ILLNESS AS INTERSUBJECTIVITY: A SOCIOLOGICAL PERSPECTIVE

THESIS

Submitted in fulfilment of the requirements for the Degree of

MASTER OF ARTS

of Rhodes University

by

DOREEN JENNIE PITFIELD

November 1991

ACKNOWLEDGEMENTS

Firstly, my grateful and sincere thanks to those who taught me all I now know about humanism - especially the one or two colleagues who discussed theory with me often, and thereby helped me to formulate my initial ideas.

Secondly, my loving thanks to my husband Derek, who not only encouraged my time-consuming endeavours, but who relieved my life of other (more mundane) duties in order that I had the time to write. At the beginning of my sociological career, it was Derek who had faith enough in my abilities to envisage this present work and I thank him for his understanding support and motivation.

Thirdly, to Jan Coetzee for the supervision of this work, my genuine thanks for the tremendous experience and knowledge imparted into the argument as it developed. Jan's final structuring of the study has ensured that it reaches its "punchline" in an air of anticipation - in true humanist "open fashion". I hope, paving the way for a reconsideration of modern medicine.

Fourthly, my thanks and gratitude to my three children. To Ashley, who's death from cancer at the age of 17 prompted this study. I hope that in some small measure his death will help to re-address the problems which human beings encounter daily within the framework of pure scientific medicine, and thereby make others' experience of medicine more humane. The only positive worth I can think of for not having undertaken this thesis would be that Ashley was still with us - so sorely is he missed.

To Spencer, who now no longer lives at home, but who nevertheless suffered endless months of having to help in the house, shop, fetch and carry the youngest child from school, and after all that, refrain from interrupting the writer in the study. I thank him for his understanding support.

To Ginny, who as the youngest in the family, suffered what has to be termed partial neglect. Somehow, the rewards for the writer cannot compensate her lost time. I hope one day she will understand my need to write this study and will find within its pages something of the mother she missed during the two years of its writing, and sadly the brother she lost.

And, finally, to Ellen Maunatlala my genuine thanks for making sure that the house continued to function whilst I was out of action.

Doreen Pitfield
Pretoria, RSA.
June 1991

ABSTRACT

This thesis explores the historical roots of scientific medicine in an effort to highlight the lack of humanist intersubjectivity within the contemporary medical model. The study notes that contemporary medicine is overtly scientific and that its scientific framework is upheld and furthered by a medical model which draws legitimation from the irrefutability of what is referred to variously within this work, as its scientific "regime". It is shown that in terms of the humanist tradition people, not science, constitute the epicentre of meaningful experiential participation in the defining of human social reality. This, it is argued, implies a radically different ontology from other sociological perspectives on medicine.

The thesis suggests that the contemporary medical model loses sight of the patient's ability to cognitively participate in the defining of illness, diagnosis and treatment in terms of his/her experience thereof, and argues that contemporary medicine, by advancing the idea that it alone has the *correct* and *only answer* to such problems, has led to a situation which promotes an overmedicalisation of society. The study gives an indication of the way in which this overmedicalisation has led to areas of human life becoming conceived of only in relation to medical expertise. In this respect it is noted that medicine has so successfully infiltrated the human consciousness (involving areas as diverse as childbirth, genetic engineering, transplant surgery and death), that decisions on health are invariably taken from a foundation of scientific legitimation which seems to exclude the patient as subject. It is argued that this way of making decisions reinforces the requirement for a scientific medical model which as it negates the human element insidiously amplifies its power over human life; thereby devaluing the very people it seeks to serve.

The thesis suggests that in terms of a humanist reading of the Oath of Hippocrates, medical decisions can only be taken within a framework of experiential involvement which includes both medical expertise and lay understanding. It is indicated that when this happens, social reality functions in terms of a symbolic participation which fosters a commitment to equalise the conditions of human existence, and promotes a dialogical negotiatory process which is both intersubjectively and ongoingly produced.

To
THE PATIENT
The often overlooked
"Third Party"
in the
Sacred
Doctor-Disease Relationship

Andrew C Twaddle (1981)

For Ashley Cliffe and the 12th May 1987

GENERAL INTRODUCTION

The study which follows is an attempt to offer a critical evaluation of the theoretical literature within medical sociology and to indicate a humane way of defining illness, diagnosis and treatment by locating these concepts within an intersubjective humanist framework.

In order to search the concept intersubjectivity within the medical model, the thesis probes the hypothesis that the scientific mechanistic medical model (with its adherence to reductionist technology), is unable to facilitate the personal ongoing meaningmaking and world construction desirous of intersubjective living and healing.

The study examines in depth the concept of intersubjectivity as it appears within the sociological literature, and the theoretical component of the study proceeds to search its theoretical lineage. This is achieved by indicating that the concept of intersubjectivity is not satisfactorily accounted for within the sociological theoretical approaches to society of both the conflict and systems perspectives. And conversely, it is argued that the humanist perspective provides a coherent outline of how the concept can be seen to account for meaningmaking in terms of humanism. It will be shown that within the humanist tradition, the concept of intersubjectivity implies a radically different ontology from that of the systems and conflict perspectives.

Chapter one offers a brief examination of the theoretical traditions of the systems, conflict and humanist perspectives. In the systems tradition the work of Emile Durkheim, Talcott Parsons and Jeffrey Alexander will be read, and an effort will be made to indicate that any notion of intersubjectivity becomes subverted by what might be termed "consensual overlap".

The chapter moves from what can broadly be defined as the traditional aspects of systems theory, through to the more modern representations of the systems tradition. In this way it will be shown that the potentiality for a negotiational platform of choices and alternatives is occluded by a view which sees human interaction in tones of role performance (in accordance with the systems view).

Within the conflict tradition, a brief examination of the work of Karl Marx, Ralf Dahrendorf and Jürgen Habermas will be undertaken, in order to seek to show that intersubjectivity (broadly defined) is here seen in terms of the way individual realities are framed by the power structures within society which appear non-questionable. In this tradition the power structures are perceived as the poles around which human intersubjectivity becomes swamped by either the interests of the group, dominant role positions or the power of what Habermas terms a distortion of communication.

Within the humanist tradition, chapter one utilises the work of George Herbert Mead and Alfred Schütz in order to base the humanist perspective in its traditional roots. In this section it will be indicated that the humanist perspective locates people as creatively involved in constructing a meaningful lifeworld. This is shown to mean that the emphasis within the humanist tradition is upon intersubjective meaningmaking which takes into account both the human possession of self-consciousness and the experiential participatory elements necessary to understand humanist social reality. It is indicated that within the humanist perspective the possession of self-consciousness suggests a potential for reflexive debate between alternative viewpoints. And, furthermore, an inherent intentionality to revise meaning structures in the light of various options which present during interaction.

Chapter one then moves on to note the frailty of the concept intersubjectivity within the sociological literature pertaining to

the systems and conflict traditions. This so called frailty is indicated to take the form of a lack of human meaningmaking and worldconstruction. The humanist tradition is then utilised in order to locate intersubjectivity in humanist terms and lays the foundation for chapter two which attempts an in-depth account of modern humanist theory. An effort is made at various stages of these reading to locate particular theoretical perspectives within the medical setting in order to show that medicine in terms of a scientific regime, is incapable of allowing for people's true meaningmaking potential and thereby can be argued to obstruct humanist intersubjective living.

The discussion of the conflict, systems and humanist perspectives undertaken in chapter one, serve as a basis from which to present the development of contemporary humanist theory in relation to the concept of intersubjectivity. Hence, in chapter two, the study proceeds to examine (so defined) humanist authors' ideas on intersubjectivity and related concepts.

Chapter two builds a narrative account of intersubjectivity as it appears through the work of variously defined contemporary humanist authors. The aim is to construct a theoretical framework with which to utilise and extrapolate the arguments of humanist oriented theorists. This examination is undertaken in order to show how the term intersubjectivity can be defined in such a way as to take account of the human meaningmaking and world-construction activities operating in society. In this regard it will be indicated that certain theorists have pointed to the way in which intersubjectivity may become distorted or constrained in society. And it is thereby argued, that according to the humanist perspective the concept of power may be considered in terms of a distortion of interaction. Later in the thesis an attempt is made to utilise the framework thus developed to examine this so called distortion of intersubjective living, both within contemporary medicine and within society.

Chapter two uses the concepts developed within the work of, inter alia, Jean-Paul Sartre, Peter Berger, Richard Brown, Cornie Alant and Norma Romm, and addresses in depth the implications of seeing

social reality as intersubjective in humanist terms. Habermas and Michel Foucault's analyses of power are also read and "humanistically" interpreted. Foucault's argument is used to highlight the insidious mechanism of power in society. His theory indicates that "power structures" so successfully control people's lives that the power mechanisms themselves can be disposed of, leaving people controlling themselves. Habermas's argument is presented here in order to draw on the critical marxist theory of power as constrained or restricted interaction (communication). It will be shown that Habermas's theory differs from the orthodox marxist view and from the Dahrendorf focus on role positions as the basis of power, allowing for the argument to be advanced that this position may be seen to concur with the humanist focus on intersubjectivity. (By using certain of the ideas of Habermas and inflecting with the positions of specific "humanist" authors in contemporary sociology, it is hoped to show how this concurrence can be effected.)

In this way the argument thus offered opposes a definition of illness which regards the medical scientific model as un-questionable and its view of diagnostic power as something which can only be defined by **experts**. And it promotes the idea that intersubjectivity (as humanists have defined the term), implies a specific definition of how reality becomes constructed. It is argued that all such construction takes place in consciousness in the belief that meanings cannot be defined outside of people's meaning structures. Meaningmaking is shown to function within a negotiational arena and assumes social reality to be symbolic and dialogical in essence. Furthermore, meaningmaking is indicated to be an ongoing process which is experiential (rather than given) and therefore in continual flux.

Ongoing meaningmaking is in turn shown to imply that knowledge of illness (or for that matter, diagnosis and treatment) may be seen as something which is experientially constructed by people rather than something which can be known through what might be termed biological **facts**. These concepts are indicated to be negotiable rather than given and are therefore, in terms of the humanist perspective, re-definable, precarious and incomplete.

Once these concepts have been developed, the framework is provided to consider the absence of intersubjectivity within contemporary medicine.

Chapter 3 looks at the scientific medical model, its historical roots and its evolution as a mechanistic scientific regime which has promoted legitimisation of the view that patients need to rely on the **expertise** of the medical profession without becoming meaningfully involved. It is suggested that the contemporary medical model functions upon what appears to be the irrefutability of scientific facts. In this way scientific medicine is proffered to have the one and only right answer to illness, diagnosis and treatment and, furthermore, can be argued to occlude humanist intersubjectivity by blocking people's potential to take part, or to take what Sartre calls co-responsibility for one's own condition. Responsibility and the potential to meaningfully take part therein, become stifled by an oppressive medical regime.

It is this stifling process which causes Ivan Illich to argue that a radical monopoly is being promoted by the medical profession which feeds upon itself and cultivates an elitist power that becomes a **malignancy**. In this way the assumptions within the medical model denote expertise as having access to **the truth** rather than to acknowledging that there can be **no one right answer** to anything outside of people's consciousness. The concept of choice in relation to intersubjectivity is therefore explored in the context of its implications for defining reality (and the realities of illness), not in terms of truth, but in terms of people's need to make sense of the world around them.

It is indicated that within the literature on medical sociology a differentiation still seems to be made between illness, treatment and diagnosis in terms of an elitist prescription of who has knowledge. Whilst in terms of the humanist tradition these concepts can have no status or life devoid of the meanings that people apply to them. It is noted that in interactionist type theories within medical sociology, the presumption is made that within the interactional setting patients can interact, or even

negotiate what might be called certain possibilities of how to relate or respond to the condition of sickness.

But the point which invariably seems to be missed is that at the very outset the definition of the sickness is itself a negotiable construct. It is, therefore, according to humanism, not the prerogative of either party to define how the person is classified as **sick** in the first place. Thereby, both patient symptom and elitist specialist knowledge should not be taken as given: both need to be subjected to intersubjective negotiation. Or otherwise stated, what should take place is what Veronica McKay (1990) refers to as a **status shift** which denotes an equalising of knowledge between parties. In this way the doctor's specialist medical knowledge becomes available to the layperson, and the patient's personal knowledge of a particular condition becomes available to the doctor. This means that **all** available knowledge, both scientific and personal, enter into the interactional forum and provide a "mingling" of what can be termed the "sum" of knowledge.

By recognising that the doctor does not have sole prerogative to diagnose - a prerogative which presupposes a rigidified base, the study suggests that within medical sociology to date there has been no attempt to uncover the process of constructing the very definition of illness. The sociological relevance of intersubjectivity applied to the domain of medicine therefore indicates how this concept, in offering a radically different epistemology or way of seeing social reality as humanly constructed, contests scientific **truth** as possessing the only right answers. It is argued that such truths have become legitimised by doctor and patient alike as the only definition possible, and that this state of affairs is due to what can be termed an infiltration of people's consciousness by the inherent prerogative within the medical model.

The study suggests that the currently accepted definition within medicine of illness, treatment and diagnosis, rather than being complete, is merely one alternative in a fluid matrix of options. It is argued that control is exercised by the medical fraternity over the symbolic worldconstruction of the sick, and by promoting a definition of illness in terms of something that the patient passively **suffers** and the doctor **solves** with dominant expert elitist knowledge, thus fails to take account of intersubjective meaningmaking and therefore fails in humane terms.

By suggesting that illness can be considered in intersubjective terms, the study seeks to offer an alternative to currently dominant medical ideology (ideology in this study is defined [after Habermas] as distorted intersubjectivity), and to indicate that no one way of seeing can be considered "healthy". The suggestion is made that rigidified meaning patterns have become established within the scientific medical model, and that actors should - rather than passively accept what can now be termed the "status quo" of medical elitism - be encouraged to recognise the relativity of their own particular point of view. And, furthermore, to envisage that this viewpoint is an open invitation for further debate.

What should be occurring is a fluid matrix of ideas which form a platform for negotiational discourse - a platform which does not encourage the belief that members of the medical profession are **genies** who not only **know** what illness is, but who are the only people who **know** what to do about it. It is argued rather, that what is needed is a forum which establishes the potential of patient and doctor alike to participate in the very definition of illness, diagnosis and treatment, through an intersubjective dialogical encounter. This points to what can be called the need for confrontational negotiation in the field.

Via a consideration and interpretation of various theorists within each perspective, the suggestion is made that the mechanistic, reductionist contemporary medical model is too scientific in

application. It is noted that an explanation of humanist sociology (with reference to intersubjective dialogical living), by defining intersubjectivity in humanist terms, takes up the ideas of Cornie Alant & Norma Romm (1990) and draws attention to the notion that human subjectivity does not indicate an exclusively individual or private experience of the world. All such experience is noted to be already imbued with knowledge that is shared with other people. Therefore, it is indicated that although people live in a **shared** world they experience the world in **original** ways. These shared and original aspects of human experience point to the notion that humans in possessing self-consciousness have the capacity to give different meanings to the so called same world. According to this view, humans are intersubjectively linked: they take account of the shared world and at the same time acknowledge that their personal experiences of the world cannot be understood in isolation.

In **Chapter 4** the theoretical framework of humanist intersubjectivity developed in chapter two, and the contemporary medical model developed in chapter three, are brought face-to-face in order to offer a critique of the so called over scientific medical model. The juxtaposed positions are shown to indicate that there is an occlusion of intersubjectivity within the consciousness of those adhering to the medical model. The integration of a theoretical humanist framework highlights not only the failings of medicalisation in mechanistic terms, but also the overpowering deficiencies which this model fosters in regard to human beings. Finally, the benefits to be gained from the reintroduction of a human essence into medicine is probed in order to suggest ways in which the world of illness can be rendered more **meaningful**.

In **Chapter 5** an evaluation of the changing nature of medical ethics is undertaken - in order to test humanist theory "in the field" - and it is indicated that the advance of medicine along

technological lines has led to a further negation of human intersubjective living. It is noted that concerns with health and illness have changed from a discipline subsumed under theology and supernatural power (which entertained the subjective, nonscientific orientations of philosophy and ethics) to a scientific technological platform which, in advancing scientific medical progress, has caused a convergence of ethics and medicine which tends to deny human meaningmaking in humane terms.

By re-reading the theorists identified in chapters one and two, and applying their work to the scientific medical model as laid down in chapter three, an indication is given that ethical and moral decisionmaking now needs to accommodate technological advancement, not merely in terms of science but also in terms of human enterprise. This means that decisions must be made not only in accordance with the situation at hand, but also by taking into account what these decisions may mean for others at a later stage. Ethical decisions can no longer be made from a basis of what might be termed cognitive, almost intuitive, medical knowledge, but are initiated in accordance with laid down criteria which supposedly accommodates a more formal intellectual framework. According to the medical model, this is the only way in which medical personnel can be expected to competently address ethical problems thrown up in response to the advance of medical technology.

It is suggested that by condoning and utilising this formal framework for criteria in decisionmaking, science is able to intervene and manipulate human bodies and minds on the basis of its unquestionability. Where intervention in the form of life support machinery is called for the questions arise: who decides, and on what basis which patient will receive these so called **benefits** of medical science? Chapter five argues that although criteria are laid down for making this judgement (when resources

are scarce and when only so many can be helped if others are denied), an area of decisionmaking exists which currently appears to relate to, and to be reliant upon, the scientific belief that medical science alone has the **right** answers. The question is posed as to whether or not these decisions can be humanely addressed in scientific terms alone.

