify and distinguish the object from the floor and other tools (2) assess how far the object is away from them, (3) determine if the object is within their arm's reach, (4) have an awareness of how his arm moves, (5) have some understanding of how to properly grip the object, and (6) position the object so that it is ready to be used. Merleau-

Ponty would argue that all of these steps are pre-conscious in that *G*. did not have to think about them. More than likely, *G*. simply thought *I have to hammer this nail*, and then completed (without thinking) all the steps that would allow him to drive the nail. However, these steps reflect a perceptual access to the world through *G*.'s body; *G*.'s embodiment allowed him to realize what objects are available to him, where they are in respect to him (i.e., to the left/right), what movements they can perform in order to interact with the object, and how they can put the object to use. In addition to this, *G*.'s embodiment allows the world to be grasped as something sensible. *G*. has ocular motor muscles that prevents his vision from constantly shift to the left or right and which allow them to experience depth, he has a vestibular system within his inner ear that allows him to experience some sense of balance so that he does not topple over, and he has sensory neurons that allows him to grasp where their limbs are with respect to his other body parts. In other words, the *G*.'s body makes sure that he can perceive the world as a sensible whole rather than some jumbled mess that they need to make aright via some intellectual activity.

It is through our bodies, then, that we come to understand how we can live as persons within the world. Merleau-Ponty elucidates this point through the case of Schneider, a WWI veteran who has suffered a severe brain trauma. For Merleau-Ponty, the case of Schneider shows us that our navigation and negotiation within the world requires the ability to have an environment pre-consciously available to us in our acts of perception. Schneider's injury still allows him to engage in what Merleau-Ponty refers to as "concrete movements". These are habitual actions in which Schneider is able to carry out when ordered to (Merleau-Ponty 2012, 107 [134-5]). For instance, Schneider is able perform a military salute and other marks of respect (*ibid*.). Yet, Schneider's injury severely affects his ability to engage in "abstract movements". Merleau-Ponty remarks that Schneider cannot imagine a set of possible actions that arise from objects and

meanings found in one's environment (Merleau-Ponty 2012, 111 [139]). For instance, if Schneider were ordered to collect a set of objects that made him happy, he would fail at this task. This is not because Schneider is incapable of conceptualizing happiness or cannot imagine what things might make him happy, but rather because he lacks what Merleau-Ponty calls "motor intentionality". In other words, Schneider lacks the ability to perceive bodily action and the world in a holistic and unified manner. Merleau-Ponty thinks that the case of Schneider explicates the idea that a world is given to us "in intuition, as opposed to constructed in thought" (Carman 2008, 116). In this respect, the capability of having an environment in which we suffuse with human or personal meanings arises from our being embodied in such a way that can imagine possibilities within a environment (Merleau-Ponty 2012, 114).

Merleau-Ponty further elaborates on how our being in the world as a body affects the way we engage with and enact personal possibilities. According to Merleau-Ponty, our "original intentionality" (i.e. our consciousness) is determined by our motricity (i.e. our ability to move and act). He states that "consciousness is originarily not an 'I think that,' but rather an 'I can'" (Merleau-Ponty 2012, 139). In essence, Merleau-Ponty intensifies the focus placed on bodily activity. For Merleau-Ponty, our consciousness is not speculative (i.e. a matter of purely mental activity which is perhaps aided by the body). Rather, our consciousness *is* our ability to act and move within the world; "Movement is not a movement in thought…" (*ibid*). By making intentionality a matter of activity, Merleau-Ponty discusses the *intentional arc* which he defines as the projection of "our past, our future, our human milieu, our physical situation, our ideological situation, and our moral situation, or rather, that ensures that we are situated within all of these relationships" (Merleau-Ponty 2012, 137). Our intentional arc consists in the way we *inhabit* our situation within the world. This is not a speculative inhabitation; it is not *thinking* about your

situation in some detached perspective. Rather, it is *lived* inhabitation; it is performing and acting within your particular worldly situation.[21] For Merleau-Ponty, there is no meaning in the world without an intentional arc. To lack an intentional arc would mean to lack a world and therefore lack the capacity and capability for engaging in personal activities within such a world.

In dis-ease, our intentional arcs are frustrated. This is a point made by the two major figures in the phenomenology of illness, Havi Carel and S. Kay Toombs, who we briefly covered in the previous chapter. Both Toombs and Carel argue that illness marks the transformation from the "I can" to the "I cannot". Toombs argues that "In illness bodily intentionality is frustrated. Objects which were formerly grasped as utilizable (and were thus largely taken-for-granted and unnoticed) now present themselves as problems to the body…. The 'I can' is rendered circumspect" (Toombs 1993, 63). Carel uses the example of dancing to illustrate this point: "the experience of dancing will be radically altered by respiratory disease, both on the level of bodily feeling, which turns from a pleasurable experience to one of exertion, and on the level of meaning, when it changes from an experience of 'I can' to an 'I cannot'" (Carel 2016, 210). Dis-ease disrupts our engagement with meaning in the world by disrupting our enaction of meaning in the world. According to Merleau-Ponty, we engender meaning within our world by acting within the world. *G*. is able to reflect what things matter to him by engaging with the world though his body in such a way that reflects this meaning. *G*. cares about fishing, so he is able to enact this caring through his body; he *can* cast his line in the lake, he *can* reel in the largemouth bass, he *can* weigh the fish, take a picture of it, *et cetera*. When *G*. becomes aware of the symptoms of CHF, the "I can" he previously

[21] By performing and acting, I do not mean in the pejorative sense: "you are *acting* sick" (i.e., you are making a bad-faith effort to play the role of being sick). Rather, by performing and acting, I mean engaging in the activities and habits that make up your situation.

experienced and lived is taken away from him. This results in a sense of longing, as the "I can" is soon realized to be the "I cannot".

Table 3: Key Concepts from Merleau-Ponty's Phenomenology

Key Concept / Short definition	**Clinical Example**	**Clinical Importance**
Lived Body: Our existence in the world is established and maintained through the involvement/activity of our body.	*G*. describes how a decrease in his bodily function has caused him to feel alienated from himself.	Understanding that dysfunction within the body has an analogous disruption within one's life allows a clinician to understand that disease presents itself to a patient as dis-ease.
Intentional Arc: Our engagement with the world is determined by how we imagine and envision present and future action through our body. We attend to the world through an "I can" that determines possibility.	*G*. recognizes that certain activities have been transformed from "I can" to "I cannot". This causes him to lose interest in and motivation to engage in activities that were previously meaningful.	Accounting for physiological dysfunction through the effect it will have on how a patient can participate in their world will help clinicians anticipate and mitigate a patient's reduction in overall functioning.
Inhabitation: How we act within the world through our bodies. Our inhabitation reflects how we interpret ourselves as bodies within the world.	*G*.'s everyday life changes as he adjusts and adapts to his dis-ease. He feels as if he has lost control over his ability to dictate his life and the activities that make up his day.	Recognizing that a disruption in a patient's bodily functions presents a parallel disruption in a patient's everyday function will help a clinician appreciate that they need to attend to both the patient's life as well as their body.

2.2: Charles Taylor's Phenomenological Person

By now, we have some appreciation of how phenomenology can offer us insight into what it means to be a person experiencing disease and how this experience results in personal dis-ease. However, this appreciation might be a bit loose ended for some readers. That is, it might be unclear how various aspects of phenomenology tie together to produce a cohesive account of personhood. In response to this, the goal of this section is to examine the philosopher Charles Taylor's writings on personhood. I will show how Taylor's understanding of personhood presents a mosaic of phenomenological ideas from Husserl, Heidegger, and Merleau-Ponty. The hope is that by the end of this section, the reader will be able to develop—for themselves—a mosaic understanding of phenomenological personhood. That is, this section should prime the reader's imagination so that they can develop their own connections between the three major phenomenological thinkers surveyed in the previous section.

The reason why Taylor's account of personhood is helpful is because it prevents us from mistaking the forest for the trees. While it is common practice in philosophy to show how thinkers are distinct from one another—so as to show the uniqueness or originality within a philosopher's writings or ideas—it is less common to flatten these distinctions and group ideas under a common heading or concept. While Taylor himself does not explicitly claim that his writings on personhood tie together the thoughts of Husserl, Heidegger, Merleau-Ponty, I think it can be demonstrated that the key concepts that Taylor develops in his writing exemplify how these three major phenomenological thinkers can be tied together in a neatly developed account of what it means to be person. In this sense, Taylor's account of personhood can be understood as a mosaic that depicts personhood through the key concepts of phenomenology.

According to Taylor, what lies at the essence of personhood is the ability to interpret and respond to meanings within the world. Taylor's emphasis on meaning is useful because, as we now

know, phenomenology is essentially a philosophical project that attempts to capture how human being come to understand their world as meaningful. One of the strands that ties Husserl's, Heidegger's, and Merleau-Ponty's respective phenomenologies together is that they all address the question: *how does the world come to have any meaning for me whatsoever*? Taylor draws emphasis to this unifying strand through his conception of persons as "respondents". He states: "A person is a being who can be addressed and who can reply" (Taylor 1985, 97). We can be addressed either by other persons, ourselves, or by our world. We can offer up a meaningful response someone ask us the question: "who are you?", we can respond when we, ourselves, ask: "who am I?", and we can face a situation or set of affairs that requires us to respond (i.e., act) in such a way that reflects an interpretation of who we are.

