The lived body as a medical topic: an argument for an ethically informed epistemology

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Introduction

In this article, we want to explore two interrelated topics concerning human health and current biomedical, clinical practice.

Firstly, we reflect upon how people are affected, with regard to their health, when their personal integrity is violated: when their boundaries are transgressed against their will or without their consent. This part of our argument is anchored in documentation from the recently established cross-disciplinary field psycho-neuro-endocrino-immunology, including the neurosciences, genetics and epigenetics.

Secondly, we elaborate how people who suffer from bad health and bodily ailments induced by integrity violation are met and understood by doctors and other health care providers. This part of our argument is grounded in a critical approach to the ontological and epistemological underpinnings of dominant biomedical notions that (implicitly or explicitly) define the human body as a biological object devoid of history and experience [1].

Finally, we argue that the evidence for adverse impact on health of violation experience makes obvious that current biomedical theory is inappropriate and calls for the phenomenological concept of the lived body. This concept denotes embodied time, space, social relations, and socio-culturally constituted systems of value and meaning.

We suggest that framing human bodies as lived bodies in this way does justice to the nature of humans, implying that medicine needs to abandon the ideal of a value-free, objectifying knowledge production in favour of an epistemology appraising the values and meanings of the human life world: in other words, an ethically informed epistemology.

Experiences – incorporations – inscriptions

Ever more solid epidemiological evidence bespeaks a strong relationship between experienced pain, fear and powerlessness induced by interpersonal and structural integrity violations – and expressed pain, anxiety and helplessness in terms of complex patterns of disorders [2–9]. At the same time, this knowledge points to its own methodologically based limitations, unidentifiable within the same framework since it can only say that experience and expression are related, but not how and why. The fact as such has generated the question concerning ‘How adversity gets under the skin’ [10]. In attempting to answer the questions of how, in general, experiences are incorporated, and why, in particular, adverse childhood experiences are inscribed on all bodily levels (organs, tissues, cells and genes), clinicians and researchers are faced with the challenges to generate knowledge about conditions and processes that can throw light on the established, documented correlations [2,9–11].

This task requires, however, analytical tools and perspectives extrinsic to medicine. We lean heavily on the phenomenological tradition and draw inspiration from the social sciences [12–14]. Of particular importance are the contributions from phenomenology linking subjectivity to the human body, a fundamental premise for superseding the traditional dichotomies between matter/mind, nature/culture and other dichotomies in their wake [15–25]. The knowledge that experiences of violation and sickness are related can be regarded as an invitation to clinicians and researchers to scrutinize their conceptualizations and classificatory schemes [26]. Likewise, they are urged to reflect on a necessary reorientation of...
Integrity – a biological and existential issue

The ability to demarcate what is self from what is the endangering other is salient for all being. Evolution, humankind’s common history, has secured this by means of elaborated systems for identification of and reaction to patterns that denote danger. Ontogenesis, the biographical process of development and learning, serves the same purpose with the same principles. By means of these principles, humankind’s history and individual biography are strongly interwoven and embedded within life-enhancing, biological structures such as the immune, hormone and central nervous system, allowing flexible adaptation while preserving stability [29]. Thus, an ability to differentiate between self and endangering other is manifest on all existential levels, from the cellular to that of personhood.

A wide range of phenomena, from typically or apparently external to internalized, and to internal, can create the personal experience of danger. The typical and pure external ones represent brief or constant physical, thermal and chemical influences or strains, that is, phenomena that have direct influence on the body, while socio-cultural and political influences are of a dissimilar nature. Short- or long-term burdens due to humiliation and scorn inflicted by societal structures or by significant others, can be regarded as internalized norms and views with both direct and indirect bodily effects. Internalized disregard is expressed in the persons’ behaviour and imprinted in their bodies in more or less detrimental ways with respect to their health. The internal phenomena, finally, are the consequences of experienced powerlessness, social shame and self-hate that initiate or permit, fuel and maintain destructive and self-destructive processes and actions.

The results can express in multiple ways: (1) in behaviours which, as seen from outside, seem to testify to a person’s carelessness linked to use of intoxicants and addictive substances, to lack of protection against contamination, or to either overt or concealed self-neglect and self-destruction [4]; (2) in signs indicating sickness, which testify to a breakdown of the innate and adaptive immune systems, expressed in clinical pictures of serial or different infections, in ‘composed’ or coinciding infectious states, or in unusual effects of presumed banal infections [30,31]; (3) in local or systemic inflammations in all kinds of body tissues including autoimmunity, the latter indicating an attack on what is self as if this were ‘other’ [32]; (4) lack of proper protection against cellular damage and against the growth of deviant cells due to suppression of the natural killer cells, a cellular part of the immune system [30,33].

