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Exploring the potential benefits of integrating phenomenology into everyday healthcare practice

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Abstract: In contemporary medical practice, a reductionist focus on physical symptoms and biotechnological interventions often sidelines the relational and emotional dimensions of patient care. This paper explores the potential benefits of integrating phenomenological approaches into everyday healthcare practice. Drawing on the seminal works of Merleau-Ponty, Gallagher, Mazis, Benner, and Svenaeus, among others, the study illustrates how a phenomenological stance — characterized by a suspension of preconceptions and an embrace of "not-knowing" — can transform clinical encounters. By acknowledging the intersubjective and affective layers of health, clinicians can move beyond viewing the body as a mere mechanistic entity to appreciate it as an embodied, dynamic presence embedded in a network of social and personal meanings. Such a perspective not only fosters attentiveness and more effective communication between patients and providers, but also challenges entrenched biomedical paradigms that isolate the physical from the experiential. Ultimately, this integrated approach calls for healthcare policies and clinical practices that respect the multifaceted nature of human existence, paving the way for a more relation-centered model of care.

Keywords: phenomenology of medicine, philosophy of medicine, relationality.

In clinical reality, countless individual experiences intertwine with cultural conditions whose meanings extend beyond the boundaries of individual social perception. Phenomenological methods offer insight into aspects of the medical world that remain elusive to the tools of biological science. This approach enables a deeper understanding of the essence of medicine itself, a clearer distinction between direct experience and scientific conceptualization, and an exploration of the relationship between corporeality and consciousness, as well as between the external world and the self. While clinical psychology provides valuable insights into the emotional structure of clinical relationships, it is crucial to complement this perspective with methodologies that extend beyond cognitive-behavioral and psychoanalytic approaches. Phenomenology allows for

an analysis of intersubjectivity and relationality as an intense and incidental encounter of multiple worlds — those of patients and healthcare providers. This has significant practical implications, as it enhances clinical communication through a more empathetic understanding of the experiences of others. Moreover, the phenomenological perspective creates space for a broader interpretation of health, illness, and suffering, one that transcends their conventional classification within medical taxonomies [1].

By making medicine the subject of its inquiry, phenomenology reveals the fundamental distinction and value of a multifaceted perspective — one that compares direct, pre-theoretical experience of everyday life with knowledge derived from statistical findings, epidemiological studies, and clinical research. This approach enables a reconceptualization of the relationship between medical knowledge (rooted in specialized medical sciences) and practical knowledge (emerging from the lived experiences of both clinical practitioners and patients). Phenomenology also highlights the difference between disease as a nosological entity and disease as an individual experience, as well as between the body as an object of scientific inquiry and the body as an engaged subject in the therapeutic process. Through the methodological approach of phenomenological reduction (epoché), it allows for a critical examination of underlying assumptions, biases, and taken-for-granted certainties that shape the medical experience but have often remained unchallenged. Confrontation with the direct description of experience opens new avenues for complex interpretations of illness as an embodied experience, analyzed through key phenomenological categories such as being-in-the-world, temporality, the lifeworld, intentionality, intersubjectivity, and lived experience [1].

The body, which lies at the center of medical inquiry, is typically — often preconsciously — conceptualized as a kind of mechanism-machine, leading to its treatment as an objectifiable, passive material entity — an anatomical and physiological object susceptible to observation, scientific analysis, and technical intervention. Only by applying phenomenological epoché to this assumption can the body be examined as a living, experientially present subject of the clinical encounter.

This openness is evident in the way sensory perception is organized, shaping both engagement with and exploration of the world—how reality appears beyond the body, as well as what unfolds within what is recognized as the body and its interior. The experience of the world is not fragmented, nor are the boundaries between its delineated parts arbitrarily drawn [2].