Offering a response or a reply requires that we have a consciousness that is able to uncover what things matter to us. As Taylor puts it, our consciousness is able to "formulate the significance of things…" (Taylor 1985, 100). The world around me is infused with significance and I am able to recognize this significance through my consciousness of things within the world. On my wall is a framed diploma that is not recognized as being significant until I focus my stream-of-consciousness upon it and recall the importance of obtaining a college degree. This is a point that Taylor borrows from Husserl's phenomenology; for Husserl, the meaning of things is arrived at through our conscious and lived interaction with the thing. The world is set aright and made meaningful by the person living within it. However, Taylor is careful to point out that: "things matter to us prior to this [formulation of the significance of things through consciousness]" (*ibid.*, brackets added). My diploma provides me with a sense of pride and self-worth in addition to allowing me to achieve future educational/professional goal. These things matter to me because I have a certain interpretation of who I am and possess a life-plan that maps on to this interpretation.

Namely, I interpret myself as a scholar who requires some reasonable level of confidence (i.e., pride and self-worth) in order to obtain a higher-level degree (i.e., achieve a future educational/professional goal). This is a point that Taylor borrows from Heidegger's hermeneutics; our self-interpretation will shape what things matter to and for us. To be a person—someone capable of offering a reply to another, themselves, or a situation—of course requires a conscious recognition of the significance of the things we find in our world, but it also requires an interpretation of ourselves so as to know how and why these things matter to us at all.

Taylor's formulation of persons as respondents (i.e., beings that are capable of offering a reply when addressed) is derived from the notion that persons are beings capable of formulating a life-plan. To know a person amounts to knowing what things matter in their life and how they have planned their life around those things that matter to them. Heidegger would refer to this as an aspect of care (i.e., concern for) which he describes as the motivation for our engagement and involvement with our world.[22] According to both Taylor and Heidegger, we interpret ourselves as filling a role within our world and then engage in the actions that fulfill this role. For instance, a surgeon *planned* to become a surgeon by interpreting themselves as someone who is capable of performing surgery and then taking part in the activities that would allow them to perform such surgeries. However, this surgeon did not come to care about surgery through pure accident, they

[22] Heidegger states that all human being is discovered as being wrapped up or enveloped in some activity that reflects its engagement with its world—this is what Heidegger will refer to as "being-in". Heidegger states: "Dasein's facticity is such that its Being-in-the-world has always dispersed itself or even split itself up into definite ways of Being-in. The multiplicity of these is indicated by the following examples: having to do with something, producing something, attending to something and looking after it, making use of something, giving something up and letting it go, undertaking, accomplishing, evincing, interrogating, considering, discussing, determining.... All these ways of Being-in have concern" (Heidegger 2007, 83 [56]). It should be noted that Heidegger distinguishes between the terms "care" (*Sorge*) and "concern" (*Besorgen*) (Heidegger 2007, 237 [193]). Heidegger uses the term "care" to refer to the overall structure of human being. In this sense, "care" can be understood as a noun referring to this overall structure. "Concern", on the other hand, represents the activity of engaging in "care"; "Concern" represents human being engaging in the *activity of being* human being. In the German, *sorge*, is the nominalization of care (e.g., he has no *care*). Whereas *sorgen* is the denominalization of care (e.g., he *cares* about his mother). *Besorgen* (translated as concern) can then be understood as "in a state of caring".

did not establish their plans to become a surgeon by simply deciding one afternoon during childhood: “Oh well, I think I’ll become a surgeon”. Rather, the surgeon has prior encounters with other surgeons who serve as an influence upon them. Perhaps their parents were both surgeons, or perhaps they underwent a major life-saving at a young age. Either way, witnessing the unfolding of another’s life-plan someway influences how we plan our own life. According to Husserl, we come to be the person that we are through the influence of others that we find within our lifeworld. Persons, Husserl would say, have an *intersubjective* identity. A person’s life-plans are not spontaneous (though spontaneity could affect their life-plan), rather, a person’s life-plans are adaptations and evolutions of another person who serves as an influence for them. How someone responds to themselves, others, and the world will depend on how they interpret what things matter to them, and how they take into account the various influences that have had an impact on how they direct their life. As we can see then, Taylor’s notion of a person as a respondent gathers together aspects of both Husserl’s and Heidegger’s respective phenomenological accounts.

In addition to this, the influence of Merleau-Ponty is not missing on Taylor’s account of personhood. Undergirding Taylor’s notion of a person being a respondent is the understanding that persons are embodied. According to Taylor, our capability to respond depends upon what he calls our “embodied agency”; I have the capability to respond to my situation because I am able to perceive that I have a world and have some grasp on my situation within such a world. This is a point taken from Merleau-Ponty, who argues that the only way we can inhabit (i.e., live within) our world is if we are able to have access to an intentional arc. Such performance requires that our ability to perceive the world remains intact. If we were unable to perceive the world as a gestalt—as a sensible whole that I can make meaning out of—then I would lack the ability to act within it; I would be unable to respond in any meaningful way to the world. Taylor uses Merleau-Ponty’s

focus on embodiment show that our capability to respond to our world necessarily depends on the way that we are embodied within the world. If we were lacking perceptual access to the world, if we were unable to perceive a world whatsoever, then we would not be able to act within it, we would not be able to respond to it and other persons found within it.

By arguing that persons are essentially respondents, Taylor ties together major ideas within the phenomenological tradition. To be a respondent requires that we have some embodied agency; it requires that we have some perceptual grasp on our world and how we can act within it. This embodied agency allows for us to interpret ourselves within the world, to cope with our human *being* and engage in the activities that our meaningful to us. However, we are also able to reflect upon our world and realize the meanings that certain things hold for us; we are capable of being reminded of why things matter to us and how we plan to preserve those things that matter to us.

Taylor provides us with a mosaic view of personhood in that various aspects of different phenomenologists can be brought to the fore when trying to understand what it means to regard a person as a respondent. In the clinical setting, such mosaic thinking is useful when trying to develop a way to understand a patient as a person. There will not be a "one-sized, fits all" approach when using phenomenology to understand a patient as a person. In certain cases, aspects of Husserl's phenomenology may stand out to a clinician. In other cases, Merleau-Ponty might be the thinker that draws the clinician closer to a patient's sense of personhood. Put simply, gaining an understanding of how a patient can be viewed as a respondent—as a person—will require an act of creative effort by the clinician. As we can see, then, putting a patient's lived experienced in conversation with the ideas of phenomenology requires the creative activity of piecing together bits of information in a way that helps a clinician better understand what it means for a patient to live with dis-ease. This is not an easy task, as one clinician states, such creativity runs against the

grain of evidence-based medicine, such creativity forces the clinician out of the comfort of definite science and into the messy practice of medicine as an art (Devi 2015). Yet, while it may be difficult, such creative thinking can help "defamiliarize the familiar, cultivating awareness of new possibilities. Such eye-opening activities can be a useful counterbalance to the kind of linear thinking that is commonplace in medical education" (Green et al. 2016). Engaging in such activities can remind clinicians that "one of the central aims of medicine is to heal, or 'to make whole,'" and it happens that "This is also the essence of creativity—synthesizing disconnected fragments into a new, meaningful whole" (Liou et al. 2016).

2.3: The Person in the Clinic

In this section, I would like to invite the reader to engage in a creative thinking by considering the following question: *what would it mean for G. to be a respondent when he enters clinical care?* From this chapter, know that it means placing *G.*'s condition in the context of his life's plans and understanding what things matter to *G.* within the context of these life plans. *G.*'s dis-ease has an effect on how he recognizes himself and his place within the world. As Taylor would say, *G.*'s embodied agency is impacted by the physiological dysfunction that prevents *G.* from fully engaging in the various activities that reflect *G.*'s response to the question "who am I?". Disease represents a frustration of personal identity which is then felt by each patient as dis-ease; the frustration of being unable to engage with the world through their prior state of relative ease.

Essentially, disease and dis-ease require *G.* to renegotiate his ability to make and reflect meaning within the world. The disease of CHF has an impact on how *G.* can engage with the world as a body—his previous "I can" is transformed to his current "I cannot". In attempting to gain a greater understanding of *G.*'s personal experience of illness, a clinician must be able to coordinate an understanding of *G.*'s physiological disruption with an empathetic understanding of the

disruption that *G*. experiences within the context of his own life. This coordination puts a third-personal perspective of physiological disruption in conversation with a first-personal perspective of the lived disruption that arises from illness. This balancing between an understanding of disease and dis-ease allows for a clinician to develop a sense of who *G*. is as a person. By momentarily pausing lines of inquiry that have to do with *G*.'s physiological pathology, a clinician can begin new lines of inquiry into how *G*.'s illness has an impact on the more *personal* aspects of his disease. These personal aspects, I believe, are revealed to clinicians by employing phenomenological concepts within clinical practice.[23] So, the concepts and theory of phenomenology can help clinicians develop a greater understanding of who their patients are as persons by considering how physiological disruption result in disruptions within a patient's own lived sense of personhood.

Importantly, these phenomenological concepts can be used to help guide clinical practice and the direction of *G*.'s treatment. If not properly treating, CHF will quickly progress to late-stage disease (class III or IV) which greatly raises the risk of arrhythmia and eventual sudden cardiac death. In addition to this, unmanaged CHF can result in potentially fatal complications; an untreated reduction in heart function will result in damage to multiple organ systems which then raises the chances of potential catastrophic organ failure. As is made evident, healing *G*. will take more than simply supplying him with various pharmacological interventions that help mitigate the physiological dysfunction within the body. Rather, healing *G*. as a person will require making clinical suggestions that appeal to *G*.'s self-interpretation and how he enacts meaning within his

[23] It should be noted that phenomenology is not the *only* way that clinician can uncover personal aspects of a patient's life. The framework of narrative medicine contends that clinicians gain a greater appreciation of a patient's illness by making an attempt to understand a patient's illness experience using the elements of narrative theory (Charon 2008). While narrative theory provides clinicians with an understanding of *the story of* a patient's illness in a way that helps uncover how a patient experiences disruption as a result of their illness, I think phenomenology presents clinicians with a conceptual toolkit that can provide more grounding to the ideas established within narrative theory. Phenomenology can provide greater insight into the various first-personal perspectives that are presented within narratives.

world. CHF is, of course, a disease that disrupts one's life, which results in lifestyle transformations. People living with CHF often become more sedentary as their dis-ease saps their motivation to engage with the world. This lack of motivation can result in depression and emotional stress (Rustad et al. 2013). These changes in lifestyle can further exacerbate one's physiological dysfunction as inactivity and emotional distress can put further strain upon the heart. To help mitigate the effects of disease, *G*. will require suggestions for how to navigate living within the world through his dis-ease. He will require help with knowing how to be a *person* coping with dis-ease.

