THE TEMPORALITY OF ILLNESS: FOUR LEVELS OF EXPERIENCE

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ABSTRACT. This essay argues that, while much has been gained by medicine's focus on the spatial aspects of disease in light of developments in modern pathology, too little attention has been given to the temporal experience of illness at the subjective level of the patient. In particular, it is noted that there is a radical distinction between subjective and objective time. Whereas the patient experiences his immediate illness in terms of the ongoing flux of subjective time, the physician conceptualizes the illness as a disease state according to the measurements of objective time. A greater understanding of this disparity in temporal experiencing provides insights into the lived experience of illness and can preclude difficulties in communication between physician and patient.

Key words: disease, illness, meaning, pain, patient-physician relationship, phenomenology, temporality

1. INTRODUCTION

Modern scientific medicine has, for the most part, adopted a paradigm of illness which defines illness exclusively in terms of the objective, quantifiable data of the natural sciences. That is, the patient's illness is understood to represent a pathoanatomical and pathophysiological fact. As Foucault notes, this modern understanding of disease can be traced back to the rise of pathological anatomy in the 19th century, at which time diseases (which had previously been understood in terms of recognizable clusters of clinical symptoms) now came to be classified according to the lesions which were found in dissected corpses [1, 2]. Not only did this new classification of disease de-emphasize the patient's experience (since the 'truth' of the disease became that which was uncovered in the pathologist's laboratory) but disease acquired a fundamental spatial (as opposed to temporal) aspect. The disease was seen to be an entity which was localizable at a certain site in the patient's body.

There is no doubt that much has been gained from this modern conceptualization of disease. But it is also the case that much has been lost. In particular, this essentially mechanistic model includes little, if anything, of the patient's experience of illness. Rather than being the central focus, the patient's subjective experiencing is relegated to the periphery. It is the X-rays, the laboratory

Theoretical Medicine **11:** 227–241, 1990.

studies, the pathology reports – and not the lived experience – which are taken to constitute the central phenomenon of disease [3, 4]. In consequence, physicians and patients find themselves separated by a fundamental and decisive gap in understanding [3,5]. The patient conceives of his illness in terms of lived experience, the physician conceptualizes it as a disease state. As Leder [6] has noted, the neglect of illness in favor of disease has resulted in many of the widely-recognized failures of modern medicine, such as the overreliance on medical technology, depersonalized treatment, non-compliance of patients, and so forth.

In this essay I shall explore one aspect of the illness experience – its temporality – using philosophical phenomenology as a guide. In particular, I shall show that phenomenology provides the key insight that illness is experienced not only as a spatial entity (i.e. as having a particular location in the body) but that it is experienced in a fundamental way as a temporal entity. This temporal constitution is important in understanding the manner in which illness is *lived through* by the patient. It is also a factor which contributes to difficulties in communication between physician and patient.

2. THE PHENOMENOLOGICAL ANALYSIS OF TIME

Husserl's phenomenological analysis of time emphasizes the radical distinction between objective time (time which can be measured by clocks, calendars, and so forth) and subjective time (the ongoing stream of consciousness in which we experience duration and temporality) [7]. Certain aspects of Husserl's analysis are particularly helpful in providing insights into the temporal structure of illness.[1]

In the first place, Husserl notes that a phenomenological analysis of time cannot explain the constitution of time without making reference to the constitution of temporal objects. Temporal objects are those objects, such as tones or melodies, which are temporally extended and yet which are experienced as wholes or unities ([7], p. 43). What is peculiar about the experiencing of a temporal object is that it is experienced not as a succession of discrete, isolatable, now-points along a given time-line but rather as a continuum – a continuum which at once incorporates not only the present now-point but those now-points which are just-past, as well as anticipations of future now-points. For example, when I hear a melody, I hear not only the present note which is now sounding, but I hear it *as succeeding* the note just-past which I still retain in my present consciousness. Furthermore, in hearing the present note, I anticipate a future note which will follow it as the melody unfolds temporally.