Particularly noteworthy in this context is the philosophy of Jolanta Brach-Czaina, who uniquely articulates the harm inflicted upon the world through its fragmentation:

"Fragments are elements arbitrarily severed from the whole, failing to form the natural structures — the very particles of existence incarnated in a concrete mode of being. Fragments constitute a mutilated reality. Severed from the whole by cataclysm — like a leg torn from a table or from a human — or isolated artificially, ostensibly to render them more comprehensible, they are ripped from their natural milieu, trimmed to the proportions of a specimen, and confined beneath an electron microscope — yet they remain silent. The act of excising fragments from reality is fueled by the mind's desperate struggle to fathom the world, yet it is carried out in such a manner that the world is not truly listened to, but instead is torn apart, crushed, and hastily exploited. Such an approach, while common, does not foster genuine understanding; rather, it rips us away from the place to which we inherently belong" [3].

From this perspective, and drawing on convincing evidence and arguments provided by numerous scholars (Gallagher, Rudebeck, Wilshire, Brannigan, Mazis, and Toombs among others), one must conclude that, in light of the ongoing interaction between body and world, neither

illness nor corporeality can be regarded solely as an "isolated" puzzle of biomedicine. Rather, they must necessarily be viewed as embodied events entangled in diffuse environmental and cultural relationships [1]. A mechanistic and reductionist understanding of the body effectively treats it as an inanimate structure, sustained by biophysical functions and the fulfillment of physiological needs. When viewed through such a clinical lens, the body becomes "dead," alienated as an object of observation and thus more amenable to control. It is no longer an individual body, but rather a "type" of body connected to the person only in a formal or nominal sense. Although this Cartesian division undoubtedly fosters the development of biotechnology, it remains uncertain whether it truly advances clinical practice understood as an integrated diagnostic and therapeutic process centered on the individual and their multifaceted circumstances. Federici argues that mechanistic thinking introduces a new conceptual and disciplinary paradigm aimed at reducing the body to an entity devoid of its own capabilities — a body fixed in space and time, capable only of predictable and controlled behaviors. Moreover, she contends that the demands of capitalist labor inherently require such mechanization, ultimately eroding the body's autonomy and creativity [4].

Many crucial aspects of health and corporeality continue to be overlooked within the medical discourse — left unexamined and denied the due respect they deserve — despite compelling evidence attesting to their significance and influence on patient well-being. The realms of lived experience and the living body remain marginalized in the clinical encounter, reducing those immersed in the medical sphere to disembodied, if not outright dehumanized, entities. This phenomenon exerts a dehumanizing impact not only on patients but also on healthcare professionals. S. Kay Toombs delineates several dimensions in which this effect is unmistakably apparent: the quality of communication, including an appropriate understanding of the nature of reported ailments and presented symptoms; the recognition of the needs of individuals with chronic or incurable conditions—or those whose afflictions defy a clear or accepted explanation; the alleviation of symptoms that are most burdensome, intolerable, and difficult to adapt to; the apprehension of the experiential and affective dimensions of illness; a reconceptualization of disability beyond its reduction to mere disease; a multi-layered comprehension of the experience of pain and suffering; an attentiveness to the unique character inherent even in the most common afflictions; and a deliberate adherence to the principles of practice [1].

In the context of embodiment, Shaun Gallagher — drawing inspiration from Merleau-Ponty's notion of the lived body — proposes a distinction between the body-image and the body-schema. These concepts prove invaluable in analyzing issues related to identity and self-knowledge, as well as in understanding certain pathological conditions (such as phantom pain, neglect syndrome, deaferentation, and schizophrenia). He also emphasizes the challenge of maintaining a genuine sense of agency and efficacy.

These insights are further enriched by the work of Maureen Connolly, who explores the phenomenon of gendered embodiment through a distinctly feminist lens. Connolly illustrates how, within clinical reality, female embodiment is constructed in ways that often lead to unequal treatment and the development of care standards that fail to account for the specific needs and experiences of those who identify as female. She contends that when clinicians embrace a phenomenological stance — a "phenomenological sensitivity" — they are better equipped to avoid the pitfalls of dysfunctional and exclusionary practices that, all too subtly, erase the multifaceted dimensions of embodiment. Following the insights of Phenomenology of Perception, Glen Mazis underscores the importance of emotionality, which kindles an engagement in the evolving dialogues between the body and the world. According to him, creating a space for this kind of experience constitutes

a constructive response to the "biomechanical colonization of the body" and is poised to transform clinical practice by fostering a holistic perception of therapeutic subjects through the prism of affectivity [1].