It is argued that there exists no allowance within the contemporary medical model for a negotiational platform which promotes intersubjective dialogue and the more humane elements of shared choicemaking. It is further suggested that this lack of shared choicemaking is derogatory to the human condition in terms of the humanist framework. And, thereby, that ethical and existential questions having become integral to contemporary medicine, tend to exclude the very people it (the medical profession) purports to serve. This is argued to be dehumanising and to be a form of devaluation in terms of humanist theoretical values. It is thereafter suggested that the authority inherent in making medical decisions need be seen as a challenge to the medical establishment rather than a normative situation, and as such should be recognised as a situation which urgently requires attention if medicine is to regain its humane relevance.

Chapter six concludes with a brief resume of the arguments presented and a recommendation for ways in which further research into a more humanised medical model may be undertaken: thereby facilitating medicine as a more humane enterprise. The need for contemporary medicine to address the discourse engendered by the blocking of human consciousness through its rigidified medical model is highlighted. This is indicated to point to a necessary reconsideration of theoretical categorisation in order to embrace the emancipatory elements which lead to unconstrained discourse, and to provide what V. McKay & N. Romm (1991) refer to as an infusion of new life into ossified (ideological) patterns of meaning.

CHAPTER 1

SOCIOLOGICAL TRADITIONS AND THE ISSUE OF INTERSUBJECTIVITY

1.1 INTRODUCTION

In this chapter the theoretical foundations of the systems, conflict and humanist sociological perspectives are explored in order to search the traditional basis against which the concept of intersubjectivity has to be situated.

Sociology is an attempt to understand human social reality and to make sense or meaning of people's place within it. This study will indicate that exactly what this understanding involves is problematic and often many-sided. Therefore the issue as to what sociological understanding entails is not clear-cut within the so called sociological discipline. This point is distinctly expressed within the sociological literature and indicates that sociologists define the theory and study of sociology in variously different ways. In attempting an understanding of the broad sociological basis within which intersubjectivity has to be studied, the main traditions in sociological thought will be covered.

Sociological theorising can be divided into theoretical perspectives which may be equated to differing ways of "seeing" and trying to understand and make sense of human social reality. For the study at hand, three sociological perspectives will be chosen. They are the consensus or systems theoretical tradition, conflict theory and the symbolic interactionist, ethnomethodological and phenomenological tradition. Under the perspectival umbrella of each perspective this thesis will consider the work of various authors who are here deemed to be relevant within a particular perspectival tradition.

It is however recognised in this respect that the choice involved in placing particular authors within a certain framework is itself not clear-cut (especially where the author concerned has not self-named

their own work as belonging to a particular tradition). Therefore, other people may indeed place the authors utilised by this thesis within different frameworks or perspective to those chosen here.

Thereby, within this chapter it will be noted that some authors are used to express principles involved within particular traditions which may at first glance appear unusual. For example Jürgen Habermas's work will at different times within the thesis be argued to fall under both the categories of so called modern systems theory as well as the neo-marxist tradition. This is deemed acceptable in the light of the fact that the placing of a particular author's work is always problematic. In the case of Habermas, it will also be shown that when combined with the phenomenological argument, his theory helps to explain and elucidate some of the tenents of the humanist approach. This allows one finally to argue that Habermas can be seen to lay the foundation for the phenomenological argument which is taken up and utilised within the following chapter.

Under the systems (consensus) perspective the work of Emile Durkheim, Talcott Parsons and Jeffrey Alexander will be read in order to suggest that systems theory pushes human interaction into what can be called consensual overlap. Under conflict theory this thesis will deal with the theories of Karl Marx, Ralf Dahrendorf and Jürgen Habermas. It will be indicated that the theories of Marx and Dahrendorf subvert human interaction into what can be termed group or role interest. Habermas's neo-marxist version of conflict theory is also here presented and indicates a move towards a view of the power structures operating within society which can be considered in terms of a distortion of communication. However (as is shown in more detail in chapter 2 of this thesis), it is noted that Habermas's work can also be placed alongside the phenomenological and ethnomethodogical tradition. In this regard, Habermas's theory of communicative action may be utilised to indicate that it is not possible to access reality through a process

of uncovering external facts within society (as systems and conflict theories do), but rather through what can be termed the knowing processes of human beings.

The chapter then moves on to consider the interactionist/ ethnomethodological/phenomenological traditions of George Herbert Mead and Alfred Schütz in order to form what might be called a bedrock for traditional humanist ideas. In this way a platform is erected from which to examine the more contemporary humanist authors to be utilised in chapter 2 of this work. This means that the thesis searches a definition of humanist intersubjectivity in order to build a framework which can thereafter be applied to the scientific medical model.

The thesis will take as its starting point the suggestion made above that sociology can be divided tripartly (many more divisions are possible). This way of distinguishing sociological tradition has been paralleled by a number of authors within the discipline - amongst others William Skidmore (1979), Randall Collins (1983), Michael Haralambos (1989), George Ritzer (1983), John Wilson (1983) and E. Cuff & G. Payne (1984). As indicated, the three chosen perspectives present different starting points and different assumptions and thereby promote differing views of human social reality. These differing views of social reality will be drawn out within the body of the work.

Working with the three chosen perspectives, various primary theorists will be categorised within the body of particular theoretical perspectives and the thesis will build upon their ideas by citing other authors' work where necessary.

Arguments within the systems, conflict and humanist perspectives will be dealt with briefly to indicate that neither systems or conflict perspective can really account for intersubjectivity (in humanist terms). Within the humanist perspective it will be shown that humanism presents a radically different ontology from that of the systems and conflict perspectives. However, this conceptualisation does not mean that sociological perspectives are

entirely separate - they often overlap, borrow from and adapt each other. They do this in a desire to uncover how social reality might be perceived, and by posing questions about the nature of people and human societies, can be seen to pursue knowledge in an effort to understand.

This chapter endeavours to show what the concept intersubjectivity means within what is here called the humanist framework and which roughly coincides with what Cuff and Payne (1984) term ethnomethodology and phenomenology, Haralambos (1989) terms interactionism and Wilson (1983) calls humanism. This is achieved by noting the lack of intersubjectivity (in humanist terms) within the systems and conflict perspectives.

1.2 SYSTEMS THEORY

1.2.1 Introduction

Two of the main thrusts within sociological enquiry are consensus (systems) theory and conflict theory, and although the one advocates co-operation and the other coercion, both address society as a systematic entity. In opposition to these views it will be indicated that humanism approaches society from a radically different angle which accentuates the intersubjective elements of "human" structures. This it does in the belief that humans have the capacity to actively participate in the creation of social reality.

The emphasis of the systems perspective invariably rests upon the concept of consensus and views social order as contingent upon the consensual acceptance of values and norms. It focuses on the ways in which the ordered nature of societies and social life are viewed as integrated wholes. Society is seen as holding together in an orderly existence of equilibrium and is suggestive of people being moulded into acceptable roles which are necessary for its (society's) continued existence. According to this view everything

about social life bears an interrelationship to the whole, and a change in one part of the system will necessitate a change in the other parts.

In this context society is viewed as separate from, or independent of, the individuals within it - what Emile Durkheim referred to as "sui generis" or as having a unique existence independent of its members. Michael Haralambos highlights this point in relation to the institution of the family by stating that:

> Rather than constructing their own social world, members of society appear to be directed by the system...they are organised into families and systems of stratification because society requires these social arrangements in order to survive... (1989:524).

It will be shown later in this thesis that according to this view of society the institution of medicine functions in much the same way. Patients accept more and more scientific medicine by relinquishing their own autonomy for illness management into the hands of the medical profession, and in this way accept the medical model as definer of health and illness because this maintains equilibrium within the system.

Within this perspective individuals are considered to have totally internalised the norms and values of the social system. These values become what John Wilson infers are their values. He states: "... actors are free to choose... but their choices are structured by dominant values and norms" (1983:98). With reference to this point Haralambos notes that

> ...it is not the consciousness of the individual which directs his behaviour but common beliefs and sentiments which transcend the individual and shape consciousness ...[and thus] members of society become constrained by [what Durkheim terms] the social fact (1989:524-5).

1.2.2 Emile Durkheim

Emile Durkheim, working within the mode of analysis known as functionalism (which is founded on the assumption that actions are to a large extent structured by the social environment), was particularly interested in social systems as moral entities and he saw human association as giving rise to expectations or patterns of conduct. Durkheim advocated that interacting humans tend to develop common ways of acting in society and that these common expectations of actions constrain and oblige them to behave in particular ways. It will be shown later that the medical profession seems to function in this way: the doctor defines and the patient passively accepts.

The social and moral pressure to conform to societal norms develops what Durkheim terms a collective consciousness and this forms the basis of an ordered society. According to Durkheim, the social fact of conforming to norms, exists almost as an external entity because people have so thoroughly accepted and internalised society's ruled system. Therefore facts are not intersubjective because they function outside of human experience in the realms of what can be thought of as a consensual moral order. Durkheim argues that it is this moral reality, which includes the collective values and the order of priorities on which the members of the society are agreed. This fosters the notion that society somehow exists over and above us (referred to earlier above as sui generis).

Using ordinary everyday concepts like fashion and religion to highlight the external properties of social facts, Durkheim argues that such concepts are a collective phenomenon which he maintains cannot be reduced to an individual level without losing the essential meaning. He suggests that this takes place because they involve the collective action and the sentiments of many persons. Specifically in the case of religion, Durkheim argues that the positive function of religion, in affording human life what might be called an existential framework of meaning, helps to maintain the

moral unity within society. Therefore, in Durkheimian terms, collective and unifying do not take account of intersubjective meaningmaking because they actually constitute what can be argued to be a distinct and separate reality. This reality deals with things external to and coercive of the actor.

In chapter 3 it will be indicated that medicine can also be seen in these terms. Scientific irrefutability provides the medical profession with what can be called a separate reality: science presents as external and unquestionable to the actor when it is not understandable in layperson's terms.

William Skidmore (1979:128) notes that the Durkheimian value system is shared by participants in structured social action and gives coherence, form and shape to all such action. This does not say that people have to think alike to accomplish social coordination, but it does suggest "...that people must share in an organised stable pattern of values so that one person can have reasonable expectations about the other person's behaviour" (1979:128).

In this way consciousness is merely an internalisation of external facts which do not require active participation to render the world meaningful. Any interaction which takes place does so by sacrificing voluntary control for the benefits of common belief and sentiments. By extrapolation, consciousness in Durkheimian terms is not an intersubjective process - it is a collective process which functions in a consensual way by upholding common values.

It will be indicated later in chapter 2 of this thesis, that human action within this collectivity is not negotiatory and participatory in the ongoing terms of humanist intersubjectivity, but is confined to certain limits only, within which limits the individual desire has free range. In Durkheimian theory, unity takes place in terms of a shared consciousness, whilst for the humanist, unity can only

exist in terms of a dialogue between opposing standpoints, which does not threaten, but rather invites participatory negotiation and a choice of unified action. Action is of primary interest to another systems theorist, Talcott Parsons, and it is to his work that we now turn.

1.2.3 Parsonian action theory

The second major theorist whose work is characteristic of the consensus approach within sociology is Talcott Parsons. Arguing to elaborate and systematise the consensual framework, Parsons by introducing functional prerequisites to his analysis of social systems, maintains that for any system to operate, both social organisation and the personality needs of the members of society should be addressed. According to Skidmore (1979) prerequisites "...entail a series of choices on the part of the actor" (1979:148) which are directed towards social objects. The actor must choose between certain pattern variables which are directly related to the social system and link together abstract aspects and individual voluntary action within that particular system. Initially this argument sounds somewhat humanistic, but as will be shown, Parsonian addressal of these needs still seems to revolve around the functional/consensual prerequisites of the system and are therefore not unlike Durkheim's theory.

Intersubjectivity exists only in the form of what may be called consensual overlap and this again restricts action to certain bounded limits within which people can act. In chapter 2 of this thesis it will be indicated that this so called freedom of choice does not take account of intersubjective humanist meaningmaking, but of equilibrium. This equilibrium is attained through a socialisation process which requires actors to interact in terms of the expectations of society. This type of interaction necessitates that people learn how to act through a process of sanctioning

/negative sanctioning and in this way, become committed to the societal value system.

The central mechanism of Parsons's grand theory is one of human action related to role and to pressures - which are largely given by society. Any choice of action in Parsonian terms is intrinsically linked to the upholding of the social structure, and the individual becomes socialised to make such choices only within the parameters of accepted societal norms and values. If socialisation is successful, the norms and values of society become internalised through interaction, and become part of the actor's consciousness to such an extent that George Ritzer (1983:196) argues: "...in pursuing their own interests, the actors are in fact serving the interests of the system as a whole...". It will be shown later that from a humanist perspective it may be argued that actors become passive and non-creative because the need for acceptance and gratification ensures that any social role they may choose to fulfil is fashioned by agreement on expectations (this point is further explored later in this chapter).

Even though Parsons advocates the need for an addressal of personality within his theory (in other words that people are not defined as mindless automatons and are therefore capable of deciding how to act), he does not really believe in free individual action (in humanist terms) because he thinks this would lead to chaos not order (1983:198). Rather he suggests that the sentiments of the people be sufficiently shared so as to maintain an ordered society and this alone provides for personality needs. This takes place as socialisation insidiously infiltrates the human consciousness in a pre-programmed, instead of thoughtprovoking fashion and this negates meaningmaking in terms of humanist intersubjective dialogical living. Although Parsons argues that interaction within the socialisation process does invite participation this thesis suggests that participation in these terms becomes severely limited by societal expectations of what particular roles involve.

Therefore this way of seeing interaction in no way addresses humanist intersubjectivity or the ongoing debate around the choices and alternatives invoked by the expectation of role. In the case of medicine this lack of intersubjective debate is clearly visible in the doctor-patient consultation. In this setting the communication which takes place can be identified as subjective rather than intersubjective. This point is taken up again in chapter 3 of this work.

Societal expectations denote the way in which the socialisation process functions. It can be defined as deterministic because it places emphasis upon equilibrium rather than on the active involvement of people. Furthermore this deterministic outlook promotes the idea that society is seen as external to human beings and, therefore, that society and social reality exist outside of human experience. It will be shown that in humanist terms nothing can be known outside of human experience: society as social reality can only become meaningful to people when it is experientially taken into human consciousness.

Therefore to suggest that Parsonian theory can be voluntaristic is not acceptable to the humanist thinker because to identify subjects as learners of norms and values, without allowance for the capacities of those subjects to intervene in the process of learning, is merely a form of determinism under the name of voluntarism. This ambiguity led Parsonian Grand Theory into methodological difficulties and in response to this, modern systems theorists have attempted to re-instate Parsons's role theory by addressing anew this problematic dilemma. One such theorist is Jeffrey Alexander and it is to his work that this study now briefly turns.

1.2.4 Systematised theory - the revival

Jeffrey Alexander (1989) takes up the debate between structure and human agency and by using the work of Parsons and Habermas, tries to

show that modern systems theory is not as "closed" as it once may have been. Arguing that there seems to be a Parsonian revival within sociology and that through the interest of various theorists who are not generally placed within the confines of the systems perspective, Alexander debates this revival in terms of its ability to make space for the phenomenological aspects of human meaning. In this regard he indicates that with the exception of the continuing strand of Marxist orthodoxy "...theory has become dramatically "Parsonised"...[in] every major branch - critical theory, systems theory, action theory, phenomenology - ...[noting that each has] absorbed some of Parsons's most important lessons" (1989:397).

Alexander notes that Parsonian theory emphasises the normative aspects of society by utilising an explanatory theory which postulates a high level of generality. And he locates Habermas's initial interest in Parsons to be his quest to unite the Parsonian focus on norms, with an understanding of the way in which pattern variables work within society. He shows that "...Habermas was attracted to the pattern variable schema [within Parsonian theory, and that he] revised it in a revealing way" (1989:399). Alexander indicates that Habermas:

> ...used the schema to complicate and differentiate the conceptual apparatus he had inherited from critical theory...[and] the pattern variables to reinstate the very dichotomy that Parsons had sought to avoid. Habermas claimed that affective neutrality, universalism and specificity were the principal norms of instrumental capitalist society; only in some postinstrumental society would the alternative pattern-variable choices come into being (1989:399).

Alexander suggests that Parsons had tried to rid his theory of the either/or choices of norms and interests by suggesting that they were in fact interpenetrating positions which could account for both the personality needs of people and the needs of society. And

he postulates that it was in the first instance this double-sided attitude within Parsons's theory which set the framework for Habermas's own theoretical development. He argues that due to Parsons's seeming insistence for the mere instrumental characteristics of structuring within the modern world, Habermas was prompted to "...turn Parsons's synthetic theory inside out" (1989:399), by also pointing to the communicative realm of human life.

Suggesting that Habermas takes up the stance that reciprocal interactions cannot be forged between social system demands and psychological needs, Alexander notes that the polarity of instrumental rationality versus human value does not merely melt away, but can actually be argued to become reestablished. He notes that in this way, Habermas uses Parsons to reflect the problems he himself sees in modern society. He says that Habermas:

> ...acknowledges that [Parsons] poses the crucial question of the relation between lifeworlds - worlds of experience and symbolic discourse - and system or structure. But...insists that Parsons...reduces symbolic experience to an instrumental reflection of impersonal "systems" life (1989:400).