In this subjective experience of duration Husserl identifies a particular type of

memory – primary memory – which he calls "retention". The enduring consciousness of a temporal object is such that past temporal phases of the object are retained in primary memory as a part of the present consciousness of the object. Husserl is concerned to show that primary memory is thus quite different from recollection or secondary memory. In recollection the object is no longer actually perceived but is recalled in memory. It is re-presented. Consequently, whereas in retention the past phases of the object are present as a part of the actual now-perception of the object (i.e. retentional consciousness 'holds' the expired notes of the melody in my consciousness along with the present note), in recollection the object is no longer actually experienced. Rather, in recollection we seem to perceive it again, but only in an 'as-if' presentation ([7], pp. 57–59). In remembering a melody, I recall the melody 'as if' hearing it again, whereas in retention I actually hear the succession of notes of the melody, as they unfold as a temporal unity ([7], pp. 54–55).

In addition to the retention of the past temporal phases in primary memory, the experience of a temporal object incorporates an anticipation (or 'protention') of future temporal phases. In hearing the present note of the melody, I anticipate a future note which is to come. Thus, the temporal object appears as a continuum in a continuity of temporal phases which are inextricably interrelated. Past, present and future phases form an inseparable unit ([7], p. 48). Consequently, although I may distinguish between the note which is actually heard now from the notes which have gone by, it is the melody as a whole that I actually perceive ([7], p. 60).[2] Carr [9] notes that Husserl's analysis of time-consciousness provides the key insight that the temporal must be considered as a "field of occurrence" with past and future providing the horizons for the present. Temporal consciousness can be compared to "a gaze which spans or takes in the temporal horizons of future and past, against which the temporal object presents itself" ([9], pp. 23–24).

Husserl's analysis reveals a radical distinction between lived time and objective time, or between inner and outer time. Inner time (lived time) is the ongoing, immediate experiencing of the temporal phases of an object through the interplay of retentions and protentions which are evoked in the stream of consciousness; i.e. it is the temporal 'living through' the melody, and the experiencing of the melody *as* extended in duration. Outer time (objective time), on the other hand, is the time that can be measured by clocks. As Schutz [10] notes the distinction between inner and outer time is readily apparent when considering the experience of the person listening to a piece of music. While living through the ongoing flow of the music, the beholder is not aware of objective time; that is, it may come as a complete surprise to him that one movement in the piece of music takes as much time (in the clock sense) as another movement. While experiencing the music, he is immersed in its ongoing

flow, in the ongoing articulation of the musical piece. Other experiences are equally indicative of the incommensurability of inner and outer time. "The hand of our watch may run equally over half the dial, whether we wait before the door of a surgeon operating on a person dear to us or whether we are having a good time in congenial company" ([10], p. 171).

In sum, then, Husserl's analysis of time provides the insight that temporal objects are experienced not in terms of isolated, discrete, now-points along a given time-line, but rather that they are always experienced as temporal wholes which span past, present and future. Retentional consciousness (which is quite different from memory or recollection) unites past temporal phases with present and future phases of the object in such a way that the object is perceived as a unity extending through time. Thus, in living through the ongoing flow of inner-time consciousness, the individual lives in a dimension of time which is incomparable with that which can be measured according to the objective time scale.

3. ILLNESS AS A TEMPORAL OBJECT

In considering the temporality of illness, it is important to note that illness is constituted as a temporal unity at various different levels of constitution (both pre-reflective and reflective). In an attempt to elucidate these different levels, I shall begin by referring to Sartre's [11] analysis of pain and illness in which he identifies four distinct levels of constitution: (i) pre-reflective sensory experiencing, (ii) 'suffered illness', (iii) 'disease', and (iv) the 'disease state'. The first three levels represent the manner in which the patient constitutes his illness; the level of the 'disease state' represents the physician's conceptualization of illness ([11], pp. 436–445, 463–470).

The most fundamental level of constitution is that of pre-reflective sensory experiencing. One first becomes aware that all is not well in the felt experience of some alien body sensation. Sartre argues that at this level the immediate, pre-reflective experiencing is a manifestation of the way consciousness 'exists' the body. A pain in the eye, for example, is not experienced as an object 'pain' which is located *in* the eyes. Rather, pain *is* the eyes at this particular moment. One experiences the eyes-as-pain, vision-as-pain, the peculiar contingency of, say, this particular act of reading which manifests itself in terms of the blurring of the words, the inability to concentrate on this particular passage in the text, and so forth ([[11], pp. 436–438).