Now, I would imagine the reaction of some clinicians might be along these lines: "this is beyond the scope of clinical practice, this is a job for a therapist or social worker". I contend that these clinicians sell themselves short. A clinician maintains a unique position within a patient's experience of dis-ease. A clinician—broadly construed here as a physician, a nurse, or anyone providing patient-facing care—has the privilege of bearing witness to a patient's lived experience as well as having advanced knowledge of their physiological dysfunction. When *G*. remarks that his dyspnea and fatigue are having an impact on his everyday life, the clinician can realize that his reduction in ejection fraction is impacting his ability to engage in the meaning-making activities that have preserved *G*.'s sense of personhood. Only the clinician will be able to place the context of personhood within clinical practice so as to dictate various treatment directions and recommendations. Only a clinician can creatively piece together a whole picture. Therapists and social workers, while trained to address matters commonly referred to as "personal", are not able to make clinical decisions that take into consideration who someone is as a person. A therapist or social worker cannot impress the importance of maintaining physical activity and managing stress

in order to help reduce further damage to *G.*'s heart. Nor can a therapist or social worker know how to manage *G.*'s medication so as to reduce side effects while still maintaining clinical efficacy.

However, without understanding who *G.* is as a person, impressing the importance of physical activity and stress management most likely will amount to ineffective, vague prescriptions: "you should still be active" or "you should take it easy, avoid getting stressed". Understanding *G.* as a respondent within the world, as a person who performs and enacts meaning through his body, a clinician will be able to have a frank and empathetic conversation with *G.*:

While I do not know what it is like to live with your illness, from what I can understand from listening to you describe your symptoms and reviewing your chart, I think the best thing we can do now is try out some changes to the activities that you enjoy. It is important that you keep active, not only because it will help with your heart function but also because it will allow you to reclaim a new sense of normal for yourself. I gather that you like doing projects around the house. Your symptoms might not let you do things at 100%, but perhaps you can try enlisting some help through some close friends or family. That way, if you're feeling like you need a short break or rest, or if you need to slow down a bit, they can help keep the project on track. Maybe you can use this as an opportunity to teach someone your close with some of the carpentry skills you've picked up over the years.

Personalized medicine, understood here as providing care that addresses who someone is as a person, requires making clinically informed suggestions that might help a person reclaim what normalcy might be for them so that they can begin to reengage in meaningful activity within their world. Dis-ease is often described as a loss of our well-being. Up to this point, I have described illness as the loss or absence of a state of ease. As Svenaeus would argue, a key part in understanding dis-ease is realizing that dis-ease renders our existence as unhomelike. However, it

is also important to understand that a key aspect in what it means to heal a person is redefining and recapturing what normalcy might look like for this person. As Carel states: “it is also important to acknowledge the possibility of continued, or regained, normalcy, and the periods of stability that often characterize chronic illness” (Carel 2016, 147). A state of chronic dis-ease does not mean that lived normalcy is forever lost and that a person will continuously suffer and mourn their inability to engage within the world as they previously had. Rather, there is opportunity in dis-ease to reimagine what activities can be understood as taking on new meaning. To use a Heideggerian frame, disease can allow for one to *re*-interpret themselves and who they are. Disease can bring about a crisis of personal identity, as the person experiencing disease might feel alienated from the world they previously inhabited. However, the dis-ease that arises from disease can also be framed as an opportunity for a continued building of one’s identity and how they interact with the world. Assisting one with identity-building within disease and dis-ease can then be construed as *personal healing*.

Chapter Summary

In this chapter, I have provided insight into how the third-personal understanding of disease can be cooperated with a first-personal understanding of dis-ease. The concepts of phenomenology provide clinicians with a way to coordinate their clinical-scientific expertise with an understanding of how disease affects patients on the level of personal, lived experience. In order to provide clinician with a way to imagine a more cohesive account of phenomenological personhood, I introduced the reader to the philosophy of Charles Taylor, who can be understood as presenting us with a mosaic of phenomenological ideas in order to understand the concept of personhood in general. I argued that this mosaic style of thinking regarding phenomenological personhood can help clinicians uncover how to apply phenomenological concepts to the specific context of their

patient's lives. In the next chapter, I hope to provide further evidence as to the clinical relevance of phenomenology and understand patients as persons. I aim to do this through re-interpreting the concept of empathy within clinical practice through a phenomenological lens.

CHAPTER THREE: EMPATHY, THE PERSON, AND MEDICINE

In the previous chapter, we gained a greater appreciation of how various phenomenological concepts and ideas can aid us in the task of understanding a patient as a person. This understanding of a patient as a person has a practical, clinical upshot. By understand a patient as a person, we are provided with a better understand of the contexts in which they live. A better understand of these contexts better inform treatment decisions, suggestions, and overall appreciation that a clinician can attend to more than just a patient's physiological condition. In this chapter, we will follow along with some of the phenomenological concepts and ideas of the previous chapter in order to gain a more thorough understanding of how clinicians can engage in a helpful and constructive form of empathy.

3.1: Diagnosing Empathy

Despite claims that empathy has a positive impact on patient outcomes and quality of care (Mercer and Reynolds 2002; Hojat et al. 2011; Canale et al. 2012), empathy, as a medical concept, remains a black box to most practicing clinicians. Empirical, quantitative research often employs various scales used to "measure" levels of empathy (Pedersen 2009, fig. 1). The most popular of these scales is the Jefferson Scale of Empathy (JSE) which was originally developed as a way to quantitatively access how physicians perceive and understand the role of empathy in medical practice (Hojat 2007, ch. 7). Yet, while quantitative metrics like the JSE provide us with the insight that empathy or empathy-adjacent beliefs or practices have some impact on medical care, it remains unclear what it means to practice empathy and how to employ this practice within a clinical context. It is in this sense that empathy still remains a black box to most clinicians.

Various attempts to capture the essence of clinical empathy—to lift the lid and peer into the black box—has resulted in a multitude of various interpretations of what constitutes empathy in a medical context (Zhou et al. 2021). However, this peering into the black box by multiple scholars from a multitude of academic disciplines has resulted in the thought that empathy is simply a grab-bag of competing accounts. Such pessimistic plurality has resulted in some scholars questioning the legitimacy of empathy as a clinically relevant concept. In a section entitled "A Sober Perspective on Empathy", Jean Decety, a neuroscientist whose work focuses on the neuroscience of empathy, remarks that "today, the term *empathy* is used indistinctly in everyday language and even in medicine to refer to a heterogeneity of relatively different phenomena. It has become almost cliché" (Decety 2020. p. 565). According to this line of thinking, it might best to set aside discussions of empathy so that we can better define the humanistic skills that we mistakenly refer to as "empathy". Decety's call to leave clinical empathy behind echoes that of Riana Betzler, who argues that an ideological obsession with empathy has resulted in the term becoming ill-suited for use within clinical practice. According to Betzler, the idealizing of empathy has resulted in it being turned into a performative imperative: *be more empathetic*. But, at the same time, it remains conceptually and practically unclear what exactly it means to be more empathic (Betzler 2018, p. 577). Unfortunately, this mismatch between the demand and its explanation will likely result in some clinicians unreflectively mimicking what they take to be the practice of empathy offered in a medical textbook or in various empathy scales that may actually have very little clinical relevance or upshot (Pedersen 2009). However, since empathy is a context-dependent practice, such unreflective mimicking of empathy will not be well suited for the kind of reflective caring that is necessary for the practice of medicine.

This conceptual unclarity surrounding empathy has not stopped medical schools from implementing humanities-based courses—arts, literature, and creative writing—that aim to foster and develop a greater sense of empathy in medical students. Much of the current and continued focus on empathy within a clinical context may be a reaction to numerous studies whose findings report a drop in empathy levels as students progress through medical school (B. W. Newton et al. 2000; Bruce W. Newton et al. 2008; Hojat et al. 2009; 2020; Neumann et al. 2011; Chen et al. 2012). Critics of this pedagogical push to instill empathy in young physicians wonder whether empathy can be "taught" or "learned". A well-known example of this skepticism can be found in Leslie Jamison's essay *The Empathy Exam*. Jamison, reflecting on her previous employment as a medical actor, wryly recounts how she was asked to evaluate medical student's interactions with her performed character by completing a checklist. She recalls that:

> Checklist item 31 is generally acknowledged as the most important category: "Voiced empathy for my situation/problem." We are instructed about the importance of this first word, *voiced*. It's not enough for someone to have a sympathetic manner or use a caring tone. The students have to say the right words to get credit for compassion (Jamison 2014).

The skepticism, of course, arises with the belief that empathy can be cultivated by teaching medical students the "empathy script" and then evaluating them on how well they adhere to this script. Much of medical education centers around what can be called a "competency model". In this model, a medical student's competence in completing a certain medical task (i.e., performing a procedure or narrowing down a differential diagnosis) is measured by how well a student can adhere to the checklist that was taught to them. In short, an order of complex operations is provided to the medical student, and how well they follow this order of operations will help determine their level of competency (Eraut 2002; Weinberger 2010). The competency-based approach is helpful in ensuring that early-career physicians are able to adhere to the standards of care that are established by their more senior peers. After all, to proclaim oneself as a physician necessarily requires that

one can *competently* perform the tasks that are expected of physicians. The question is, then, whether the competency model can teach and measure competency in empathy in the same way it can teach and measure competency in the treatment of a heart attack in an acute care setting.

