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SCIENTIFIC CONTRIBUTION

# Heidegger, communication, and healthcare

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**Abstract**
Communication between medical professionals and patients is an important aspect of therapy and patient satisfaction. Common barriers that get in the way of effective communication in this sphere include: (1) gender, age, and cultural differences; (2) physical or psychological discomfort or pain; (3) medical literacy; and (4) distraction due to technological factors or simply being overworked. The author examines these communicative barriers from a philosophical lens and then utilizes Martin Heidegger's phenomenology and hermeneutics to provide guidance for medical professional–patient interactions. The phenomenological approach espoused emphasizes the particular, contextual nature of such interactions, and thus is opposed to abstract, theoretical principles. Heidegger's hermeneutics provides a philosophical approach to communication that may guide the back-and-forth interpretation that should happen between medical professionals and patients to achieve effective communication.

**Keywords** Medical professionals · Patients · Hermeneutics · Phenomenology · Autonomy

If we agree with Descartes (1637/1988) that health is "the first good [*le premier bien*] and the foundation of all the other goods in this life" (p. 143), then we can infer that all persons care or ought to care about their health. This fundamental fact plays a major factor in regard to interactions between medical professionals and patients. A person who goes to a medical professional can be typically said to be showing a vested interest in his or her health that should clearly be acknowledged by the medical professional. Even if this is acknowledged, however, health is notoriously difficult to define. Nietzsche (1887/1974) states that since health depends on "your goal, your horizon, your energies, your impulses, your errors, and above all on the ideals and phantasms of your soul" (p. 177), medical professionals should avoid thinking in terms of "normal health." A patient's understanding of what comprises health and a medical professional's understanding may vary widely. If we couple the implied interest in a patient's own health with the understanding that persons have different views as to what counts as healthy, we come across a basic issue in regard to the medical professional–patient relationship: how do we ensure medical professionals and patients are truly communicating their aims, interests, and goals?

This question dates at least back to ancient Greece. In the *Laws*, Plato (1961) distinguishes between the "slave doctor" who "prescribes for each what he deems right from experience, just as though he had exact knowledge, and with the assurance of an autocrat" and the "free doctor" who "talks with the patient himself, … [giving] no prescription until he has gained the patient's consent" (p. 309).[1] In commenting on Plato's distinction, Jaspers (1959/1989) makes it clear that "only the physician who establishes [personal] relationships with particular patients fulfills the authentic vocation of the physician" (p. 255), thus demonstrating the moral superiority of the free doctor. In a contemporary context, the way in which slave doctors of ancient Greece treated their patients would be labeled a type of "paternalism," while the free doctors could have been said to respect patient autonomy. Veatch (1991) argues that in the traditional Hippocratic model that held sway for much of Western civilization, "the patient was a passive uninformed recipient of the physician's largess" (p. 6). With the rise in the value placed on patient autonomy since the 1970s backed philosophically by the ethics of Kant (1785/2002) and others, medical professionals should not only be respectful of the interests of the

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[1] For an excellent commentary on Plato's thoughts on medical practice, see Stempsey (2001).

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patients but also mindful that the patient's interests may not entirely match their own. Thus, as Goldman (1980) argues, paternalism is a flawed model for most physician–patient interactions. Emmanuel and Emmanuel (1992) note that the paternalistic model assumes a shared objective criteria for determining what is best. In many cases, however, there are communicative barriers that prevent such criteria to be elucidated. Indeed, the very nature of health may make it difficult not only to explicate such criteria consistently, but even to establish a truly shared objective in the first place. I aim to expound some of the communicative barriers that exist between medical professionals and patients from a philosophical lens and then provide guidance as to communication in medical professional–patient relationships using Martin Heidegger's phenomenology and hermeneutics.

## Communicative barriers

There is undoubtedly a wide array of factors that comes into play leading to communicative barriers between medical professionals and patients. Given the scope of this paper, I will focus on four: barriers stemming from (1) gender, age, and cultural differences; (2) physical or psychological discomfort or pain; (3) medical literacy; and (4) distraction due to technological factors or simply being overworked.