In other words, all categories of perceived, experienced or reactivated danger may initiate or fuel three types of processes, all of which, in a certain sense, are responses: infection, inflammation and invasion in the sense of tumour growth. By means of a chronic overtaxation of the systems safeguarding human adaptability and vitality, namely the flexible interplay of the immune, hormone and central nervous system, health is threatened in multiple ways. Typically, this appears as complex chronic disease exemplified by heart and lung diseases, diabetes II, obesity, depression, metabolic syndrome etc. and, even more typical, as patterns or combinations of these, commonly termed co- or multi-morbidity.

In conclusion, we may say that people who suffer express – in their suffering – that their existence is threatened. Their very being is informed by efforts to maintain or restore a demarcation between themselves, which is the threatening or dangerous other. This is why they are disturbed in their everyday life and usual tasks, and these disturbances are the reasons why they seek professional assistance. Integrity and vitality are phenomena that constitute human being-in-the-world on all levels, again: from the cellular to that of personhood.

Separate units or united function

Instead of maintaining a model and a terminology of three separate systems, it seems more appropriate to consider these as aspects of human integrity on cellular, hormonal and neural levels, which is strongly supported by the increasing and converging insight in precisely the fields of knowledge the domains of which, until now, are the three aforementioned systems. Given the fact that these specialties increasingly ‘talk together’, the following common message has been engendered: ‘The disparity between physical and psychological stressors is only an illusion. Host defence mechanisms respond in adaptive and meaningful ways to both’ ([34], p. 114). Consequently, the researchers are confronted with a challenge to their professional demarcation lines: so-called psychosocial phenomena have an impact on basic objects of their research – cells, hormones and nervous structures – which has been articulated as follows: ‘Fortunately, the initial controversies about whether psychological processes could really impinge upon and modify immune responses have now receded into the pages of history under the weight of the empirical evidence’ ([35], p. 1000). Thus, the books of history concerning the dogma of the non-influence of mind on matter have apparently been closed exactly due to the undisputable evidence that mind informs matter, or even shorter: mind matters. This implies that the traditional biomedical framework, grounded in a dualistic concept of mind and matter as both separate and different, with the latter providing a full explanation of the former, has been invalidated. But biomedical researchers keep referring to human experience in the traditional language, informed by both an epistemological and ontological dichotomy.

Reproduction or reorientation

The tendency to remain within a frame of reference that keeps subjectivity and the body apart can hardly be understood unless we take the hegemony of the Cartesian legacy into account. This legacy leaves us with disembodied subjects that communicate, on the one hand, and silent bodies ‘open’ for scrutiny and intervention, on the other. Thus, the prevailing correlation between patient – symptom – physician – diagnosis – treatment – outcome etc. and, even more typical, as patterns or combinations of these, commonly termed co- or multi-morbidity.

Although patients’ experiences, social relationships and their life circumstances are increasingly coming in focus for scholarly
attention, the very way these ‘psychosocial’ concerns are presented and discussed bears witness to a deep-seated view that does violence to the human condition – to the fact that human beings live as embodied, social beings in a world of meaning. The term ‘stressor’ and the way it is used is, but, one example [36]. ‘Stressors’ – be it a divorce or living with constant fear of a violent father – are conceived of as if they were solely external forces that hit the victim as roofing tiles. In addition to this physicalistic legacy, research and professional discussions are characterized by an oversimplification and decontextualization of human and social affairs. A social event such as a divorce is supposed to mean the same for all people, but what immediately appears as the ‘same’ may be proven to be very different when – if – one gains insight into the particular case. Concordant with the simplified use of ‘stressors’, it is often claimed that the brain is the autonomous interpreter [37], and that human suffering can be objectified with brain-imaging techniques [38,39].

This confusion, reducing the mind to the brain, illustrates clearly the fallacy of biologism, sometimes called the ‘mereological fallacy’ because properties more properly ascribed to the whole person (such as suffering or action) are ascribed to a part of that person – such as the essential organ that is the brain [40].

