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Phenomenology and its application in medicine

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Abstract Phenomenology is a useful methodology for describing and ordering experience. As such, phenomenology can be specifically applied to the first person experience of illness in order to illuminate this experience and enable health care providers to enhance their understanding of it. However, this approach has been underutilized in the philosophy of medicine as well as in medical training and practice. This paper demonstrates the usefulness of phenomenology to clinical medicine. In order to describe the experience of illness, we need a phenomenological approach that gives the body a central role and acknowledges the primacy of perception. I present such a phenomenological method and show how it could usefully illuminate the experience of illness through a set of concepts taken from Merleau-Ponty. His distinction between the biological body and the body as lived, analysis of the habitual body, and the notions of motor intentionality and intentional arc are used to capture the experience of illness. I then discuss the applications this approach could have in medicine. These include narrowing the gap between objective assessments of well-being in illness and subjective experiences which are varied and diverse; developing a more attuned dialogue between physicians and patients based on a thick understanding of illness; developing research methods that are informed by phenomenology and thus go beyond existing qualitative methods; and providing medical staff with a concrete understanding of the impact of illness on the life-world of patients.

Keywords Embodiment · Disease · Illness · Phenomenology · Experience of illness · Medical training · Merleau-Ponty · Philosophy of medicine

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Introduction

Phenomenology is a philosophical tradition dating back to the early years of the twentieth century. Within the tradition, there are different views and emphases, but most generally, phenomenology is a philosophical approach that focuses on phenomena (what we perceive) rather than on the reality of things (what really is). It focuses on the experiences of thinking and knowing: how phenomena appear to consciousness [1, p. 1]. Phenomenology examines the encounter between consciousness and the world, and views the encounter as constitutive. It is the science (*logos*) of relating consciousness to *phenomena* (things as they appear to us) rather than to *pragmata* (things as they are).

As such, phenomenology may be considered metaphysically modest: it focuses on the data available to human consciousness while bracketing metaphysical debates and ontological commitments. Classical phenomenology does not posit this data as empirical, real, or absolute, but rather, as transcendental.[1] It simply describes the mental activity taking place in different acts of consciousness, such as perceiving, thinking, knowing, imagining, and so on. Because of its metaphysical modesty, phenomenology can be applied to a range of philosophical problems and be used compatibly with a range of metaphysical views.[2] This paper is a programmatic outline of the ways in which phenomenology can be applied to the study of illness. As such this paper explicates the contribution phenomenology could make to medical research and practice, providing examples along the way.

Phenomenology is primarily a descriptive philosophical method, aiming to be a practice rather than a system [1, p. 4]. As a practice, it has been used in a range of disciplines such as sociology, film studies, anthropology, nursing, musicology, and others. It can be used to describe one's experiences of something, for example, the experience of viewing a particular painting, as in Heidegger's analysis of Van Gogh's 1886 painting *Peasant Shoes* [7, pp. 158–161]. It can be used to describe how, given a certain environment, something appears from a particular point of view, as in Merleau-Ponty's analysis of Cezanne's paintings [8, pp. 9–25]. Or it can be used to analyse the experience of listening to a melody [9]. Phenomenology has been employed in literature (famously in the work of Sartre) as well as to describe aesthetic experience, analyse social relations, and focus on aspects of human existence, such as embodiment and sexuality [5].

Phenomenology is used to attend to various aspects of our experience, providing a method for discerning and describing human experience. It is particularly useful not only for analysing discrete units of input (e.g., a spoken sentence) but in understanding the particular background against which the input is perceived and

[1] Its transcendental, rather than empirical, data is what differentiates phenomenology from experimental psychology. While experimental psychology generates empirical data about different mental acts, phenomenology generates transcendental data on the conditions of possibility of certain mental acts. Famously, space and time are such conditions of possibility, without which experience would be impossible [2, A32/B48; 3, pp. 75ff.].