Regarding the first barrier, Street (2002) has shown that gender differences can play a role in medical professional–patient communication since they can be linked to differing goals and perceptions of each of the parties. If we agree with Butler (1990/1999) that gender is more of a performance than an innate characteristic, then medical professionals and patients alike must respond to patients in their particularity, rather than appeal to given gender stereotypes when interacting with patients. Age differences also play a factor in communicative barriers between medical professionals and patients. Perceived age discrimination is associated with unhealthy outcomes and dissatisfaction among older adults (Fernandez-Ballesteros et al. 2017). Beauvoir (1970/1996) has called the marginalization of the elderly "society's secret shame." Writing in 1970 as she herself was in her 60s, she offers advice that is useful for medical professionals: "let us recognize ourselves in this old man or in that old woman" (p. 5). In recognizing oneself in another, one develops a sense of sympathy that promotes a healthy medical professional–patient relationship. Finally, cultural differences oftentimes lead to differences in values, priorities, and may lead to language barriers in some instances. Gadamer's concept of "transposing oneself" is an apt tool for dealing with cultural differences, which, as he states, "consists neither in the empathy of one individual for another nor in subordinating another person to our own standards; rather, it always involves rising to a higher universality that overcomes not only our own particularity but that of the other" (1960/2006, p. 304). Genuine communication among those who culturally differ requires a "fusion of horizons" between the participants.[2]

Second, in a healthcare setting, patients may be experiencing physical or psychological pain or discomfort that prevents effective communication. Indeed, the very meaning of the word "patient" indicates this as it stems from the Latin word *patiens*, meaning "suffering." Bentham (1780/2005) famously states that pain is in itself an evil and thought this was so obvious that it needed no qualification. Regarding communicative ability, physical discomfort clearly inhibits a person's ability to convey one's thoughts accurately. The pain scale used by medical professionals (e.g., "How would you rate your pain on a scale of 0–10?") is typically used as a gauge regarding what level of pain medication to administer. It should also come into consideration regarding the ability to communicate as such. Regarding psychological pain, Ackerman (1982) has shown how denial, depression, guilt, and fear play a contributing role in compromised autonomy on the part of the patient. Regarding physical pain, Van Hooft (2003) has pointed out that in "cases of extreme, chronic, and unbearable pain … sufferers often find themselves unable to speak" (p. 257), thereby limiting autonomy. When a person's autonomy is compromised, one can expect communicative barriers.

Third, since the medical field is notoriously filled with specialized jargon that laypeople generally do not come across on an everyday basis, medical professionals should be cognizant of differences in medical literacy between themselves and patients. There is evidence that translating medical jargon into plain language enhances communication skills in medical professionals (Bittner et al. 2015). Many medical professionals have training in interpersonal communication, though as in all communication endeavors that involve an expert and a layperson, there must be a nuanced respect to the particular context in order to communicate without talking above (or below) the other person, given the varying levels of health literacy of patients. Contributing to this communicative barrier of medical literacy is the prevalence of technological equipment that is often unfamiliar to patients. As Jaspers (1959/1989) states, "The patient sees himself in a world of apparatuses, in which he is worked up without his understanding the significance of the events which are transpiring above him" (p. 256). Explaining the significance of any relevant equipment on the part of the medical professional in language that the patient can understand is imperative if medical professionals are to respect patient autonomy.

[2] For Gadamerian approaches to the hermeneutics of medicine, see Svenaeus (2000b), Svenaeus (2003), and Landes (2015).

Finally, distraction can play a negative factor in communication between medical professionals and patients. Gupta (2015) has rightly noted how "electronic medical records encourage clinicians only to check the boxes on the screen" (p. 266). This should be highly worrisome, especially if we heed Levinas' persuasive analysis of the importance of face-to-face contact. For Levinas (1961/1979), "the face speaks to me and thereby invites me to a relation incommensurate with a power exercised" (p. 198). A person's face establishes an ethical connection with another that may not be formed when the medical professional's attention is directed to a computer screen. Regarding the issue of being overworked, a study in 2014 of U.S. physicians suggest that around 50% are experiencing professional burnout, which often includes exhaustion, cynicism, and reduced overall effectiveness (as cited in Shanafelt and Noseworthy 2017). An exhausted and cynical physician will typically be a less effective communicator than the same physician who feels rested and optimistic (Shirom et al. 2006).

Given an acknowledgement of these common barriers of effective communication between medical professionals and patients, what philosophical approach to communication might be useful? Using concepts from Heidegger's hermeneutics and phenomenology, I aim to provide some guidance as to how to approach communication in medical professional–patient interactions.