Therefore, according to Alexander, Habermas reinstates the dichotomic aspects of Parsons's theory in order to graft onto it his own form of theorising (as will be shown in more detail in chapter 2 when Habermas's communication theory is read). But in doing so he incurs Alexander's criticism. Alexander says:

> Habermas's "critical Parsonianism" seems to me one-sided and wrong. He has drastically depersonalised the social system and overly moralised the lifeworlds of culture and experience. His theory finds answers...brilliantly...[but] in doing so Habermas has reintroduced the epistemological and ideological dichotomies of idealism (1989:400).

By this Alexander alludes to the fact that he himself disagrees with the way in which Habermas treats the symbolic realm of ideas being generated in discourse.

What is the source of Alexander's critique of Habermas's focus? The answer to this question appears to lie in the way in which Habermas defines rationality. Habermas argues that rationality is not mechanistic or already realised in the world as structured, and cannot therefore be "normatively ascribed" as Parsonian theory maintains. Rather, he argues, rationality has to be communicatively achieved through symbolic understanding. Only when communication involves understanding, can it be seen to imply a rational choice which embraces a view of the lifeworld. But Alexander argues that this focus on communicative interaction of Habermas's is overdrawn. Alexander says "It is true and not true at the same time" (1989:245). He argues that linguistically-structured worldviews cannot be reduced to mere humanly constructed interpretations because people continue to infuse values in terms of narrative traditions. And he notes that:

> ...deeply held conceptions of self, nature, society...continue to structure modern action in a relatively arbitrary way.... For rationality to develop it must be invested with cultural power....This is usually done by connecting rationality to the sacred centres of a modern society.... The relation between rationality and tradition is a complex problem....That the relation exists...points to a serious weakness not only in Habermas's account of contemporary society but also in his theory of communicative action itself (1989:245).

Alexander suggests therefore that where co-operation is achieved it can only be voluntary in the conditional sense because it is always mediated by <u>cultural constraints</u> which exist outside of people's conscious control. He argues that this situation arises because of

"... institutionally coercive processes that can never be completely superseded" (1989:247). Alexander seems therefore to indicate that the marriage of Parsonian systems theory and Habermas's communicative action theory, whilst it allows a description of social order which is richer and more complex, nevertheless upholds the original dichotomies within systems theory. In this way decisions are still taken in terms of systematised options and people's capacity for creative participation which function within the realms of "set" rather than totally "fluid" alternatives which are at all times unknown prior to communication taking place. In other words Alexander wishes to emphasise that communication takes place within structured settings.

In this thesis it is argued that Alexander's reading of Habermas's theory fails in humanist terms because participation, as Alexander defines it, is linked to a rationality which appears to flow from inherent pre-defined conditions within society (culture and traditional values), rather than to an intersubjective experiential framework. In Alexander's framework, action is linked to rigidified pre-existing conditions rather than to ongoing re-definition. It will be indicated later (in chapter 2), that Habermas's theory can instead be read to incorporate communicative action within the humanist framework of symbolic living, wherein human action becomes the springboard for discourse and debate. In chapter 2 it will be argued that Habermas presents the relationship between "structure" and "lifeworld" in a way which does not reduce symbolic experience to an instrumental reflection of impersonal systematised action. And it will be shown that by reading Habermas in this way the occlusion of symbolic experience (as Habermas defines it) results in a form of distorted intersubjective living. (See chapter 2 section 2.5.3).

1.2.5 Does systems theory provide for intersubjective living?

It seems quite clear that within systems theory the ideal of

intersubjective living (in humanist terms) becomes blurred - what might be termed, diminished in the light of systematised power relationships. People do make choices in terms of a "subjective" criterion, but such criteria relate to a restrictive framework of systematised options. As such, the choices taken can only be considered as "surface" choices (in terms of the humanist argument) because they do not involve the "real" choice mechanism of humanist intersubjectivity.

Seen in this way, the choices available to people are not actually open choices because they are made from amongst what might be called inflexible options. These options do not involve actors in the creation of their own social reality because choices are made from set alternatives which have been agreed upon by the system as a collectivity rather than in terms of the individuals who make the system up. There is almost an obligatory element at work here because (as was noted in section 1.2.3 above), human interaction within the system as it becomes more depersonalised and normative, requires the actor to address less and less personal options and to rely upon consensual rules and modes of action. In chapter 4 it will be shown that this is indeed the way in which the medical model functions within society. However, in answer to the question posed by this sub-section, "intersubjectivity" can only be located in what must be termed a consensual overlap. People negotiate and agree on a level which equates to a collective consciousness.

In terms of the humanist argument to be put forward later it will be indicated that this so called consensual overlap implies that people are alienated, because they take little autonomous responsibility for the choices they make. It will be suggested that humanism makes provision for a form of negotiation which in no way leads to fully common situational definitions. On the contrary, humanism argues that communication in the form of symbols, are merely starting points for the mediation of what particular symbols may mean to people. Later in this chapter the work of George Herbert Mead will draw this point out more fully (see section 1.4.2. to follow)

The next sociological model to be presented deals with the structuralist orientations of conflict theory.

1.3. CONFLICT THEORY

1.3.1 Introduction

The second major perspective within sociological theory identified by this thesis is that of conflict theory which can be said to focus on the tensions and contradictions within society. The conflict theorist is intent on finding out how power structures operate. If theorists are working from a Marxist standpoint, they will view the unequal access to the means of production as the main conflict causing element within the societal structure. In this respect, conflict is regarded as inherent within pre-socialist society and is defined by Karl Marx as primarily economic. This economic definition is intimately linked to the unequal access to the means of production and to the unequal distribution of scarce resources between classes in a particular society.

The Marxian analysis of class and social inequality related to the mode of production is one classification of inequality. Randall Collins notes in this respect that: "Some Marxist-influenced work is focused on issues of class and the political implications of economic power...[whilst]....Other work is properly dialectical..." (1983:327). For example the concepts status, race, sexually related divisions, and even role acquisition (see section 1.3.3.1), are areas of stratification which certain theorists choose to stress in opposition to class stratification. Although not directly related to economically determined class divisions, these stratifying concepts can still be power orientated and therefore be seen to address contradiction and conflict within society.

However, for the purposes of this study a brief consideration of conflict within society from a Marxist perspective is initially undertaken. Thereafter attention is directed to the work of

Ralf Dahrendorf in order to seek an alternative approach to power structures which do not rely for analysis upon unequal access to the means of production.

1.3.2 The Marxist view of conflict

Marx was not concerned with class relations as a thing - a given entity - but with class as a process of movement, change or development. Therefore, from a Marxist position, class is not a static phenomenon as it may be seen in the systems perspective, but a force acting through history in a way which helps to grasp the problems of social change. Class division understood as a social relationship and defined with reference to the means of production is thereby a constantly recurring process of both material production and social reproduction. This relationship is founded on the unequal distribution of the forces of production which give rise to two separate classes - the owners of the means of production and the workforce who own nothing but their labour power.

Class division identified as social relations to the means of production, reflect what can be termed the prior distribution of the means of production, and which maintain the respective positions of the groups that make them up. It is the dialectic tension between incompatible forces which brings forth conflictual contradictions within society. Therefore, class as a constantly reoccurring process reinforces exploitation of the wage-labourer by the capitalist owners. Although in one sense this dialectic tension does not take place within an overtly coercive atmosphere - because it is based upon what might be called a freely entered into contract - it does occur within definite forms of social consciousness.

Marx's insight in this regard can be seen to raise an important point with reference to medicine. Differentiation does enter into the doctor-patient relationship in the form of a doctor who is seen to have elitist knowledge and a patient who seems to be knowledgeless. Also there is what can be termed a freely entered

into contract - the doctor heals, the patient relinquishes responsibility for that healing. Later it will be shown that this type of situation can be seen to be somewhat coercive when considered in terms of elitist knowledge: the doctor uses science to back his claim of having the right answer to human illness.

Therefore the so called freedom of contract relates not to a freedom of individual consciousness because as intimated to above, it maintains the respective positions of opposing groups and therefore upholds the ideology inherent under capitalism (and medicine), rather than a freedom of liberation. Thereby, in Marxist theory, interaction can be seen to occur in the form of group interest. The Marxist answer to this conflictual situation lies in revolution to a socialist state which would manifest in a reorganisation of the mode of production. For the Marxist theorist this would constitute worthy social change.

In opposition to this idea it will be shown in chapter 2 section 2.5.1, that worthy social change for the humanist theorist can only come about through a true liberating freedom of consciousness. This means that the undialogical interaction of group interests is replaced by a dialogical interaction of individuals, leading to symbolic intersubjective worldconstruction and meaningmaking. In medicine this would indicate what Veronica Mckay (1990) terms a "status shift" (see page vi of the general introduction to this thesis) situation: the doctor and patient <u>both</u> share their knowledges. However, revolution in Marxist terms (to exchange one structural ideology for another - capitalism for socialism), is considered to be worthy change. In humanist terms this is merely one choice in a matrix of options and therefore of no more import than other alternatives. Even the term socialism (in humanist terms) is a negotiable concept, open to an ongoing re-negotiation. (This idea of negotiated concept is taken up again later in Chapter 3 with reference to the definition of the concept illness).

Norma Romm (1991:141) takes up this argument (discussing Habermas's distorted communication theory as distorted intersubjectivity, and

using as an example Marx's account of the institution of the free labour contract as an ideology operating within capitalist societies), notes that:

> ...the ideological or illusory character of the contract ...makes the object of conflict unrecognisable...[by] restricting communication...it thwarts public communication on the way in which...relationships are to be organised in society...because it predefines from the outset that such relationships are to be based on wage labor and that this is a fair arrangement.

The idea that Romm's argument is alluding to here is that ideology, in promoting negotiated group interests, restricts intersubjective communication because the terms of its relationships are already predefined in terms of wage labour as the right starting point to negotiate from. This in effect means that the platform on which the two conflictual classes meet is a closed arena where meaningmaking is framed by opposing material positions, not intersubjective meaningfulness.

In the writings of Marx it is often expressed that he sees the structures of pre-socialist society as impinging upon people's capacity for creativity. In Marx's terms, creativity is creative labour - the things which people produce through their physical labour. He argues that the development of the capitalist mode of production separates the means of production from labour and thereby forms opposing classes which are intimately based upon the mode of production. People's creative labour now becomes the means by which the capitalist mode of production is upheld. Marx notes that:

> ...the law of development of the capitalist mode of production, is to separate the means of production increasingly from labour, and to concentrate the scattered means of production

> more and more into large aggregates, thereby transforming labour into wage-labour and the means of production into capital (in Thompson and Tunstall, 1979:245).

Marx argued that as the capitalist mode of production advanced, the needs of new markets forced the corporate guilds to vanish in the wake of machinery which, whilst it revolutionised industrial production, robbed the workpeople of their ability to creatively produce. In this respect Marx notes that "...owing to the extensive use of machinery and to division of labour, the work of the proletarians has lost all individual character...all charm for the workman. He becomes an appendage of the machine..." (in Thompson and Tunstall, 1979:241). Marx argued that the bourgeoisie reduce the ties which once bound man to hearth, home and community, to what he calls the ever callous "cash payment". He notes that:

> It has resolved personal worth into exchange value and, in place of the numberless indefeasible chartered freedoms, has set up that single, unconscionable freedom - free trade. In one word, for exploitation, veiled by religious and political illusions. It has substituted naked, shameless, direct, brutal exploitation (in Thompson and Tunstall, 1979:239).

By indicating that as world markets grew the wants of people change and could no longer be satisfied by the productions of their own country, Marx notes that: "In place of the old local and national seclusion and self-sufficiency we have intercourse in every direction..." (in Thompson and Tunstall, 1979:240). He notes that the bourgeoisie, in order to keep pace with the growing world market, agglomerated the population and more and more centralised the means of production which in turn led to a centralisation of political interests.

Free competition on a world scale developed production forces which in terms of class interests saw the bourgeoisie became a class of capital accumulators, and the proletariat a class of labourers whose only means of survival was reliant upon their finding work or labour

which increased capital for the bourgeoisie. As a class of wage-labourers, the proletariat became tied to a system from which they could not extract themselves (to a condition which restricts the worker to a level of mere subsistence and maintenance). In this way it could be argued that in terms of the proletariat their interest was to overthrow the capitalist mode of production - to try to free themselves from the capitalist "structures" of domination. And in terms of the opposing class (the bourgeoisie) Marx argued that their interest was to maintain the "status quo" (the capitalist structures) in order to continue to extract surplus value.

As noted earlier, whilst the use of machinery advanced the amount of goods produced, the proletariat class became concentrated in greater masses and their class identity and strength became their weapon against the ever unceasing increase and improvement of machinery which made their livelihood precarious. Marx notes that the workers' answer to this precariousness was to form trade unions. He says: "Thereupon the workers begin to form combinations against the bourgeois; they club together in order to keep up the rate of wages; they found permanent associations..."(in Thompson and Tunstall, 1979:242).

Therefore, within Marxist theory, it can be argued that the human potential for creativity becomes intrinsically tied to what Marx considers are the immovable structures of capitalist society within which the two classes act each in accordance with their own interests. Human potential therein, relates to a form of group class consciousness whereby people's capacity to act, in the words of George Ritzer (1983:91) becomes "...subverted as a result of the unanticipated consequences of capitalism". But, as will be shown, the Marxist focus on this subversion detracts in humanist terms from the real issues involved. Humanism argues that Marxist theory is robbed of creative intersubjective meaningmaking for the reasons now put forward.

This so called "robbery" in the terms of this thesis, can be seen to operate on three fronts which present oppositionally to the way in which Marx considers people's creative involvement within social

reality. For Marx, the involvement of people is intimately tied to their creative ability to labour and this labour is in turn placed within an exploitative economic framework which functions upon the relations of domination. As noted above the proletariat have to use their labour power to uphold and develop the capitalist mode of production if they are to survive. Their only redress towards the inequality of this insidious situation lies in group action.

The first criticism which humanism can be seen to point to is the idea that creativity is bound by creative labour. It will be shown in chapter 2 that for the humanist, creativity can only be experienced by people in the form of taking part - in other words within an interactional framework which involves the taking into account of others' ideas. Therefore, in the terms of this thesis, it is not labour which is the problematic within society - creativity in humanist terms is a much broader concept and throws open for consideration both the concept labour and creativity. Humanism argues that labour and creativity are symbolic entities which do not inhere one meaning - they are both only definable and understandable within the framework of a negotiated human participation (See section 1.4.2.3).

A second point of critique, from the humanist standpoint, is that Marx advocates that people's ability to creatively labour is tied to the class structures which operate within society. The humanist would again argue that these so called structures are not clear-cut, they are open to redefinition in terms of the meaning they may have for people and, therefore, again cannot inhere one meaning. The humanist argues that societal structures as structures of the self consciousness of people, are ongoingly created. Therefore in terms of humanist theory the structures within society are less important than the way in which they become defined.

Thirdly, whilst humanism would agree that the relations of domination pointed to by Marx is indeed intrusive, humanism would

argue that these relations are not problematic in the same way as presented by Marx. As noted earlier, for Marx the problem of domination lies in the fact that one class restricts the ability of the other class to labour creatively. In turn, this class domination upholds the unequal relations of the means of production. For the humanist the problem lies rather in the fact that domination suppresses the voices of actors and thereby prevents their creative participation within the fabric of social life in the form of offering alternative visions. This reading of the problem of domination is brought out by the neo-Marxist tradition later in chapter 2 section 2.5.3. It will be shown that Jürgen Habermas recognises the importance of domination, but links his critique not to material inequality or unequal distribution within society, but to what he sees as the most powerful lack of creative participation: domination in the form of a suppression of voices.

Therefore, in terms of Marxist theory, the freedom and individual capacity and ability to act is actually not brought to fruition. It melts into the dialectic contradictions of two opposing classes and takes on a form of group consciousness which loses intersubjectivity (as the humanist wishes to define it) in the process.

This study now moves on to discuss the work of the conflict theorist Ralf Dahrendorf. It is noted that whilst Dahrendorf is also interested in the dialectic tensions within society, he locates these tension not in the economic base related to the access to the means of production, but in the power inherent within certain economic roles within society.

1.3.3 Authoritative roles as power - Ralf Dahrendorf

Dahrendorf's work, like the work of most conflict theorists, was greatly influenced by the writings and theory of Marx. Therefore Dahrendorf's theory begins, as so many other writers on power, stratification or conflict do, with a critique of Marx and his

ideas. Writers in this field develop their own ideas from reading Marx and so have not only been influenced by the Marxian tradition, but have in the process drawn criticism from other writers for their interpretation thereof. Dahrendorf is no exception, but his argument in seeking to answer the following question is of interest to the argument developing here (1969:41):

> Do classes and class conflicts belong to that group of phenomena by which only the capitalist type of industrial society is characterised, or is their existence a consequence of industrial production itself, and are they therefore a lasting feature of industrial societies?

In looking for an answer to this question Dahrendorf postulates that a Janus faced dialectic (what he refers to as Janus headed) between conflict and consensus exists within society. It necessarily follows that from these two faces there will grow two different ways of interpreting social reality. Power and its use or misuse, are central to both conflict and consensus because on the one hand its application can achieve social integration, whilst on the other, a divided people or society.