[2] Thus we can find a broad range of metaphysical views in this tradition. Husserl's idealism [4] can be contrasted with Merleau-Ponty's realism [5] and with Heidegger's emphasis on ontology [6].

interpreted (e.g., a background of sexism providing a particular context to the sentence (cf. MacKinnon [10]). Phenomenology understands perceptual experience as embedded in a particular culture and as having a particular meaning based on the concepts and values of that culture. But it is not merely an anthropological method. Phenomenology is a distinctly *philosophical* method as it investigates the conditions of possibility for having a particular experience; it is thus a transcendental method of inquiry rather than an empirical one [11, pp. 132–137]. While phenomenology is normally described as a transcendental mode of inquiry, as we shall see, the boundaries between the transcendental and the empirical can become blurred. Some phenomenologists even downplay the significance of the transcendental nature of phenomenology. For the purposes of describing the experience of illness, it is enough to consider the general features of illness without insisting on the transcendental nature of its features (but cf. Toombs [12] for a transcendental analysis of illness).

A small number of authors have begun to explore how phenomenology may illuminate the embodied experience of illness. They have drawn on a host of phenomenological writings ranging from Husserl to Merleau-Ponty, Sartre, Gurwitsch, and Heidegger. One of the earliest authors is Zaner [13, 14], whose seminal work, *The Context of Self*, has had considerable influence on phenomenological work within nursing and health care research.[3] Zaner's early work examined embodiment while taking pathology and illness as limit cases that illuminate normal embodiment [13]. His later work on narratives of illness was more implicitly phenomenological, but its starting point—seeing patients' ethical dilemmas as grounded in concrete existential situations—remained phenomenological [16]. Other notable authors are Toombs [12, 17, 18], Svenaeus [19–21], and Kirkengen [22], who each developed a unique phenomenological model of illness.

An insight these authors share is that in order to describe the experience of illness we need a phenomenological approach that can account for the body's central role in human life and acknowledge the primacy of perception. Such an approach is found in the work of Maurice Merleau-Ponty, who developed an embodied phenomenology to which I now turn.

Merleau-Ponty's embodied phenomenology

Merleau-Ponty's understanding of phenomenology is unique in providing a robust account of human experience as founded on perception [5, 23]. Perception, in turn, is itself an *embodied* activity. In order to see, we need eyes, optic nerves, and light; in order to touch, we need skin and a nervous system; and so on. This is not just an empirical claim about perceptual activity but a transcendental view that posits the body as the condition of possibility for perception and action. For Merleau-Ponty the body is 'the origin of the rest, expressive movement itself, that which causes them to begin to exist as things, under our hands and eyes' [5, p. 146]. As Gallagher and Zahavi write, '…the body is considered a constitutive or transcendental

[3] A special issue of *Theoretical Medicine* [15] was dedicated to Zaner's work.

principle, precisely because it is involved in the very possibility of experience' [11 p. 135].

On Merleau-Ponty's view, perceptual experience is the foundation of subjectivity. The kind of creatures we are is circumscribed by the types of experiences we have and the kinds of actions we perform, both of which are shaped by our bodies and brains. Any attempt to understand human nature would have to begin with the body and perception as the foundations of personhood [5, p. 146]. This claim is a radical one in the context of the history of philosophy, in which rationalism and an emphasis on a disembodied mind have been central. It is also, as we shall see, highly significant to understanding illness as an essentially embodied experience.

Merleau-Ponty rejects a broadly rationalist view by bringing out the importance of sensual knowledge and perception. Because of the inseparability of embodiment, perception, action, and subjectivity, changes to one's body can lead to far-reaching changes in one's sense of self. The fundamental role Merleau-Ponty affords perception and the body gives rise to his criticism of rationalist views of knowledge as conceptual and innate. But Merleau-Ponty is also dissatisfied with the broad view he calls empiricism. On his view, empiricism is unable to account for the qualitative first person experience that arises from sensual stimuli. Moreover, he thinks that empiricism, because it views sense data as the basic unit of experience, fails in the attempt to describe how perceptual acts take place. Seeing perception as an aggregate of discrete units of information can never yield a meaningful, ordered human conscious experience, he argues [5, pp. 3–12].

What Merleau-Ponty offers is a novel 'third way', a view of the human being as essentially embodied, a body-subject that arises from acts of perception. These acts of perception are global and meaningful; they are not discrete units of data. Thus 'we hear the door shut in the house and never hear acoustical sensations or even mere sounds' [7, p. 152]. Perceptions are 'inhabited by meaning' and are always grasped as meaningful for us [5, p. 52]. As Heidegger says, 'we do not throw a "signification" over some naked thing which is present-at-hand' [6, p. 190].