One avenue to gain insight into the experience of illness and disability lies in attentive listening to first-person narratives. Arthur Frank advocates directing a "phenomenological gaze" toward the narrative itself, so that — alongside the clinical perspective that fixates solely on the disease — the narrative reveals its situatedness within a lived world that is reshaped by bodily disturbances and by the ways in which it is spoken of. In turn, Irena Madjar demonstrates the extent to which the perception of pain is reduced to a "pure sensation," thereby neglecting its embodiment, social expression, and perception, the experience of being wounded, and the meaning conferred through the search for significance beyond that conveyed by standardized biomedical concepts and numerical values. The experience of pain also assumes a paradoxical dimension in medicine, for besides an orientation toward its alleviation (or sometimes suppression), there arise situations that necessitate the indirect infliction of pain — such as when performing interventions in life-threatening circumstances. The tension stemming from such ambivalence can, at times, serve as an implicit cause of numerous misunderstandings in clinical relationships [1].

Glen Mazis unveils yet another paradoxical dimension of clinical reality, where the full spectrum of the body's affective expressions emerges — shaped by a vast array of experiential scenarios, ranging from routine outpatient encounters to unforeseen, traumatic events, or situations that demand long-term management of crises and health decompensations [5]. All of this gives rise to the authentic and extra-rational expression of emotions, sometimes with an exceptionally fluid intensity — not solely on the part of patients. Moreover, the very experience of medicine finds itself poised at the intersection of identity tensions and cultural meanings, radically transforming the ways in which the subjects of clinical encounters perceive themselves. Nevertheless, healthcare systems are typically structured in such a way that clinicians — whether already at the onset of their training or due to the constraints imposed by their work environment — are deprived of methods that facilitate an open response to the affective manifestations of the body, often leaving them unable to accommodate the inherent awkwardness, uncertainty, fear, or even aggression. The biomedical model of therapy disregards emotionality, neglecting not only its role in shaping identity but even its potential to facilitate healing. Mazis identifies several implicit assumptions inherent in this paradigm regarding affectivity. The task of physicians and other healthcare professionals is confined to correcting disrupted bodily physiology, while the responsibility for addressing patients' emotionality is relegated either to those within the patient's immediate milieu or, at best, to mental health specialists. Consequently, clinicians are encouraged to deny their role as co-constructors of the affective dimension of the medical experience, thereby precluding a phenomenological insight into the intersubjectivity of clinical processes by assuming that the sole realm of affective experience resides within the patient's subjective world. Moreover, all objects integrated into patients' bodies through medical intervention are perceived merely as "mechanical parts," thus overlooking the emergence of a renewed sense of embodiment. Furthermore, decision-making is approached from a perspective of autonomy that disregards the situated context of actions and choices — one in which emotionality underpins adaptation to uncertainty and ignorance, as well as the capacity for collaboration [5].

Medical experience is rooted in a sense of uncertainty and fear related to self-recognition within a world of meanings and personal values. The uniqueness of a patient's lifeworld and their well-being emerges from the intricate web of relationships and connections with other worlds.

Mazis demonstrates that in clinical reality there exists no isolated subjectivity; rather, there are inseparable interconnections with other worlds and selves, revealed through "perceptual matrices of bodies" marked by vulnerability and dependency. Suffering — and the quest to rediscover oneself in illness as a new, decompensated form of health — demands the presence of an attentive witness, an individual or a group, ready and competent to participate in the reconstruction of self-image, also by acknowledging the inherent deficits in possibility, hope, and meaning. The Cartesian tradition of understanding corporeality and emotionality significantly impedes this endeavor, while the disintegration and isolation stemming from the oppression of rationality and a dualistic constitution restrict our shared movement through the world. Phenomenological sensitivity, however, equips us with perceptual tools for discerning co-presence, thereby demystifying the isolation inherent in bioreductionism. An awareness of what falls within the scope of embodiment — what becomes the motif of identity narratives — enriches the emotional dimension of caring for wounded subjectivity [5]. Merleau-Ponty rejected the notion of interiority, dismissing the body as a closed container. Transgressing arbitrary divisions — including the conventional (or metaphorical) inside–outside dichotomy — can expand the clinical perspective by revealing flashes of affect that enable attunement to the dynamic interplay between body and world, as well as the interweaving of corporeality and technology.