In contrast, Sartre says, if I reflect on my pain and attempt to apprehend *it*, the pain ceases to be lived–pain and becomes object–pain. In the reflective act, the pure quality (consciousness) of pain is transcended and a psychic object, pain-

as-object, is constituted. This psychic object which transcends the pure quality of lived-pain is constituted as the 'suffered illness' ([11], pp. 440–441). As lived unreflectively (or pre-reflectively) the pain *is* the body. When reflected upon, pain becomes a psychic object (illness) outside my immediate subjectivity and thus becomes identified as, say, pain 'in the stomach'. For the reflective consciousness, then, illness is *distinct from* the body and has its own form. Nevertheless, it is important to note, that the relation with 'suffered illness' is not a cognitive relation. At this point I do not conceive of the illness as the cause of the pain but rather "each concrete pain is like a note in a melody: it is at once the whole melody and a 'moment' in the melody" ([11], p. 442). With each pain I apprehend the illness and yet "it transcends them all, for it is the synthetic totality of all the pains, the theme which is developed by them and through them" ([11], p. 442).

At yet another level of reflection illness is constituted by the patient as 'disease'. At this level illness represents an objective disease, such as ulcer of the stomach, which is known to the patient by means of bits of knowledge acquired from others (i.e. such knowledge as the principles of physiology and pathology described to him by others) ([11], p. 466). In the normal course of events I do not experience my body as a neurophysiological organism (i.e. as a skeleton, brain, nerve endings, and so forth). It is only if I conceive of my body as an object (in Sartre's terms, as a 'being-for-others') that I may constitute it as a malfunctioning physiological organism. 'Disease' represents such objectification. The immediate experience of the stomach painfully-lived is now constituted not only as pain 'in the stomach' but, further, as 'gastralgia'. Furthermore, this level of constitution incorporates the knowledge of a certain objective nature possessed by the stomach ([11], p. 466).

The level of the disease state represents the physician's conceptualization of the patient's illness. Illness is identified with a pathoanatomical or pathophysiological fact. Sartre notes that illness is thereby wholly conceived as "a question of bacteria or of lesions in tissue" ([11], p. 466).

I should now like to explore the temporal structure of illness at these four distinct levels of constitution, using insights gained from Husserl's phenomenological analysis of time.

3.1. Illness as Pre-reflective Sensory Experience

As an example of the most fundamental level of constitution – that of pre-reflective sensory experience – I shall consider the phenomenon of pain. The immediate sensation of pain is constituted as a temporal object (i.e. as a unity which is extended durationally) through the synthesizing activity of inner time-consciousness. That is, rather than experiencing each twinge of pain as a discrete

entity which occurs in isolation from every other twinge, the person in pain experiences his pain as a continuum. As Schrag notes pains just-past are retained in consciousness, along with the present now-pain, and future pains are anticipated as part of the present experience ([12], pp. 116–117). The durational dimension of pain is such that pains 'endure'. They must be lived through. Even if pain is experienced only for a moment, this moment is "never an abstracted, discrete, atomic instant" ([12], p. 122). Rather than representing a succession of discrete, homogeneous, instantaneous nows, the 'now' of pain represents a "stagnating present with breadth and thickness that moves ever so slowly toward a hoped-for liberating future"; each moment represents the "continuing flow or duree of disquietude" ([12], p. 122).

It is readily apparent that the immediate experiencing of this continuing flow of disquietude occurs in inner, rather than outer time. The 'now' of pain appears to be endless.

> The moments of pain ... do not follow the regular and ordered sequence of seconds and minutes that are marked off by the swing of a pendulum or the ticking of a clock. Clock time is isotropic. The values of its units are uniform. The time of one's being in pain is anisotropic. Its values vary with the intensity of the pain, the accompanying emotional weight, and the press of concerns at hand ([12], p. 122).

