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Nursing and Medicine

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Phenomenology is a descriptive philosophical method, aiming to be a practice rather than a system (Moran 2000: 4). It can be used to describe one's experience of something; for example, the experience of looking at Van Gogh's 1886 painting, *Peasant Shoes* (Heidegger 1993: 158-161). It can be used to describe how something appears from a particular point of view, in a certain environment, as Merleau-Ponty's analysis of Cezanne's paintings does (1964: 9-25). Or it can be used to analyse the experience of listening to a melody (Husserl 1990). As such phenomenology is uniquely suited to describing the experience of illness. Its influence on theory and research in nursing and healthcare has been substantial. Its impact on medicine and on the philosophy of medicine only recently begun to be seen. It has also been used, to a lesser extent, in medical training and teaching and in healthcare training.

Not all of these applications of phenomenology in healthcare and medicine have been successful. This article examines the ways in which phenomenology has been used in these fields, presents some criticisms of its use, and suggests further ways to employ this productive method in healthcare, nursing and medicine.

1. Phenomenology's influence on nursing and medicine.

Phenomenology began to interest researchers and experts in nursing in the 1970s, an interest accompanied by growing attention paid to humanism. The logic behind this interest was simple.

Nursing and healthcare researchers are interested in understanding how patients experience their illness and what meaning they attach to it. As a method for discerning, ordering and describing experience and meaning-making processes, phenomenology can enable a comprehensive description of the human experience of illness (Carel 2008: 8-13).

This interest also arose as a response to the dissatisfaction felt by those interested in the experiential features of illness, who felt that mainstream medicine was too narrowly focused on biological disease and dysfunction, whilst overlooking the qualitative and experiential dimensions of illness and receiving healthcare. As such the interest in phenomenology is often closely aligned with a humanistic worldview; so phenomenology and humanism are frequent bedfellows in the nursing literature, although the philosophical underpinnings of these two movements are very different.

Certain areas within nursing research came under the influence of phenomenology particularly strongly. These include qualitative research, quality of life research and chronic illness research. However, phenomenology is by no means an orthodox or dominant view in these fields. Rather, it is one approach that has been used in a variety of studies, mainly as an interview and text analysis method. In this context it has been used as a philosophical framework which prioritises the first-person experience of illness.

Some nursing researchers have made phenomenology the core method and philosophical basis for their work. These include Patricia Benner, Josephine Paterson and Rosemarie Parse, among others (Benner 1989, 1994; Paterson 1988; Parse 1995). Benner's work was influenced by Heidegger (1889-1976) and Gadamer (1900-2002), as was Parse's, while Paterson was influenced by the later Husserl (1859-1938) and his notion of the lifeworld (*Lebenswelt*).

Within nursing, in recent years particular attention has been paid to embodied phenomenology, which Maurice Merleau-Ponty (1908-1961) developed in his book *Phenomenology of Perception* (1962 [1945]). This approach sees the body as the locus of subjectivity and rejects the mind/ body

separation traditionally espoused by philosophers and theologians. 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” (1962: 146). This is not just an empirical claim about perceptual activity, but a transcendental view that posits the body as the condition of possibility of perception and action. As Gallagher and Zahavi write, “... the body is considered a constitutive or transcendental principle, precisely because it is involved in the very possibility of experience” (2008: 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, 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 (Merleau-Ponty 1962: 146). 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 in its environment. To be is to be a body that constantly perceives the world. This body is situated and intends towards objects around it. Human existence takes place within the horizons opened up by perception.

The body, for Merleau-Ponty is the existential locus of human existence. Thus, when we become ill, this is not simply a biological dysfunction of a body part, but a pervasive disturbance of our being in the world. On an embodied phenomenological view, illness is not a localised dysfunction of a body part, but an all-pervasive existential concern. Thus we see the habits which anchor our everyday routines disrupted, for example, when one is unable to run for the bus. This disruption of habits is not a superficial or localised disturbance. The habitual body, as Merleau-Ponty calls it, is very much at the core of lived experience. The ease and expertise with which we perform everyday actions leads us to view them as trivial tasks. But in illness, the trivial tasks that make up our everyday and enable us to engage with the world, become mammoth, demanding, and require planning and attention. It is this kind of disruption to our existential projects and our ability to act effectively in

the world that turns illness into an existential transformation. To see this disruption at its clearest requires a phenomenological vocabulary and description.