## Heidegger's phenomenology and hermeneutics

Martin Heidegger's *magnum opus, Being and Time* (1927/1962), has left a lasting impact on Western philosophy, especially with regard to his contributions to phenomenology and hermeneutics. Phenomenology comes from the Greek root φαίνειν [*phainein*], which means "to bring to light" or "to make appear" (Liddell and Scott 2003, p. 854), making phenomenology the study of things as they appear. Heidegger understands phenomenology as a method for doing ontology, which is the study of the way things are. He states, "the term 'phenomenology' expresses a maxim which can be formulated as 'To the things themselves!'" (Heidegger 1927/1962, p. 50). The famous phrase "To the things themselves!" [*Zu den Sachen selbst*] comes from his mentor, Husserl (1900/2001, p. 168), who is considered the father of phenomenology. Heidegger's aim in utilizing phenomenology as a method is to stay true to the way things actually are as they appear, rather than appealing to abstract theoretical constructs while engaging in interpretation. Hermeneutics comes from the Greek word ἑρμηνεύειν [*hermeneuein*], which means "to interpret" (Liddell and Scott 2003, p. 315), making hermeneutics the study of interpretation. Heidegger (1927/1962) explicitly links phenomenology with hermeneutics in *Being and Time* in that the meaning of phenomenological description lies in hermeneutics (p. 61).

Heidegger's version of phenomenology is an attempt to overcome the tendency of philosophers to interpret the world from an "ivory tower" perspective, as it were, wherein the ideal is to detach oneself from everyday life and emphasize objectivity and rationality. Instead, Heidegger stresses that philosophy should begin with the everyday world in which we actually live. Any interpretations that we engage in should be mindful of the actual conditions in which such interpretations occur, rather than acting as if ideal abstract conditions are always in place. With this in mind, Heidegger's phenomenology and hermeneutics is a fitting platform from which to approach communication in medical professional–patient interactions since such interactions are always particular to a context and situation.

Heidegger's phenomenology has been used in various ways to understand and approach healthcare (Toombs 2001; Svenaeus 2010b, 2018). Heidegger himself worked with Medard Boss, a Swiss psychiatrist, and his colleagues from 1959 to 1969 in an attempt to show the importance of phenomenology to various medical fields. These exchanges are captured in *The Zollikon Seminars* (Heidegger 1987/2001). Heidegger's philosophy has also been used as lens to understand illness (Svenaeus 2000a, c), organ transplantation (Svenaeus 2010a, c), mental health (Aho and Aho 2008; Aho 2008, 2013), and various aspects of nursing (Benner 1994; Mackey 2005; Newman et al. 2010; Haraldsdottir 2011) and midwifery (Miles et al. 2013). Indeed, in the realm of nursing, interpretive phenomenology has become a common methodological lens from which nurse researchers approach their work (Chan et al. 2010). Many of the research in interpretive phenomenology stems from the work of Patricia Benner, who, with the help of Hubert Dreyfus, has demonstrated the importance of phenomenology to nursing in her research for several decades (Benner 1984, 1994).[3] Rather than looking specifically at how phenomenology and hermeneutics can be used to approach a specific profession, my aim is to look specifically at how Heidegger's phenomenology and hermeneutics can provide guidance as to how to approach medical professional–patient communication.

Phenomenologically, Heidegger (1919/2000) was explicitly against the Cartesian tendency of treating the self as an isolated ego and rather stressed that human beings are social in nature from his earliest writings. For Heidegger (1927/1962), "the world is always the one that I share with Others" (p. 155) so he designates Being-with (*Mitsein*) as an

[3] As Porter (1998) notes, however, nursing research under the title "interpretive phenomenology" often pays lip service to Husserl and Heidegger without actually engaging in their philosophies at any depth. Indeed, Crotty (1996) has argued that much of this research misinterprets the philosophy.

essential structure of our being. As Guignon (1983) points out, Being-with characterizes our essential relation to others in the field of meanings of the social world. Another essential structure of our being is that we care about our being: "Dasein, in its being, has a relationship towards that Being" (Heidegger 1927/1962, p. 32). Dasein, which is Heidegger's word for the sort of being or existence of the human being, has at its core a structure of care (*Sorge*) that is so fundamental to its being that it "cannot be torn asunder" (Heidegger 1927/1962, p. 238). This means that to be human is to care about one's existence. If we combine Being-with with our fundamental structure of care, it becomes clear that a proper orientation to another human being whom one is related should acknowledge that person's interest in his or her being.