Despite attention to interplay and complexity within the body and despite the recognition – and evidence – that life circumstances have impact on health, most publications from medical and natural scientific quarters give support to the understanding of biological processes as prior, thus remaining, as pointed to by critics from various fields, with a focus on the micro; they ‘prefer to look inward, finding a kernel of truth in biological objects and events’ as Pat Spallone expresses it ([26], p. 56).

In sum, the new advances in biological/natural scientific knowledge can be conceived of as an indication of a reorientation at the same time as they – at another and more basic level – represent continuity and a reproduction of conventional ways of thinking. That subjectivity – the human world of experience and meaning – and therefore also social and cultural processes have corporeal aspects remains unnoticed or at best incomprehensible when perceived through the traditional conceptual lenses [13,14].

**Beyond the silent body and the speaking mind**

An insight into the corporeal aspects of human experiences, however, is provided by phenomenology. Very briefly formulated, phenomenology is about the analysis of how experiences are given. Phenomenologists are interested in understanding the nature of experience – understanding how we come to know the world.¹ They offer a non-Cartesian view that emphasizes the embodied, enacted and contextualized nature of experience and perception [15–20].

Our reference here is Maurice Merleau-Ponty since he is the theorist who most systematically grounds human subjectivity in the body. To be a subject, according to his philosophy, is identical to being in the world as embodied. It is *through* the body that we experience the world, learn about the world – have access to the world. The body is the very *centre* of all experience; my body is ‘the pivot of the world’, that ‘by which there are objects’, he writes ([15], pp. 82, 92).

The *lived* body therefore is not an object *akin* to other physical objects in the world. I do not have a body as I have a house or a car [20]; the body is not something I possess; it is something I *exist* as. Contrary to the dominant view of the body as an ‘it’ in the third-person perspective, a pure physical object, the body in Merleau-Ponty’s view is a subject in the first-person perspective, an ‘I’, and as such, the body is a source of knowledge for the individual person him- or herself.

As human beings, we are never – and can never be – cut off from our corporeal situation; the *permanence* of the body is absolute ([15], p. 92). In other words, my body is not something additional to me, not an appendage to the subject. It is what I am, Merleau-Ponty argues, which means that under normal circumstances there is no perceived separation between body and self. The body has in other words a double status; I *am* and I *have* a body. Each individual exists as an incarnate subject and a biological organism simultaneously. This two-sidedness of the body means that I am always ‘intertwined’ (to use Merleau-Ponty’s own term): ‘a visible-seer, a tangible-toucher, an audible-listener’ etc [15]. The subject status is, however, primary in the sense that it is an experiencing and expressing embodied being I go around doing my things, and I am still an experiencing body when the gravity makes it pull on me as a material phenomenon – when I am in upright position or in lying, when I dance, go skiing or play. Consequently, the object status of the *lived* body is *qualitatively* different from the Cartesian body that is *solely* physical matter.

The concepts of ‘life world’ and ‘being-in-the-world’ are frequently used in phenomenology. They refer to the world, as we immediately perceive it without conscious reflection, to our taken-for-granted experiences, and to our familiarity with and belonging to the world. The embodied – incarnate – subject in phenomenology is not a detached observer, but a practical and social agent ‘inseparably bound up with the world’ ([17], p. 80), embedded *in* and part of the world.² As part of the interest for cognition and cognitive science in recent decades, several phenomenologically inspired authors have documented how embodied, concrete and unreflective experiences are decisive for our ability to give *meaning* to things, phenomena and events, and for cognitive function in general [20–22].

**Subjective experience – intersubjectivity – communication**

Recognizing our embodied existence has far-reaching implications for the understanding of humans and social life in general. It

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¹ Phenomenology is often presented as a tradition that is concerned with the world as it appears for the subject – not in the world as such. This statement has been much discussed, and it is often misunderstood as if phenomenologists were *uninterested* in the world, which is wrong. The crucial point here is that experiences are viewed as subjective in the sense that only individual subjects can experience – and any fact has to be established by an active organization of the human consciousness, which is why the correct name for the tradition is a philosophy of *constitution* [19].

² Merleau-Ponty used the expression ‘être-au-monde’ in French, his mother tongue, which literally means ‘being-to-the world’. This is commonly translated to ‘being-in-the world’, a translation that is commented on by several authors since there is a difference in nuances ([19], p. 564). Merleau-Ponty is concerned with human beings as ‘having a world’ ([15], p. 146), which is to be ‘implicated in the world. . .to be *at* things’ as Richard Zaner writes ([18], p. 183).
means, for instance, that experiences cannot be obliterated. By recognizing incarnate subjectivity, it follows logically that human experiences can only be lived in and through the body, and that people cannot but express and convey their history in bodily ways. Experiences remain with us, not only as thought and conscious memories, but also as part of our embodiment. We may mentally and consciously forget, but our body remembers; what we have experienced is both imprinted and expressed in our bodies [14]. Experiences are inextricably subjective phenomena, which are expressed in some way or the other, but not necessarily, and most often not, in a straightforward way.

