

# What Can Phenomenological Approaches Contribute to Medicine?: A Call for a Phenomenological Approach to Theological Bioethics.

KADIN J. G. WILLIAMS, M.DIV., M.A.

[kadin.joshua.gard.williams@temple.edu](mailto:kadin.joshua.gard.williams@temple.edu)

Philosophy Department, Temple University, Philadelphia, Pennsylvania, U.S.A.

**Keywords:** Spirituality, holistic medicine, phenomenology, disability, the disabled.

**Abstract:** Although contemporary bioethics is largely seen as the domain of analytic philosophical and theological discourse, the nature of the relationship between healthcare and spirituality should propel bioethicists towards a more constructive dialog between the resources of analytic bioethics and continental phenomenology. Phenomenology's unique approach to the question of human consciousness, as a matter of embodiment, can help supplement the insights that the analytic tradition has unraveled in its attempts to help practitioners find better means of caring for patients as emotional and spiritual beings. To this end, phenomenology is particularly useful in helping one think about the patient's experience of time, space, social interactions, and the experience of illness on an affective level. If medical practitioners and chaplains hope to be more effective in treating issues related to a patient's spirituality, then it is essential to develop a phenomenological engagement with theological bioethics.

## I. INTRODUCTION

The phenomenological tradition<sup>1</sup> – as adapted by Havi Carel, Oliver Sacks, and S. Kay Toombs – is an essential resource for thinking about medical treatments of the ill and disabled. As a methodology, phenomenology is drawn from the desire to better understand things in and of themselves. To understand things in and of themselves, the phenomenological tradition studies the structures that compose and constitute human existence, particularly as they are experienced in the relationship between the mind and the body. Phenomenology as a methodology largely rests on an investigation of the interrelationship of intentionality and embodiedness, particularly in the experience of illness.

<sup>1</sup> Phenomenology as a unique philosophical discipline is the study of how human consciousness runs and what consciousness is as experienced from the first-person perspective. Thus, the phenomenological observer is not “we” or “she” but always “I” with its central focus on how “my” intentionality is directed towards something as an experience of and about it. In the West, its unique approach was first introduced by the early 20th century philosophers such as Husserl and Heidegger in Germany and later settled in France as a prominent philosophy through the works of Sartre, Merleau-Ponty, and others.

\*Address correspondence to: Kadin J. G. Williams, M.Div., MA., Philosophy Department, Temple University, 1801 N Broad St, Philadelphia, PA 19122, U.S.A. E-mail: [kadin.joshua.gard.williams@temple.edu](mailto:kadin.joshua.gard.williams@temple.edu)

+To cite this article: Kadin J. G. Williams, “What Can Phenomenological Approaches Contribute to Medicine?: A Call for a Phenomenological Approach to Theological Bioethics,” *The Journal of Healthcare Ethics & Administration* 4, no. 2 (Fall/Winter 2018): 26-31, <https://doi.org/10.22461/jhea.1.71617>

This work is brought to you for free and open access by the Institute of Clinical Bioethics (ICB) at Saint Joseph's University, Philadelphia, PA, U.S.A. It has been accepted for inclusion in *The Journal of Healthcare Ethics & Administration* by the editorial board and an authorized administrator of the *JHEA*. For more information, please contact [support@jheonline.org](mailto:support@jheonline.org)

The experience of illness and disability affects a person's experience of their world, their body, and their respective social context in a number of ways that help illustrate the idea of intentionality and embodiedness. Carel notes that Husserl conceived of intentionality as "a relationship between mental phenomenon and their objects."<sup>2</sup> Our desires for and about things fit into this notion of intentionality, but Carel goes on to also draw on Maurice Merleau-Ponty's idea of an intentional-arc. According to this idea, our intentions towards objects fit within a larger arc which connects our mental and bodily movements.<sup>3</sup> This spatial concept helps us think about the ways our intentions relate to the movements and functions that we perform in ways that often go unnoticed.