For this reason patients are often hard pressed to report the duration of their experience of pain (and indeed the duration of other alien body sensations) in terms of the objective time scale. Their immediate experience occurs in inner time and, as such, it is not measurable according to the units of the objective time scale. The person in pain is like Schutz's beholder of a musical piece. Just as the beholder of the musical piece has no awareness of clock time while listening to the music and hence he may be surprised to later learn that one movement takes exactly as much clock time as another, so the person in pain has little awareness of clock time as he is actually living through his pain.

3.2. Suffered Illness

At the next level of constitution, the pre-reflective sensory experiencing is constituted as 'suffered illness'. The pain becomes an 'it' which is somehow distinct from the body. That is, rather than being simply experienced as the stomach painfully-lived, pain becomes a separate entity which is located 'in the stomach'. Indeed, patients often refer to this psychic object, the 'it', when attempting to communicate their lived experience of illness.

> And then it seemed to me that the gripping shifted ... It'd go on for a minute or two ... then it shifted to a lower part ... And then in the morning it persisted ... but it seems to be centered around here, in the middle of the stomach ([13], p. 14).

It seems clear that two things occur at this level of constitution. In the first

place the pre-reflective sensory experiencing is sufficiently unusual, prolonged, uncomfortable, and so forth, that it must be explicitly attended to by the patient and reflected upon. Consequently, at this point, the experience becomes one that must be given meaning ([13], p. 26). In explicitly attending to the unusual sensory experience and attempting to give it meaning, the patient constitutes such experience as 'illness'.[3] However, 'illness' at this point is not constituted as a *particular* illness – that comes at the next level of constitution.

In addition, at this reflective level, there is an intuitive awareness on the part of the patient that his symptoms are part of a larger whole. That is the various isolated bodily symptoms point to, or protend, a more complex entity of which they are simply one phase or facet (i.e. they are not experienced as discrete sensations bearing no relation to a larger unity). It is, however, important to note (with Sartre) that the relation with 'suffered illness' is not yet a cognitive relation. Illness, at this point, is still an immediate lived experience. 'Suffered illness' manifests itself *as* the collection of alien body sensations which disrupt sensory experiencing at the pre-reflective level.

In considering the constitution of 'suffered illness' as a temporal object, then, it is important to note that this constitution occurs in inner, rather than outer, time. For example, the psychic entity (the pain-as-object) – although now reflected upon and constituted as, say, a pain 'in the stomach' – is nevertheless experienced in its immediacy. The pain 'in the stomach' which is just-past is retained in retentional consciousness, just as the future pain 'in the stomach' is anticipated (protended). There is no question here of an 'as-if' presentation in which the pain just-past is recollected, rather than held fast in retentional consciousness.[4]

3.3. Illness as Disease

At yet a further level illness is constituted as 'disease'. 'Disease' represents a 'being-for-others' in that it is known to the sick person by means of concepts derived from others. The patient experiences his body as an object (i.e. as a neurophysiological organism which possesses a certain objective nature). Furthermore, he experiences the disruption in his everyday experiencing (his 'suffered illness') as being a disease state – an abstract entity residing in but in some way distinct from his body.

In this regard Engelhardt has pointed out that illness is experienced not simply as suffering but "as a suffering with a particular portent and meaning, as a suffering of a specific kind" ([14], p. 146). He notes, for example, that a person with urethritis may experience his illness *as* 'gonorrhea', or as 'likely to be gonorrhea'. A lump in the breast may be constituted as 'cancer' or 'likely cancer'. At this level of constitution the patient's experiencing of illness is

influenced by the theoretical understandings that are embedded in the life-world. That is, for those who live in a highly technological society, "pathoanatomically based theoretical concepts are expressed in the constitution of the lived experience of one's body" ([14], p. 141). Consequently, individuals in such a society come to experience themselves not simply as having pain, or pain 'in the chest', but as 'having a heart attack' ([14], p. 141).

How then is illness constituted as a temporal object by the patient at the level of 'disease'? In the first place it should be noted that this level also represents reflective, rather than pre-reflective, experiencing. The person who constitutes his illness as 'having a heart attack' is explicitly attending to his pain and assigning a specific meaning to that pain. His understanding of what it is to have a heart attack may represent more or less detailed knowledge depending upon whether or not he has discussed his illness with a physician. In any event, as Sartre points out, the patient's experience of 'disease' represents bits of knowledge acquired from others and, as such, it involves the setting-into-play of a type of constitution which is quite distinct from that which is operative at the levels of purely lived experience and 'suffered illness' (i.e. at this level 'disease' is a 'being-for-others' and, as such, it is transcendent to subjectivity and no longer represents the lived experience of illness).