The first insight phenomenology provides is that it is nothing less than our agency, our ability to operate in the world that is restricted when we are unable to walk, talk or see. An extreme example would be Jean-Dominique Bauby's account of a stroke, which left him in complete paralysis, or 'locked-in syndrome'. In the space of a few minutes Bauby turns from being an active man in the height of life, an editor of the French *Vogue*, to lying helplessly in bed, unable to communicate or eat. Although his mind is alert as ever, the complete paralysis of his body necessarily also imposes a complete halt on all the activities he previously enjoyed. Even his account of his illness was painstakingly dictated using the batting of his one functional eyelid. (An assistant would read out the alphabet and Bauby would blink when she got to the letter he wanted – a process which took many months.) The laboriously produced account was published as a novel, *The Diving Bell and the Butterfly*, and made into a film directed by Julian Schnabel (Bauby 1998).

It would be impossible for us to ascribe the changes to Bauby's existence merely to physiological changes. These changes have to be understood not biologically, but existentially. We can begin to appreciate the changes to his life by thinking about simple things, like going for a meal with friends, or having a shower, things that Bauby became unable to do. It was not merely paralysis he experienced, a physiological dysfunction, but a complete shutting down of his existential horizons, of his world.

Thus illness changes our relationship to the world, or in more specific terms, our relationship to the environment, to other people and to existential possibilities. The geography of our world changes with illness, when old invitations (a stairway leading somewhere) become new limitations (Carel 2008: 25). Toombs describes how a bookcase in her house was initially a place to store books, then

became an object to hang on to as her walking became less steady, and eventually an obstacle she has to wheel her wheelchair around (1995: 16).

Similarly, our social world may be transformed by the illness. The ill person's relationship to other people may have to be renegotiated. Some relationships may become less natural, or weighed by guilt, shame, awkwardness and other social responses to illness. One's illness, especially if it is visible, may mark the ill person out, or posit her in a 'sick role', whether in accordance with or despite her wishes (Parsons 1991: 436ff.). A phenomenological concept like Heidegger's being-with (*Mitsein*) is required in order to capture the magnitude of the change brought about by illness. By being-with Heidegger expresses the inherent sociality that lies at the core of a human being (1962: 149-150). So anything that modifies our ways of being-with will have far-reaching consequences, stretching beyond the mere physiological process of disease.

Finally, our relationship to ourselves, in terms of our existential possibilities, our goals and aims, is also modified by illness. When one is faced with a poor prognosis, with substantial limitations on work and leisure, with a pressing need to change habits and to rethink plans for the future, illness becomes an overarching existential concern influencing every dimension of human life. Here, too, we can see how useful a phenomenological-existential framework is for understanding the full impact of illness. Heidegger views the human being as a temporal synthesis of past, present and future; as a temporal creature whose actions are informed by her past, and directed towards her future. This temporal dimension also includes finitude, as all our plans for the future are always constrained by our finite existence, as a stretch from birth to death (Carel 2006: 70). So when we are faced with a poor prognosis or with severe limitations on our abilities, we also need to rethink our life plans and to readjust our expectations to what remains possible. Again, this process of adjustment is a reflexive and time-consuming, but adaptation is possible, albeit never fully compensates for the freedom that is lost (Carel 2007: 104ff).

Merleau-Ponty devised a few novel concepts that can be used to further explicate the changes to the life and world of the ill person (Carel 2008). These include the habitual body, motor intentionality, and intentional arc (Merleau-Ponty 1962). I will briefly describe each.