Merleau-Ponty also used a gestalt view to develop his notion of the phenomenal field, the horizon of perception through which we encounter the world [5, p. 60]. When we perceive a black dot, we do not perceive it on its own; it is located in a visual field, against a particular background. This background and perception itself are never static or passive. In the following moment, our eyes may move away from the dot to another visual object or may be shut. Each of these possibilities is a possible horizon, indicating the openness of our phenomenal field. This openness is both spatial (where do we look next?) and temporal (the dot may change its appearance when night falls) [5, p. 68].

Merleau-Ponty sees the body and perception as the seat of personhood, or subjectivity. At root, a human being is a perceiving and experiencing organism, intimately inhabiting and immediately responding to her environment. To think of a human being is to think of a perceiving, feeling, and thinking animal rooted within a meaningful context and interacting with things and people within its surroundings. Instead of artificially separating mind and body, Merleau-Ponty pointed to the unity of body and mind. This more organic view of the human being as a human animal (with culture, sociality, and a meaning-endowed world) sees the body as the seat and

sine qua non of human existence. To be is to have a body that constantly perceives the world. As such, the body is situated and intends towards objects in its environment. Human existence takes place within the horizons opened up by perception.

In a normal situation, the body-subject engages in a 'primordial dialogue' with the world. This dialogue is a prereflective absorbed engagement with the environment, and takes place constantly in everyday activities. For example, when we go for a walk, our legs propel the body forward, the labyrinths in our ears keep us upright and balanced, and our eyes provide visual information about the path ahead and any obstacles to be negotiated. A second dialogue takes place between different body parts and types of information, allowing the body-subject to synthesize information coming from different body parts to create a unified experience.

All the while, the walker could be avidly discussing Nietzsche, paying no conscious attention to her body. This does not make her disembodied. It simply shows that embodiment is a condition of possibility for a realm of subjectivity to exist. This holds true even if no attention is paid to the body, as is often the case when one is absorbed in a task. Whether consciously experiencing bodily sensations or being preoccupied by a completely abstract mathematical problem, both activities, and the whole spectrum in between, are possible only in virtue of existing as embodied in a world.

The habitual body, motor intentionality, and intentional arc

Many of our actions, particularly everyday routine actions, are prereflective: they are the product of habit rather than conscious reflection. A complex web of such habits makes up our world. Our habits and ordinary ways of engaging with our environment constitute a meaningful world with which we seamlessly interact. Against this often invisible background activity, reflection and conscious thought take place. Normally we pay attention to what is preoccupying us at a given moment rather than to the cup of tea we are preparing. But Merleau-Ponty wants to direct our attention to the significance of this silent background.

The body is a physical thing, an object that can be weighed, measured, and described using purely physical or naturalistic terms. But it is also the source of subjective feelings, perceptions, and sensations; it is the seat of subjectivity, the place where consciousness occurs. As such the body is a subject-object, a unique being that can be experienced both from a first and a third person point of view.

Merleau-Ponty uses the example, taken from Husserl [4], of two hands touching each other. Each hand is touching, active, and sensing the other hand but also being touched, passive, and sensed by the other hand. As Merleau-Ponty describes it, 'When I press my two hands together, it is not a matter of two sensations felt together as one perceives two objects placed side by side, but of an ambiguous set-up in which both hands can alternate the roles of "touching" and being "touched"'[5, p. 93]. This view of the body as both an active, touching subject and a passive, touched object posits it as unique in nature.

Merleau-Ponty also develops the novel notion of motor intentionality. He challenges the view that only mental phenomena can have intentionality by extending intentionality to include bodily intentionality. This is the body intending towards objects, directing itself at goals, and acting in a way that is 'about' various aims and objects. For example, if I reach with my hand to grasp a cup of tea, my hand intends towards the intentional object, the cup. The position of the hand, the direction of the movement, and the tensing of the fingers are all directed at, or intended towards, that cup.

Motor intentionality connects my body to the cup of tea. This notion captures the intelligibility and goal-directedness of bodily movement. Thus we are able to make sense of a collection of disparate bodily movements, unifying them into a meaningful action [5, p. 136]. In this sense, we could say that motor intentionality is an analogue of mental intentionality. But Merleau-Ponty is making the stronger claim that bodily intentionality is primary to, and the foundation of, mental intentionality. He sees motility as basic intentionality [5, p. 137]. There can be no mental intentionality without bodily orientation in a world. 'Consciousness is being-towards-the-thing through the intermediary of the body… to move one's body is to aim at things through it' [5, p. 139].