Once illness has been constituted as 'disease' the patient may choose to seek the advice of a physician. In seeking the physician's assistance, he attempts to describe his illness by giving a narrative history. In so doing, the patient is obliged to recollect past events and relive his illness, not in its immediacy, but in an 'as-if' presentation (i.e. he recalls past pains rather than living through them). In this respect the temporal nature of 'disease' differs markedly from the temporality of 'pain' or 'suffered illness'. In the living through 'suffered illness' past pains are held in retentional consciousness in such a way that they are retentional phases of the actually perceived now-pain. In recollection, past pains are recalled but are no longer experienced as present.

Furthermore, in reflecting on his 'disease' and providing a narrative history, the patient often presents a sequence of events.

> The first thing that happened was that my eyes swelled up ... the very next day ... I got a very bad pain in the back of my left leg ... And then that developed ... that lasted for about two days and then ... the whole procedure has been one thing following another ([13], p. 13).

Such a sequence of events is reported according to the objective time scale which provides a common language for time.

The necessity for referring to the objective time scale to provide a common language for time is important. Husserl's analysis of inner time-consciousness indicates that, in living through the ongoing flow of consciousness, the individual lives in a dimension of time which is incomparable with that which can

be measured according to the objective time scale. Consequently, such a dimension of time is incommunicable. At the levels of pre-reflective experiencing and 'suffered illness', the patient is living through the experience in inner time. As Sartre points out, pure pain does not belong to objective time. It is the "simple lived" which cannot be reached. It belongs to the "category of indefinables and indescribables" ([11], p. 438).

In this regard Scarry has likewise noted that physical pain 'resists' language and is inexpressible. There are no words to describe adequately one's experience of pain to another ([15], p. 4). Consequently, one of the most strident characteristics about lived pain is its 'unsharability':

> when one speaks about 'one's own physical pain' and about 'another person's physical pain', one might almost appear to be speaking about two wholly distinct orders of events. For the person whose pain it is, it is 'effortlessly' grasped (that is, even with the most heroic effort it cannot *not* be grasped); while for the person outside the sufferer's body, what is 'effortless' is *not* grasping it (it is easy to remain wholly unaware of its existence; even with effort, one may remain in doubt about its existence or may retain the astonishing freedom of denying its existence; and, finally, if with the best effort of sustained attention one successfully apprehends it, the aversiveness of the 'it' one apprehends will only be a shadowy fraction of the actual 'it') ([15], p. 4).

I would argue that an important factor that contributes to the unsharability characteristic of pain is the incommensurability of inner and outer time. The patient must describe his illness in terms of outer time (since this is the common language for time). Yet he experiences his illness in its immediacy in terms of inner time. The reference to outer time represents an interpretive scheme imposed upon experience.

In constituting his illness as 'disease', and in giving a history, the patient may also do so in terms of a causal chain, "where one event follows another, as though the first caused the second, caused the third, ad seriatum" ([13], p. 31). The causal chain is constituted with reference to objective, rather than inner, time (i.e. it represents a series of discrete moments or events which take place along a time-line).

In sum, then, at the level of 'disease' illness is encountered as an entity which is transcendent to subjective consciousness.[5] Thus, 'disease' may be constituted by the patient as a temporal process according to the units of the objective time scale (i.e. as a sequence of discrete events or a causal chain). Unlike pain and 'suffered illness' which are experienced as a continuum of retentional and protentional phases in inner time, 'disease' is reflectively described as a series of discrete, atomic instances which occur along a time line.