In philosophy, a category mistake refers to the confusing (i.e., mistaking) of a thing from one category within the context of another, inappropriate category. When the used-car salesman says: "this car sells itself" they are—strictly speaking—making a category mistake. Cars do not sell anything; they do not belong to *the category* of things that are capable of selling things. Critics and skeptics regarding the teachability of empathy in medical school would likely regard it as a category mistake to say: "I learned empathy from my empathy textbook", "I am certified in empathy because I took empathy training", or "I got high-marks on my empathy exam, so I'm competent in empathy". Engaging in empathy may not belong to the same category of things as performing a valvuloplasty, correctly diagnosing ulcerative colitis, or intubating a patient for mechanical ventilation to treat acute respiratory distress syndrome. As critics and skeptics would likely argue, it would be a category mistake for someone to claim: "I am competent in empathy" because engaging in empathy is a highly context dependent, intersubjective activity that cannot be broken down into a competency checklist.

In addition to this skepticism regarding the teachability of empathy, there also persists a worry that perhaps our current methods for establishing empathy in medical schools might unhelpfully reframe a patient's suffering as something that a clinician can fully understand. One established way to try and bolster empathy in medical school is to teach students the general tenets and principles of what is referred to as narrative medicine. A common exercise within the practice of narrative medicine is to write a medical history from the patient's perspective so that clinicians gain a better understanding of where the patient is coming from (Garden 2007, p. 554). This

exercise is used as a way for physician to better understand the situation from which their patient attends; to try and "get into the patient's shoes". However, Rebecca Garden, a medical humanities scholar, aptly asks: "what part, if any, of a narrative that is written *as if it were* the patient's perspective accurately represents the patient's point of view if the narrative is written by a medical professional?" (Garden 2007, p. 555). Garden advises that one should use caution while trying to establish a clinical empathy since suffering is not the expertise of the clinician, but rather the patient: "while students may seem to master knowledge of a first-person account or short story about illness, they never assume mastery over knowledge of the patient" (Garden 2007, p. 564). As Garden would argue, even if a clinician is able to better understand their patient through a literary or narrative investigation, it should be acknowledged that certain aspects of a patient's suffering remain uncommunicable due to suffering being a uniquely personal experience.

Perhaps the worry here is that the boundary between the personal and the medical is becoming increasingly blurred or dissolved.[24] As this boundary fades, some worry that patients may lack a true sense of autonomy within medical encounters. Relating this to a discussion of empathy, some may worry that if clinical empathy is only practiced as a way to get patients to better comply with medical treatment, then it certainly seems that clinical empathy might be recognized to be merely a tool of power that the institution of medicine wields in order to get patients to do whatever is in the interest of the institution—rather than do what may be within the best interest of the patient.[25] If we teach clinicians-in-training that the purpose of clinical empathy

[24] It is necessary here to reiterate that my conceptualization of a personalized medicine is not meant to dissolve the boundary between the personal and medical so that clinicians can ensure patients comply with treatment plans. Rather, the goal of personalized medicine is to uncover who their patients are *as a person* in order to offer treatment recommendations that can help alleviate some aspects of this person's dis-ease. Put another way, the goal of a personalized medicine is to develop a form of medicine that begins with a desire to better understand patient's perspective of the world and then reimagine what it means to heal a patient based on insight into this perspective.

[25] See (Hooker 2015) for an analysis on the relationship between clinical empathy and biopolitics. Hooker argues that if clinical empathy becomes a way to enroll "patients into their own therapy and for entangling ethical and medical

is to "master" the patient's perspectival view of suffering in order to justify clinical interventions and treatments to alleviate such suffering, then we might worry that perhaps empathy is not being used to the patient's benefit but rather for the benefit the clinician who just wants their patient to go along with their treatment. Unless a clinician truly grasps what empathy *is* and what it is *for*, the worry persists that perhaps clinicians might only be using a concept like empathy to further their own interest rather than the interests of the patient themselves.

Taking all this into account, it certainly seems like we are led to a pessimistic diagnosis regarding the role of empathy within a clinical context. If you are convinced by the arguments presented above, then you are possibly led to think that we should abandon discussion of empathy within a clinical context. At this point, you might be led to believe that the idealization of clinical empathy has rendered it an almost cliché term that has been implemented (and evaluated) in medical school curriculum so that overachieving students can obtain mastery over a patient's suffering in order to get them to better comply with their treatment plans. Certainly, these critiques of clinical empathy sober us by presenting a perspective of clinical empathy that does not start with the assumption that clinical empathy is desirable or necessary for the practice of humanistic medicine. Yet, we might wonder if this sobering account should cause us to lose hope in the prospect of embracing clinical empathy, or if it should rather cause us to reimagine what clinical empathy might amount to.

If we are to take the latter route and reimagine empathy within a clinical context, we will need to establish some desiderata in order to ensure that a revisioning of empathy can withstand the scrutiny of the aforementioned critiques of clinical empathy. First, this account of clinical empathy must lift the lid on the black box of empathy; it must provide some explanation for *why*

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objectives" (Hooker 2015, 547), then we should suspect that clinical empathy merely preserves the power of the institution rather than the interests of the patient.

empathy can result in higher quality of care and better patient outcomes. Second, this account of clinical empathy must be theoretically robust enough to cause its practitioner to actively engage in reflection on a context or situation rather than the reciting of a script or an unreflective "going through the motions" with respect to empathy. Third, this account of clinical empathy must establish and uphold a perspectival or phenomenological distance between the empathizing clinician and the suffering of the patient; the clinician must understand that the patient's dis-ease is a foreign experience that they only have access to via the patient. The following table explains these three desiderata in greater detail.

Table 4: Desiderata of an Account of Clinical Empathy

Desiderata	**Why is it desired?**	**Alleviates the worry that…**
Must lift the lid on the black box of empathy.	Lifting the lid on the black box of empathy ensures that we can determine what about empathy makes it useful for clinical practice. It ensures that we understand *why* it is the case that empathy can aid in the task of attending to a person's dis-ease.	Clinical empathy is an empty or cliché notion that simply refers to a disjunct set of other humanistic practices such as sympathizing or acting out of compassion.
Must cause the clinician to reflect on the patient's specific context and situation.	Given the context dependent nature of empathy, it cannot be the case that a general script or set of empathic gestures can be understood to be equivalent to empathy. Empathy must result from the recognition of a patient's specific condition which causes the clinician to reflect on the patient's condition.	Clinical empathy is not really empathy because it is simply a matter of going through a checklist of phrases or actions that a medical school has determined to be a representation of empathy.
Must establish/uphold a phenomenological distance between the clinician's empathy and the patient's lived dis-ease.	Allow for a phenomenological asymmetry between the clinician's experience and the patient's experience maintains that caring for a patient requires viewing the patient as the expert of their dis-ease.	Clinical empathy diminishes the role of the patient in the healing relationship by having clinician think that they have full and immediate access to a patient's dis-ease.

In the sections that follow, I will provide an account of clinical empathy that I argue will satisfy all three of the desiderata listed above. This account will draw from the phenomenological description of personhood established in the previous chapter as well as introduce the reader to Edith Stein's influential phenomenological account of empathy.

3.2 Lifting the Lid on the Black Box of Empathy

I argue that lifting the lid on the black box of empathy requires clinicians to recognize that (1) clinical empathy is a process rather than a single mental act or ability and (2) the unique importance of clinical empathy can be understood through the effect it can have on clinical practice. Regarding (1), though there are numerous definitions of empathy within medicine, one of the most well-known is the one offered to us by Carl Rogers, a clinical psychologist and early pioneer of a humanistic approach to clinical practice. Rogers states that empathy is "to perceive the internal frame of reference of another with accuracy as if one were the other person but without ever losing the 'as if' condition" (Rogers 1959, p. 210). Other definitions of empathy within a clinical context more or less follow along the lines established by Rogers (Hojat 2007, p. 5-6). Now, the problem with these definitions of empathy is that they often portray empathy as a single action or an ability. In many of these definitions, the empathizer is able to *perceive*, or *mindread*, or *get in someone else's shoes*. In this sense, empathy is made out to be a trick of sorts: I perform the empathy trick and I end up in a state of empathy with another person. We can make empathy less tricky by illustrating the steps that goes into the trick itself. Illustrating these steps is crucial to lifting the lid on the black box of empathy.

Regarding (2), we can distinguish clinical empathy from other humanistic clinical skills by noticing the unique impact that the process of clinical empathy can have on clinical practice. One barrier that persists in developing a practical understanding of the process of clinical empathy is the relative unclarity of how empathy should be distinguished from sympathy or compassion. Hojat, who is often cited as establishing a distinction between sympathy and empathy, states that empathy can be understood to be *cognitive* in character whereas sympathy can be understood to be *emotional* in character (Hojat 2007, p. 10-13). Empathy, according to Hojat, involves an intellectual processing that allows someone to "*know* another person's concerns better" (*ibid*.)

whereas sympathy is an affective processing that allows someone to "*feel* another person's concerns better" (*ibid*.).

Yet, we might wonder: is it natural to think of empathy as an emotionally detached understanding and sympathy as an emotionally attached understanding? Jodi Halpern, a psychiatrist who has written extensively on the topic of clinical empathy, states that: "doctors have aimed for their own idealized version of empathy, one in which they suppress personal emotions yet are motivated by an altruistic yet 'detached' concern for patients" (Halpern 2014, p. 301). Proponents of detached concern argue that this way of caring for patients protects clinicians from becoming too involved in their patient's dis-ease; clinicians who try and match their patient's emotional states might themselves become "paralyzed" or "blinded" by such emotions and therefore become unable to provide appropriate or professional care for their patients. There is a real worry, then, about whether the current distinction between empathy and sympathy is an artificial, institutional distinction. We might worry that such a distinction might only find support amongst clinicians who assert that it is necessary for clinicians to care for their patients in an emotionally detached manner.