The conflict face of Janus in relation to role interests us here and Dahrendorf sets the scene in this way:

> ...here it is not voluntary cooperation or general consensus (as with integration theory) but enforced constraint that makes social organisations cohere. In institutional terms, this means that in every social organisation some positions are entrusted with the right to exercise control over other positions in order to ensure effective coercion; in other words, that there is a differential distribution of power and authority. One of the central theses of this study consists in the assumption that this differential distribution of authority

> invariably becomes the determining factor of systematic social conflicts of a type that is germane to class conflicts ...(1969:165).

Dahrendorf asserts that the origin of class conflict should be sought in the arrangement of social roles which are either endowed with expectations of domination or subjection and furthermore, that it is the differentiation between these two types of positions which initiate social conflict. He works with Max Weber's definition of power as being the probability that one actor will be in a position to carry out his will despite resistance, and authority as the probability that a command with a given specific content will be obeyed by a given group. His main argument concerning these two concepts is that power is essentially tied to the personality of individuals and authority is always associated with social positions or roles (1969:166). It will be shown in a later chapter that the authority inherent within the doctor's role places patients into what Dahrendorf suggests is a role of subjection. This in no way allows for intersubjective meaningmaking within the doctor-patient relationship.

Because this thesis wishes to highlight the concept of conflict in society in opposition to Marxist theory, it is this aspect of authority relating to social roles which will interest us here. As indicated previously the Marxist theory of power, and thereby conflict, is located firmly in the camp of the haves within society relative to the economic structure, whereas the concept of conflict in Dahrendorf's terms states:

> ...that while power is merely a factual relation, authority is a legitimate relation of domination and subjection...authority can [thus] be described as legitimate power (1969:166).

1.3.3.1 <u>The structural relations of power</u>

Dahrendorf is now able to argue that group conflicts rest with the

fact that they are not the product of structural relations of power, but appear whenever and wherever power and authority are exercised, and he locates the concept of conflict in imperatively coordinated associations (ICAs) which he states are institutions governed by relations of authority. It will be argued in a later chapter within this thesis that the institution of medicine is just such a case in point. (See chapter three sections 3.3.2, 3.3.3).

Here it will be indicated that the scientific medical profession can be seen in terms of a conflictual relationship (in humanist terms) when the doctor invokes the power and authority seen as inherent within the professional role. Dahrendorf argues that: "... authority, is a type of social relation present in every conceivable social organisation" (1969:168), and that ICA's relate to structures of coercion and constraint which generate conflicts of interest and therefore become the birthplace of conflict groups.

Dahrendorf maintains that authority is a universal element of social structure and that such relations of authority can be found wherever there are people whose actions are the subject of legitimate and sanctioned prescriptions. These prescriptions therefore "... originate outside [of] them but within [the] social structure" (1969:168). Two groups are therefore identifiable, those who exercise authority and those who are subject to it. Each of these two groups has certain interests: one group aims to keep its authority, and the other aims to readdress its subordinate position.

1.3.3.2 Authority as occupied role position

However, these two identified groups cannot merely be defined as haves and have-nots as in Marxist theory. And here Dahrendorf argues that authority also has two faces - the plus-side and the minus-side. What he means is that authority is actually located in

the particular role position a person occupies and as such "...the domination in one association does not necessarily involve domination in all others to which (a person) belongs" (1969:171). By this Dahrendorf is suggesting that in a democratic state the same person can occupy a position of subordination in one setting and a position of power in another. He states:

> ... a cabinet minister may be, in his church, a mere member, i.e., subject to the authority of others. ... the set of roles associated with an individual...do not usually present an unambiguously dichotomic authority structure...within every ICA in any given society.... There is a distinction of aggregates of those who dominate and those who are subjected... [with] total societies [presenting] the picture of a plurality of competing dominant [and, conversely, subjected] aggregates (1969:171,172).

1.3.3.3 The power position re-directed

However, the occupants of positions of domination and the occupants of positions of subjection hold by virtue of these positions, certain interests which appear not immediately unlike the Marxist theory of power (two opposing interest groups seeking either to overthrow or preserve the status quo). What has happened is that it is now not exactly the owners of property - as it was in the historically specific period in which Marx was writing - but rather people who fill specific roles within organisations or associations who have power. Their power relates not to their ownership of an organisation, but rather to their position within the system which lies in its [the organisation] continuance if they are to retain their own power within it.

Dahrendorf argues that by furthering the interests of the organisation, an authority is exercised which exists as an expectation independent of the specific person occupying the

position. And furthermore, that this places a restriction upon the chances of the occupants of positions of subjection to upward mobility. It is noted in chapter 4 section 4.2.3, that this restriction can be seen to be operational within medicine if the doctor is unwilling to share scientific knowledge with patients.

1.3.3.4 Class conflict as authority differentials

In submitting a model of class conflict which is defined in terms of authority differentials, Dahrendorf offers a theory which is unlike Marxian theory in two ways. Firstly it does not relate directly to the unequal distribution of wealth but rather to the inequality of power inherent within certain roles, and secondly it is not historically specific.

Some roles offer a domination of position in relation to the amount of authority they afford, others subjection - a lack of authority or power. The domination roles which people occupy in ICA's are, in most cases, pressed upon them and this means that they are exercising power not from a position of economic superiority - as with the bourgeois in Marxist theory - but from what might be called a once removed position which at one and the same time protects both the organised system and the interests of the role encumbent. Conflict occurs when those in positions of subjection - who want more authority - and those in positions of domination - who wish to preserve both their own position and therefore the status quo - meet.

The protection aspect of Dahrendorf's theory is also of interest for the institution of medicine. It will be argued later that doctors protect their professional status by projecting a professional attitude which denotes a closed interactional system to the patient. Conflict may occur when patients require a more open arena for negotiation of illness or diagnosis.

1.3.3.5 Authority differentials and humanism

For interests to relate to **position** and not to human endeavour for dialogical living, the humanist ideal of participation and the belief that social reality is rooted in the experience of participants, is non-existent in Dahrendorf's theory. To protect interests, position occupants develop within groups - trade unionism is a case in point - and thereby exchange individual freedom for the agreed upon interests of the group. Dahrendorf notes this point in this way:

> A... prerequisite of effective conflict regulation is the organisation of interest groups. ...in order for effective regulation to be possible, the opposing parties in [societal conflict] have to agree on certain formal rules of the game that provide the framework of their relations. ...these rules normally protect the survival of both parties... [and] introduce some predictability into their actions. [They] ...protect third parties from undue harm...(1969:226).

When these certain formal rules of the game are no longer effective the services of an impartial arbitrator become necessary. The arbitrator's decision on the negotiation in hand is final and this, not surprisingly, can be the seat of a problematic in conflict regulation because it relates directly to the issue of power and authority which Dahrendorf, in the terms of his theory, can do little to rectify.

However, as noted in the general introduction to this thesis, Habermas's communication theory argues that power and authority within society need be seen in terms of a restriction of communicative rationality rather than structural or role differentials. Therefore, he refutes the idea that power is inherent in either structures within society or role position, by arguing that human social reality cannot be found in an external existence outside of the knowing processes of human beings.

In this chapter Habermas's theory is utilised to suggest a neo-Marxist argument which roots power within society in symmetrical communication. Later, in chapter 2 section 2.5.3, this same theory will be used to account for the way in which communication can become distorted by certain power media operational within society - a distortion which may be classified as distorted intersubjectivity. Habermas's theory may thus be linked with the humanist tradition in this respect. At present however, a brief examination of Habermas's neo-Marxist argument is proffered.

1.3.4 Habermas and the power of communication in human action

Habermas defines his theory in relation to the Frankfurt School of contemporary critical theorists, whose efforts Romm notes "...were directed at examining the possibility of instilling a critical social consciousness within society" (1991:133). This critical theory Habermas proposes in opposition to:

> Traditional theory [which] designates the model... dominant ever since Descartes, of a closed system of statements constructed according to logical rules, while critical theory is governed by an interest in rational conditions...(1982:45).

As was noted earlier in section 1.3.3.5, Habermas argues for what he calls a communicative rationality, as opposed to the closed system located within pregiven "logical" rules. A rationality which is chosen by people in accordance with their interests and made possible by humankind's ability to use language as the basis of its capacity for rational actions couched in understanding. For Habermas, this ability is expressed in communicative action which is oriented towards a shared understanding. Shared understanding, in Habermas's terms, can only mean a public arena which thrives upon communicative discourse.

In this respect Arie Brand (1990) notes: "Thus in communicative action the coordination of action is not based on an a priori normative consensus...but on the participants own fallible accomplishments of reaching understanding" (1990:16). In this way it is apparent that shared understanding in no way assumes a consensual understanding, but takes up the possibility for different implications for action. Such implications have to do with what Habermas terms the speech act, and it is to this area of Habermas's theory that we now turn.

Habermas argues that there are three elements which link together to form the coordination of action implied by communicative action, and he notes that a listener reacts to what he calls a speech act in one of these ways. Dependent upon the understanding of a communicated message, a yes or no position will lead either to a conventional action or to a discourse in which speaker and listener can change position. Brand's (1990) explanation of what Habermas means by this suggests that understanding of meaning is invariably linked not only to the communicated message itself but to people's knowledge of what lies behind what is said. In this respect Brand notes that: "...it is...the fact that this [communicated message] can be warranted which makes the listener understand the request and which rationally motivates...[them] to follow it up (1990:28).

The speech act therefore allows for a shared negotiated understanding which then leads to action. This means that people are called upon to make judgements in relation to their own understanding of a situation rather than in accordance with stereotypical reasoning. Habermas argues in defence of his version of interpretive understanding in this way:

> A hearer knows the content of what is said when he knows what reasons...the speaker would give for the validity of his speech act. But reasons are of a special nature. They can always be

> expanded into arguments which we then understand only when we recapitulate...them in the light of some standards of rationality....The interpretative reconstruction of reasons makes it necessary...for us to place their standards in relation to ours, so that in the case of contradiction we either revise or relativise...we cannot understand reasons without at least implicitly evaluating them (1990:32).

Habermas's argument is very much linked to a participatory element which manifests in a dialogue in which different or opposing insights on reality are exchanged within communication. Reality as such does not exist in law-like regulations or structures which are communicated to people through language. Nor does reality exist outside of people's understanding because as we have seen, understanding is intimately linked to the participatory elements in communication. These participatory elements are in turn linked to rationality and claims of validity. Therefore rationality for Habermas refers to what he sees as a more genuine dialogical relationship. Power within society is focused upon the suppressions of speech as embodied in language and interaction, wherein not all voices have symmetrical input. Romm notes Habermas's insistence that:

> ...when undertaking social theorising with the intention of recovering the potential for reason in society, the task is clearly not a solely theoretical one. The very act of theorising expressly embodies the particular goal with which the theorist identifies. [This goal in Habermas's terms is] the goal of generating a social community of undistorted communication (1991:135).

Therefore Habermas's theory of communication points to the power within society as stemming from the restriction of discursive elements contained in communication. Later it will be shown that it is this discursive element which, in Habermas's terms, allows for human emancipation.

Power does not lie in external structures within society nor does it manifest in the form of opposing groups (orthodox Marxism) or role position (Dahrendorf), but within the revolutionary power inherent in an emancipated expression/communication. This is why Romm notes that "...the motor of human emancipation... [does] not rest in history...but solely in the potentialities possessed by human beings themselves" (1991:133).

Now the question must be asked as to whether or not conflict theory can successfully address intersubjectivity in humanist terms, and it is to this question that this chapter now turns.

1.3.5 Does conflict theory provide for intersubjective living?

It was shown that in the terms of Marxist theory human potential to interact is characterised by a focus on structures, of for instance capitalist society, within which the two classes of actors (the bourgeoisie and the proletariat) interact in accordance with own interests. As was noted in section 1.3.2 these interests relate to the relationship between the two opposing classes and the mode of production. In identifying two major classes Marx argues that there is an inherent antagonism within their specific interests. Section 1.3.2 points out that groups do interact and negotiate within the framework of their particular interests, for example the proletariat within the trade union movement. In this way interaction may take place within the confines of specific issues in terms of fighting over aspects such as wages, working conditions, worker satisfaction, etc., or the struggle for a new mode of production. But this type of interaction is not to be seen in terms of a humanist intersubjective relationship because true (humanistic) involvement cannot work in terms of actors who are determined by collective impulses.

In these terms, Marx can be argued to make human beings subjects only in so far as they are subjects within group identities which express material interests. This focus upon group interests does not allow for people to have alternative ways of conceiving interests or ways of responding to situations. This thesis argues

that seen in these terms people become tied to a group consciousness which in no way allows for humanist intersubjective living because the group interests, which are fundamentally tied to material interests, appear to exist almost separate from individual interest. This means that Marx seems to advocate that people can only think along the lines of the interests of their particular group or class and this way of conceptualising amounts to what is variously termed within this thesis as a lack or distortion of intersubjectivity.

When Marx speaks of the suppressions within society whereby people become constrained, he refers to the constraint imposed by the opposing class structures linked to the mode of production. For the humanist constraint becomes a problem when people's subjectivity is constrained to belong to a particular group. On the other hand intersubjectivity implies that there are subjects who are able to perceive reality in terms other than those which are prior identified - in other words identified in terms of the idea that one can posit that they have certain material interests. According to Romm (1991:140-141) one can argue that prior group interest, as opposed to intersubjective interest, restricts intersubjective communication because the terms of its relationship are already predefined in terms of wage labour as the right starting point to negotiate from. (This argument is expressed in Habermas's neo-Marxist focus on suppression of intersubjectivity.)

Thus the problem with the orthodox Marxist position is its excessive focus on the way in which meaningmaking is framed by opposing material interests rather than intersubjective lifeworld construction. This implies that people's intersubjectivity becomes confined to the closed arena of "interactions" in terms of identified material goals. In this way it is argued that Marx does not see structures as structures of consciousness but rather as structures in terms of economic material interests which constrain people. Thereby in the final analysis the inability of orthodox Marxism to take into account people's creative ability to enter into communicative discourse, highlights its failure to come to grips with intersubjectivity in terms of the humanist perspective.

In terms of Dahrendorf's argument the situation is very similar in that the role positions taken up within society determine in the first place how people think and how they start questioning. Actors are seen to negotiate and act only within the restricted arena of particular roles within society, or particular quasi groups. In humanist thinking this lack of provision for conscious exchange of viewpoints does not allow for a truly intersubjective ongoing process of dialogue, interpretation and negotiation, and therefore can be argued to be a form of materialism which rather than seeing viewpoints in terms of an expression of meaning, sees interpretation in the form of expressions relative to role position. On the other hand Habermas's theory of communicative rationality may be seen to pave the way for a truly humanist appreciation of what intersubjective living can mean. Habermas's theory can be read to indicate the idea of a speech act where dialogical consideration of viewpoints allows for humane interaction between participants.

In the next section of this chapter the work of two so defined humanist authors will be addressed in order to provide the traditional roots of humanist theory. In chapter 2 these so called traditional roots will be directed towards a more contemporary debate of humanism in order to indicate how, when social reality is seen in terms of an experiential participatory nature, the field of scientific medicine can be seen to become a more humane experience.

1.4. HUMANIST THEORY

1.4.1 Introduction

The main thrust of the humanist argument is characterised by the suggestion that human social reality is not a private world, but a world which is at one and the same time common to all and yet embraces an experiential area leading to different interpretation. This denotes the world of humans as unfinished, or incomplete and

points to the notion that humans have to actively and meaningfully create their own lifeworld. This is what Norma Romm (in Alant, 1990:17) means when she says:

> The actions of people...[are] meaningful to them...people themselves define their situation and act in certain ways in order to attain certain ends.

The way in which humans achieve meaning in their lifeworld is through interaction with other human beings, and this takes place via a dynamic process of negotiation involving a continuous and ongoing interpretation and mediation by all parties. Society therefore is not a static structure, but a flowing symbolic reality wherein people take account of things around them on the basis of the meanings they have for them. Through dialogue, meanings are negotiated and modified as people interact and try to make sense of reality.

Human social reality therefore, is a symbolic reality which functions intersubjectively and thereby allows for what can be termed "sameness" and "otherness". Two writers who have addressed this area of meaningful worldconstruction are George Herbert Mead and Alfred Schütz, and it is to their theories that this study now turns.

1.4.2 Symbolic interactionism - George Herbert Mead

1.4.2.1 Mead's view of human capacities

George Herbert Mead has long been recognised as the father figure within the field of Symbolic Interactionism. William Skidmore notes that Mead was not a sociologist but was a philosopher with an interest in social processes (1979:198). Nevertheless, we have come to associate his field of sociology as concerned with the human actor and his/her thoughts and conduct relevant to social action.

For Mead, the starting point to any investigation of the human being begins in the knowledge that people have the ability to think in

terms of concepts and thus to delay their responses to stimuli. This is the characteristic, in Mead's terms, which sets humans apart from animals: they have an intelligent mind which enables them to make choices. This ability to think as we shall see later - not only in first person terms but also abstractly - predisposes humans to the development of what Mead calls a self. People are the only beings who are:

> ...capable of being both subject and object, that is man can both undergo experience and be aware of this experience. If human beings are to anticipate the future, to plan their actions and to reflect on past conduct, they must be able to reflect on themselves, to look on themselves in the same way as they look upon any object. They must not only be aware of other things [including other people] which make up their environment, they must also possess some awareness of themselves as things in the same environment (1934:118-9).