The idea of embodiedness rests on a similar notion. In his attempt to describe his very personal experience of losing and regaining the use of his leg, Sacks argues that the "ghostly, cogitating, solipsistic 'I' of Descartes, which never feels, never acts, *is not*, and *does nothing*" is misguided.<sup>4</sup> The disembodied 'I' of Descartes and Avicenna is a fiction precisely because it ignores the intimate connection between consciousness and the body.<sup>5</sup> If we draw a sharp distinction between the mind and the body, then we risk committing ourselves to a dualistic worldview which would hardly be practical to the practice of medicine. This is why Carel argues that there is a:

broader metaphysical error: the thought that they are two distinct realms, the internal and the external, that are completely distinct. In fact, if we return to embodiment, we can see that there is no distinction between the two realms. We are embodied; our consciousness or our self is one and the same as our body. [...] The body is something that is both highly personal, highly subjective, and also exists as an object within a natural order of things.<sup>6</sup>

Alternatively put, our experiences provide the best foundation for critical self-reflection. But these experiences do not lend any evidence to the idea that our consciousness is anything but embodied. Our only experiences are subjective and located in the first-person point of view. From that point, we relate to other objects (in the third-person), and sometimes these objects are even our own bodies, but this reflection, this reflection of the subject-object, should not be confused with a disembodied state of perception. If the clinical practitioner and medical institutions as a whole can better understand the experiences of the patient – as persons who often undergo experiential changes in their relationships to space, time, society, and even their own bodies – then there would be hope for advancements in the treatment of patients' disassociation with wellness.

## II. SPACE

As creatures who are involuntarily bound to the limits of our environments that we all experience some degree of limitation and opportunity when we approach the objects that constitute our environment. However, people experiencing certain kinds of illness or disability often experience space in different ways. A person who moves around the world in a wheelchair lives in a manner that is often experientially disjointed from the spatial arrangements that society deems to be normal. Likewise, people who suffer from LAM<sup>7</sup> experience a set of changes in how they interact with distances, elevations, and the possibilities of travel that many other people take for granted.

Toombs is quite explicit in many of the challenges she has faced since she developed progressive multiple sclerosis. Her interactions with airplanes, hotels, and even other people show the impact of one's interactions with spaces that are often designed in manners that are less amenable to a person with her type of condition. Likewise, her interactions with her environment often

---

<sup>2</sup> Havi Carel, *Illness: The Cry of the Flesh* (Durham: Acumen, 2013), 28.

<sup>3</sup> *Ibid.*, 29.

<sup>4</sup> Oliver Sacks, *A Leg to Stand On* (New York: Simon & Schuster, 1998), 121.

<sup>5</sup> By bringing up Avicenna, I intend to note a source of the Cartesian view that Carel and Sacks both reject. While his Floating Man experiment was certainly interesting, there is very little reason to accept his disembodied view.

<sup>6</sup> Carel, *Illness*, 70-71.

<sup>7</sup> LAM (lymphangioleiomyomatosis) is a rare lung disease of which common symptom involves shortness of breath and chest pain. The disease usually strikes women.

influence the ways other people interact with her. Clerks often speak about her, in her presence, to whoever might be accompanying her. On other occasions, people have simply taken hold of her wheelchair in order to push her to her desired location. It is an effort that likely stems from altruistic feelings but is also capable of completely ignoring the reality of Toombs' experience of spatiality. People who are confined to a wheelchair or the use of a prosthetic device often experience those tools as extensions of personal space, seemingly because they come to regard those tools as parts of themselves. After repeated use, a person can come to accommodate these types of devices in such a manner that establishes an intentional-arc [Merleau-Ponty]. When someone takes hold of a wheelchair, a cane, or a prosthetic device without asking, it could rightly be perceived as an invasive act. The act would be experienced as such precisely because of the mind's relationship to the body and the manner by which some conditions, which might be as artificial as a wheelchair, can come to be experienced as an element of one's own body.