More importantly, it certainly seems unlikely that patients would regard clinical empathy as being an "emotionally detached" form of caring. Given that empathy is thought by most non-clinicians to be a form of affective (i.e., emotion-driven) communication, it seems unlikely that patients would report *emotionally detached* care as being empathic care. In a recent qualitative study researchers found that a key theme associated with patient's perceptions of empathy was *emotional resonance* (i.e., attempting to feel how the patient is feeling) (Sinclair et al. 2017). Given this, there is reason to suspect that the current manner of distinguishing empathy from sympathy results in further conceptual confusion. It remains unclear why we should distinguish empathy

from sympathy in terms of cognitive versus affective processing, especially considering that patients are likely to assume that empathy requires some sort of affective processing. I argue that a better way to distinguish between the two concepts—and therefore add conceptual clarity to empathy—is to elucidate how the process of empathy results in a unique impact (i.e., an impact that sympathy cannot provide) on clinical practice.

Taking into account (1) and (2) from above, I assert that we can lift the lid on the black box of clinical empathy by examining the phenomenologist Edith Stein's account of empathy (Stein 1989). Stein, a student of Husserl, wrote her doctoral dissertation on a phenomenological account of empathy. The remaining text we have from her dissertation is a published book section entitled: *On the Problem of Empathy* in which Stein provides an account of how it is possible for someone to understand what Stein calls "foreign experience". Stein's dissertation uses Husserl's phenomenological method and terminology to provide an account of how it is possible for our own consciousness to understand another person's conscious experience. The problem is this: while it seems relatively straight forward for Husserl's phenomenological framework to account for *my own* conscious experience of pain arising from a needle's prick, it is not so straight forward for Husserl's framework to account for how I can become conscious of *another's* sharp pain when they are jabbed with the syringe. Stein's question is: how is the other's pain presented to us within our own conscious experience; how can I feel *as if* I am the one being stuck with the needle? More generally: how is another's experience presented to us within our own conscious experience; how can I feel *as if* I am the one undergoing the experience?

While the entirety of Stein's account of empathy deserves its own thorough analysis, for our current purpose of better understanding clinical empathy I will focus on how Stein treats

empathy as a process rather than a single act. This process is laid out for us by the philosopher of medicine Fredrik Svenaeus, who writes:

> Stein takes empathy to be a *three-step process* in which the experience of the other person (the empathee) (1) emerges to the empathizer as an experience had by the empathee, the empathizer then (2) follows the experience of the empathee through, in order to (3) return to a more comprehensive understanding of the meaning of the experience had by the empathee (Svenaeus 2018, 742, emphasis added).

I argue that by situating these three steps within the context of clinical practice, we are provided with a more robust understanding of clinical empathy. In what follows, I clarify Stein's empathy process and then connect this process to the practice of empathy within medicine.

According to Stein, the empathy process begins when we notice the presence of a sensation or feeling that does not originate within ourselves. The snoring, slumbering student suddenly hears their name get called by the teacher. They snap out of their nap and look up with a surprised expression and a bright red face. A fellow student thinks to themselves: *how embarrassing!* In this scene, the fellow student is able to recognize that the slumbering student is experiencing embarrassment. The fellow student is able to notice the presence of a feeling—the slumbering student's embarrassment—despite not having that feeling originate within themselves (i.e., they are not the one that is embarrassed). This fellow student's recognition of another student's embarrassment exhibits that they can grasp feelings or sensations that are not their own. This begins the empathy process because it allows the empathizer to understand that the subject of the experience is not themselves, but rather another person with whom the experience originates.

The next step of the empathy process takes place when the empathizer begins to engage with the non-original feelings or sensations. By this, I mean the empathizer responds to the non-original feelings or sensations *as if* they were the empathee. The fellow student thinks: *how embarrassing!* Following with this thought, the fellow student's body tenses up, their own face

goes red. They *feel* embarrassment even though this embarrassment did not originate within themselves. Now, according to Stein, our sensations and feelings result from what she calls our "zero-point of orientation" (ZPO). What this means is that we attend to and participate within our world through the standpoint of our own bodies. What makes sensations and feelings my own, then, is that fact that they arise from my ZPO in response to some state of affair facing me within the world. When *my* toe slams against the leg of the table, the pain that results belongs to *me uniquely*; it is *my own* since only I have access to *my ZPO* and the pain that arises from it. Put another way, only I am able to have *experiential access* to my own body, no one else can experience what it is like to be within my body. As a result, the pain felt when I stub my toe *must be my own*: it cannot belong to anyone else. The same is true for the slumbering student's embarrassment; the embarrassment *belongs* to the student because only they were alerted out of their nap by the voice of the teacher. We can, however, *imagine* what it is like to have access to another person's ZPO. This does not mean that *we can* enter into another person's ZPO (only I can feel my own pain), rather it means that we can act or respond *as if* these feelings were our own. Responding to non-original feelings and sensations—tensing up in response to another's embarrassment, wincing to another's pain—results from being able to first being able to recognize another's feeling or sensation (i.e., embarrassment, pain, etc.) and then responding to those feelings and sensations *as if* they were your own.

The third, and crucial final, step of the empathy process consists in the empathizer returning back to the empathee's experience in order to gain a better understanding of the empathee's experience. In step two, the fellow student feels their own face get red as they respond to the snoring student's embarrassment; they feel *as if* they, themselves, are facing such embarrassment. The third step of the empathy process consists in the recognition by the empathizer that the feeling

or sensation that they have responded to is not their own but rather originates within the empathee. So, in following through with the third step of empathy, the follow student recognizes or realizes that the embarrassment they feel within themselves is not *their* embarrassment, but rather the embarrassment of the student's whose nap was interrupted by the teacher's call. This final step of empathy directs the empathizer back to the empathee so that the empathizer can better understand the empathee's experience. The empathizer becomes aware that whatever occurred within them during step two could have occurred within the empathee. To carry on with our example, the fellow student becomes aware that the uncomfortableness they underwent during step two could have been felt by the napping student in response to their embarrassment.

To summarize, the empathy process begins with the empathizer recognizing a sensation or feeling that originates within an empathee. After this recognition, the empathizer engages with the empathee's sensation or feeling *as if* it originated within themselves. Finally, the empathizer directs themselves back to the empathee, using the content gained from step two in order to better understand what it might be like for the empathee to experience this feeling or sensation. We can relate this empathy process back to clinical care by associating it with the phenomenology of personhood developed in the previous chapter. The recognition of a sensation or feeling that originates within another person—the beginning of the empathy process—will require some familiarity with the person in which such a sensation or feeling first arises. While some foreign sensations and feelings may be easy to recognize—seeing contentment in another's smile, embarrassment in another's red face, or pain in another's wince—other, more complex sensations and feelings can only be recognized in a more advanced understanding of a person and their dis-ease. Hence, the framework of phenomenological personhood helps us better understand the complex sensations and feelings that might arise within clinical practice.

In an oft-cited example, psychiatrist Jodi Halpern recounts caring for a successful executive, Mr. Smith, who was paralyzed from the neck down due to a neurological disorder which had left him ventilator-dependent:

> When I entered his room, I saw a helpless, locked-in, cathectic man, whose eyes showed a glimmer of interest in meeting the psychiatrist. I greeted him warmly, and, I later realized, sorrowfully. Gently, I asked him to talk with me. He struggled, trembling and red-faced, to speak a few words through his tracheostomy tube, then asked me to leave him to rest, and his eyes glazed over. I felt ashamed of having pushed him to make a futile effort (Halpern 2001, p. 87).

Ultimately, Halpern was able to recognize that Mr. Smith was expressing hopelessness within his situation. We can understand this as taking part in the second step of the empathy process insofar as she was imagining what it would be like to be "a powerful older man, suddenly enfeebled, handled by one young doctor after the next" (*ibid*.). That is, Halpern imagined the kind of *person* Mr. Smith and what it would be like for this *person to experience dis-ease*. In the previous chapter, we saw how various phenomenological concepts could be used to aid in this imaginative effort. For instance, using Husserl, we can imagine how Mr. Smith *made sense and meaning* of his world by attending to it as a person of status and respect. Prior to dis-ease, Mr. Smith—an executive—would likely take pride in having others do his menial tasks for him (i.e., getting him his coffee, bringing him his mail, etc.). As one can expect, it is unlikely that having others do menial task remained a point of pride for Mr. Smith during his current dis-ease; having others do things for him likely made him feel enfeebled. So, for Mr. Smith, we can imagine that the world had lost its sense, Mr. Smith suddenly lost the point of reference from which he made sense of the world. Consequently, we can then imagine the hopelessness that might arise when we lose this point of reference within the world; we can imagine the hopelessness of feeling lost and not being able to do anything that can help us find our way again. All of this is just to say that when we imagine

what it might be like to be Mr. Smith within the context of the kind of person Mr. Smith is, we are able to better imagine what it might be like to feel hopeless as he might.