Adverse experiences may, for example, be expressed in the musculoskeletal system in the form of muscular tension and restricted breathing, ‘closed’ body expressions and hampered movements, or in what may appear as paradoxical: muscular slackness and bodily resignation, ‘open’ borderline states and limitless behaviour [41,42]. The former can be viewed as an expression of defence, the latter as a way of giving up. In this article, however, we do not pursue this kind of bodily manifestations of boundary transgressions, but musculoskeletal dysfunctions are actualized in the case history below.

The process from illness-inducing conditions to manifest illness may be extremely complex. Illnesses and disorders are always about the mutual constitution of, and interactions between, biological and social processes, and physical forces and universes of meaning [14]. In this sense, the body is a conveyor of life and history and we get new insight into the patients’ world of experience and meaning. Verbal and bodily information and expressions are no longer seen as categorically different, belonging to the separate worlds of ‘res cogitans’ and ‘res extensa’, and thereby, they can be made to complement each other. This position opens possibilities for developing an improved understanding of connections between lived experiences and bodily dysfunctions. Moreover, the patient gets new opportunities to participate.

The lived and expressive body is, in other words, a source of knowledge both for observers – fellow men and women, health care providers – and for the persons themselves. As embodied, historical beings we cannot, following Merleau-Ponty, not communicate; we are doomed to be accessible for one another; we are, as stressed, visible seers [18,27]. The double status of the human body is the very premise for a human and ethically grounded epistemological position. Such a position provides a premise for clinical practice and generation of knowledge that departs significantly from the dominant one in that it makes ethics an integrated part of epistemology.

### From human biology to human biology

Biological explanations of human sickness, although correct in the methodological sense, fail to do justice to human experiences and meaning. Generally, researchers have focused on sickening mechanisms at the expense of the sick person’s world of experience and meaning. By failing to take meaning into account, they may have underestimated how artificial in vitro research actually is, and likewise how insufficiently animal-based models explain human disease. We lean to Elling Ulvestad [29] when claiming that epistemological sophistication is urgently needed in order to transform research on human biology into research on human biology.

Groups of researchers in immunology, endocrinology, the neurosciences, genetics and psychology are at present contributing to documentation that bears witness not only to close connections, but also to stunning similarities with regard to measures and structures designed for integrity protection, which are to be found on all levels of the biological hierarchy, including that of human self-reflection and self-awareness. The converging messages become increasingly explicit with regard to how deeply and permanently experiences of integrity violation are inscribed in human beings in the sense of bodily manifestations [6].

Multidisciplinary research has documented multilayered manifestations of integrity-enhancing and integrity-restoring abilities and efforts as the core of humankind’s nature. This evidence renders two medically unexplained phenomena of human illness accessible for exploration and comprehension. The first is the variety of sickness expressions, in diseased people, resulting from what are supposed to be identical causes of defined disorders, indicating that every person is diseased in her or his own way. This applies to the logic of the individual process of embodiment, the becoming of the lived body. However, this is not to say that an individual’s suffering is solely unique; the common structure, that is, the eidetic nature of illness-as-lived is well documented ([23], pp. 228–229), but it is ‘articulated’ and modulated depending on several intertwining processes and conditions, not the least the suffering person’s biography [7]. The second phenomenon concerns the sickness expressions interpreted as autoimmune processes, in other words, ‘defence mechanisms gone astray’. The fact that a person mistakes own for other and attacks or destroys what is self bespeaks the logic of confused, blurred, violated or transgressed boundaries. Both phenomena are types of particularities, and as such, they defy the methodology of the biostatistical mean.

All kinds of situations or processes where selfhood is either at risk or disrespected call upon protective measures by the person under attack. However, when what is other not only forcibly invades but totally overpowers what is self – which is the case in abuse and neglect in the family by highly significant others – the ‘battlefield’ is by necessity the self, the embodied, experiencing person. When all self-protective measures are exhausted, when the person’s adaptability is broken down, then the most central premises for existence are no longer provided. Severe, complex sickness and even premature death may be a consequence [8].