Medical practitioners need to have a sensitivity to the ways their patients might experience a changed or alternative sense of space. This can help them better confront the obstacles that most hinder a person's actual experience of illness or disability. A phenomenological approach to this particular structure of experience can help medicine develop new means of overcoming spatial barriers and advocate for societal spaces that are more accessible to people whose needs might be different.

### III. TIME

There are a number of important ways that a patient's experience of time also changes through the experience of illness or disability. The first starts with an illustration everyone can relate to. When a small child performs an activity that she dislikes, time often seems to drag on, and the experience of discomfort is prolonged. Alternatively, when the same child performs a task that she enjoys time seems to slip away. Similarly, patients in medical institutions are often stuck with feelings of uncertainty, anxiety, and impatience. Consequently, their experience of time is often framed by the slowness by which the discomfort dissipates. This affective experience is perhaps not the most important element of effective medical treatment, but it does highlight questions surrounding the efficiency of medical systems, particularly when patients might have to unnecessarily wait for long periods of time with little support for their emotional wellbeing.

The second major change to a patient's experience of time relates heavily towards an internalized concept of intentionality. When people look at their own lives, they project and shape their intentions and expectations to match what they perceive to be reasonable expectations. For a healthy person in their twenties, this might mean an expectation of another sixty years of life as well as a number of experiences like getting married, promoted, or having children. When a person is affected by debilitating illness or disability, however, these expectations change. In the case of shortened life expectancy, a patient might have to revise not only their goals but also the speed by which they might hope to achieve some portion of new or old desires. It is easy to imagine that the loss of an opportunity to even pursue goals that had once been central to a patient's sense of self could easily result in psychological problems like depression, fatigue, and resignation. These are all factors that could seriously affect the patient's well-being and adjustment to new circumstances. As a result, they deserve attention from the medical community.

The other major element of this changed relationship between time, one's sense of self, and one's own body rests on the experience of time as it remains. While young people sometimes see time as a deep resource that can be approached wastefully, those towards the end of their lives are often forced to realize that their remaining time is extraordinarily limited. This raises a number of serious issues. The first is addressed by Cavel when she argues that people can experience health within illness.<sup>8</sup> It is easy to see that this should be a goal of medical treatment. A person's life expectancy might have been cut drastically short, and their mobility might be limited, but that should not discourage the medical community from seeking to help the patient find meaning and enjoyment in their new experience of historically, socially, and physically situated projection.<sup>9</sup>

Phenomenology can be employed within frameworks of illness to help patients confront their circumstances and find well-being in the midst of their conditions. When people are confronted by a collapse of their projected sense of time, they can either respond by fleeing the reality of their fate through denial or by facing it in what Heidegger calls "Being towards death." This practical stance

---

<sup>8</sup> Carel, *Illness*, 91.

<sup>9</sup> Carel, *Illness*, 111-112. I am making reference to Heidegger's notion of "thrown projection" here.

of recognition frees us because it illuminates all of the available possibilities we have within the framework of our finiteness.<sup>10</sup> But this intention towards one's fate should not be taken to be some singular moment. It is, rather, a process by which someone faces the question "how should I live now?" This is a question that therapy, philosophy, and medicine can all work together to address.

#### IV. SOCIETY

There are two main areas in which society seems to be intimately connected with the experience of illness or disability. First, Carel and Toombs both provide accounts for how their diseases shaped their interactions with other people, particularly insensitive people. Society often seems to be unable or perhaps ill-equipped to deal with disability and illness. Strangers and friends sometimes avoid interacting with an affected person and others seem only to make a person's condition more obvious or hurtful. This is a large-scale problem, so it might seem to be beyond the scope of medical practice. However, it is also worth noting that there also seem to be a number of cases in which medical professionals display similar types of behavior. This is problematic. Medical professionals need to empathize with a patient's experiences not just to clarify diagnoses, but to help patients recover and return to as great of a state of health within illness as possible.