Many of our actions, particularly everyday routine actions, are pre-reflective: 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. This transparent functioning of the body is the backdrop and condition of possibility for having a world, having subjective experience. Illness can be seen as a disruption of this set of habits, which forces the ill person to explicitly plan and think about what they are trying to do. Bauby's efforts to swallow, a simple action we perform throughout each day, becomes the explicit object of learning. It is this process of routine actions becoming explicit and artificial that forces the ill person to suddenly become aware of what Sartre calls the 'taken for grantedness' of the body. Illness can play a unique instructive role by forcing the ill person to devise new ways of achieving a goal (Carel 2007: 104-106).

Merleau-Ponty also develops the novel notion of motor intentionality. He challenges the view that only mental phenomena can have intentionality by extending it to include bodily intentionality. This is the body's 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 book, my hand *intends* towards the book. The position of the hand, the direction of the movement, the tensing of the fingers are all directed at, or intended towards, that book.

Motor intentionality connects my body to the book. 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 (Merleau-Ponty 1962: 136). Merleau-Ponty sees motility itself as basic intentionality (1962: 137). Moreover, there can be no mental intentionality

without bodily orientation in a world. He writes, “consciousness is being-towards-the-thing through the intermediary of the body [...] to move one’s body is to aim at things through it” (1962: 139).

Motor intentionality is part of an intentional arc. This 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 1962), a human setting, and a moral and existential situation. These capture the unique relationship a human being has to the world, which is not only physical, but also embedded in cultural and social meaning and is ultimately an *existential situation*, rather than a mere physical position. The intentional arc brings about the unity of the senses, intelligence, sensibility and motility (Merleau-Ponty 1962: 136). It is this intentional arc – the existential relationship to the world – which ‘goes limp’ in illness (ibid.).

This overview should make clear how different a phenomenological account of illness is to the medical account. The use of phenomenology enables conceptual acuity and a sensitive account of the existential impact of illness, applying the concepts explained above. Authors who write on illness from a phenomenological perspective aim to explicate the overarching impact of illness and therefore to contest the narrow understanding of illness as merely a glitch in some body system. But this is not to say that phenomenology necessarily excludes a naturalistic description of illness. It is also possible to think about the two as compatible and of a phenomenological description of illness as complementing a naturalistic account of disease (Carel 2009: 83-84).

Before we turn to medicine, it is worth noting a further use of phenomenology as a research method in nursing research. Phenomenology has been used as a framework for qualitative research. It is used as an interpretative technique in the social sciences, which helps researchers to distil salient themes emerging from interviews. Van Manen’s work has been influential in this regard and many researchers have used his description of the six research activities involved in phenomenological research in the social sciences, including in nursing and healthcare research. On van Manen’s

account, phenomenology can be used to select a phenomenon of interest to the researcher (namely, lived experience); investigate this experience as we live it, not as it is conceptualised; reflect on essential themes characterising the experience; describe the experience through writing and rewriting; maintain a strong and oriented relationship to the experience; and finally, balance the research context by considering how the parts relate to the whole (2006: 31-31).

Another research method used in qualitative interviews in nursing and healthcare research is Interpretative Phenomenological Analysis (IPA). IPA is a qualitative research method with an idiographic emphasis. Its aim is to offer insight on how a particular person or small group (usually between 5 and 15 interviewees) in a particular context (say, suffering from multiple sclerosis) experience a certain phenomenon (their illness, or their sexuality, or some other aspect of their lives). IPA normally uses interviews, focus groups or diaries to gather data. IPA is a unique method in that it does not set out to test a hypothesis, but rather is a more self-reflexive and open-ended method, in which the researchers acknowledge their own biases and preconceptions, and attempt to bracket these in order to produce an account of the experiential world of their subjects. IPA is influenced by hermeneutic phenomenology, and is ultimately aimed at understanding meaning-making processes, using both a phenomenological description of an experience and a multi-layered interpretation of that experience (Larkin et al 1996).