Heidegger makes this evident by making a distinction between Dasein and mere objects in the world, which he refers to as present-at-hand entities. He states, "Dasein does not have the kind of Being which belongs to something merely present-at-hand within the world, nor does it ever have it" (Heidegger 1927/1962, p. 68). This means that one should not approach another human being like one approaches an object or tool, for instance. Indeed, Heidegger (1954/1977) was weary of speaking of the "supply of patients for a clinic" (p. 18) since it took away from the essence of what it means to be human. The proper mode of relationality with other humans is that of solicitude, which is the common translation of the German word *Fürsorge*. As the translators of *Being and Time* note, *Fürsorge* is "the kind of care which we find in 'prenatal care' or 'taking care of children'" (p. 157, footnote 4). In fleshing out what Heidegger means by *Fürsorge* in this sense, he states that it must be guided by *Rücksicht* and *Nachsicht*. *Rücksicht* is translated as "considerateness," but can also be translated as "consideration," "thoughtfulness," or even "respect." *Nachsicht* is translated as "forbearance," but can also be translated as "tolerance," "patience," or "lenience." If we apply these philosophical concepts to the medical professional–patient relationship, we can say that the medical professional should care for the patient (via *Fürsorge*) through showing consideration of the patient's wishes (via *Rücksicht*) and being tolerant of differing perspectives and values (via *Nachsicht*). In the *Zollikon Seminars*, Medard Boss notes that Heidegger (1987/2001) "saw the possibility that his philosophical insights would not be confined merely to the philosopher's quarters but also might benefit many more people, especially people in need of help" (p. xvii). A demonstration of solicitude on the part of the medical professional is an initial step in this direction.

Along with this phenomenological disposition of solicitude comes the hermeneutical approach that Heidegger sets forth. First and foremost, Heidegger (1927/1962) stresses that "an interpretation is never a presuppositionless apprehending of something presented to us" (pp. 191–192). Rather, interpretations always happen in a context wherein the persons involved have presuppositions, biases, and prejudices built in. Moreover, regarding communication, "our ways of speaking are means of sharing a world with one another, but they have only proven themselves in and for the world from which they have been inherited" (Dahlstrom 2010, p. 405). Like his student Gadamer (1960/2006), Heidegger rejects that one can ever achieve a stance of pure objectivity or rationality. Instead, all interpretations have a threefold structure: a fore-having, a fore-sight, and a fore-conception. These three aspects are not states of interpretation but rather equiprimordial aspects, meaning all three are there "all at once," as it were, in any given interpretation.

Heidegger (1927/1962) states, "In every case … interpretation is grounded in *something we have in advance*—in a *fore-having*. As the appropriation of understanding, the interpretation operates in Being towards a totality of involvements which is already understood" (p. 191). The fore-having (*Vorhabe*) of interpretation is a person's implicit understanding of the world, which not only determines the way in which one engages in interpretation but also determines the possible ways that things can show up as they do. Along with a background understanding, there needs to be some tentative view of how to engage in interpretation. This is what Heidegger calls "fore-sight" (*Vorsicht*). He says that interpretation "is always done under the guidance of a point of view, which fixes that with regard to which what is understood is to be interpreted. In every case interpretation is grounded in *something we see in advance*—in a *fore-sight*" (Heidegger 1927/1962, p. 191). Fore-sight is the slant one takes in approaching interpretation or the angle from which a person comes from. Of course, one's fore-sight will depend upon one's fore-having. In other words, the point of view or angle that one takes in engaging in interpretation will depend on the background understanding that one has acquired. Rounding out the threefold structure, Heidegger (1927/1962) states that "the interpretation has already decided for a definite way of conceiving [what is to be interpreted]; … it is grounded in *something we grasp in advance*—in a *fore-conception*" (p. 191). The fore-conception (*Vorgriff*) can be thought of as the expectation of what a person will find out in engaging in interpretation.

In engaging in interpretation with another, Thompson (1990) notes that there is a back-and-forth "between a background of shared meaning and a more finite, focused experience within it" (p. 243). Since, however, the backgrounds of meanings—or, to use Gadamer's phrase, "the horizons" (Gadamer 1960/2006)—of the two in dialogue do not necessarily coincide, persons must be open to others if true communication is to occur. Heidegger (1987/2001) calls this openness "*Gelassenheit*," which is often translated as "letting be": "As a physician one must … let the other human being be" (p. 211). Letting be is not a passive indifference,

but rather consists in avoiding manipulation or dominance and allowing for genuine communication to unfold. Working upon Heidegger's thought, Gadamer (1993/1996) notes how genuine communication is increasingly difficult in modern medicine: "In the modern world … the opportunities for doctor and patient to enter into genuine dialog with one another are extremely limited. The local doctor who was virtually a member of the family is a thing of the past…. Any sort of closeness between doctor and patient has become an extremely fragile achievement" (p. 127). Thus, Gadamer (1993/1996) recommends viewing the dialogue between doctor and patient as part of the treatment itself in order to highlight its importance (p. 128). An ideal dialogue in the clinical encounter leads to a partial fusion of horizons (Svenaeus 2000d), which includes overcoming strangeness (Gadamer 1976, p. 22).