The second interaction of society and illness comes into focus when we look at the ill or disabled person's interactions with public spaces, social activities, and institutions. Each of these realms is often designed with a certain set of presuppositions in mind that omit the needs of those who might be invisible to those in charge of creation and management. Sidewalks, entrances, bathrooms, and many other places fail to fully account for the needs and experiences of people who move and live in the world in different ways. Sometimes these hurdles are insurmountable. As an example, it would be unreasonable to expect society to create a space for a person confined to a wheelchair within a military unit like an infantry fire-team. There are, however, many other instances in which medical professionals and society at large could work to improve a patient's health, even in the existent framework of disease or illness.

#### V. AFFECTIVE BEINGS AND EFFECTIVE TREATMENT

Naturalistic or biologically-based medical practice is extraordinarily effective in many ways. However, it has limits in terms of the scope by which it can diagnose and treat a variety of ailments. This is a result of the fact that humans experience illness as a disruption to lived everyday experience, rather than an abstract or objective biological category. Illness is experienced in an embodied way precisely because we are embodied; and all perception is filtered through that fact. We are essentially composites of our experiences as they exist within the limits that surround our intentionality.

As a consequence, effective medical treatments and therapies must treat patients with an eye towards this subjective element or risk missing the teleological ends of medical practice that drive the discipline. The phenomenological approaches utilized by Carol, Sacks, and Toombs help highlight the need for treatments that meet the experience of illness as it is actually experienced. Effective medical practice must account for the fact that patients are affective beings whose conditions are largely centered around the effects of pain, immobility, anxiety, and social conditions or spaces that hinder the full range of possibilities that differently abled people could enjoy. As Toombs argues, medical procedures and technical solutions are far less "likely to be effective if explicit attention is not given to the affective responses, such as shame and embarrassment, that inevitably accompany such solution."<sup>11</sup> There is a limit to how effective pure naturalistic medicine can go without the utilization of a method that recognizes and treats these kinds of affective responses to disability or illness. Patients have to learn to accept and incorporate new experiences (such a wheelchairs or prosthetic limbs) into their lives in a way that is intimately personal; and this is unnecessarily difficult to achieve when medical practitioners fail to employ methodologies, like the phenomenological methodology, that recognize the experiential elements of bodily space, time, and social interactions.

---

<sup>10</sup> Carel, *Illness*, 116.

<sup>11</sup> S. Kay Toombs, "The lived experience of disability" *Human Studies* 18, no. 1 (Jan. 1995), 20.

Carol, Toombs, and Sacks all demonstrate the benefits that the phenomenological tradition can bring to the practice of medicine. Their utilizations vary, but they all touch upon similar themes. The lesson rests on the idea that a patient's experience of their environment is critical to effective treatment. Illness and disability are both experienced in the embodied experience of the subject-object (person) and can only be alleviated insofar as medical methodologies affect this realm.

## VI. THEOLOGICAL IMPLICATIONS IN THE EXPERIENCE OF ILLNESS

In recent years bioethicists and clinical communities have shown an increasing amount of interest in the relationship between spirituality and health care. This development is primarily a reaction against medicine's movement away from the traditional model of care for the whole patient, rather than a service-oriented treatment of the individual as a consumer. Technology has obviously given us the ability to prolong life and enjoy ever-increasing qualities of life, and yet this has often been accompanied by a loss. Phenomenologists like Husserl and critical theorists like Theodor Adorno have noted this larger pattern with terms like 'instrumental reason.' The key theme for both figures is the loss of some humanity or, more specifically, the ever-present danger of epistemological totalitarianism. In the case of medicine, there is a risk of losing of the original meaning of medicine altogether, that is, care for the whole person. The art of medicine lies in its capacity to meet the needs of a patient as a material, spiritual, and theological being whose humanity rests in the very intersections of each respective dimension. Thus, it is commendable that Christian clinicians and theological bioethicists are currently making efforts toward returning to a practice of medicine that addresses spiritual care

However, contemporary bioethics has largely become the domain of analytic philosophy and theology. Consequently, the subjects of spirituality and health care are discussed largely in the analytic fashion. While these methodologies have their strengths, I believe that phenomenological language can better help address and explain the experiences of patients. If we hope to provide holistic care for patients as persons, rather than objects, then this is essential. I believe that the phenomenological method should be employed to address the relationship between spirituality and health care.