Motor intentionality is embedded within a broader concept: the intentional arc. The intentional arc is the overarching term describing our relationship to the world. This relationship includes a layer of motor intentionality but also a temporal structure (cf. Heidegger [6]), a human setting, and a moral and existential situation. These capture the unique relationship a human being has to the world—a relationship that is not only physical but also embedded in cultural and social meaning, and is ultimately an *existential situation* rather than a mere physical position. 'It is this intentional arc which brings about the unity of the senses, of intelligence, of sensibility and motility. And it is this which "goes limp" in illness' [5, p. 136].

This view sees the body as an intelligent, planning, and goal-oriented entity. The body is not a passive material structure waiting for mental commands, but is actively engaged in meaningful intelligent interaction with the environment. Through its directedness, the body executes actions that are not merely physical movements but also goal-directed movements that can only be understood as such. 'For us the body is much more than an instrument or a means; it is our expression in the world, the visible form of our intentions' [23, p. 5]. Thus the body is the core of our existence and the basis for any interaction with the world; it is our general medium for having a world [5, p. 146].

This view of embodiment as the fundamental characteristic of human existence is in line with recent literature on embodied cognition [24–26], enactment, and some of the attempts to reconcile phenomenology and naturalism [27]. This view goes beyond philosophical research and has been adopted by researchers in diverse fields, including education, linguistics, ecological psychology, and artificial intelligence [28, 29]. Although working in diverse fields, these researchers share the understanding that 'cognition and behaviour cannot be accounted for without taking into account the perceptual and motor apparatus that facilitates the agent's dealing with the external world…' [28, p. 7]. This broad research program adopts

(implicitly and explicitly) phenomenological ideas and methods. It regards embodied phenomenology as a useful philosophical framework through which to think about issues such as the mind-body relationship, perception, action, embodiment, and a wide range of issues in the philosophy of mind [30, 31]. The use of embodied phenomenology to describe the experience of illness is part of this research program.

Phenomenology of the ill body

Phenomenology can be used to describe the experience of illness by focusing on first person accounts of what it is like to suffer from a particular illness.[4] On Merleau-Ponty's view, our experience is first and foremost an embodied experience, an experience of fleshly physical existence. Thus embodied phenomenology seems doubly suited for describing the experience of illness, which often includes a radical shift in one's embodiment.[5]

An important feature of phenomenology is the distinction between the objective body (which Husserl called *Körper* and Merleau-Ponty called *le corps objectif*) and the body as lived (*Leib* and *corps proper*, respectively). If we go back to Merleau-Ponty's view of the body as both object and subject, we can see how these two terms are useful for understanding illness. The objective body is the physical body, the object of medicine. The body as lived is the first person experience of this objective body. In the everyday experience of a healthy body, the two bodies are aligned, in harmony.

The healthy body is transparent, i.e., taken for granted. This transparency is the hallmark of health and normal function. We do not stop to consider any of its processes because as long as everything is going smoothly, it remains in the background. 'The body tries to stay out of the way so that we can get on with our task; it tends to efface itself on its way to its intentional goal' [11, p. 143]. This does not mean that we have no experience of the body but, rather, that the sensations it constantly provides are neutral and tacit. A good example is that of the sensation of clothes against our skin. This sensation is only noticed when we draw our attention to it or when we undress [33, p. 303].

Although we may have moments of explicit attention to the wellness of our body, for example, when a headache goes away or while exercising, it is when something goes wrong with the body that it moves from the background to the foreground of our attention.[6] When functioning normally, our attention is deflected outwards, away from our body and towards our intentional goal or action. It is not that the body is absent but, rather, that our experience of it is in the background while the object of our focus is in the foreground. In contrast, when we become ill, our attention is drawn to the malfunctioning part, and all of a sudden, it becomes the

[4] It can be used to understand any type of bodily experience, e.g., the experience of being pregnant [32].

[5] It is also useful for a number of other issues in medicine, as will be explained below.

[6] I thank an anonymous referee for pointing out that the experience of wellness can also be explicit and draw attention to the body.

focus of our attention rather than remaining as the background for our activities. It is at this stage that the harmony between the objective body and the body as lived is disrupted.