In addition to this the third step of the empathy process—returning back to the empathee with a better understanding of how they might feel—can also be related back to clinical care through the framework of phenomenological personhood. In using phenomenology to better understand who a patient is as a person, clinicians are better able to return to a patient when they engage in the final step of the empathy process. Now, in some instances, it might not be an onerous task to recognize complex clinical feelings such as hopelessness, frustration, angst, shame, or guilt. When the oncologist relays to their patient that the recent scan shows more aggressive metastasis, the oncologist might be able to recognize the exhaustion and frustration expressed through their patient's elongated sigh. The oncologist might even be able to imagine what it is like to be told such terrible news and how they, themselves, may feel exhausted and frustrated by such news. However, placing that feeling of exhaustion and frustration within the context of their patient's life will require some familiarity with who the patient is as a person. Using phenomenology in the way described in the previous chapter can help provide such familiarity. For instance, the clinician might employ Heidegger's concept of comportment to recall that their patient interprets themselves as a leader within their community, as someone who values being able to make positive and lasting impacts on the lives of those around them. After the clinician imagines what it might be like to be exhausted and frustrated by terrible news, they can imagine what it might be like to feel that news as someone who comports as a community leader. They might imagine how frustrating it might be to have to withdraw from the community relationships that one has helped establish and maintain or how exhausting it might be to have to share bad news with their community. Through this phenomenological imagining, the oncologist is able to relate their

recognition of their patient's sense of frustration and exhaustion back into the context of the patient themselves. Hence, this phenomenological imagining allows clinicians to engage in the third step of the empathy process by placing complex sensations and feelings that arise within the clinical setting within the context of their patient's life.

3.3: Separating out Empathy, Sympathy, and Compassion

Now, one might still wonder: can we not just get all of this from engaging in sympathy or compassion? What does this empathy process add that sympathy or compassion does not? I argue that engaging in the empathy process in the clinical setting has a unique impact on clinical care in that it allows (and requires) clinicians to *return to their patients* in a way that sympathy or compassion does not. This return to the patient within the empathy process allows clinicians to better engage in the shared decision-making process and establish a treatment plan that addresses a patient's experience of dis-ease.

A clinician who feels sympathy for a patient does not necessarily need to place their sympathy within the context of a patient's life. A radiologist who reviews a patient scan and reports in the scan's impressions that a cancer has spread in comparison to a previous scan can feel sympathy for this patient; they can feel a sense of sorrow directed at the patient having to read such bad news. However, this radiologist's sympathy will never reach the patient or be placed within the context of their life. Sympathy remains largely with the sympathizer, as it is a first personal response to secondhand misfortune: "*I* feel bad *for you*".

Different from sympathy, compassion is often regarded as "feeling with" a patient. In this sense, compassion requires a clinician to interact with a patient in order to offer clinical guidance to this patient. An oncologist whose patient is quite visibly suffering greatly from the rapid progression of their aggressive cancer as well as from the side effects of an ineffective

chemotherapy can engage in compassionate care by having a conversation with their patient and making an earnest attempt to listen to them relay their suffering and worries. Using the information gathered from this conversation, the oncologist can then attend to the patient from their place of suffering, they *feel with* the patient by expressing a common desire with the patient: *alleviate this suffering*. The oncologist then offers clinical guidance in order to help alleviate this suffering; the patient could discontinue chemotherapy and enter into a palliative care program that focuses on symptom relief. While compassion joins the patient and clinician together through a common desire, it does not require a clinician to imagine what suffering, pain, angst, or anxiety *might feel like for a patient*. Compassion may require the first step of the empathy process—a recognition of a sensation or feeling (e.g., suffering from pain)—but it does not include or require the clinician to engage in the further steps of the empathy process.

Both sympathy and compassion have relevance within clinical practice and play an important role in humanistic clinical care. However, neither sympathy nor compassion have the aim of better understanding the meaning behind a patient's feeling. Let us consider Halpern's clinical encounter with Mr. Smith from above. Sympathy can help a clinician appreciate that Mr. Smith's situation is quite dire and unfortunate; such sympathy is a first step in understanding the impact that Mr. Smith's pathological condition is having on his life. Often, sympathy may be the clinician's first affective response to a patient's suffering and this response might serve as the grounds from which they engage in further affective reflection. In a like manner, compassion can help a clinician respond to Mr. Smith's suffering by allowing a clinician to experience a common desire with Mr. Smith. That is, both the compassionate clinician and Mr. Smith wish to alleviate, mitigate, or address his suffering. Such compassion can be expressed by offering treatment option that take into consideration Mr. Smith's state of suffering. In this way, compassion provides

clinicians with a way to allow a patient's suffering to dictate clinical decision-making rather than merely asserting that the "best" treatment for a patient is that which will address an underlying pathology.

The empathy process, with its roots in phenomenology, aims to contextualize complex clinical feelings within the life of a patient from whom these feelings originate. Mr. Smith, a person who once commanded a great deal of respect within his life, feels immense hopelessness as he is treated much like one would treat a helpless child. We can all imagine what hopelessness means within our own lives; we can all think about what hopelessness would look like for ourselves. The empathy process allows us to translate such a feeling within the context of another person so that we can imagine what that feeling *means* to them. A short, bedside visit to Mr. Smith will allow a clinician to recognize the hopelessness that Mr. Smith feels within his current condition (step one). A clinician can then imagine how hopeless they might feel if they were in the same condition as Mr. Smith—they might imagine what it would be like to suddenly have to surrender their ability to care for their patients on account of a pathology (step two). Finally, a clinician returns this imagined hopelessness within the context of Mr. Smith's dis-ease. In step two, the clinician understands what hopelessness *means to themselves.* In step three, the clinician uses this understanding of what hopelessness *means to themselves* in order to translate it into what hopelessness *means to another*. The hopelessness in not being able to care for patients (i.e., what hopelessness means for the clinician) is translated into the hopelessness of not being able to command the respect and dignity afforded to a business executive (i.e., what hopelessness means for Mr. Smith). Engaging in the empathy process provides the clinician with a better understanding of what it *means* to be hopeless in the way that Mr. Smith feels hopeless. Only the empathy process can provide this sense of understanding within the clinical setting, while sympathy and compassion

may make use of step one and step two of the empathy process, they do not require a *return to the patient* in the same way that the final step of the empathy process requires.

Yet, while one might be convinced that the empathy process requires a return to the patient as outlined above, it might still not be clear what the practical, clinical upshot might be for engaging in the empathy process. Earlier, I had mentioned that returning to a patient helps clinicians engage in the shared decision-making process. Shared decision-making is considered an ideal way to engage in what is called "patient-centered" care (Veatch 1972; Brock 1991). Engaging in the shared decision-making process requires a clinician to factor in a patient's values and preferences when establishing a treatment plan. This consideration of a patient's values and preferences helps ensure that a patient's own best interests—expressed through their values—are being served by a particular treatment plan. Proponents of shared decision-making process argue that engaging in the process can help establish a bridge between an evidence-based, scientific medicine and a values-based, humanistic medicine (Hoffmann et al. 2014). In other words, shared decision-making puts a patient's preferences and values in conversation with the available pharmacological, surgical, or technological treatment options. It is argued that this incorporating of a patient's values and preferences may help mitigate unnecessary harms that might arise from the overuse or underuse of treatments (Stiggelbout et al. 2012). Through uncovering what treatments reflect a patient's values and best interest, shared decision-making aid clinicians in determining what is the appropriate treatment on a patient-to-patient basis.

The empathy process aids clinicians in placing complex clinical emotions within the context of a patient's own life which then helps clinicians better understand a patient's values. This better understanding of a patient's values gained through the empathy process can then help bolster the process of shared decision-making. Once a clinician places Mr. Smith's hopelessness

within the context of Mr. Smith's life, it is revealed to them that such hopelessness arises from Mr. Smith's valuing of respect, dignity, and competence—none of which he believes has been reflected within his clinical treatment and care. The return to the context of a patient's life and personhood within the empathy process reveals possible ways to approach patients and their care such that their values and preferences are taken into consideration. Once the process is undertaken, a clinician is able to understand that they must approach Mr. Smith in the way that they would approach their clinical supervisor. A clinician might speak in a frank and terse manner to Mr. Smith—something they might not do with other patients—in order to reflect a sense of business-like respect that Mr. Smith is accustomed. Put in phenomenological terms, a clinician might comport themselves in a manner that reflects Mr. Smith's own comportment within the world.

All of this is to say that certain patient values are revealed to the clinician through the empathy process and that these values not revealed through sympathy or compassion alone. Feeling sympathy might reveal a sense of sorrow felt for a patient, but this sorrow may or may not reflect what a patient is themselves feeling. As such, sorrow may or may not reveal any access to a patient's values or personal experience. Engaging in compassion requires that a clinicians recognize some aspect of suffering and thus engage with a patient's dis-ease, but this recognition serves as a motivating factor in establishing a desire to mitigate such suffering on the behalf of the patient. Only the empathy process, in the way that I have described it, places a patient's complex clinical emotions within the context of their own dis-ease. This return to the patient reveals their values as a clinician begins to understand what it *means* for their patient to feel hopeless, exhausted, frustrated, angry, or resolute. This better understand of a patient's values can then be used to determine whether the patient's treatment plan is appropriate or requires a revisiting.

I believe my analysis has help lift the lid on the black box of clinical empathy by providing insight into how clinical empathy proceeds as a step-by-step process rather than as a singular action. In addition to this, I have shown how the empathy process stands apart from sympathy and compassion in that the empathy process requires a clinician to return to their patient in order to uncover what a particular emotion means to them. This return to the patient helps reveal a patient's values which can then be used to bolster the shared decision-making process. Yet, my analysis of the empathy process has yet to address the two other desiderata established at the end of the first section. In the next section, I will show how the empathy process, as I have described it, can also cause the clinician to reflect on a patient's specific context and condition as well as establish a phenomenological distance necessary to respect a patient's lived experience.

3.4: Context, Condition, Phenomenological distance

One worry that arises when discussing empathy within clinical care is the possibility of clinical empathy becoming an unreflective set of questions or procedures that a clinician undertakes simply because it has become another administrative task that they must complete. I argue that the empathy process can alleviate this worry insofar as it requires a clinician to reflect upon their patients' specific context and condition. By requiring such reflection, the empathy process allows clinicians to attend to each patient's individual dis-ease rather than going through an "empathy checklist" in order to appease administrative demands and documentation requirements.