The development of the human being from child to adult - from a creature who engages in imitation to one who possesses a self-consciousness which allows for thoughts in terms of the self as object - is intricately linked to Mead's ideas on the formation of the self. According to Mead humans can never reach full potential unless there is a healthy mix of the two components which he indicates form the self of every individual. These two components he calls the "Me" and the "I". A closer examination of the "Me" and "I" is now undertaken.

1.4.2.2 The formation and development of the self - the "Me" and "I"

Mead argues that the self is not inborn but is something which develops over time in interaction with others. David Hargreaves (in Blackledge and Hunt, 1985:238) states: "...the central idea...is that a person's self develops in relation to the reaction of other

people to the person...as they perceive other people reacting to them...". It will be shown that in this way the "Me" accommodates society's regulations whilst the "I" can be argued to offer unique reactions to societal stimuli. In relation to the argument to follow concerning the medical profession, this might be seen as a reason for the growth of alternative medicine as a reaction to the growth and dominance of scientific medicalisation (this point is developed further in Chapter 3).

In Mead's view the development of a consciousness of self is an essential part of the process of becoming a human being, and this becoming involves an intersubjective ability to place oneself in the position of others. Thereby people can appreciate the morality involved in different positions within society. H. Joas makes note of this point in this way:

> Mead's interest in a theory of intersubjectivity developed through his opposition, on the one hand, to considering individual egoism to be an innate characteristic of human beings and, on the other hand, to hypo-statisation of collectivities, which negated the individuality of the collectivities' members (1985:121).

Joas argues that it is only by accepting the practical implications inherent in Mead's concept of intersubjective living that people become able to distinguish between rationally guided common activity and selective self-gratification. Rational resolutions of moral problem-situations consist in taking into account and understanding all values which appear in a situation. Joas notes that: "This does not mean that one merely juxtaposes these values in relativistic fashion; rather, it means questioning...based on communication and cooperation" (1985:137). Therefore moral and ethical problems cannot be solved from a standpoint of either conviction or mere responsibility, but from an understanding and consideration of other selfs and other values through self-conscious reflection. (Chapter 5

considers what these ideas might mean for ethical decisions within the field of medicine).

Human interaction is not merely the acquiring of a socialised language, but a symbolic language which allows the individual to intersubjectively make meaning of social reality in different ways. Therefore, the self does not consist simply in the bare organisation of social attitudes. It is not a mere reflection of society but an intelligence which can contribute. The Meadian "Me" takes on the generalised attitudes within society and the "I" acts in novel ways towards these stimuli. Because people have this capacity to act in novel ways society is ever changing, always in a process of re-definition - what was noted earlier as the dialectic relationship between people and society, and what will later be referred to as an intersubjective dialogue between tradition and novelty.

1.4.2.3 Symbolic reality

To enter into intersubjective dialogue requires that people communicate with each other. In communicating, people share, define and re-interpret via what Mead terms symbol (language), and this means that people become actively involved in constructing and reconstructing the meaning patterns in their lives. It is a dynamic process of continuous interpretation and negotiation which denotes society as a symbolic reality. People take account of things around them on the basis of the meanings they ascribe to them, and through dialogue these meanings become modified as people interact. This means that symbolic reality is an intersubjective reality.

Mead's use of symbol as the corner stone of human living together points to the fact that people share in the process of assigning meanings. It is a social process, and therefore symbols evolve via communication in the social setting. Everyday life is produced by people acting together and producing their own roles and patterns of action. These roles and patterns are mediated in dialogue. For Mead

the use of language provides for rational conduct because it enables the consideration of options, thinking before acting and a consideration of the consequences of these actions. Mead notes this point in the following way:

> When we speak of the meaning of what we are doing we are making the response itself...the meaning is a stimulus for the preparation [to act]...[this] is what we call a reflective individual. That is the general mechanism of what we term thought, for in order that thought may exist there must be symbols, vocal gestures generally, which arouse in the individual himself the response which he is calling out in the other...(1934:72-73).

According to Hargreaves (1985:241) the choice of any action involves people taking account of what they believe to be an understanding of what others expect of them. This does not mean that actions only take place in accordance with this expectation (this would merely be fulfilling a role), but that actions take account of others' meanings. As will be noted later, Cornie Alant and Romm suggest that society as a symbolic structure cannot function without involving the consciousness of participating members of society and this suggests that meanings become mediated through the medium of language.

All symbols by implying provisional meaning form the starting point of human worldconstruction and meaningfulness. In this respect Michael Haralambos (1989:544) notes that: "...symbol does not simply stand for an object or event: it defines them in a particular way and indicates a response to them" . But this definition and response become mediated by reconsideration within the individual consciousness and the mediating factor involved is the intelligence, or, as Mead refers to intelligence, the Mind.

1.4.2.4 Mead and the human intellect

Self formation via the use of symbols is made possible because

people are able to think. Mead maintains that there can be no mental activity unless people live with others and develop a shared language in terms of which they can make choices, develop new meanings and re-consider old ones. Mental activity, like the formation of the self, is not an individual function, but rather a social dimension which is dependent upon symbolic living and the social process. Therefore general expectations associated with position may be interpreted differently. For example in the context of the institution of, say, the family, it can be argued that this institution seems to embody what we could call accepted modes of thought and conduct. But according to Mead, modes of thought and conduct which are not continually being questioned/scrutinised imply a rigid and unacceptable way of organising anything. Looking at the symbol mother within the family Mead would ask, what is a mother? And would answer that there is no fixed definition because this has to be defined and renegotiated in specific contexts. In other words the symbol mother itself is not clear-cut because people's intellectual capacities provide for symbol interpretation and in this way the mind contributes to the social process. Thus there can be no one prescription for someone who bears children. The definition of who and how the caring and rearing will be organised is always open to debate. Therefore the general expectations associated with certain positions may be interpreted differently.

When a symbol is introduced there appears a mix of possible definitions based on different people's viewpoints as to what this symbol conjures up. The term mother as a symbol forms a basis for communication and debate between people who share some understanding when the symbol is invoked. Mead thus allows for people's differences concerning their understanding of symbols and in the light of these differences, suggest that people will often revise their our own way of thinking to accommodate new meanings.

This way of understanding symbols through the intellect's ability to participate can also be applied to the work of other writers. Karl Marx's definition of worker or socialism thereby does not inhere one meaning, but is open to human interpretation of what these terms mean because all symbols are open to re-definition through negotiation and revision. In these terms Marx's definition of the worker as one who has no access to the means of production conflicts in Dahrendorf's terms with the worker as someone who holds a particular role/authority position. Both workers are defined with regard to their position in a structure: in Marx's terms the owners or non owners of the means of production and in Dahrendorf's terms, in relation to their role of either dominant authority position or subjection.

Mead's view of symbol indicates that the symbol, once invoked, forms a basis for communication and debate between people. In other words, no term can have a clear-cut prescribed meaning outside of people's meaning structures. Each symbol is open to question and renegotiation in specific contexts. (In chapter 4 of this thesis attention will be given in similar vein to the terms illness, diagnosis and treatment). However of import here is the need to recognise, as noted earlier, that: to live in what can be termed purely Meadian "Me" terms is not to experience human life to the full. It will be shown in the section to follow that in accordance with Alfred Schütz's theory, this way of experiencing life is to live in terms of what he calls typification. It is to Schütz's ideas that this thesis now turns.

1.4.3 Schützian social reality

Alfred Schütz's sociological orientation is that of phenomenology. Phenomenology is principally concerned with the study of interpersonal social interaction and with how this interpersonal social interaction becomes meaningful to social actors. This is what William Skidmore refers to as "...to discover what the participants

in social action think they are doing...what rules they follow and why" (1979:236). E. Cuff and G. Payne locate Schützian sociological interpretation firmly at the feet of the phenomenological philosophy of Edmund Husserl who advocated that human experience is linked to the ability to "...grasp the essence of the phenomena we perceive" (1984:152).

Therefore interpretative reality is for Schütz the key to the nature of humans and their social world. Schütz argues that the social world is experienced by people as common and shared. This world has the appearance of being a given, out there, organised, independent existence the knowledge of which human beings assimilate. But this world has to be interpreted and made sense of, and this people do through particular experiences thereof. M. Rogers (1983) notes that "...knowledge is a concern with experience...All knowledge presupposes not only acts of consciousness but also experience" (1983:13). The human world is assimilated into consciousness by what Schütz refers to as typifications which basically denote a common-sense knowledge of the world.

This common-sense knowledge of the world allows people to make practical assumptions about everyday activities, about how they should act and about how others may act in a given situation. This Schütz refers to as reciprocity. This is what Michael Barber terms the Schützian view of socialised intentionality (in Cuff & Payne, 1984:11), and what may be seen as merely another way of taking account of the intersubjective elements of a shared space and time. (Socialised intentionality refers to the common-sense shared aspects of social life - the knowledge of which allows for the practical assumptions mentioned above).

1.4.3.1 Schütz and intersubjectivity

Schütz explains his position with regard to intersubjectivity in

relation to common-sense knowledge and reciprocity in the following way. He argues that the world is intersubjective because "...we live in it as men among other men bound to them through common influence and work, understanding others and being understood by them" (1973:10). This understanding operates within what Schütz calls the historicity of culture and by this he means that any understanding we may realise is via a knowledge which encounters and involves our understanding of traditions and customs. The world we deal with today is instituted by human action "...our own and our fellow men's, contemporaries and predecessors" (1973:10). Schütz says that in this respect we need to take into account that this world is not a private world, that knowledge is not a private affair, but an intersubjective one which takes for granted intelligent fellow-men who either know the objects in the world or who in principle have access to such knowledge. Schütz says that people know this and take it for granted. They also know that same must mean something different to me and to any of my fellow-men. Schütz explains the argument noted above in this way:

> My and my fellow-man's biographically determined situations and therewith our respective purposes...must differ, at least to a certain extent common-sense thinking overcomes the differences in individual perspectives resulting from these factors by two basic idealisations...the interchangeability of the standpoints: I take it for granted - and assume my fellow-man does the same - that if I change places with him so that his here becomes mine, I shall be at the same distance from things and see them with the same typicality... I take it for granted - and assume my fellow-man does the same - that the differences in perspectives originating in our unique biographical situations are irrelevant for the purpose at hand of either of us and that he and I, that "We" assume that both of us have selected and interpreted the actually or potentially

> common objects and their features in an identical manner...(1973:11-12).

In this way Schütz maintains that the section of the world taken-for-granted by us is also taken-for-granted by others. He argues that humans do not use the word "We" as "Us", to include only you and me, but to include everyone who is one of us, who shares our same situational world. Thus Schütz says the general thesis of reciprocal intersubjective living leads to objects being actually known by you and potentially known by me as the knowledge of everyone (1973:13). This does not imply consensus because whilst Schütz maintains that subjects do act in typification terms (taken-for-granted ways of action), he also argues that these typifications do not remain static, they are alterable because of biographical experience.

This is especially true within what Schütz terms the "We" relationship where he indicates that people do not always act in terms of anonymous typification. Therefore, typifications can be seen as starting points, which can be thought of as recipes for action, whilst remembering that revision is possible in the light of experience or on the basis of encounters/interaction. This idea is taken up again in chapter 4 section 4.4.4 in terms of the encounters/ interaction of patient and doctor.

1.4.3.2 The lifeworld - "We" and "They" relationships

As has been indicated above, Schütz believes the lifeworld encompasses certain taken-for-granted aspects which can in certain situations find people tending to act in habitual fashion if they fail to exercise the capacity to make and remake taken-for-granted actions. Within the lifeworld the difference in relationships has a bearing upon the taken-for-granted aspects of social life and Schütz categorises these relationships as "We" and "They". He argues that the pure "We" relationship is an intimate face to face interaction

where the two people involved enter into the consciousness of the other. On entering such a relationship people are initially armed with only typification knowledge, but as the interaction proceeds such typifications are re-written, revised, tested and modified.

Schütz maintains that people are more comfortable with the recipes they know and trust but when they encounter inappropriate thoughts and actions, they are forced to reflect and come up with a unique response. On the other hand "They" relationships are interactions between impersonal contemporaries and as such are dominated by anonymous typifications. What Schütz is saying here is that typifications rule the day in the "They" relationship because culturally taken-for-granted typifications can be more easily applied to impersonal contemporaries. Individuals can of course define their own interpretations of these anonymous typifications in unique ways.

But the idea that "They" relationships relate to impersonal contemporaries, according to Schütz, means that people work in ideal typical form which provides the common-sense practical knowledge necessary for everyday living.

Schütz argues that:

> Only a very small part of my knowledge of the world originates within my personal experience. The greater part is socially derived...socially distributed...my actual knowledge is merely the potential knowledge of my fellow-men and vice versa... (1973:13,14).

However by making this point Schütz also indicates ways in which people can impart their own personal experience. He argues therefore that both "We" and "They" relations are the stock of knowledge from which people organise their negotiational input. Therefore "We" and "They" relations can be classified as different levels of anonymity

which are negotiated in terms of an intersubjective interaction, but which for the most part become hidden under a a cloak of ideal typical common-sense knowledge of the world. Schütz states therefore, that typification and generalisation prevail within a linguistic in-group which exist "...in an open horizon of unexplored content" (1973:14).

By arguing in this way it can be seen that Schütz defines intersubjectivity as operating within social life in the form of both "We" and "They" typifications which realise this unexplored content as precisely people's ability to make an input into the taken-for-granted stock of knowledge. In this way it can be argued that Schütz implies "They" relations involve intersubjectivity in so far as people when making use of anonymous typifications still impart their own interpretation and appropriation. Whilst "We" relations are intersubjective to a greater degree because people's different subjectivities are brought into the interactional forum and negotiated meanings are arrived at in specific contexts. In this way people organise their negotiational input by utilising typifications as a starting point from which they impart personal meanings onto the shared stock of knowledge. People's subjectivity thereby comes into play within the interactional forum and involves a stock of knowledge which is ongoingly reinterpreted by the participants within the interactional process in order for them to make sense of the world.

Therefore, within Schütz's theory clearly the term intersubjectivity, as he explicitly uses it, is accounted for within the operation of the "We" and "They" relationships in social life. Here Schütz can be argued to concur with certain ideas in Mead's theory. Although Mead does not use the term intersubjective, by making provision within his theory for the operation of the "Me" and the "I", Mead does point to people's ability to make an input into the symbolic world of human meaningmaking. It can be argued that there is a clear connection between both models by the way in which people are seen to operate in terms of shared symbols onto which they are still able to impart their own definition.

Therein both authors within this section make provision in some way for the concept of intersubjectivity although Schütz does so in a more explicit way because he actually uses the term. In this way it is suggested that both Mead and Schütz can be argued to be humanist thinkers who provide a platform of humanist theory from which to search intersubjectivity within the work of contemporary humanist authors.

In the chapter to follow, the basis of the humanist tradition which has been developed within this chapter will be expanded through the work of variously defined contemporary humanist writers, and will be diversified in order to explore issues such as, choicemaking, responsibility, freedom, etc.

1.5 CONCLUSION

In this chapter the work of various authors within the systems, conflict and humanist tradition have been searched in order to build a narrative account of the humanist term intersubjectivity. The rationale for building a narrative account by searching intersubjectivity within systems theory, conflict theory and then humanist theory, lies in the wish of this thesis to highlight the radical ontology of humanism as opposed to other perspectives within sociology.

This means that the systems and conflict view of social reality was shown to relate to the structures of society. The humanist perspective (by defining Mead and Schütz as traditional humanist theorists) was shown to contest what can be termed external structures, in favour of an ontology which argues that people make sense of the world through a process of ongoing meaningconstruction. This ontology indicates that people's knowledge of the so called societal structures can only be known and understood when taken into consciousness. In other words when experienced through a participatory interaction which debates what meaning these structures may have for people.

1.5.1 Systems perspective

Within the systems perspective the work of Emile Durkheim, Talcott Parsons and Jeffrey Alexander was read. It was shown that intersubjectivity, in humanist terms, does not exist within this perspective. It was indicated that the interaction which does take place between people is seen as being of a collective nature, rather than intersubjective. This means that within systems theory little provision is made for people's creative and meaningful construction of a lifeworld (as the humanist wishes to define it). Individuals are free to make choices insofar as the dominant norms which uphold the system remain undisturbed, and furthermore, that roles are taken up in like respect. Therefore, there is a failure to address humanist intersubjective living because there is a tendency to see human interaction located within the collectivity of a consensually agreed upon system. Interaction therein can be termed one of consensual overlap.

1.5.2 Conflict perspective

Within the conflict perspective the work of Karl Marx, Ralf Dahrendorf and Jürgen Habermas was presented. Marxist theory was shown to relate to a class struggle which is based upon the material production of goods. The proletariate were argued to have only labour power at their disposal and were shown to stand in opposition to the bourgeoisie who have direct owner access to the means of production. The bourgeoisie therefore were shown to control both the mode of production and its inherent relations. It was argued that interaction between the two opposing classes derives from what can be termed a collective struggle. The bourgeoisie form a collectivity which is intent upon upholding the capitalist structures - in order to further their interest of excess capital. The proletariate form a collectivity through membership of trade unions - in order to promote amongst other things, the struggle and eventual overthrow of capitalist structures. In this respect it was argued that interaction takes place between the two opposing classes in the form of group interests, rather than intersubjective meaningmaking. In this way interaction was shown to relate to

group interests which were intimately tied to material interests rather than to the furthering of human discourse as advocated by the humanist tradition argued for within this thesis.