We can find a useful analogy in Heidegger's tool analysis. A pen is a tool we use to write a cheque. While using the pen, we do not notice it. It is inconspicuous. Our attention is focused on the end while the means are relegated to the background. But when the pen fails to write or the car refuses to start, suddenly these tools become the centre of our attention. They cease to be an invisible background enabling the achievement of some goal and become stubborn saboteurs [6, pp. 102–103].[7]

This inconspicuousness holds true for tools and even more so for our bodies. Whereas we can throw out the useless pen and grab another, our bodies stand in a very different relation to us. Our bodies cannot be replaced or repaired as readily as we would like. My head with a headache remains attached to me and becomes increasingly conspicuous, increasingly disabling. The claim here is not that the body is a tool, but that a similar process of becoming conspicuous characterises both forms of malfunction. But the body is different from a tool in important respects. Its dysfunction is so important, so intimately linked to our well-being because it *is* us. Illness is a painful and violent way of revealing the intimately bodily nature of our being.

Another reason the difference between the objective body and the body as lived emerges in illness is that the body as lived is in large part habitual. It is used to performing certain tasks with ease. Routine actions can be performed expertly and efficiently because they have become habit. Again, the actions are harnessed to the goal of the activity. While getting ready to go to work, one rarely notices the multitude of actions and the expertise required to have a shower and get dressed. It is only when we watch a novice that we appreciate the complexity of the activity and our expertise. The ease with which we perform habitual tasks often disappears in illness. While retaining the know-how, the ability to carry out an action is lost. Illness thus accentuates the difference between the objective body and the habitual body.

Another example given by Merleau-Ponty is the phantom limb. A phantom limb is the sensation emanating from a limb that has been amputated. The phantom limb feels painful or itchy, but the real limb has been removed. Merleau-Ponty explains the phantom limb as a rift between the objective body and the lived experience of it. The objective body has no limb, but the body as lived feels that limb as present. The phantom limb is the expression, based on years of having a body image and a body schema with four limbs, of the body as it used to be. The habitual body is a relationship to an environment and to a set of abilities that are no longer available to the amputee. 'To have a phantom arm is to remain open to all the actions of which the arm alone is capable; it is to retain the practical field which one enjoyed before mutilation' [5, pp. 81–82].

Another example of the rift between the objective body and the body as lived is anorexia nervosa. If we look at the objective body, we may see a skeletal, emaciated

[7] Similarly, when one is ill or disabled, tools may become conspicuous because of the body's inability to use them. For example, a pen is normally a tool to be used. But for a quadriplegic the pen presents a challenge or even becomes an obstacle [18, p. 251].

body. This is the objective body whose thinness can be measured by weighing it or calculating its BMI. But if we ask the anorexic to describe her body, she may say that she experiences it as obese and cumbersome. Denying this experience by making an appeal to objective facts is unhelpful. In anorexia, the rift between the body as it is objectively and the body as it is experienced is the crux of the disorder.

Because illness changes the body and the body understood through embodied phenomenology is accorded a central role, the tremendous impact of illness becomes visible. On this view illness is not merely a dysfunction of a body subsystem (cf. Boorse [34]) but a systematic transformation of the way the body experiences, reacts, and performs tasks as a whole. The change in illness is not local but global; it is not external but at the core of the self.

Application in medicine

Having laid out the principles of embodied phenomenology and how these illuminate the experience of illness, I now turn to the application of this approach in medicine. This application is not limited to medical training and practice. Indeed, there are important ways in which embodied phenomenology may also contribute to the study of therapeutic outcomes and illuminate methodological issues. Thus, for example, using phenomenological methods to assess the efficacy of medical treatments may help explicate the significance of patients' expectations. The methods used to understand and report the experience of illness can be developed and taken beyond the existing paradigm of questionnaires and interviews to include a host of nonverbal embodied methods (see below). And finally, and most broadly, the methodologies used in a wide range of issues in medicine (e.g., trial design, outcome measures) can be expanded using phenomenological ideas.

Phenomenology, in its embodied understanding of human being, differs from other first person approaches such as certain narrative approaches and qualitative interviews. This is particularly important when we come to think of actual research methods that may arise out of this approach. So, for example, a narrative approach focuses on verbal and written self-reports, and qualitative interviews are conducted while sitting down and conversing with the interviewee or by using questionnaires. In contrast, embodied phenomenological research methods glean information about the experience of illness in ways that go beyond verbal accounts. They may use 'walking with' exercises, videotaping (thus including nonverbal information about bodily movement and gestures), and reports relating sensual and perceptual experiences (e.g., looking at changes to sense of taste). Such phenomenologically informed research may also focus on the body of the carer and use phenomenological methods to examine health professionals' visceral responses to the ill person.