Crucial here again is the idea that empathy requires a return to a patient in order to understand what a certain feeling or sensation means for a certain patient. The final step of the empathy process individualizes it, and therefore makes it unique to each individual patient's personhood. While certain emotions may be more prevalent in particular clinical contexts, what it

means to feel these emotions will vary from patient to patient—from person to person. For example, The frustration that is felt by a single mother who has just learned they have to come to the clinic once a week for routine infusions to treat an autoimmune disorder means something different than the frustration felt by a marathon-runner who has just learned they will need surgery to correct a tear in their peroneal tendon. For a single mother, such frustration means needing to find someone to watch her children during her infusion as well as explaining to her supervisor that she will need a change in her work schedule in order to accommodate her infusions. For a marathon-runner, such frustration means needing to forgo their training schedule for upwards of four months as they recover from their surgery and allow their tendon to fully heal.

Differences in meaning result from the fact that persons attend to the world from their own unique perspective. As Stein would say, each person has a different zero-point of orientation from which they participate within the world. To complete the empathy process is to appreciate the diversity of personhood at work within the world; to appreciate that each individual person attends to the world from their own unique standpoint within it. This appreciation of an individual's perspective cannot arise from scripted exercises that are meant to mimic actions and phrases commonly associated with empathy or compassion. Rather, this appreciation must be cultivated by an attempt on behalf of the clinician to understand who their patient is as a person. The previous chapter provided clinicians with a phenomenological framework that can be used to better understand their patients as persons by piecing together a patient's sense of meaning, self-interpretation, activity, embodiment, and ability. Put to use within the empathy process, this framework provides the groundwork for clinicians to understand what it means for their patients to experience the various emotions and feelings that arise when living through dis-ease.

All this being the case, the empathy process stands against the prevailing pedagogical model within medical education: the competency model. As was stated earlier in the chapter, we might find it absurd to hear someone remark that they are "competent at empathy" in the same way that they would remark that they are "competent at orthopedic surgery". Whereas a scientific expertise can be measured using a competency examination, humanistic skills such as empathy might evade measurement through such exams. Whether or not someone can consider themselves empathic—at least in the way I have described empathy—will depend upon how well they can proceed through the steps of the empathy process. It is not necessarily the case that going through the steps of the empathy process is an isomorphic procedure in the same manner that an appendectomy is. To be empathetic is to appreciate the variances expressed in each individuals' personality and life. Appreciating such variance stands contrary to the belief that empathy can be a competency that is measured via a standardized test.

With this having been said, educational programs that aim to bolster humanistic skills can help aid clinicians with engaging in the empathy process. VitalTalk™, a program that seeks to enhance a clinician's communication skills, employs a communication strategy referred to as "N.U.R.S.E. statements" in order to articulate empathy (VitalTalk 2019). NURSE statements consist of (1) **naming** an emotion (e.g., *it sounds like you are really frustrated by this*), (2) acknowledging **understanding** (e.g., *I can appreciate how frustrating it must be to go through this*), (3) **respecting** another's efforts (e.g., *it is very commendable that you have tried your best at this*), (4) providing statements of **support** (e.g., *I will do my best to make sure that you are comfortable through all of this*), and (5) **exploring** various meanings (e.g., *can you tell me a bit more about what is contributing to this feeling of frustration?*) (*ibid*.). NURSE statements serve as a practical tool for clinicians who desire a way to express the empathy process. Naming an

emotion requires a clinician to recognize an emotion experience by their patient, acknowledging understanding likely means that a clinician has imagined what such an emotion might feel like, and exploring various meanings represents a clinician's desire to return to their patient in order to gain a better understand of what it means for them to feel a certain emotion or live through a certain experience. When engaging in the empathy process, NURSE statements might serve as a general schema which a clinician might use to build rapport with their patients in order to gather more information about their patients and the contexts that situates their emotions. These NURSE statements, however, are by no means a stand-in for empathy. Being able to reproduce NURSE statements does not represent the ability to proceed along the empathy process, nor does it represent the ability to reflect on how a patient's dis-ease impacts how they inhabit the world. Put in other words, an administrative program that determines how frequently physicians use NURSE statements will not be a reflection on how empathetic their clinicians are; NURSE statements should not be treated as an "empathy examination".

Another worry that arises when discussing empathy within clinical care is what I refer to as a proper respect of the phenomenological distance between a clinician and patient. One of the key themes of the phenomenology of illness is the phenomenological gap that exists between the clinician and their patients. In a foundational works of the field, *The Meaning of Illness*, Toombs spells out how patients and clinicians attend to the same phenomenon (i.e., pathology) from two radically different perspectives. A clinician, using scientific expertise and clinical competency, perceives illness as a scientific concern, whereas a patient, through their lived experience, perceives illness as dis-ease (Toombs 1993). This difference in perception marks out two spheres of expertise that undergird the clinician-patient relationship: the clinician inhabits the sphere of medical expertise whereas the patient inhabits the sphere of their own experience. In this sense,

respect within the clinician-patient takes place by not encroaching too far within another's sphere of expertise. It would be considered disrespectful for a patient to claim they have more scientific or medical expertise than their clinician. In the same manner, it would be considered disrespectful for a clinician to claim that they have a better understanding of what it feels like to experience dis-ease. When a clinician does claim that they have mastery of the patient's experience, I refer to this as a disrespect of phenomenological distance. I argue that the empathy process, as I have described it, safeguards against this disrespect of phenomenological distance.

As was expressed in the first section of this paper, one concern that arises when introducing empathy to early-career clinicians is the possibility that these clinicians may regard themselves as "experts" regarding a patient's experience of their dis-ease. Clinicians might boast that their well-cultivate sense of empathy might allow them to have almost immediate access to their patients. They "get" their patients, and this allows them to understand what their patients are going through. The problem that arises is that clinicians are not patients; they do not possess and experience dis-ease in the way their patients do. A clinician only has an *imagined* access to a patient's experience. They can only imagine what it might be like to be told their cancer has metastasized, that they will need emergency surgery to place a stent, or their blood test has come back with alarming abnormalities. This imagining, however, is not a substitute for the experience itself. As such, Phenomenological disrespect arises when a clinician considers their imaginative abilities superior to the patient's ability to experience their dis-ease.

Keeping an appropriate and respectful phenomenological distance is necessary to engaging in the empathic process. Recall that for Stein, each person's experience begins at a zero-point of orientation (ZPO). Our ZPO is what makes our experiences *our own* as opposed to another's. For Stein, ZPOs are important because they separate the origin of a feeling or sensation from the

recognition of that feeling or sensation. A ZPO separates the empathizer from the empathee by assigning the *mineness* of a certain experience to the experiencer. A person touches a hot plate and immediately recoils their hand, such pain *belongs to* the person who touched the plate. The person's friend sees them recoil their hand and begins the empathy process by recognizing the pain experienced by their friend, but never in the empathy process do they think they *have* or *possess* this pain in the same way that their friend does. The friend, if they follow along with the empathy process, never actually thinks they are the one in pain. Rather, the friend engages in an imaginative exercise to better understand or appreciate *what it may be like* to experience the world from another's ZPO. The *ownership* or *mineness* of an experience is established by the fact that only one person can possess their own bodily standpoint in the world and so only they can have an authentic, immediate understanding of that experience. Another person can only imagine what it *might be like* to experience the world from a bodily standpoint that is not their own. The third step of the empathy process exemplifies this point, as it requires the empathizer to realize that their imaginative exercise needs to be contextualized through the experience of the empathee.

Within a clinical context, the empathy process helps establish an appropriate phenomenological distance between the clinician and the patient. When a clinician wishes to engage in the empathy process in order to better understand their patient, they never assume that they know more about the patient's dis-ease than the patient themselves. Beginning the empathy process the clinician understands that the feelings or sensations that they recognize in the first step of the empathy process are *foreign* to them. In this sense, the clinician is aware that these feelings and sensations have originated within another person—their patient. This awareness of the otherness of these feelings or sensations carries on to the second step of the process, in which the clinician imagines what it *might be like* to have those feelings or sensations themselves. Insofar as

a clinician is aware that the second step of the empathy process is an imaginative enterprise, they are not likely to think that they have special insight into what it is *really like* for their patient to live through such feelings or sensations. The final step of the empathy process ensures that a clinician returns these feelings to a patient's context; they consider what these feelings or sensation might mean in the context of their patient's life. Insofar as a clinician retains the subjunctive character of the previous statement (i.e., they are aware of the importance of the term: "might"), then they do not the risk assuming that they actually have certain and absolute knowledge of what a feeling or sensation *actually means* in the context of a patient's life.

3.5: Summary of the Empathy Process:

At this point, I believe I have provided and further developed a notion of clinical empathy that satisfies all of the desiderata provided and explained at the end of the first section of this chapter. Edith Stein has provided us with a useful theoretical framework for understand how empathy operates. Stein's novel approach to empathy provides us with an understand of empathy that moves beyond the simple, but conceptually unclear, "stepping into someone else's shoes". This process centered approach to empathy allows potential empathizers to envision the various steps that go into empathizing which, in turn, allows empathy to become a more self-aware and conscious enterprise. In this sense, I believe my elucidation of the empathy process has lifted the lid on the black box of empathy. However, I do not think that I have said all that can be said about the contents of this black box. Important questions remain about the more minute details of the empathy process. For example: what about ourselves makes it possible for us to empathize whatsoever? The empathy process starts at the recognition of a foreign emotion or sensation, but what about our psychology, being, or experiential standpoint allows us to achieve this recognition

in the first place? Answers to these questions might further provide conceptual and practical clarity regarding clinical empathy as well as empathy in general.