The work of Dahrendorf was shown to locate antagonism in society within two separate groups identified as either occupying positions of authority, domination or subjection, rather than opposing groups linked to material interests as in the case of Marxist theory. In terms of Dahrendorf's theory it was argued that, for interests to relate merely to group or individual role position and not to a human endeavour for dialogical living, forced his argument into the realms of group negotiation. Such a position fails in humanist terms to locate intersubjectivity because interaction takes place between role occupants in terms of role position of either domination or subjection. It was indicated in this respect that power based upon role prescription cannot provide the freedom and liberating effect argued for by this thesis.

Finally the theory of Jürgen Habermas was utilised to lay a foundation for the humanist perspective to follow. Habermas's theory was shown to relate not to specific structural elements but to communication in terms of a conscious rationality. Therefore an indication was given that, in Habermas's terms, power does not lie in either orthodox Marxist or Dahrendorf structures or roles, but in the potentialities of people to communicate.

1.5.3 Humanist perspective

Within the humanist perspective the work of George Herbert Mead and Alfred Schütz was read in order to lay the theoretical foundations for chapter 2 of this thesis which will search the term intersubjectivity within the work of various (broadly defined) contemporary humanist authors. In this chapter Mead's theory of symbolic interactionism was shown to denote the way in which humans interact, both with each other and with society, through the

development of a self. It was indicated that Mead argues that the self is not inborn but is something which develops over time in interaction with others. Mead's theory shows that the development of a consciousness of self is an essential part of the process of becoming a human being, and this becoming was noted to involve an intersubjective ability to place oneself in the position of others through the simultaneous interactions of the "Me" and the "I".

Alfred Schütz's theory of social typification was shown to indicated how Mead's theory of symbolic interactionism might be seen in terms an of operational theory. It was noted, that although Mead does not specifically use the term intersubjectivity (whilst Schütz does), these two theories could be argued to be humanistic because both theorists make provision for people to input their own meanings into the world. In this way people take up the shared aspects of social life through the initial recognition of symbols - common typified meanings according to Schütz's theory - and then use their uniquely human intelligence to inject new meanings into the social matrix. This was shown to indicate that human life is continuously evolving as people interact together in order to make sense of social reality.

This thesis now moves on to Chapter 2, where the foundations to the humanist tradition laid above will be built upon in order to indicate what intersubjective and meaningful worldconstruction means for the contemporary humanist. In this way a comprehensive framework is built in order to research scientific medicine in humanist terms.

CHAPTER 2

MAIN ISSUES IN THE CONTEMPORARY HUMANIST USAGE OF INTERSUBJECTIVITY

2.1 INTRODUCTION

Within the humanist tradition the basic ontology of intersubjectivity offers a radically different conception of human living. Social reality is conceptualised in terms of symbols and symbolic meaningmaking which is seen to form the very "stuff" of society. This way of "seeing" presents a direct opposition to the systems and conflict perspectives because it allows for ongoing debate concerning the meaning symbols hold for people. Unlike the systems perspective which adheres to common norms and values, and role performance within predefined structures. Or the conflict perspective which defines in terms of materialist interests in relation to class or role occupancy. The humanist perspective argues that these concepts are not clear-cut. Concepts like role, norm, value and interest, are ongoingly re-defined within the social fabric: mediated by dialogical interaction which is intersubjective rather than subjective.

2.1.1 Society is meaningful

Symbolic living implies that to live dialogically is to accept "...that each party aims to understand the other party through the assumptions and experiences which they share, whilst at the same time allowing the other to have a different viewpoint" (Alant & Romm in Alant, 1990:49). Not only does this mean that people take cognisance of other viewpoints, but that they recognise the reflexive attributes necessary to make life meaningful. To be reflexive means to reconsider one's own ideas, as well as the ideas of others, in the light of different alternatives. Alvin Gouldner (1980) refers to reflexivity as the ability of humans to accept both

the "good" news and the "bad" news of alternative positions (in other words to be open to the consideration of other people's "visions").

In this way people remain open to ideas which initially seem hostile or which contradict their original standpoint. Human beings can and do dialogue both with others and with themselves, and this Gouldner notes is self-transforming in the sense that an open attitude to "bad" news (listening to information which runs counter to one's cherished standpoint), actually transforms one's very self. Human living therefore is not a private datum. On the contrary, it is very much a shared experience which depends upon not only "sharedness" but simultaneously upon "otherness" (a capacity to see the world in different ways), and reflexive confrontation. As Alfred Schütz (1973:490) has said:

> From the outset, we the actors on the social scene, experience the world we live in...not as a private but as an intersubjective one, that is, a world common to all of us, either actually given or potentially accessible to everyone.

This in Schützian terms is common-sense knowledge and by this he means that the categories by which we classify the world around us, reach agreement with fellow human beings and make sense of society through knowledge of the typifications operating within social reality. To say that people live in a shared world however does not mean that everything about social reality is completely the same for everyone. This would be far from the humanist argument. For the humanist, to possess self-consciousness means that not only do people have the capacity to take on common-sense knowledge, but they also have the capacity to be different, to make new meanings of old, to choose, to be innovative and in the final analysis to say no.

Cornie Alant and Norma Romm explain humanist intersubjectivity in this way:

> [to say that society]...is an intersubjective reality...means that human beings share a common understanding of the world, but that they also tend to experience this world in different ways: human life is characterised by sharedness (common understanding) as well as otherness (different interpretations) (in Alant, 1990:46).

Sharedness then is also simultaneously involved with differentness and these two areas of human living are intricately linked to the way in which humans perceive social reality within consciousness. To the humanist thinker the structures of human living can only exist in self-consciousness. This is not to wish away the fabric of social life, but rather to accept that the very fabric itself is only knowable to the human specie within human consciousness. As Alant and Romm further state:

> To really understand society one should, according to Mead, Schütz and especially Brown (1978), recognise society as a symbolic structure. Being a symbolic structure, social reality does not have any status when abstracted or isolated from the consciousness [constitutive facilities] of participating members of society (in Alant, 1990:47).

A closer look at what Richard Brown has to say about social reality will be undertaken later in this section, but for the time being this study takes up the important aspect of participation.

2.1.2 Human participation

Participation is the key to the humanist framework of social reality. Human living is participatory because, as indicated above, no one occupies a completely private world. All have the capacity via self-consciousness, to become creatively involved in the defining of the social world. To be otherwise is in humanist terms to be inhuman (alienated). Everyone has the capacity to take part

in the defining of their own, and others', experience of social reality. Because social reality is symbolic there can never be one right answer to anything, there can only be constant flux and re-formation. This is what is meant by the precarious nature of humanist social reality, or what Alant and Romm refer to as "...qualities of human existence...[which carry]...different interpretative possibilities while at the same time appearing to express shared qualities" (in Alant, 1990:47). There is then about human social reality an openness towards alternatives in the knowledge that negotiated arrangements can, and more than likely will, be changed. Therefore in humanist terms, today's answers can only provide tomorrow's questions.

2.1.3 Dialogical living

To live dialogically takes up the non-finality of human existence as Alant and Romm note:

> ...the conception of human reality as a hermeneutic circle...[which]...means that the human condition is never to be finalised but bears the trademark of incompleteness. To know what society is about one has to unravel how the structures of society appear in the minds of participants (in Alant, 1990:47).

The question need now be asked: how do people "unravel" the structures of society. According to the humanist thinker this takes place via a negotiation between tradition (the past) and novelty (the present) in the form of an ongoing debate. All individuals take part in this debate each to their own ability, and it is in the experiencing and taking part that the ideas of other individuals become part and parcel of our own ideas, to be considered and reconsidered (reflexivity) in the light of different alternatives. Therefore, human living is not a private enterprise. It is

intersubjective because even subjective knowledge is permeated by the knowledge, experience and participation we share with others.

The humanist argument in denoting social reality in terms of a hermeneutic circle defines the ongoing debate as precarious and never finalised. If people forget, or give up the ideal, that human social reality should be conceived of in this way, they live on the periphery of human life in a state of what various humanist authors refer to as alienation. It will be shown in the following section that Jean-Paul Sartre interprets a human social reality, in relation to a reality which does not allow for human involvement, as lacking in freedom in the true sense of the word.

In other words, if people do not take part in defining reality through their experience thereof, life takes on what could be called a straight-jacket type of existence which incarcerates the human consciousness. In this way when people accept the status quo without question, they are living an existence either in Schützian typified form or Meadian "Me" terms, and this means that they do not take account of the dialectic interplay between the lifeworld of people and society . In this way human potentialities become occluded and experiential participation in reality becomes confined to a form of "conformity" to external rules.

Sartre's concept of humanity is rooted in human freedom and this concept forms a core which is threaded through the arguments of various humanist thinkers. Sartre introduces human freedom into his theory in order to highlight the importance of participatory existence. Sartre's argument for human freedom is the substance of contemporary humanism and forms the bedrock for many later writers on the subject, all of whom recognise that if people are to live to their full potential they must experience and take part in the dialogical encounter which is human worldconstruction. The next section thus turns to Sartre's position.

2.2 FREEDOM - JEAN-PAUL SARTRE

Jean-Paul Sartre is an existential theorist who is particularly

interested in the human condition. This condition Sartre sees as problematic in as much as he notes people striving for goals which are not only never attained but are invariably what could be called un-definable. People are therefore called upon to invent themselves, to make choices, to take responsibility for those choices and thereby to bear the weight of freedom and the suffering and anguish that such freedom of choice invariably brings.

This means that in terms of Sartre's argument the concept of freedom is the essential starting point. In this way Sartre sets the scene for other theorists writing in humanism because he conceives of people as having to take part in social reality (even though he terms this painful), to achieve what he sees as a true human freedom. People have to interact and make choices and in so doing simultaneously and automatically have to accept responsibility for their choices.

Norman Green writes the following about freedom in Sartre's sense of the word:

> Such freedom is, apparently, difficult to bear...man must feel that he has acted rightly and yet has no reliable guide to right action....Escape from freedom, while not strictly possible because of its central role in human reality, is a constant temptation (1966:9).

2.2.1 Freedom as responsibility

How can one escape the responsibility to live? Only, one would suppose, by not taking up the responsibility to act. Sartre however (1973) makes it quite clear that rather than not act, people must act. He says:

> He is...nothing else but the sum of his actions, nothing else but what his life is...there is no reality except in action...(1973:41).

And thereafter reaffirms this belief by stating that existentialism cannot be a philosophy of quietism "...since it defines man by his action" (1973:41).

2.2.2 Sartre and intersubjectivity

Intersubjectivity is also an important part of Sartre's theory. Using the starting point of the subjectivity of the individual he chooses his point of departure as being that "...there cannot be any other truth than this, I think, therefore I am, which is the absolute truth of consciousness as it attains to itself" (1973:44). He argues that truth is attainable by all because it exists in one's immediate sense of one's self. Sartre's justification for this stance is that he sees this starting point alone as compatible with the dignity of people's very being. I am is the absolute truth of consciousness. It calls out a self-respect of true worth in that it sees people not as objects but as interacting subjects who unto themselves need to command self respect. Sartre does not speak here in individualistic terms, rather he defines his subjectivity for a standard of truth as not only one's own self, but those of others too. He states:

> Contrary to the philosophy of Descartes, contrary to that of Kant, when we say I think we are attaining to ourselves in the presence of the other, and we are just as certain of the other as we are of ourselves (1973:45).

Sartre goes on to state what now is obvious, namely that the other is indispensable to one's own existence and vise versa. He notes:

> Under these conditions, the intimate discovery of myself is at the same time the revelation of the other as a freedom which confronts mine....Thus at once we find ourselves in a world which is, let us say, that of "inter-subjectivity". It is in this world that man has to decide what he is and what others are (1973:45).

He further argues that this is not to say that there is any such thing as a universal human essence, rather he sees it as a universal human condition. And he sums up his argument on the points now covered in this way:

> In every purpose there is universality, in this sense that every purpose is comprehensible to every man. Not that this or that purpose defines man for ever but that it may be entertained again and again. There is always some way of understanding...in this sense we may say that there is a human universality, but it is not something given; it is being perpetually made. I make this universality in choosing myself; I also make it by understanding the purpose of any other man (1973:46,47).

2.2.3 Existence as participation

Taking the existentialist stance advocated by Sartre, i.e. that existence precedes essence and that there is no a priori, unavoidable, or instinctual human nature, Maurice Natanson (1973) argues that people are seen as defining themselves through the actions and deeds they perform. Seen in this way the self is the result of the choices it makes and at the same time is open to change and alteration. This being so the self <u>is</u> only in so far as it acts, and whether one desires it or not any choice within a situation involves not only oneself and others, but mankind in

general. What this means is that freedom of choice, with all its anguish in choosing is actually more painful, because it carries responsibility not only for oneself, but for others also. It is less painful not to choose but impossible not to do so because as already noted, the self can only exist at all in the act of choice. For Sartre the act of choice is one of total responsibility and total anguish. This is made more difficult in the knowledge that having chosen one's choice is not permanent because existence is in flight, and reconstruction is an ever present part of existence as long as one lives.

2.2.4 Sartre's relevance summarised

S. Stumpf notes that this dilemma in terms of human freedom prompts Sartre to state that "...from the realisation that we are limited to what is within the scope of our own wills....We cannot expect more from our existence than the finite probabilities it possesses" (1966:471). That people are finite, Sartre argues, brings forth an element of despair in human existence because as soon as one is conscious, one is aware that apart from essence there is nothingness, which Sartre notes "...lies coiled in the heart of being, like a worm" (1966:471). This so called worm nibbles away at the very being because one cannot find anything either inside or outside on which one can rely. Human freedom thereby becomes condemned to be free, to act, to make choices and to be responsible for them in the knowledge that there is nothing forcing from behind or luring into the future.

In Sartre's terms there is no determinism, and therefore no objective system of values to which one can simply submit without choice, and no built-in essence to determine our conduct. What one is is what one makes oneself and this making is dependent upon the "other". In this way people's experience of social reality becomes the definer of human action and interpretation and is dependent upon

a sharedness which takes the form of a recognition of the "other" as subject.

In this way Sartre emphasises the notion that existence is manifest in the fact that subjects as individuals are called upon to mediate and filter social reality in accordance with what Sartre deems is the realisation that "...if there is an other then I have an outside" (1966:20). He alludes to the idea that human beings have to take account of the "other" in their actions. And he points to the ego as the primary source through which interpretation and expectations of the "other", and of the decisions as to how to take account of the "other", become taken up in human consciousness. Sartre states:

> The other appears, looks at me and I find myself no longer a free subjective relation to an ideal possible state of myself. Instead I am constituted as an ego, as a character with certain objective characteristics. Whilst I am responsible for this "being-for-others" in the sense that it is constructed from my behaviour, I do not control it....The being for others is in fact a new dimension of my own being, my being-as-object (1966:20).

In this way Sartre suggests that the individual is social, not in the sense that people fit harmoniously into the collectivity, but in the sense that human reality for the individual is mediated through the other members of the collectivity. This mediation is focused upon experience and interpretation which, according to Sartre, is at one and the same time unpleasant and inevitable, and furthermore, is suggestive of people as products of their own actions and situations.

Alant and Romm also argue that "Social reality is understood to be rooted in the experience of participants...[and is] the method whereby the intersubjective experience of reality is established" (in Alant, 1990:50). The focus of this experiential nature is taken

up by Peter Berger in the form of a dialectic relationship. It is to this idea that this thesis now turns.

2.3 THE DIALECTIC RELATIONSHIP - PETER BERGER

Peter Berger introduces his theory of society as a dialectic phenomenon, by arguing that society is a product of people and people are products of society. He says: "It [society] has no other being except that which is bestowed upon it by human activity and consciousness. There can be no social reality apart from man" (in Berger P.L. & Luckmann T.,1976:13). According to Berger society was there before the individual was born and will be there long after that individual has died. It is the social processes which form individual into a person, provides identity, and makes it impossible for people to be defined apart from society. This idea can be seen to extend Sartre's notion of the inextricable nature of freedom, choice-making, responsibility and anguish: society and people are concomitant. The dialectic process of society is dependent on what Berger calls the "three moments", viz. externalisation, objectivation and internalisation. He states:

> Externalisation is the ongoing outpouring of human being into the world, both in the physical and the mental activity of men. Objectivations is the attainment by the products of this activity...of a reality that confronts its original producers as a facticity external to and other than themselves. Internalisation is the reappropriation by men of this same reality, transforming it once again from structures of the objective world into structures of the subjective consciousness (1976:4).

2.3.1 The three moments operational in society

What Berger is saying here is that humans externalise new meanings into the world, hear them as objectified meanings or structures and

internalise them into subjective consciousness as a facticity. This leads Berger to suggest that people are born into an unfinished world which they must finish, or fashion, for themselves - because the world is imperfectly programmed and remains open to definition and re-definition through the three moments. As such there is an instability, a precariousness, about the relationship between people and their world because it is in continuous flux. People construct cultures which are continuously in a process of being reproduced, and it is this continuous re-building which brings forth the inherent unstable character within human social reality. Berger states:

> The stuff out of which society and all its formations are made is human meanings externalised in human activity. The great societal hypostases [such as the family, the economy, the state, and so forth] are...the human activity that is their only underlying substance (1976:8).