3.4. Illness as Disease State

A further level of constitution of illness is that of the disease state. The disease

state represents the physician's conceptualization of the patient's illness as a pathoanatomical and pathophysiological fact. As such, it is constituted as a temporal process wholly according to the units of the objective time scale (i.e. as a causal process occurring through time). It should be noted, however, that although the physician constitutes the disease state in terms of a causal chain, the events identified in this causal chain may not (and almost certainly do not) coincide with those events identified by the patient.[6]

It is important to re-emphasize that the disease state known and described by the physician is quite different from the 'disease' which is constituted by the patient. As Sartre has noted, the former is "a question of bacteria or of lesions in tissue", the latter is a psychic state. A concrete example may help to clarify this distinction: suppose one has a neurological disorder. At the pre-reflective level the disorder is immediately experienced as a dragging of the leg which manifests itself in terms of the inability to climb the stairs without difficulty, a propensity for tripping up the curb, and so forth. At the reflective level, the dragging of the leg is constituted as 'suffered illness'. It signifies or points to a larger entity of which the dragging of the leg is but one part. Furthermore, it is experienced not simply as the inability to climb the stairs but as a disorder which is located 'in the leg' or 'in my leg'. When the illness becomes further constituted as 'disease', the dragging of the leg is experienced as 'a dragging of the leg which may indicate neurological disease' or as 'possible multiple sclerosis' or 'possible brain tumor'. If a visit to the physician confirms, say, 'multiple sclerosis' then from that point on the dragging of the leg is constituted by the patient *as* 'multiple sclerosis'. Consequently, if asked how he is faring, the patient will now say "the multiple sclerosis is progressing" or "I'm having problems with the M.S.". It is important to recognize, however, that even though the patient may understand his 'disease' *as* 'multiple sclerosis' and, consequently, as involving a disruption of the nerve pathways which control motor functioning, he does not experience the disruption of the nerve pathways directly (i.e. he does not directly experience the lesion in the central nervous system which is the disease known by the physician).

In contrast, the physician constitutes the patient's illness directly as a disease state (i.e. as 'bacteria and lesions in tissue'). It is not simply that the physician constitutes the fundamental alien body sensation as 'suffered illness' and further as 'multiple sclerosis' (indeed since, this represents the subjective experience of illness, he is unable to constitute this at all) but rather that he regards the fundamental entity as being the lesion in the central nervous system. Thus, for the patient, the fundamental entity is the body painfully-lived; for the physician the fundamental entity is the disease state.

In sum, then, illness is constituted as a temporal object at four distinct levels of constitution. At the first level, which is pre-reflective, illness is constituted as

a temporal unity in the actual living-through an alien body sensation such as pain (i.e. the immediate sensation of pain is itself experienced as a temporal unity). This fundamental temporal unity is, in turn, experienced at another level as part of a more complex temporal unity which is constituted as 'suffered illness' (i.e. 'suffered illness' is a synthetic totality which incorporates the immediate bodily sensations – the various and varied aches and pains – as parts of a larger whole). Pre-reflective experiencing and 'suffered illness' represent lived experience and, consequently, temporal constitution occurs in inner time. At yet a further level of constitution, illness is conceptualized by the patient as 'disease'. 'Disease' represents a type of constitution which is distinct from the immediate experiencing of illness and, consequently, its temporal constitution may occur in objective, rather than inner, time. At yet another level, illness is constituted as a disease state by the physician. At the level of the disease state, the constitution of the temporal object occurs wholly in objective time.

4. IMPLICATIONS FOR MEDICAL PRACTICE

The foregoing analysis of the temporal structure of illness provides some additional insights into the fundamental disparity which exists between the essentially mechanistic model of disease (a model which defines illness exclusively in terms of the objective, quantifiable data of the natural sciences) and the lived experience of illness. In particular, it is noted that there is an important temporal dimension to illness and, since the immediate experiencing of time is in no way comparable to an objective accounting of time, physician and patient constitute the temporality of illness differently. In living through his illness, the patient does so in terms of the ongoing flow of consciousness in inner time. Ilness-as-lived is experienced as an ever-present, enduring consciousness of disorder which resists measurement in terms of objective time. In his preoccupation with the exigencies of the here and now, the person who is ill pays little attention to clock time. Minutes may seem like hours, hours like days. Time seems to 'stand still' in that past and future coalesce into a stagnating present. The physician, on the other hand, uses the objective time scale to measure the physical events and biological processes which define the patient's illness as a disease state. Consequently, physician and patient are constituting the temporality of illness according to two different and incommensurable time dimensions. This fundamental difference in temporal constitution between the lived experience of illness and the disease state adds to the already existing disparity between the patient's and the physician's conceptualization of illness. Rather than representing a shared reality between them, illness represents in effect two quite distinct realities – the meaning of one being distinctly and qualitatively different from the meaning of the other.