### From battering to breakdown: a case history

Karin Kosmo, 50 years old, divorced, mother, grandmother and highly achieving head of department in a publishing house, had been treated for ever increasing pain in her neck, lower back and knees for more than a year. Examination with X-rays of upper and lower spine and both knees had been performed yet had not demonstrated pathological findings. Various anti-inflammatory medications and painkillers had been prescribed – and discarded, either due to lack of adequate effect or to unacceptable side effects. A regular training programme had been advised, which, however, had increased the pain and consequently had to be terminated after a short time. Extensive physiotherapy had been applied, but Karin Kosmo’s expanding and increasing pains had not responded to any of these treatments.
When leaving for a postponed holiday abroad, she fell acutely ill the second day of her journey, apparently due to a severe, bacterial intestinal infection. Due to her impaired state, she was immediately hospitalized, and all relevant examinations were performed. However, the source of her disease could not be verified. After 2 weeks of stationary treatment she was sent back to Norway and admitted to a university hospital where she stayed for months for examinations and treatments in several departments, among these the gastroenterological, gastro-surgical and neurological. After discharge, and due to her persistent incapacitation, she was included in an extensive out-clinic follow-up. After 2 years without improvement, she had to apply for a limited disability pension. However, neither the origin of her diseases had been identified, nor had the nature of her incapacitation been properly diagnosed by then.

None of her numerous doctors and therapists elicited what precipitated her breakdown. She had been entrusted a delicate task by the board of her company, namely, to limit the destructive impact of an aggressive male employee on colleagues and staff by persuading him to renounce certain privileges and adhere to therapy addressing his violent behaviour. While working towards these aims – and learning that this man previously had been sentenced for attacking a person with a knife, she got steadily increasing pain in her neck, back and knees, necessitating numerous consultations, examinations and treatments at the medical centre of her company. Although the man, first covertly but ever more openly, threatened Karin, she refused to have the police involved. When he finally accepted the conditions and she, praised yet exhausted, could leave for a holiday, she fell sick due to, in a medical sense, ‘nothing’.

None of the numerous medical experts involved in her case was, however, aware of what negotiating with a violent, unpredictable and irresponsible man had reactivated in Karin. She herself did not suspect that there is a connection between her childhood experiences and her reactions to the behaviour of this man, and consequently, she told nothing about her life history. And her doctors and therapists did not ask. That she had been tortured as a child, at home, legitimized as punishment, by her mother and, in extreme measures, by her father was information Karin later related: ‘I was battered until I begged him mercy. Therefore I am fearful of others’ rage. My body has been an object of torture and the place of violation and afflicted pain. It was the pain that forced me upon my knees. It was the pain that made me bend neck, back and knees. Pain is the essence of torture. This pain in my body made me complicit in my own humiliation. This pain made my body “cheat” me. It took my self-respect, because I did what my father aimed at: I bent neck, back and knees, admitted my misfortune and confirmed the righteousness of his punishment. Then he gave in. But there was a way, first, I felt rage and hatred, but he made me terrified of being killed, so my rage was literally battered into horror – making me lick his boots.

Karin describes how parental maltreatment ‘unmade’, in the wording of Elaine Scarry ([25], pp. 41–42), her world: unmaking her father and making him her potential murderer, unmaking the father–daughter relationship to that of torturer–victim, unmaking her home to a dangerous place, and her own body to an object of torture and, thereby, instrumental to her being humiliated and subjected, evoking self-loathing for being fearful of – and corruptible by – bodily pain. This pain, inscribed in her body by acts of terror that also unmade her own voice to a pure shriek and false conviction, simultaneously inscribed her body into the socio-culturally imposed world of the unspoken, shameful and silenced. As a child, she was unable to address – and accuse – her parents’ abuse, legitimized by being termed ‘punishment’. She was unable to name the guilt of misuse of paternal authority and to speak the silenced acts behind close doors in a respectable home. She could not know the experientially grounded link between shame and pain.