Patricia Benner, in her exploration of care phenomena, has identified several dimensions of the clinician–patient relationship that influence diagnostic and therapeutic practices. The affective layer of the clinical encounter establishes the conditions under which specific ailments and modes of experiencing suffering may emerge. This, in turn, shapes our understanding of the patient as a person — and thus their entire lifeworld — enabling us to grasp how sometimes irrational or unconventional patient behaviors are rooted in their self-perception and worldview, and thereby to discern models of health and illness as well as patterns of self-care and dependency on others. Collaboration with an individual who demonstrates significant dependency on caregivers and susceptibility to their influence is markedly different from working with those who, opposing any form of dependency (including care), express resistance — sometimes entirely unconsciously, acting against their own health interests. The capacity of clinicians to provide care, including their rhetorical skills, determines the type of knowledge about health and the body that patients are able to assimilate and, through that, reintegrate their embodied being in the world. Clinicians should be keenly aware of how their ostensibly purely technical practices and seemingly neutral presence can suppress emotionality and preclude the possibility of mutual attunement, thus hindering genuine collaboration. Every clinician ought to cultivate a critically developed self-awareness and a relational style in their professional interactions — one that prevents them from being overwhelmed by escalating affective dynamics, while maintaining a vigilant presence that enables them to perceive the patient through the lens of the patient's needs and their own capacity to respond [6].

Arthur Frank argued that there is a fundamental distinction between what we call illness and what we classify as disease. Illness is that state — the sense of being unwell—rooted in the experience of loss and the disruption of one's lifeworld integrity. In contrast, the symptoms of a disease — disorders in the structure or functioning of various body systems that disturb the everyday normalcy of being — naturally shape the experience of being ill. Yet, it is possible to eliminate or cure a disease while leaving the individual with a persistent sense of illness. Similarly, a diagnosis of disease does not necessarily compel one to recognize or experience illness; being a person with a disease (or, even more so, with a disability) does not imply assuming

a patient identity. Experiencing oneself and one's body from the perspective of illness opens up the possibility both of vulnerability and of being cared for. Benner, for her part, proposes conceiving care as something radically distinct from a merely sentimental basis — a conception that, through its paternalistic authority, ontologically subjugates the person receiving care, reducing them to a narrowly confined identity of a dependent body. Care should construct a "human world — a life of care and possibilities," so that through family, environmental, and professional systems, knowledge about everyday human needs and limitations is developed, thereby providing insight into the fundamentally relational nature of being oneself. The practice of care must take into account the structure of meanings and the identity of each individual — not to objectify or appropriate them, but to dynamically incorporate them within the intersubjective context of care delivery. Although the transition from childhood to maturity occurs through gaining independence and assuming responsibility for one's actions and choices, one never fully extricates oneself from the social structures of care, which, whether overtly or subtly, provide the conditions for living freely as an individual [6]. The experience of illness within a relevant care relationship reveals the fundamentally, even ontologically, vital role played by the network of interdependence among people — especially when it manifests as a reciprocal, intersubjective reference that resists normative and pathologizing reductions.