In addition, the necessity for using the objective time scale as a means for communicating the lived experience of inner time (i.e. objective time is the common language for time) creates difficulties for the person attempting to communicate the experience of illness. It is often hard for the patient to gauge the duration of alien body sensations in terms of clock time since he is not aware of clock time when he is living through such sensations. This, in turn, may lead the physician to suspect that the patient's subjective report is unreliable. This suspicion on the part of the physician is further bolstered by the unshareability characteristic of inner experiences, such as pain – a characteristic which makes it difficult to find language adequate for communicating such experiences. As a result, as Scarry has noted, many people's experience would bear out the conclusion that "physicians do not trust (hence, hear) the human voice", that they perceive the patient to be an unreliable narrator, and conclude that the patient's voice must be "bypassed as quickly as possible so that they can get around it to the physical events themselves" ([15], pp. 6–7). However, to bypass the voice of the patient is necessarily to bypass the person who is ill and, thereby, to ignore the lived experience of illness.

Another key insight derived from Husserl's analysis of time is that the temporal is constituted as a field of occurrence with past and future providing horizons for the present. Thus, to consider the present as an isolated instant apart from past and future is to ignore the temporal structure of lived experience. This horizonal temporal structure is evident, not only at the fundamental level of pre-reflective experiencing, but is also exhibited at more complex levels of experiencing. Carr, for example, argues that this temporal structure pervades all experiencing from the most basic level of passive experience, through the level of simple actions, up to the level of complex sequences of action ([9], pp. 18–72). Such horizonal temporal structure is also exhibited at the level of the life narrative ([9], pp. 73–99; [16], pp. 190–209).

In considering the lived experience of illness, it is vital to take into account this horizonal temporal structure. Illness in its immediacy is an episode which is embedded in the life narrative of the patient. That is, the present 'fact' of illness represents not so much an isolated instant along a given time-line as it does a present-now which must be considered against the horizons of past and future. It is particularly important to understand that present meaning is always constituted in terms of past meanings and future anticipations. That is, the meaning of illness to a particular patient will depend upon 'the collectivity of his meanings' – a collectivity which is necessarily a function of his life narrative ([5]; [17], pp. 203–205).

In addition, it is important to consider the manner in which the constitution of illness is *itself* a function of the patient's life narrative. That is, the moment at which pre-reflective sensory experiencing is constituted as 'suffered illness' (i.e.

the moment at which an alien body sensation must be attended to and given meaning) is a function of the narrative which the individual within a culture is all along constituting. Thus, this will differ in different cultures, historical periods, and so forth.[7] Similarly, the manner in which the patient constitutes his illness as 'disease' is obviously a function of his autobiographical situation. Those living in a highly technological society, for example, will constitute illness as 'disease' in quite a different manner from the way primitive peoples do. In addition, individuals within a given society will constitute 'disease' according to their idiosyncratic life histories. It is the case, therefore, that any adequate understanding of illness must take into account the illness-as-it-is-experienced by a particular patient.

The experience of illness results in a sense of alienation from body ([20], pp. 214–220). This is manifested in many ways, one of which is (as Sartre has pointed out) the objectification of illness as 'disease' (i.e. as a 'being-for-others'). The foregoing analysis suggests that a contributory factor to this sense of alienation is the difference in temporal constitution between the various levels of intentional experience. As one moves from the temporal constitution of inner experiencing at the level of lived experience to a reflective description in terms of objective time, illness is transformed into an objective entity which is transcendent to subjective consciousness. The further one moves from lived experience, the greater is the sense of alienation from one's body.