In medicine the influence of phenomenology is more recent and directly linked to the more general interest in medical humanities that became a substantial area of research and work in the 2000s. A handful of philosophers who turned their attention to illness, using a phenomenological lens, have generated a small but rapidly growing literature, starting with S. Kay Toombs' seminal article "Illness and the Paradigm of Lived Body" (1988). Toombs' article applies Merleau-Ponty's distinction between the body as lived and the biological body to the case of illness, demonstrating the problems and limitations arising from understanding illness as merely a disruption of biological function.

Rather, Toombs argues, illness disrupts the lived experience of one's body, leading to an overarching existential disruption of the ill person's way of being in the world and their lifeworld.

Toombs' work also explores temporal changes in illness using Sartre and Husserl, as well as examining the patient-clinician encounter through a phenomenological lens (1990, 1987). She also uses phenomenology to characterise the general features of chronic illness and disability, weaving together examples from her life with multiple sclerosis and phenomenological analysis (1995, 1993).

Toombs' trailblazing work was followed by Fredrik Svenaeus and Havi Carel. Svenaeus published a series of articles developing a Heideggerian analysis of illness as an uncanny experience. He describes medicine's role as showing the patient the way home, back from an uncanny experience (2000a, 2000b). His work was further developed in a monograph, entitled *The Hermeneutics of Medicine and the Phenomenology of Health*. In this book Svenaeus develops a unique account of medicine's aim, using a hermeneutic phenomenological approach to describe medicine as an interpretive practice (2001). This emphasis on hermeneutic aspects of the patient-clinician encounter, as well as on the interpretative work involved in diagnosis and in other epistemic aspects of medical work, draws on Gadamer's account of illness as based in social and interpretative practices of generating meaning.

Carel's book, *Illness*, uses Merleau-Ponty and Heidegger to provide a comprehensive description of the first-person experience of illness (2008). The book confronts the tendency of philosophy to work from a third-person perspective and criticises the central debate in the philosophy of medicine, between those advancing a naturalistic value-free description of illness and those claiming that illness is fundamentally a social and normatively laden concept. Carel argues that this debate excludes the actual experience of illness, which is highly relevant to the concept of illness. She suggests augmenting this gap by providing a phenomenological account of the first-person

experience of illness, examining the personal, social, physical, temporal and existential dimensions of illness.

Recent years have seen a dramatic increase in the number of workshops, conferences, projects and journal articles devoted to phenomenology of illness, written by and for philosophers. This recent growth bodes well for this approach, which has so far been radically under-utilised in philosophy and in medical teaching and training.

2. Criticisms of phenomenology's application in nursing and medicine.

Is phenomenology simply a methodology or is it a substantive metaphysics? The blurred boundary between phenomenology's use as a research method and as a philosophical approach has been discussed by Vickie Earle (2010). But other researchers and practitioners do not agree that this is a deep-seated problem for phenomenology. On their view, phenomenology can be stripped down to a research method (as described in section 1), without taking on board the substantive metaphysics of Heidegger or Merleau-Ponty. Others reply that doing so directly betrays the essence of phenomenology, which requires a radical shift of the traditional metaphysical conception of the world. Anything short of that, they claim, is not, strictly speaking, phenomenology. This debate is far from settled, and we will see work published on it in the future (Carel forthcoming).

Other problems have made phenomenology's influence in nursing problematic. Earle notes the difficulty of authors with no philosophical training in getting to grips with complex and difficult philosophical ideas, often couched in 'esoteric language' (2010 in press). Also, the breadth of the phenomenological movement and the variety of views represented in it may lead to confusion (ibid.). A further problem is that phenomenology is often used as a vague inspiration or general motivation for conducting qualitative interviews. But in some of this work, phenomenology is not

understood or applied with great detail or much rigour. Thus for example, Heidegger's notion of care (*Sorge*) is sometimes used to speak about ways of caring for patients. This use of Heidegger's term is imprecise, as it applies an ontological concept to an ontic domain. Moreover, there is no humanist or empathetic flavour to Heidegger's concept, which is a technical concept meant to capture Dasein's involvement in its world as an ontological structure.