Berger argues that people's externalising brings forth not only a world of one's own making, but a world which then seems to confront one as a facticity outside of oneself (out there). Once society and its culture is formed it takes on the appearance of a non-negotiable reality. In this way people form institutions which, once formed, confront the individual as powerful controlling elements.

Berger uses logical steps to set out his argument of how the socially constructed world may attain the status or character of objective reality. Some of the statements used to make this point are: "... [The] transformation of man's products into a world that not only derives from man, but that comes to confront him as a facticity outside of himself...". "Man invents a language and then finds that both his speaking and his thinking are dominated by its grammar" (1969:18).

2.3.2 Social institutions as objectified reality

What Berger is pointing out is that the values produced by us and objectified within social institutions, seem to take on a life or an identity of their own which fights off an intersubjective consciousness and leaves a reality which imposes itself upon the individual (Durkheim's sui generis has relevance here). A strange situation now exists, a situation whereby society and its people made institutions confront the human being as real, and in this respect Berger notes that "...society is commonly apprehended by man as virtually equivalent to the physical universe in its objective presence" (1976:20).

In this way any contravention of these (initially man made) values leads to a feeling of guilt - for people believe that they have to, or need to conform. Berger indicates that the socially constructed world must be continually mediated to, and actualised by, the individual because everyone experiences certain decisive cornerstones within everyday experience and conduct which require a personal addressal. He argues that:

> ...[there appears] to be a ready-made world that is simply there...to live in...[and on the other hand that]...man modifies it continually in the process of living in it...validation...must be undertaken by the individual...[because there is need for]...ongoing interaction with others who coinhabit this same socially constructed world (1976:7).

By suggesting that this dialectic relationship between social structure and psychological reality is the way in which human beings in specific situations intersubjectively experience themselves, Berger is able to argue that:

> A particular social structure generates certain socialisation processes that, in their turn, serve to shape certain socially recognised identities. In other words, society not only defines but shapes psychological reality...the relationship between the two...is dialectical rather than mechanistic, because the self, once formed, is ready in its turn to react upon the society that shaped it (1976:28).

2.3.3 Mead and Berger's theories join forces

In this way Berger coalesces with George Herbert Mead's argument in that the two way dialectical process, in acting back upon society via externalisation, is not merely a process of internalising cultural socialisation, but is at one and the same time a two way intermingling which makes and remakes meanings. Social reality for Berger, as for Mead, does not mean an objective reality because this immediately becomes fashioned by subjective mediation which humanists argue is intersubjective living. Humanism draws together this dialectic in the concept of dialogical living whereby humans take account of both sharedness and differentness, thereby maintaining that the same world can be seen in different ways.

Like many other theorists within the humanist perspective, the work of Richard Brown (1978) focuses upon different forms of thinking in society which he links to human reality as symbolic. Brown focuses upon a type of thinking which tries to reflect so called objective reality - this would be for him science. And, he focuses upon a type of thinking which tries to show how people attribute subjective meaning - this he terms art. It will be shown that for Brown subjective thinking which admits the importance of meaningmaking in society, and objective thinking which appears more scientific, are in fact theories of knowledge which can be seen in the same terms: as viewpoints which become negotiated through symbolic reality. It is to Brown's work that this thesis now turns.

2.4 COGNITIVE AESTHETICS - RICHARD BROWN

Richard Brown (1978) sets out to try to "bridge the gap" between objective and subjective conceptions of social reality by indicating that both scientific and artistic thinking within society are theories of symbolic knowledge which are open to negotiation within human consciousness. He attempts this by developing what he calls a conceptual vocabulary which at one and the same time accommodates the areas of objective (science) and subjective (art) in terms of what he calls cognitive aesthetics.

Brown utilises the term cognitive aesthetics to denote the idea that modes of thinking in society are always conceived of as an act, or faculty, which are symbolic. This means that both science and art become recognised as interpretations of reality. In the field of science this way of thinking is quite revolutionary because people tend to see science as what might be termed a true representation of reality. But Brown argues that science has to be seen as part of an intersubjective symbolic framework because it has to be interpreted to make any sense to people. When science is seen as providing a true reality, Brown suggests that people have forgotten the symbolic (and poetic) side of objective reality. In like manner he suggests that poetry is not merely a subjective pastime. Poetry too, seen in terms of Brown's cognitive aesthetics, becomes not subjective but intersubjective because it is part of a symbol system.

Brown (1978) argues that Sociology, as a form of poetry, can also be seen in terms of his cognitive aesthetics. He notes that some sociologists have tried to make sociology into a science, whilst others have attempted to make it into a discipline which is more subjective and therefore focuses upon people's subjectivity. But Brown argues that sociology is merely another form of thinking - another form of language within society - it itself is poetic, and this means that the grand division between objective and subjective in sociology is non-existent. It falls away within the terminology of Brown's conceptual vocabulary. (See section 2.4.3 for a fuller discussion.)

2.4.1 Science and art as a mode of thinking in society

Seen in these terms, it can be argued that scientific theories require aesthetic adequacy and so do works of art. If both are viewed as presenting knowledge which is rational, organised and therefore experienced meaningfully, then a cognitive aesthetics of knowledge undercuts both scientific and sensual absolutes. In this way Brown suggests that:

> ...for cognitive aesthetics, both science and art are rational...they both presuppose various criteria...such criteria are those by which we organise experience into formal structures of which knowing is constituted (1978:3).

In this way the presupposition that science itself constitutes a commitment to values and that the appreciation of art does not, becomes nonsense when evaluated in terms of Brown's aesthetic criteria of rationality. In arguing that there is no fundamental difference in the way in which science and art are empowered to articulate or inform the world, Brown focuses on ways in which symbolic form constructs reality:

> Just as science affects perceptual and cognitive transformations by changing our models of the world as a natural order, art similarly affects paradigm-induced expectations...(1978:24).

Because, in Brown's terms, both science and art are symbolic forms there is no reason to speak of internal versus external properties. Both are associated with feelings unique and particular. Both views transcend yet integrate symbolic realism despite their differences. At one and the same time there is agreement that all ways of knowing the world are both symbolic and perspectival because by implication, both science and art are symbolic forms that frame or create their

own domains of application. In arguing this point Brown suggests that the debate between science and art comes down to hard versus soft research techniques. In this regard he notes:

> Physical science...assumes a natural standpoint from which reality is strictly distinguished from the symbols that represent it. From this position the meaning of a word or expression is the thing or behaviour to which it refers. Statements that are true are those that correspond to objectively verified events or conditions out there. Statements which cannot be so verified are false, nonsensical or emotive (1978:25).

In these terms the part of communication that cannot be reduced to mathematics is declared subjective and hence epistemologically invalid. In chapter 3 it will be shown that certain thinkers do indeed argue that knowledge of history and the social world is uncertain if not impossible, because it can never be objective in the manner of mathematical physics. Humanism concurs that social reality is precarious (or uncertain), but not in terms of an objective verification. According to humanism the precariousness of social life is relative to its intimate dependence upon symbolic reality and this means that not even in mathematical terms can anything be known in concrete.

In opposition to this way of thinking - a social reality which can be verified - Brown argues that this kind of conceptualising forms what he calls a symbol cloak beneath which reality remains hidden and where personal meaning is pushed into the realms of symbolic and subjective (and thereby argued to be unworthy of any note), consigned, he says, to the field of poetry and viewed as nothing more than ingenious nonsense.

Applied to medicine, Brown's argument for a merging of science and art points to an ideal in which medical science and human intuition become one in the fabric of human meaningmaking. (This idea is taken further in Chapter 4 to follow.) In this way, with the fall of absolute distinction an opening is created which addresses

viewpoints that are at once scientific and humane and Brown argues that this means there can be be no one correct doctrine because each approach is reliant upon the other for completeness. The point which Brown is endeavouring to make is that rationality, as it operates within society, can be seen to involve a form of communicative rationality in the sense that there exists a communication between different viewpoints. In Brown's terms these viewpoints can come from either a scientific or a more romantic direction, and still be seen in terms of a symbolic negotiation alluding to a communicative rationality which embraces differing points of view.

2.4.2 Rationality and norms

Brown's use of rationality in terms of embodying different viewpoints can also be used to point to the way in which his view of norms within society do not have an exact ambiguous meaning. For Brown everything in society is at one and the same time poetic and scientific and therefore even norms are open to symbolic reinterpretation. This way of thinking has implications for the normative relationship between people because it highlights Brown's belief that norms have also to be interpreted and not just assimulated into consciousness. He notes:

> No longer...[should]...we search for the out there structure of reality but should ask, how is reality socially constructed? ...interaction becomes not the reciprocity of roles and norms or a situation where hapless actors serve as media of social forces, but instead a situated process of inference and interpretation...sharability is treated as a problematic feature for actors to create and realise (1978:19).

This in turn indicates that different viewpoints and ways of thinking in society, whether scientific or artistic, or involving norms and roles, are ongoingly open to people's symbolic reinterpretation. Therefore, roles and norms should not be conceived of as constraints (as for example in the systems approach), but rather as invitations for interpretation on what particular roles and norms mean for people. Language as poetry, therefore, is seen to encompass science, art, norms and roles in terms of Brown's

cognitive aesthetics. And, as symbolic, both the language of science and art (norms and roles) are rational in terms of an experiential participation and interpretation of the symbolic fabric of social reality. This in turn points to the idea that communication within society is also rational in the sense that it allows for an exchange of different viewpoints between ways of seeing social reality. (This can be seen to link with Habermas's conception of rationality as an exchange of viewpoints. See chapter 1 section 1.3.4.) Thus Brown indicates that by offering a theory which is seen to be symbolic and interpretative in all its forms, for example in normative structures for action and in all modes of thinking (science and art), his theory can be shown to take up and utilise the ideals of humanist intersubjective living.

2.4.3 Brown's view of sociology in terms of cognitive aesthetics

By suggesting that everything in social life is symbolic Brown can be seen to be offering a view of sociology which in his terms encapsulates the humanist argument. However, it would appear that he also wishes to draw attention to the idea that humanism as a form of sociology itself draws upon ways of "seeing" which have traditionally been called scientific. But humanist sociology can only encapsulate those ways of seeing by recognising that all sociological perspectives on reality, themselves have to be interpreted in a specific way. In other words, even though certain perspectives pose themselves as being scientific, for instance certain traditions within systems theory and Marxism, for Brown the fact that they pose as scientific is not sufficient grounds to call them scientific and thus objective.

What Brown is alluding to here is the idea that sociology as a form of meaningmaking amongst other forms of meaningmaking, should not be seen in terms of either objective or subjective representations of reality. He wishes to make the point that humanism, usually placed within the arts side of thinking in society and argued to embrace areas of intuition and emotion, for him is a sociological form of thinking in society which can at one and the same time encapsulate scientific, as well as intuitive, elements. Therefore, for Brown, the humanist argument which happens to focus upon how human

symbolic meaningmaking takes place in society, is neither totally scientific nor intuitive.

As was noted above in section 2.4.1, Brown's argument points to the idea that normative relations and roles within society do not exist independent of people's interpretation thereof. That science, art, norms and roles can all be seen as negotiational concepts within the social fabric of society, denote them as debatable entities which do not inhere one meaning or action and which are, therefore, open to what Cornie Alant refers to as intersubjective dialogue. It will be shown that Alant argues that social reality functions dialogically and that this dialogical concept, encompasses all people in an arena of intersubjective meaningmaking which allows for people's symbolic interpretation. In this way Brown's cognitive aesthetics in the form of a conceptual vocabulary is taken up and extended by Alant in the form of dialogical living. It is to Alant's theory that this thesis now turns.

2.5 INTERSUBJECTIVITY AS DIALOGUE - CORNIE ALANT

Cornie Alant states his position on dialogical living in this way:

> What dialogue reasoning actually does is to show effectively the paradoxicality of the world-taken-for-granted. The concepts of culture, value, and norm do not represent objectively specified truth in society as they are often thought to do; rather do they constitute primary vehicles of communication for the continuing dialogue on the content of social reality (1990:53).

In short this quotation of Alant's theoretical standpoint has encapsulated the spectrum of concepts inherent within the humanist perspective, save for one, that of freedom. (The issue of freedom was taken up earlier in section 2.2 of this chapter and is addressed by Alant in section 2.5.1 to follow.) In terms of the above quotation Alant argues that dialogical reasoning shows up the paradoxicality of the world-taken-for-granted because cultural values and norms are not objective truths, they are elements of our personal lifeworld which function in terms of negotiation.

So many times in this chapter has the idea of interpretative reality been alluded to. (For example, Mead's interrelationship between the "Me" and the "I", Berger's people as both product and producer of social reality, and Romm's sameness and otherness, etc.). This paradoxical situation becomes problematic for the humanist when the concepts of culture, value and norm present as so called objectified truths in society rather than negotiated symbols. How can these concepts relate to so called external truths if they are only knowable in consciousness?

2.5.1 Intersubjectivity as symbolic

It has been noted in this chapter that intersubjectivity is not a private individual experience - it operates socially. Meadian symbols are not defined individually. They rely upon social encounter for their meanings (see Chapter 1 section 1.4.2.3). "Rather, (symbols) constitute primary vehicles of communication for the continuing dialogue on the content of social reality" (Alant, 1990:53). This means that social reality is precarious, ever changing and open to redefinition. As Alant notes, socialisation is not merely the passing on of culture, or the mere choosing between past, future and present situations. It is:

> ...[A] process by means of which society constantly confirms and revises its own being; a process whereby the socialising agent also participates as socialisee, and the socialisee likewise fulfils the role of socialising agent...children are formed by their elders but the elders themselves are also formed by the children (1990:53).

Symbols, as traditional culture, in this way are continuously either reaffirmed or opened up to reconsideration and the bringing forth of new meanings. People create the world in which they live because they are creatively involved in its very definition. To suppress discourse within a dominant ideology or culture is (as shown in Chapter 1 section 1.4.2.4) to take on a life of moronic existence. Therefore as was noted in Brown's argument, interaction is not

merely the reciprocity of roles and norms but a process of interpretation and shareability (but not consensus). To live dialogically then accepts the taken-for-granted aspects of life whilst at the same time questioning its validity. Or, as Alant further states:

> The dialogue approach clearly recognises that truth does have a distinct fact, but that its face is never cast in concrete, and always remains human.... As a feature of human reality truth just as fact and validity is produced intersubjectively; it does not pertain to one or other formula [logical or otherwise] existing independently from consciousness....As a process truth is located in dialogue; as a structure, truth is always of a dialectical constitution (1990:10).

Seen in this way, people are free - free to choose from alternatives; free to accept tradition or to contribute to revising it; free to make such choices in the knowledge that others do the same; and furthermore in doing so, to acknowledge that others may have different perspectives on the situation. Alant's definition of freedom considers the concept in terms of a social phenomenon (i.e choice, redefinability in the light of alternative options, etc.), which become negated by the operation of power structures within society. As was noted in Chapter 1 section 1.3.4 Jürgen Habermas considers that power within society rests firmly within the communicative arena. It is to this idea that we now turn.

2.5.2 Power as a distorter of intersubjective living

Jürgen Habermas's argument, and indeed the argument of Michel Foucault (chapter 3 section 3.6.2), focus on the problem of power distortion. As noted, in Habermas's terms distortion can and often does cause a constraint in communication. In this respect Arie Brand (1990) who was mentioned earlier in Chapter 1 section 1.3.4, suggests that the "Steering media [of] money [as] power takes over the integrative role of language...in the field of action" (1990:54).

Brand explains this point by noting that the functional conditions of system reproduction in modern societies "...penetrate via money and power, into the lifeworld and destroy communicative processes..." (1990:54).

There is a reification of what Habermas calls the rational foundations of communicative action in the lifeworld which can result in blockages to truly communicate because people believe that a particular ideology is the only way to see things. Patrick Scambler (1986) in this respect makes note that:

> The lifeworld is seen in terms of communicative action [whereas], social systems are seen in terms of purposive-rational-action. These concepts of system and lifeworld, which are interrelated but cannot be reduced to one another, provide the key to Habermas's theory of social or cultural evolution (1986:171).

In terms of Habermas's theory, purposive-rational-action relates to communication in terms of strategic action, and this Habermas indicates is a communication which is orientated towards success. He explains strategic action in this way:

> Strategic action is judged along one particular dimension of rationality. It can be appraised from the standpoint of the efficiency of influencing the decisions of rational opponents (1982:264).

Medicine can be argued to fit into Habermas's framework of purposive-rational-action which is geared to success in terms of science. In this way communicative action does not incorporate emancipatory and discursive elements because it flows from a particular ideology: scientific proveability.

On the other hand the interests of communicative rationality are relative to emancipation as discursive, and Habermas argues that these interests are incorporated within what he calls the "critically oriented sciences" (1971a:308). Romm (1991) notes that:

> These are the sciences which focus specifically on criticising the given state of affairs in society in order to engender a society in which an unrestrained discursive communication can reign (1991:138).