When it comes to communication, Heidegger not only stresses the threefold structure of interpretation that is involved but also the level of involvement of the persons participating and their affectedness. The level of involvement in the situation is expressed by Heidegger's concept of Being-in (*In-Sein*), while the affectedness of the persons is expressed by Heidegger's concept of *Befindlichkeit*, which is translated as "state-of-mind," (Heidegger 1962) as well as "affectedness" (Dreyfus 1991), "attunement" (Heidegger 1927/1996), and "disposedness" (Blattner 2006). *Befindlichkeit* has to do with how one finds oneself affected by a situation. Heidegger (1927/1962) states, "Being-in and its state-of-mind are made known in discourse and indicated in language by intonation, modulation, the tempo of talk, 'the way of speaking'" (p. 205). All of these subtle variances matter because they portray the level of involvement of the person and how one is affected by the communication. Moreover, bodily gestures also communicate such interests, as Heidegger (1987/2001) makes clear in the *Zollikon Seminars*. Merleau-Ponty (1945/2002), who was heavily influenced by Heidegger, puts this point the following way: "There is not a human word, not a gesture, even one which is the outcome of habit or absent-mindedness, which has not some meaning" (p. xx).

With these concepts in mind, how can we approach communication between medical professionals and patients in a way that is mindful of the communicative barriers? Regarding the first barrier of gender, age, and cultural differences, one should be cognizant that many of these aspects of humans are linked to what Heidegger (1927/1962) would call their "thrownness" (*Geworfenheit*), which is to say that they are to some extent given as opposed to chosen (p. 174). One should not hold persons negatively responsible for things they did not choose in the first place; thus, gender discrimination, ageism, and racism are all problematic.[4] Regarding the second barrier of pain, one should be cognizant that this pain can affect one's level of involvement (i.e., Being-in). A patient may, for example, be in so much pain that paying attention to the details of the situation is difficult, if not impossible in such a state. If this is the case, ensuring that a family member is present may be appropriate. Moreover, the medical professional should acknowledge the pain felt by the patient and, ideally, empathize with the patient. Agosta (2014) has argued persuasively that Heidegger's concept of affectedness is useful in approaching a hermeneutics of empathy in the clinical context. He states, "Optimally, in empathic receptivity one experiences a trace, a sample, a vicarious representation, of the other's experience of suffering, joy, or indifference, so that one 'gets it' experientially and emotionally as well as cognitively" (Agosta 2014, p. 283). Regarding the third barrier of medical literacy, one should be cognizant that the medical professional has developed a level of mastery that the patient simply has not, and this means that what is encountered circumspectively (Heidegger 1927/1962, p. 98) on the part of the medical professional may be encountered as foreign or alien on the part of the patient. As Svenaeus (2000b) has rightly pointed out, the medical meeting "is radically asymmetrical in the sense that the patient is the weak help-seeking party asking for aid from the expert in health matters" (p. 179). The medical professional should continually heed this asymmetry and adjust one's language to the level of the patient's literacy. Finally, regarding the possibility of distraction, one should be cognizant of the effect that this has on the patient's therapy and satisfaction. A distracted person gives the impression to the other that he or she is not significant (Marder 2011). The affectedness of tempo, body language, and tone have a significant but oftentimes understated effect on persons. Thus, a medical professional should be mindful of how one's actions portray his or her level of involvement with his or her patients.

## Concluding thoughts

Because medical professionals and patients may have different understandings of what it means to be healthy, they must communicate in order to come to a mutual understanding as to what comprises health on the part of the patient. Medical professionals should be cognizant of barriers that can affect such communication, including gender, age, and cultural

[4] Those who are quick to accuse Heidegger of racism due to his connection with National Socialism (Faye 2009) or of sexism due to his treatment of women (Maier-Katkin 2010) should keep in mind that failures in a philosopher's personal life do not take away from the legitimacy of his or her philosophy.

differences; physical or psychological pain; differences in medical literacy; and distraction. Heidegger's phenomenology provides a philosophical lens to approach communication that highlights the contextual nature of medical professional–patient interactions. The hermeneutical approach he sets forth provides guidance as to how to engage in effective communication. Moreover, concepts in his philosophy allow us to better understand the nature of communication in medical professional–patient interactions, which may allow medical professionals to be more cognizant of communicative barriers and, to some extent, alleviate them, which should increase patient satisfaction.

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