Earle also notes the imprecise application of phenomenological ideas in nursing research (2010). She gives examples of numerous authors who have been critical of the way phenomenology has been used in nursing theory and research. Among the problems is lack of philosophical knowledge required to understand some phenomenological texts; misunderstanding and misapplication of key concepts, which end up bearing little resemblance to the original; reducing phenomenology to a mere descriptive method; lack of attention to phenomenology's critique of Cartesian dualism (by continuing to use dualistic language); disregard to the way in which phenomenological ideas have been applied in the social sciences; and continuing emphasis on epistemic issues, whilst disregarding phenomenology's emphasis on ontology (Earle 2010 in press; Ortiz 2009). In addition, Crotty (1996) has noted the lack of understanding of the critical dimension of phenomenology, which he claims has been used in nursing mostly as a descriptive humanistic method.

Others have noted the match between nursing values and the principles of phenomenology (Edwards 2006). Edwards notes the uniqueness of the person, importance of individual discovery and exploration of the meaning of experience as some themes phenomenology shares with nursing (2006: 238).

3. Future influence of phenomenology on nursing and medicine.

The application of phenomenology in nursing and medical research and teaching is still at its infancy. Despite important work done, the range of potential use of phenomenology in healthcare and medicine has not yet been fully explored. The sensitivity and versatility of phenomenology as a research method, as well as the set of phenomenological concepts useful for explicating the experience of illness, indicate a rich and constructive future for this field.

Phenomenology has been used as a research method in interview and analysis (see section 1). It has also been used to describe the experience of illness through books, films and plays inspired by phenomenology. But there is future scope for developing further phenomenological research tools. Existing tools include 'walking with' exercises and a host of research techniques that go beyond the traditional qualitative interview. For example, some have argued that researchers need to use the body language and facial gestures of interviewees, rather than merely their words, in order to understand the meaning they are trying to convey. Miczo (2003) recommends the use of video recordings, rather than merely using transcripts of interviews, as is commonly done. The phenomenological 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 non-verbal embodied methods.

Phenomenology is also starting to be used as a teaching and training tool. Basic phenomenological concepts, like the distinction between the biological and lived body, motor intentionality and habitual body, are used to instruct healthcare professionals and trainees about the changes to their patients' lives. This use of phenomenology as a pedagogical use has proved useful and efficient in several pilots and in medical school teaching (Carel, unpublished reports). Providing healthcare professionals with an understanding of basic phenomenological concepts of embodiment would enable them to understand the existential and embodied nature of illness. By understanding their patients as body-subjects 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.

Phenomenology can also be used in ethical training of medical staff. In recent teaching done at Bristol Medical School such training has been piloted. A similar program has been piloted as a Continuing Professional Development workshop for health professionals (Carel, unpublished reports). 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.

Another future application is the development of a 'phenomenological toolkit' which would enable patients to systematically and comprehensively describe their experience (Carel, forthcoming). Such a toolkit would enable patients to take a fractured and upsetting set of experiences, and to make sense of it through describing and ordering it. This information can then be presented to the clinician, as well as aiding the patient's self-understanding. 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, which could in turn improve trust in physicians and compliance rates.

These applications are not limited to a particular domain of clinical medicine. Indeed, there is currently a growing literature on phenomenology and psychiatry (Ratcliffe 2008; Matthews 2007; Stanghellini 2004). So the application of the phenomenological approach is not limited to any particular physical illness, and indeed yields important insights in the study of mental disorder as well. Another contribution would be in narrowing the gap between external objective assessments of wellbeing in illness, and subjective experiences which are varied and diverse (see Carel 2007, 2009).

Phenomenology could also be used to monitor and enhance overall experiences patients have of their healthcare system. Much has been written on patient-centred care (Fulford 1996) 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 (Sitzia & Wood 1997). By understanding through a phenomenological lens the experience of interacting with healthcare professionals in a clinical setting, a better understanding of these experiences could be achieved and improvements could be made.

Related topics

The body

Intentionality

Martin Heidegger

Maurice Merleau-Ponty

Perception

Philosophy of science

The subject and the self

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