In the secular continental tradition, philosophers of medicine have written extensively about patient experience vis-à-vis the goal of medicine in the same vein as the three philosophers that I have introduced here maneuvered the phenomenological tool. In so doing, they have used the meaning of spirituality without a religious or theological implication. As an example, Eric Cassell says, "Religion is a spiritual activity, but spirituality has a larger meaning"<sup>12</sup> and "suffering, is also a state of social deprivation and isolation even in the midst of others; and therefore it is also a loss of spiritual connection to the world. Suffering is a spiritual injury."<sup>13</sup> What is interesting is that many analytic theological bioethicists (or theological bioethicists not trained in phenomenological tradition) use spirituality in the manner that Cassell does. For example, Alan Astrow, Christina Puchalski, and Daniel Sulmasy, the physician bioethicists one of whom (Sulmasy) is a theologian, argue that spirituality "is the name given to a person's or a group's relationship with the transcendent, however that may be construed."<sup>14</sup> "Spirituality is about the search for transcendent meaning" regardless of his or her religious concerns or commitments.<sup>15</sup>

This trend in contemporary bioethics' search for care of the whole patient can be further enriched if the analytic and continental traditions are both utilized to evaluate conditions where spirituality and healthcare interact. It is insufficient to merely designate a thin-level of meaning for the relationship between spirituality and healthcare. The issue is, after all, encompassed in the larger mind-body problem which is notoriously complicated. My hope is that rather than imagining a narrow, or thin, relationship between the practice of medicine and the spiritual elements of a patient's experience, we might rather envision a thick theological concept which can be strengthened through dialog with existing theological literature. John Paul II's "theology of body" which emphasizes the inseparability of the body and the workings of Spirit is but one example among many Roman Catholic resources. Likewise, one can

---

<sup>12</sup> Eric Cassell, *The Nature of Healing: The Modern Practice of Medicine* (New York: Oxford University, 2012), 126.

<sup>13</sup> *Ibid.*, 226

<sup>14</sup> Alan B. Astrow, Christina M. Puchalski, Daniel P. Sulmasy, "Religion, Spirituality, and Health Care: Social, Ethical, and Practical Considerations," *The American Journal of Medicine* 110 no. 4 (March 2001), 226.

<sup>15</sup> *Ibid.* 226.

find helpful references to God-consciousness in the work of the Lutheran theologian Rudolf Otto (who stands in the Kantian analytic tradition) and attempt to use it by blending it with the insights that phenomenology can provide. Sometimes it is helpful to remember that the divisions between the Anglo-American and Continental traditions are overblown and that both traditions have developed, at least in part, through interactions with the other. Each tradition can and should listen to the other, particularly when it comes to matters of healthcare.

## VII. CONCLUSION

Phenomenology is a helpful resource because it helps illuminate some of the critical issues inherent to the relationship between consciousness and the body. When a person is ill, they do not experience their illness as a matter of objective or reductionistic categorization, but rather as a matter of dislocation, disassociation, and often alienation from places, groups, and experiences that were formerly places of joy or meaning. To care for a patient, we must address these moments for effectively and imagine new strategies for treatment.

## VIII. BIBLIOGRAPHY

- Astrow, Alan B., Christina M. Puchalski, and Daniel P. Sulmasy. "Religion, Spirituality, and Health Care: Social, Ethical, and Practical Considerations," *The American Journal of Medicine* 110 no. 4 (March 2001): 283-287
- Carel, Havi. *Illness: The Cry of the Flesh* (Durham: Acumen, 2013).
- Cassell, Eric. *The Nature of Healing: The Modern Practice of Medicine* (New York: Oxford University, 2012).
- Sacks, Oliver. *A Leg to Stand On* (New York: Simon & Schuster, 1998).
- Toombs, S. Kay. "The lived experience of disability" *Human Studies* 18, no. 1 (Jan. 1995): 9-23