In modern medicine, a division has been established between the physical and the social, and by focusing solely on diseases as manifestations of the physical body, relational care has been forsaken in favor of the development of biotechnology — whose successes have nurtured mythical dreams of transcending our human conditions of finitude, embodiment, and dependency. However, Benner points to a paradox inherent in the consequences of biomedicine. The success of modern therapies has led to an astonishing increase in the population of those with chronic illnesses, including the elderly, whose medical treatment is profoundly dependent on social well-being, physical activity, nutrition, and the environment — including appropriately adapted urban infrastructure. In other words, attending to these dimensions of social life is tantamount to upholding the structures of systemic care, while their neglect poses a tangible threat to health and life. Western societies are steeped in tendencies to construct possibilities for the objectification or detachment of our perspectival positioning from the world, thereby rendering the body solitary, unfeeling, and devoid of situatedness. Following Levinas's thought, Patricia Benner reconstructs an Aristotelian anthropology, drawing on the conviction of a primordial bond among people through mutual care for survival. In this context, subjectivity is shaped by "local, particular human worlds that are alternately opened and closed," rendering it extraordinarily distinct and inescapably Other, yet at the same time significantly Identical through the ontological facts of being situated, historical, finite, and embodied [6]. By carefully attuning themselves to patients' narratives, clinicians are afforded the opportunity to glimpse—even if only in the fleeting radiance of an ephemeral encounter — the meanings ascribed to various manifestations of illness, how these meanings resonate with the patient's lifeworld, and the consequences they bear for the integrity of the self. A phenomenological insight, when paired with biomedical explanation, can work complementarily to foster acceptance and understanding of that which in subjectivity has proven to be fragile and wounded.

Fredrik Svenaeus observes that the success of medical sciences has two faces. By narrowing the clinical gaze to aspects of corporeality susceptible to biotechnological manipulation, those dimensions of health discernible solely through the prism of the clinical relationship have been neglected. Consequently, this has led to mutual frustrations, the stark polarization between the

"entitled patient" and the "dismissive physician," and a clear erosion of trust and understanding — elements that are vital to stabilizing care structures, ultimately fueling various forms of conflict. Because this aspect of experience is too sensitive to persist in a perpetual state of "cold war," it eventually became necessary to devise ways to resolve disputes and prevent their escalation. On one hand, numerous movements emerged advocating for patient rights and autonomy, unconventional health practices garnered increased interest, and new medical specializations (such as psychosomatics, geriatrics, and psycho-oncology) evolved. On the other hand, discussions around medical ethics gained popularity, medical law became stricter, and the intensification of medical bureaucracy and proceduralization of clinical practice served to shield healthcare professionals. This historical moment has also become a new subject of interest for philosophy, including phenomenology [7]. Equally crucial for medicine is the theory of health, illness, and disability, as these concepts are inextricably linked to ideas of the human being, identity, and subjectivity; moreover, the assumptions that clinicians hold regarding these theories profoundly shape their practice. From a phenomenological standpoint, this is not about endorsing a purely psychological theory or any "dualistic attempt to overcome materialism" [8]. Rather, the phenomenologist of medicine seeks to probe the intersubjective reality of clinical encounters by suspending judgments about its presumed ontological structure.

Summary

The elusiveness and hidden nature of health situates clinicians in a state of fundamental uncertainty — a kind of essential not-knowing that shields patients from overly hasty, classificatory judgments and from intrusive interpretations which would trap them in a dichotomy of either defiance or submission to the medical agenda. Phenomenology, in turn, empowers medicine to embrace this state of not-knowing — not as a sign of incompetence or a clouded clinical gaze, but as an advanced capacity for multifaceted perception and a posture of humility in the face of the myriad possible meanings and worlds of experience.

In light of these observations, there is a need for new policies and healthcare systems that more robustly support the very structures of care. The task of phenomenology is not to establish a new medical paradigm, but rather to draw attention to the necessity of integrating dimensions of care and attentiveness toward the patient's lifeworld, as well as the intersubjectivity and relationality of clinical processes, into everyday health practice.

Rather than reducing patients to mere collections of symptoms or mechanistic entities, a phenomenologically informed approach in medicine invites us to reframe clinical practice as a deeply relational and affective engagement. This perspective challenges the prevailing biomedical model, which tends to isolate the physical from the social and emotional, and instead advocates for a practice that honors the full complexity of human life. Embracing uncertainty and the multiplicity of meanings inherent in health, illness, and care, clinicians can foster a more attentive, responsive, and ethically grounded framework that recognizes patients as whole persons, intricately connected to their lifeworlds.

Conflict of interest

None declared.

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