Embodied phenomenology differs also from the commonplace medical view of the body, which often sees it as a physical body alone. The tendency to focus on the physical body stems from the naturalistic foundations of medicine, according to which disease is a bodily dysfunction that can be fully understood using purely objective terms [34, 35]. This tendency is understandable within the medical and

allied health professions. It sits well with the training many practitioners have received and with their workplace culture.

But this view is at odds with the patient's point of view. The patient experiences her illness from within, as a transforming experience impacting all dimensions of life. She experiences her illness as a disruption of her previous lived experience; this includes bodily alienation, an altered experience of space and time, frustration of bodily intentionality, social changes, and challenges to self identity and integrity [18, p. 248). She does not compartmentalise the disease, nor does she understand it solely as a set of physical symptoms. Rather, for her, the illness is an ongoing presence that modifies her life. The impact is not only physical but also psychological, social, cognitive, emotional, existential, and temporal [36].

By using the distinction between the objective body and the body as lived, we can expose a potential difficulty in patient–physician communication. Generally speaking, the clinician understands illness as a biological process, in abstraction from lived experience. For the patient, on the other hand, illness is experienced in its qualitative immediacy, grounded in lived experience. For example, clinical data may be viewed as knowledge to the physician, but they are 'news' to the patient [17, p. 227]. This gap between the third and first person experiences of illness is not a difference in knowledge level but a difference in the approach to illness. So when patient and clinician are discussing the patient's condition, there is often no shared set of assumptions or a common understanding of the object of discussion, the illness [17, 37]. Most significantly, phenomenology does not see the patient's experience as a subjective account of an abstract objective reality; rather it takes this experience to represent the reality of the patient's experience [17, p. 236].

Phenomenology can be used to present to the clinician some of the invariant features of illness as experienced, such as bodily change and reduction in ability to perform daily activities.[8] As demonstrated above, phenomenology can be used to examine the nature of the difference between patient and physician understandings, make explicit the assumptions that result in the distortion of meaning, and provide a detailed account of illness as lived [17, pp. 221–222].

I am currently developing a 'phenomenological toolkit' which would enable patients to systematically and comprehensively describe their experience [38]. Such a toolkit would enable patients to take a fractured and upsetting set of experiences and make sense of it by describing and ordering it. This information could not only aid the patient's self-understanding but also be presented to the clinician. Bringing to light the different perspectives on illness can help construct a shared meaning of illness. This would improve communication and understanding in patient–clinician dialogue and possibly also increase patients' trust in physicians and compliance rates.

More generally, presenting the main themes of embodied phenomenology to health care professionals would enable them to understand the existential and embodied nature of illness. By understanding their patients as body-subjects,

[8] Toombs provides a list of essential (or 'eidetic') characteristics of the experience of illness, including the perception of loss of wholeness, loss of certainty and control, loss of freedom to act, and loss of the familiar world [17, p. 229].

clinicians would be able to appreciate the impact illness has on patients' lives not just as a secondary effect of the biological disease but as a primary phenomenon.

These applications are not limited to a particular domain within clinical medicine. Indeed, there is currently a growing literature on phenomenology and psychiatry [39–41]. So the application of the phenomenological approach is not limited to any particular physical illness but, indeed, yields important insights for the study of mental disorder as well. Phenomenology can be used to bring out the diversity and variation in the experiences of illness [42]. Illness is experienced and understood individually and subjectively, so third person generalisations are unable to capture each experience [36].

Once a better understanding of the experience of illness is achieved by using phenomenological tools, this understanding could assist in devising useful interventions based on specific knowledge of what will have a positive impact on the life-world of the patient. Interventions could then be tailored to target real, rather than assumed, needs and would, therefore, offer greater benefit to patients. Interventions may also identify needs that go beyond the medical condition itself, allowing for an improved quality of life for the patient. Although much work has been invested in this area, the rich understanding that phenomenology may offer can advance existing work.