Karin Kosmo survived by being excellent at school, and good results never provoked parental rage. She became a multi-qualified, overachieving work addict keeping existential anxiety at bay by working instead of drinking, as she herself put it. But when a childhood bodily inscription of pain was reactivated in an encounter with a person of the kind of her father, it took all her strength not to give in for her fear because she knew that would mean loss of self-respect. The price was her total breakdown and complete incapacitation, leading to yet another humiliating experience: her pain had no name – in terms of an unambiguous medical diagnosis. The lack of objectively identified substrates for her sickness rendered it ‘subjective’, thus unreliable, called somatization and, as such, a psychiatric disorder. A pain necessitating medical encounters could not be given adequate words – from the side of Karin since it became unspeakable 50 years earlier and loaded with shame and self-loathing. Of the same reason, this pain rendered her own body an enemy because incapacitating her. In addition, it became an eventual source of scorn or rejection from the side of medical professionals because these could neither verify nor explain or alleviate it.

Ethics and epistemology – integrated

The preceding arguments, including the sickness history unfolded above, urge the scientific community to formulate an epistemology informed by the ethics of the lived body in order to secure a defendable production and application of knowledge concerning health and disease. This knowledge must be characterized by insight into firstly, how experiences might be transformed into bodily processes and manifested in disease, and secondly, how dysfunctions inform persons’ perception both of the world and of their own body. As outlined by several phenomenologists, in illness, the lived body can no longer be taken for granted or ignored [18,20,23,24]. It is experienced as at once ‘intimately mine but also other-than-me, in that there is a sense in which I am at its disposal and mercy’ as S. Kay Toombs puts it ([23], p. 229), or in the words of Drew Leder, ‘The body may emerge as an alien thing, a prison or tomb in which one is trapped’ ([24], p. 87). The diseased person perceives of herself or himself to be no longer a ‘whole person’ but ‘less of a person’, an object of medical investigation rather than a suffering subject ([23], p. 230).

As underscored by many, much effort has been made to make medicine more ‘humanistic’ [43,44]. However, this enterprise can only succeed if the biomedical model is superseded by a paradigm, which incorporates an understanding not only of illness as lived. The patient’s history before falling ill has also to be taken into account. Karin Kosmo, as an example, tells about not only being violated, but in addition, being deprived of voicing the violation. This means, prohibited from making sense of her world – a highly conflicting and consistently unmade world – by having her

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experiences confirmed. To gain a comprehensive view of the world demands sharing experiences with other fellow beings, by acquiring an intersubjective understanding of their meaning ([27], p. 3). Both the process of falling, being and remaining sick may be intimately linked to the lived experience of loss of integrity. Thus, the most appropriate framework for understanding the impact of such losses is provided by phenomenology due to its concern with meaning and the essences of human experiences grounded in the lived body. Here, then, is the very basis for an ethically guided epistemology. A phenomenologically informed production of medical knowledge can restore what the abstracting grips of biomedical research have taken away. Such an approach has the potential to create experientially grounded concepts and categories, reflecting the patterns of lived meanings that show up in more than one individual case. Phenomenologists are generally concerned with pan-human conditions and the essence of experiences, and philosopher Maurice Natanson writes, with reference to clinical work: ‘Just as the sick man remains a man, the . . . therapist continues to be a man as he functions in his professional role’ ([45], p. 81). Said in other words, the socio-moral dimension is ever present in any clinical encounter. This means that medical professionals have a particular obligation to create situations where it is possible for patients to present themselves as subjects with integrity and legitimate opinions, and it means that research, which does not take account of human beings as meaning-producing and meaning-conveying incarnate subjects, may generate reliable but irrelevant knowledge.

Conclusion

The new advances in biomedical knowledge represent potentials for a reorientation in the health care sector, but, hitherto, it seems as if they merely contribute in supporting the position of such knowledge as primary and prior to all other kinds of knowledge, thereby consolidating the Cartesian legacy and a positivistic epistemology. Within this framework, it is difficult or impossible to recognize, look for and discover that the human world of experience and meaning – and therefore also social and cultural processes – have corporeal aspects, and that the body is an interacting unity that does not function in accordance with the divide constructed by medical specialities. Inspired by phenomenology, we challenge the notion of the fragmented body extrinsic to the self and social relationships. We urge clinicians and researchers to strive for a view that takes human conditions seriously and links subjectivity to the body, a fundamental premise for both superseding traditional dichotomies between mind/matter and nature/culture and for replacing the compartmentalization of the body.

In this article, we have attempted to throw new light on biological processes and pathology by connecting them to various forms of boundary transgressions. We have emphasized the importance of recognizing that human beings live in a world of meaning, and that this is not an additional matter – a ‘human’ appendage to the ‘real’ clinical practice and research work, but the very basis of both. In other words, we argue for an ethically informed epistemology in medicine and the health care sector.

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