Finally, the analysis of temporality emphasizes that illness is experienced in a *fundamental* way as a temporal entity. Nevertheless, the temporal nature of illness has been de-emphasized in favor of its constitution as a spatial object (i.e. as an entity having a specific location in the body). This neglect of the lived temporal experience of illness further alienates the patient from his body and adds to the already existing disparity between the objective conceptualization of the disease state and the illness-as-lived.

NOTES

[1] It is not my intention in this context to provide a critical analysis of Husserl's investigation of time. For an excellent commentary see [8].

[2] It is not altogether clear on Husserl's account as to what limits are placed on retentional consciousness. Husserl seems to argue that, in experiencing the melody as a unity, *all* previous phases of the melody are retained until the last note has sounded. However, he also indicates that retentions are more or less clear depending upon their proximity to the now-point with those retentions lying further back in the past being "wholly unclear" and "empty" ([7], p. 46). Nevertheless, it does seem to be the case that the melody is experienced as a temporal unity in virtue of retentional consciousness regardless of the limits of such consciousness. In the case of a long piece of music, it may be that the beginning notes are no longer available to retentional consciousness (i.e. they are no longer clear), yet the melody itself is still perceived as a unity in the ongoing flow of

subsequent retentions which are close enough to the now-point to be fully retained. Perhaps a distinction needs to be made between the constitution of the melody as a temporal unity, and the constitution of the melody as a whole. In the case of a long melody, perhaps the constitution of the melody as a *whole* is a combination of retention and recollection (i.e. the beginning notes are available in recollection but not in retention); yet the constitution of the melody as a temporal unity is a function of retentional consciousness.

[3] In this regard Cassell notes that symptoms of illness are the patient's report of what is experienced as an alien body sensation. He notes that the key point is that the sensation is experienced as alien or unusual. Not all abnormalities are symptoms in that, if the person has become acclimatized to the abnormality, then it is no longer regarded as an alien body sensation – and hence as a symptom. As an example, Cassell notes that heavy smokers may deny that they have a cough even though one may hear them coughing. 'Cigarette cough' has become part of them. It is a way of life and, since it is not experienced at the pre-reflective level as an alien body sensation, it is not constituted as 'illness' at the reflective level ([13], p. 25).

[4] Sartre argues, however, that there is a crucial difference between a temporal objectivity like a melody and a temporal objectivity like illness. Illness is 'purely lived' and consequently it is at once transcendent to consciousness as a synthetic totality, yet at the same time it *is* consciousness ([11], p. 442). That is, at the levels of pre-reflective sensory experiencing and 'suffered illness', illness is a temporal objectivity but not a temporal objectivity in objective, worldy time as a melody is. It is only at the further level of constitution of 'disease' that illness is encountered as an object which is transcendent to consciousness in the same way that a melody is transcendent to consciousness. Nevertheless, there are helpful analogies between the immediate experiencing of illness and the experiencing of the melody. Both occur in inner time and, consequently the person lives through the experience without reference to the objective time scale. The present 'now' is extended so that it reflects a continuum of past, present and future phases, rather than representing a discrete, now-point, an atomic instant which can be isolated from every other now-point. In addition, there is an analogy between the experiencing of a familiar melody and the experiencing of chronic illness. Once a melody has become familiar, the protentions of future notes are no longer entirely empty anticipations. The listener who is familiar with the melody not only anticipates that a successive note will follow the present note, but he anticipates the pitch and timbre of that successive note. Likewise with chronic illness, the patient who is familiar with the vagaries of his illness not only protends future sensations but he may anticipate the quality and duration of such future sensations.

[5] It should be noted that since 'disease' represents a type of constitution which is wholly distinct from the levels of lived experience, it seems clear that 'disease' can never *itself* be directly experienced by the patient (i.e. both the 'disease' which is constituted by the patient and the disease state constituted by the physician wholly transcend subjectivity with neither one representing the lived experience of illness).

[6] In this regard, Cassell has noted that the causal story of an illness occurs at several levels: macromolecular, involving say the platelets; the organ level, involving blood vessels and lungs; the whole organism level, the person's functioning as a whole organism, and so forth ([13], p. 18).

[7] For an interesting study illustrating how the meaning of 'illness' varies in different historical periods see [18]. For further illustration of the idiosyncratic constitution of illness see [19].

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