Another contribution of phenomenology would be in narrowing the gap between external, objective assessments of well-being in illness and subjective experiences, which are varied and diverse (see Carel [42, 43]). Empirical evidence shows that objective assessments of health and well-being are poor predictors of subjective well-being [44, p. 508]. People who suffer from ill health, measured objectively by physician reports or co-morbidity counts, are no less happy (on their accounts) than healthy controls. As Angner writes, 'With the exception of debilitating pain and urinary incontinence, which were associated with lower happiness scores, we found no correlation between the objective health measures and happiness' [44, p. 508]. This seems to defy expectations as, *prima facie*, health would seem an important predictor of well-being. More work is required in this field to answer some key questions. For example, if objective health measurements do not track subjective well-being, should we worry less about them? Should the interventions we design aim to improve objective health or to increase subjective well-being?

A case in point is a currently ongoing study examining the helpfulness of mindfulness-based cognitive therapy (MBCT) to chronic obstructive pulmonary disease (COPD) patients who also suffer from depression and/or anxiety. The study asks whether MBCT may improve quality of life in COPD patients [45]. The study looks at objective health parameters (e.g., spirometry) as well as quality of life and subjective well-being. Part of the study examines the correlation between objective health measurements and subjective well-being measurements. This kind of study contributes to an understanding of the relationship between first person data provided by the patient and data gleaned from objective procedures.

The study design is influenced by the kind of phenomenological thinking described in this paper. It emphasises the significance of embodied experience to well-being, and aims to modify this experience through exercises that combine new physical routines (e.g., relaxation through breathing) with mental practice (e.g.,

kindly attention meditation). There is no explicit split between the two domains and the notion of well-being used in the study is explicitly holistic. It is also designed by a team which includes a respiratory patient so the first person experience is used not only to evaluate the program but also in the study design itself. The assessment of well-being that will be provided by participants will be compared against objective health and well-being measurements (e.g., depression score) so as to enable the researchers to better understand the relationship between the two sets of measurements. Finally, the intervention is not directed towards improving lung function but, rather, towards improving the quality of life of the participants. The chronic condition is treated as a given and the aim of the study is to enhance the ability of the participants to experience well-being within the constraints of their illness (cf. Carel [43]).

Phenomenology could also be used to monitor and enhance overall experiences patients have of their health care system. Much has been written on patient-centred care [46, 47], but overall patient complaints about particular aspects of their care remain common. In addition, there is no generally accepted and methodologically robust way of measuring patient satisfaction [48]. By understanding through a phenomenological lens patients' experiences of interacting with health care professionals in a clinical setting, a better understanding of these experiences could be achieved and improvements to their care could be made.

This work would not only explore patients' views via questionnaires and interviews, both of which have limitations and methodological flaws [42, 49], but also use phenomenological methods currently in use in the social sciences. These include 'walking-with', video work, lived experience diaries, and haptic exploration of place and space. These research tools pay special attention to all sense modalities through the exploration of the taste of food, sounds in hospital wards, visual experiences, and so on. Additionally, these methods reject the Aristotelian categorisation of the five senses in favour of a more sophisticated and empirically informed view of perception [50, p. 768].

The types of sensuous experiences that can be examined with these research tools are also unique in another sense. They create an emotional evocation—a mood, or attunement, as Heidegger calls it [6, pp. 172ff.). Mood is not an internal mental state, nor is it entirely objective; different people can respond differently to the same stimulus. The category of mood captures the phenomenological rejection of the inner/outer distinction as it is both objective (it is a response to the world as it is) and subjective [6, pp. 172ff.; 5, p. 61]. It is the filter through which we come to experience a world, and in this sense, it is a transcendental category [51]. Mood as an existential category is a significant dimension of illness, encompassing both unique moments in the illness experience, such as diagnosis, as well as long-term emotional adjustment to the illness. Understood as expressing our openness to the world, mood could also be explored phenomenologically.

Finally, phenomenology can also assist in ethical training of medical staff. Such training has been piloted at the Bristol Medical School, and a similar program has been piloted as a Continuing Professional Development workshop for health professionals at the University of the West of England, Bristol [52]. By drawing attention to the lived experience of illness and to the pervasive impact of illness on the patient's life-world,

new insights and sensibilities can be developed in medical staff and students. The relationship between phenomenology and ethics has been noted by several authors [53, 54] and could be usefully implemented in medical training and teaching.

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