In addition to providing more of an explanation to how empathy unfolds, the empathy process also ensures that empathizers reflect on an empathee's condition. The empathy process attends to the empathee's personhood insofar as it requires a return to the empathee's own sense of meaning. I might watch an elite athlete make an uncharacteristic and costly blunder; they express their shame, frustration, and dread accordingly. As a spectator, I, myself, suddenly feel shame, frustration, and dread arise within me. In my own personal context as a scholar, these feelings might only arise if I were to receive a desk-reject from a journal, or harsh feedback from a colleague on a manuscript. In my standpoint within the world, this is *what it means* to feel these emotions. In understanding the athlete's emotions, to make sense of them, I need to imagine what these emotions *meant to them*. In this sense, I imagine what it might be like to have years of training, self-discipline, and enormous sacrifice suddenly appear to vaporize because of a single error or misjudgment. Phenomenology can aid us in this imaginative enterprise, as its concepts allow us to think about what it might be like to attend to the world from a standpoint other than our own. The final step of the empathy process places this phenomenological imagining front and center, as it requires the empathizer to return to the empathee in order to get a better sense of what thoughts, feelings, and sensations might mean within the context of the empathee's own personal experience.

Finally, the empathy process—as I have laid it out—should make the empathizer aware that one's own imaginative capabilities are what assists them in moving along the empathy process. Engaging in the empathy process does not grant the empathizer epistemic or phenomenological privilege into the empathee's life. Rather, the empathy process should allow the empathizer to realize that phenomenological distance is necessary feature of empathy itself. After all, if one could

truly move beyond the phenomenological gap that separates one's personal experience from another's personal experience, then it would seem unnecessary to engage in empathy at all. That is, if I could perform some phenomenological trick that suddenly allowed me to attend to the world as you from your personal perspective on the world, then such a trick would remove the need to engage in empathy. As is evident, we are unable to attend to the world from a personal perspective other than our own, and hence the empathy process makes us aware that there exists a gap between myself and another. The empathy process allows us to engage with our imaginative capabilities to help envision what occurs on the other side of this gap, but it never assumes that this imagining can serve as a stand-in for another's lived experience.

3.6: Putting Empathy into Practice within a Personalized Medicine

To conclude this chapter, I would like to provide an account of how empathy can assist clinicians in their task of healing persons. As has become evident in recent years, persons from marginalized communities are less likely to receive the quality of care afforded to their non-marginalized counterparts. As was discussed in the first chapter, African American patients are often under-treated for pain. Two meta-analyses conducted seven years apart from one another came to roughly the same conclusion: a person's race has an effect on whether or not their pain is addressed in an acute care setting (Meghani, Byun, and Gallagher 2012; Lee et al. 2019). The most common and compelling explanation as to why a person's race affects the treatment of their pain is racial bias that persists amongst clinicians (Hoffman et al. 2016). A persistent stereotype of black individuals is that they have a higher tolerance of pain than white individuals. Hence, clinicians who harbor this stereotype will be less likely to offer adequate pain management to their black patients. This inadequate pain management certainly does not aid a clinician in the task of healing their black patients.

In addition to this, trans persons often face numerous barriers to quality healthcare (Roberts and Fantz 2014). Compounding with the financial burden of obtaining gender affirming hormones and gender confirmation surgeries, trans persons may face discrimination from clinicians. Such discrimination often results in the avoidance of healthcare systems by trans persons (Kcomt et al. 2020). This avoidance of the healthcare system is significantly more deleterious for trans persons, as certain gender affirming therapies (e.g., HRT) can result in higher instances of cardiovascular and bone-related complications (Rosendale et al. 2018). Putting all of this together, the attitude of clinicians towards their trans patients has a profound impact on the healthcare outcomes of their trans patients. Once again, it certainly does not seem that discriminatory or disparaging attitudes towards trans patients aid clinicians in their task of healing trans persons.

Numerous other examples of a clinician's bias affecting quality of care can be found throughout medicine. Medicine has a well-documented history of discrimination and bias against women (Cleghorn 2021), disabled persons (Iezzoni et al. 2021), and obese patients (Phelan et al. 2015). From all this, it is evident that bias, stereotyping, and discriminatory beliefs are barriers that prevents clinicians from recognizing and treating their patients as persons. While medicine is becoming increasingly aware of these barriers (Rosenkranz et al. 2021), it still seems that there is room to imagine how best to address the quality of care gap that exists between marginalized and non-marginalized communities. The empathy process, as outlined and elucidated throughout this chapter, provides clinicians with a way to attend to their patients' sense of personhood. By attempting to better understand the complex emotions and meanings linked to their patient's dis-ease, clinicians understand that their patients are unique individuals who hold a diverse set of beliefs and values. The empathy process allows a clinician to imagine what it might be like to have to make a difficult decision, to hear disheartening news, to experience vast suffering, or to be

discriminated against. Empathy, in this way, requires clinicians to understand that their patients come from many different backgrounds, participate in many different lifestyles, and interpret the world in many different ways. Taking part in this understanding requires some effort, on behalf of the clinician, to uncover what implicit biases they may harbor and what preconceptions they might have made.

While the empathy process is not a cure-all to inequality within modern medicine, it certainly seems that clinicians who to practice empathy when caring for their patients will also desire to examine and mitigate their implicit biases, reject the practice of stereotyping, and deconstruct any discriminatory beliefs that they may hold. In other words, taking part in the empathy process would seem to require clinicians to uncover, examine, and ultimately reject any practices and beliefs that serve as a barrier to their ability to understand their patients as persons.

CONCLUSION: A PERSONALIZED MEDICINE

In this project, I have argued that medicine can be approached by two perspectives: a first personal and third personal perspectives. These two perspectives result in two distinct frameworks of medicine: the framework of naturalism and disease and the framework of phenomenology and dis-ease. Unless an attempt is made to coordinate these approaches, it is likely that they will be set upon divergent paths. The framework of naturalism and disease seeks to provide scientific solutions to the problems facing medicine; pathology and abnormality are realized as objects of scientific investigation that can then be subjected to treatments whose effectiveness are measured via scientific means (efficacy studies, post-treatment tests and imaging, etc.). The framework of phenomenology and dis-ease seeks to provide an understanding of how illness causes specific disruptions within one's life plans and uncovering *what it is like* to experience such a disruption. These two projects do not necessarily need to intersect with one another. As is evident in most emergency medicine settings, patient can be treated for an ailment without the clinicians having any interaction with the patient beyond their physiology. As well, someone can gain a robust understanding of a patient's experience with dis-ease despite not having any understanding of the underlying physiological cause that might be responsible for their dis-ease.

However, as I have argued in the preceding chapters, attempting to coordinate these two frameworks is beneficial to medicine. By understanding the effects disease can have a patient's sense of personhood, clinicians are better able to determine which treatment options fulfill medicine's task of healing a person. In recent years, there has been a trend within medicine to develop therapies and treatment plans that are personalized to each patient. This form of personalized medicine attempts to weave together advances in pharmacology, genetics, and

biochemistry in order to produce therapies that are tailored to each individual's unique genetic and physiological characteristics (Vogenberg, Isaacson Barash, and Pursel 2010). In a way, this focus on individualized care represents the beginnings of a paradigmatic shift in medicine. A personalized medicine calls into question the idea of a "standard of care" in which treatment options are determined based on a pathology or disease state alone. Personalized medicine contends that the standard of care might vary from patient to patient based on a patient's genetic markers, how a patient's unique biochemistry responds to a certain treatment, and the theoretical suitability of treatment based on established prior research.

The preceding chapters have hopefully made clear that there exists another iteration of personalized medicine. This iteration of a personalized medicine contends that attempting to understand a patient's first-personal perspective of their dis-ease allows for clinicians to develop an approach to medicine that takes into consideration how medical interventions have an impact on a patient's sense of personhood. As was hopefully made evident in the preceding chapters, how a patient inhabits the world through their lived body has an influence on how a patient interprets themselves as a person. Illness disrupts how one would normally participate within their world and this disruption in participation disrupts how they would interpret themselves as a person. Developing a personalized medicine seeks to not only address how medicine can eliminate and alleviate suffering, but also address the disruption that illness has caused in a patient's life. Put another way, a more personalized medicine seeks to address both a patient's disease *and* dis-ease.

By enacting a more personalized medicine, I believe that medicine is better able to perform its task of healing persons. This healing does not mean simply curing a patient of their disease, but also attempting to uncover how clinicians can help in making patients feel whole again (Toombs 1993, p. 116; Stoddard 1992, p. 175). A modernized version of Hippocrates' famous oath has

clinicians pledge that "I will remember that I do not treat a fever chart, a cancerous growth, but a sick human being…" (Lasagna 1964). To address more than a patient's physiological disruptions requires some effort, on the part of the clinician, to better understand how a patient's illness has resulted in disruptions within their life-plans, within their self-interpretation, within how they make sense and meaning out of their world.

The concepts of phenomenology are useful tools in allowing clinicians to develop a robust understanding of their patient's sense of personhood. This project has provided the reader with a way to envision how phenomenological concepts can be coordinated with one another to develop an understanding of personhood that is relevant to clinical practice. These concepts help clinicians better understand a first-personal perspective of illness and uncover how best to practice a personalized medicine. My hope is that clinicians are able to engage in creative thinking in order to imagine what a more personalized medicine might look like within their own clinical practice.

A more personalized medicine will, hopefully, also be a more empathetic medicine. By gaining a better understanding of a patient's sense of personhood, clinicians are able to establish a deeper sense of empathy for their patients. This sense of empathy can help clinicians determine how to engage with patients from a perspective of common understanding. By imagining how patients inhabit and attend to their world, clinicians are better able to understand what things *mean* and what things *feel like* within the context of their patient's life. In developing a greater sense of empathetic understanding with their patients, clinicians are better able engage in the share decision-making process as well as engage in more empathic communication with patients themselves.

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