In these terms, purposive action does not allow for emancipatory elements or for the possibility of reflection and Habermas argues that the social sciences have a part to play in bringing about a human freedom which rests firmly in what he calls the potentialities of people. By this Habermas alludes to the idea that critical theory needs to highlight this potential in the form of communicative discourse. And he further argues that by pointing to communicative discourse in terms of drawing out the potential inherent within the lifeworld of human beings, critical theory paves the way for people to be able to communicate in a truly discursive (emancipatory) fashion.

Habermas argues that in the current situation the social sciences (unless critical) have tended not to focus on communicative discourse. By indicating that there is indeed a different way of organising things which can make the social sciences more relevant and hence their input into society more appropriate for human enterprise, Habermas argues for a "genuinely emancipated society...in which individuals actively control their own lives" (1987:167).

On the other hand, if these emancipatory elements become blocked, there exists the possibility for what Habermas calls a distortion of communication which results, according to Romm (1991), in the "...conceal[ment] from members of society the fact that there is a possibility of reflecting upon, and reconsidering and subjecting to debate, particular existing social...[action]" (1991:135). This distortion of communication can manifest in the form of Brand's steering media (power and money [purposive-rational]), and thereby lead to a destruction of the lifeworld (in Habermas's terms). If this is to be prevented, Habermas argues that the social sciences

must focus on the potential of people for communicative rationality. When these "blockages" in communication patterns are addressed Romm indicates that:

> Habermas's dialectic approach in shifting emphasis from the theoretical and empirical to the realm of experience, can facilitate an experience wherein the subjects of society themselves come to utilise the theorectical hypotheses as a basis for their (self) emancipation (1991:144).

In this way Romm is able to allude to Habermas's suggestion that "...underlying the fact of distorted communication and the suppression of generalisable interests...is the potential for an alternative" (1991:134). There is a need to "...account for the interests underlying the logic of empirical scientific analyses - otherwise it will operate behind our backs and...control us" (1991:142). In line with this argument, Brand indicates that "...when we engage in communication to conduct a discourse... which is by its nature, a true discourse...(rather than) just a forced one or one which is proclaimed only for the sake of peace" (1990:20), reality does not operate behind our backs because it actually involves people in its definition - in true emancipatory communication. This means that in the process of discourse, different alternatives are addressed and negotiated and this Brand notes "...leads not to truth as might be expected in disputes concerning the objective world, but to rightness" (1990:20).

2.5.3 Distorted communication as distorted intersubjectivity

The main point, however, is that through the medium of distorted communication and the backing power of ideology, certain individuals gain power by impressing this ideology upon others and causing what Habermas calls a distortion of intersubjectivity. Ideology serves to make the symbolic network in society appear rigid. It attains this by stifling people's consciousness to such an extent that they

themselves do not think in any other categories. Whilst Habermas suggests that this takes place via a distortion in communication, Foucault argues that power distortion in the form of state intervention ensures that people internalise power ideologies, not through coercion, but through an infiltration of people's meaning patterns which allows them to forget that there are other ways of seeing the world and constructing reality. In this respect Foucault argues that the:

> ...effects of power circulate through progressive finer channels, gaining access to individuals themselves, to their bodies, their gestures, and all their daily actions (1980:77).

In other words power has an insidious mechanism. In chapter 3 section 3.6.2 of this study it will be noted that in particular Foucault suggests that in the medical field the effects of such power have been highly successful in fostering a medical ideology upon people which is both pervasive and impersonal. Therefore the effects of power upon the symbolic worldconstruction of human living becomes an effective block to intersubjective dialogue and to the ideal of Alant's concept of freedom.

But whatever the anguish, in seeking a humanistic sociology David Friedrichs argues its worth in relation to a human "...commitment which promotes the obliteration of demeaning and degrading dimensions of human existence" (in Alant, 1990:2-3). In these terms he suggests that humanistic relevance lies in its "[commitment] to studying the principal barriers to a fully realised human dignity, autonomy and equality..." (1990:2).

2.6 CONCLUSION

It has been proposed in this chapter that dialogical living purports to living a life of ongoing meaningmaking in the knowledge that if freedom is to be found at all (remembering Sartre's comments, even

this is open to debate), it lies not in the security of objective truths, but in the experiential nature of social reality. Social reality of this type is only located (in the terms of this thesis), through the intersubjective arena of a negotiated experience of the world.

In this way it was suggested that the humanist perspective presents a radically different ontology to that of the systems and conflict perspectives read in Chapter 1. The "difference" was explained by indicating that the symbolic nature of social reality implies that the concept of intersubjectivity relates to the way in which people make meaning in their lifeworld, rather than in a belief that reality can be located as an external entity. The arguments of various authors within the humanist tradition were used to highlight this radically different approach to human living.

Firstly the work of Jean-Paul Sartre was read and the concept of human freedom was shown to indicate that although it is painful to enter into the negotiatory interaction of human life, the human being has no other way open to him/her. It was shown that according to Sartre, to live means to enter into the dynamism of life and this in turn involves taking a co-responsibility for human decisionmaking and action, and at the same time accepting the anguish that this type of living presents.

The argument of Peter Berger was shown to suggest that whilst people do not live in a private world, a common world cannot become a consensual world because worldbuilding is actually about human beings having the freedom to make choices. Berger indicated that choicemaking and questioning form the basis of his theory of the dialectic, and this in turn was shown to imply that there can be no clear-cut norm for human beings to follow.

The theory of Richard Brown focussed on the issue of meaningful cognition and argued that people have to be involved in a form of cognitionmaking which encompasses all understanding. Brown's

argument for cognitive aesthetics was shown to bridge the so called objective and subjective areas of human social reality. It was noted that he suggests both objective and subjective ways of defining social reality (so called science and art) be seen as integral parts of the same continuum, and therefore, in terms of a meaningful experience within the consciousness of people.

The argument of Cornie Alant indicated how the theories of the various authors utilised within this chapter, can be seen to negate a mere subjective living in favour of a focus on the experiential participatory elements of symbolic reality in terms of intersubjectivity. In this respect Alant argued that subjectivity cannot exist in isolation outside of the human framework for worldconstruction, because in order to be meaningful, worldbuilding must take place intersubjectively through a process of dialogical living.

In the chapter to follow, the suggestion is made that the medical model hampers, rather than enhances, the symbolic essence of social reality argued for by this chapter in relation to health and illness.

CHAPTER 3

THE MECHANISTIC MEDICAL MODEL: THE ABSENCE OF INTERSUBJECTIVITY

3.1 INTRODUCTION

In this chapter the mechanistic medical model will be explored in an effort to highlight how the implementation of a purely biomedical model of health care has grown through scientific theories of reductionist medicine which today place the human being, not at the epicentre of responsibility for their bodily health, but at what would seem to be the periphery in sociological theory and medical sociology. Fritjof Capra's explanation of what this means for the treatment of illness cannot be bettered and is reproduced here in full:

> Through the history of Western science the development of biology has gone hand in hand with that of medicine. Naturally then, the mechanistic view of life, once firmly established in biology, has also dominated the attitudes of physicians toward health and illness. The influence of the Cartesian paradigm on medical thought resulted in the so called biomedical model, which constitutes the conceptual foundation of modern scientific medicine. The human body is regarded as a machine that can be analysed in terms of its parts; disease is seen as the malfunctioning of biological mechanisms which are studied from the point of view of cellular and molecular biology; the doctor's role is to intervene, either physically or chemically, to correct the malfunctioning of a specific mechanism. Three centuries after Descartes, the science of medicine is still based on the notion of the body as a machine, of disease as the consequence of breakdown of the machine, and of the doctor's task as repair of the machine.
>
> By concentrating on smaller and smaller fragments of the body, modern medicine often loses sight of the patient as a human

> being, and by reducing health to mechanical functioning, it is no longer able to deal with the phenomenon of healing...(1987:118).

In this respect Karl Figlio (1987:77), writing on sociological theory and medical sociology notes what he calls "...the loss of the subjective dimension...(which) alienates health and illness from the life history of the individual and of the society..." leaving the actual human experience, or what can be referred to as the individual lifeworld, un-involved.

3.2 THE MEDICAL REGIME

3.2.1. Medical truths

Medicine seen in this light seems to suggest that we can obtain scientifically proven truths for diagnosis and treatment which can repair the **ailing machine**. And furthermore, that such truths once discovered, exist in a sort of scientific isolation which excludes the complex interplay of physical, psychological, social and environmental aspects of the human condition. However, as noted in the previous chapter, the human being is essentially not an automaton but a questioning interacting individual who constructs a meaningful lifeworld. This in turn implies that to picture health as a static condition rather than a continually changing and evolving process, is unrealistic. The same must apply to the condition of illness. Therefore truth is not unquestionable - it is redefinable within a forum of ongoing choice making.

This study argues, therefore, that however far science has taken us (and within the medical field we have to acknowledge that science has advanced the human state considerably), facts do not speak for themselves. They are open to an interpretative element which can be approached from alternative directions. The medical field seems to be saying that truth is to be found in the correct representation

of facts. However the humanist would argue that there is a gap between knowing and believing one knows, and this gap is filled by intersubjective meaningmaking. As Martin Buber notes:

> Truth in the world of man is not to be found as the content of knowledge, but only as human existence. One does not reflect upon it, one does not express it, one does not perceive it, but one lives it and receives it as life (1970:89).

Applied to the modern day scientific medical model there is a realisation that medical science, for all its expertise, still seems to have a lot to learn. In the words of Capra:

> In the long rise of scientific medicine, physicians have gained fascinating insights into the intimate mechanisms of the human body and have developed their techniques to an impressive degree of complexity and sophistication. Yet in spite of these great advances ... health does not seem to have improved significantly...(1987:130).

Capra goes on to give his reasons for this statement which basically suggest that whilst scientific medical regimes have made the lives of many thousands of individuals longer (through the employment of scientific medical truths), it is also possible to argue that at the same time it has burdened many people with lives of lesser quality - what one might call saved by medical science and yet condemned to live lives with increasing dependence on medicine and high technology. This means that medicine in these terms not only has to do with patient and doctor but also with the much broader social, economic and moral issues.

In this respect (as noted in chapter 2 section 2.5.2 of this thesis), Jürgen Habermas, Arie Brand and Norma Romm take up this issue of how truth is located. Social reality as intersubjective and symbolic, allows for choice and revision in the light of alternative options, new knowledge and other's meaning structures. This means

that no one person can define the symbol truth alone and, therefore, no one person can decide what truth might be or what the **right** course of medical action is. As indicated, Habermas, Brand and Romm stand firmly in the Buberian camp of truth not as the content of knowledge, but only as human experiential existence. Romm takes up Brand's notion of a true consensus by noting Habermas's point that "...true theories of society are always moulded by their connection with the emancipatory interest" (1991:139). The only way in which verification of truth can come about therefore is "...when it initiates a process of self-reflection on the part of the subjects in society, which results in their becoming emancipated" (1991:139).

Romm goes on to note Habermas's reference to the field of psychoanalysis in order to show how this point of truth as human emancipation can be verified. In this respect she indicates that patient neurosis is only considered as proved "...when it becomes accepted by the patient and utilised as a basis for his or her self-reflection" (1991:139). This point is further expanded upon in the chapter to follow.

3.2.2 The extent of medical knowledge

Along these lines it is also not difficult to show that there is still much that scientific medicine cannot explain mechanically and yet, it sits in a position of what appears to be unreproachable superiority when it comes to dealing with human health because it applies a subjective rather than an intersubjective framework. Doctors have achieved considerable success in the field of transplant surgery, they can reasonably successfully address conditions like diabetes, furred arteries, broken bones and open heart surgery to name but a few medical conditions which have benefited from scientific medicine. Medical science, whilst not claiming to know everything, claims superiority because of the belief that it has the best knowledge available through scientific investigation and provability.

But it is possible to note that medical knowledge is still limited in certain areas, for example the integrative action of the nervous system which appears, in spite of all manner of diagnostic technical advancement, to remain something of a profound mystery. Neuroscientists have been able to clarify many aspects of brain functioning but not how neurons (nerve cells which have the ability to receive and transmit nervous impulses) work together, how they integrate themselves into the functioning of the human body. The argument in this thesis is that because nothing is ever fully known (the humanist tradition indicates that everything is open to ongoing definition), medical science and the treatments it offers should be seen as somewhat precarious rather than a facticity which inheres a one and only truth.

3.2.3 Medical knowledge and patient involvement

In the light of the above it can be proffered that the medical profession work with the knowledge they have, but this knowledge is invariably utilised in terms of a scientific irrefutability which appears to negate human involvement. This thesis argues that medical knowledge can be much enhanced when human intersubjectivity is also taken into account. Seen in this way, medicine needs to remain open and to facilitate any and all areas of human life, not only the scientific. To discard human meaningmaking in the field of human sickness because it is seen to be un-scientific, is to discard the open matrix of collaboration which accepts alternatives and affords medicine that humane element necessary for human life to be meaningful in humanist terms.

In chapter 2 section 2.4.1 Richard Brown was shown to suggest that both science and personal meanings be seen in terms of criteria which are organised through experience, into formal structures of which knowing is constituted. In this way medical knowledge is enlarged, enhanced and strengthened, because it can be seen to facilitate the involvement of people by allowing them to become a part of their own treatment and healing programmes which encompass a personal responsibility. This responsibility means that people make

choices between alternative paths of action and in so doing, accept some accountability for their own health, and furthermore, for the construction of their own social reality. The next chapter examines this situation with reference to the concept of intersubjectivity.

3.2.4 Medicine - partnership or radical monopoly?

What this study argues for is not only that patients become involved in diagnosis and treatment regimes but that professional personnel, rather than being trained to deal with smaller and smaller fragmented pieces of the body machine, join patients in a two-way interactional undertaking which takes account of the intersubjective elements of human living. This implies a process of participation by all parties in arriving at an account of the illness and the decisions involved in how to explain and deal with it. Martin Buber highlights this point when he notes that: "All real living is meeting" (1970:48). If this meeting does not take place, the stage is set for what Ivan Illich (1977) calls social iatrogenesis (all impairments to health that are due to the institutional shape of health care), or a medical monopoly.

Illich argues that medicine causes as many medical problems as it solves by allowing for "...professional autonomy (to) degenerate into a radical monopoly (whereby) people are rendered impotent to cope with their milieu" (1977:41). Thereby the condition of social iatrogenesis becomes the main product of the medical organisation. Radical monopolies impinge upon freedom and independence because the physician decides who is sick, and very often this means that little or no consideration is given to how the patient sees the sickness or to how the patient's meaning structures are affecting that sickness. The argument of Illich is expanded upon in section 3.6.4 of this chapter.

3.2.5 Medicine as negotiational status shift

With this argument in mind, it can be suggested that some serious

illnesses like cancer may be effected and even induced by psychological disturbances, and that treatment may be more successful if these disturbances are taken into the diagnostic framework. Intersubjectivity within the medical framework allows not only for medical science to play its part but also for the sick to be considered as human beings who have physical, psychological and social needs which impinge upon their state of health and which should therefore be granted equal weight with science. Intersubjective living (meaning that none of us inhabit a private world, or have a private experience of it) joins forces with dialogical living (meaning that human reality can only manifest itself as an ongoing process of interpretation between opposing positions) to echo Buber's words that all real living is meeting.

Such meetings are two way affairs which require not only that the doctor imparts information, but that the patient does likewise. Veronica McKay's (1990:290) status shift referred to earlier in the introduction of this study is applicable here. In this way all available knowledge and meanings actually conflate. Interestingly Capra (1987) highlights just this point when speaking of the healer as a mechanic:

> The best results proceed from a "negotiation" in which the practitoner's viewpoint and that of the patient come close enough together for true communication...I (as doctor) often tell patients how I would treat myself if I had their illness. My choices may not include some of the things they're doing. Likewise, their choices may not include some of the things I would do. But I do not take away the benefit of their methods by saying they're no good. Instead I work to see how our beliefs can mesh (1987:56).

Capra's concept of negotiation captures the idea of intersubjective dialogue. (This point in relation to human choicemaking is

expanded in the chapter to follow). However, Capra indicates that he was not trained to negotiate. He states that throughout his training he learnt not to empathise with patients and he emphasises this point by saying that even when called to a heart attack victim the hospital page operator calls "Code 5". Capra maintains that this impersonal emotional distance hurts both parties. How has this type of impersonal scientific training within the medical model come about?

3.3 THE FOUNDATIONS OF THE MECHANISTIC MEDICAL MODEL

3.3.1 A historical overview

During the seventeenth century the world was characterised in organic terms as having to do with the interdependence of spiritual and material phenomena. The reasoning behind the world as organic relied upon "faith" as a means to inject meaning and significance into human life and Capra notes that:

> Medieval scientists, looking for the purposes underlying various natural phenomena, considered questions relating to God, the human soul, and ethics to be of the highest significance (1987:38).

But changes and advances in the understanding of astronomy and physics brought to the fore names like Descartes, Newton and Bacon. With them came the idea that the hitherto notion of the universe as organic, living and spiritual, be replaced by a mathematical analytic reasoning which advocated that the world and everything within it be thought of as an entity which could be reduced to quantifiable measurement.

This change of thinking about humans and their universe became known as The Scientific Revolution and was due in no small measure to thinkers like Galileo, who for the first time advocated that both

nature and human life could be thought of in terms of mathematical postulates. The psychiatrist R. D. Laing, quoted in Capra (1987:30) notes a fundamental problem with thinking about human living in quantifiable terms:

> Out go sight, sound, taste, touch and smell and along with them has since gone aesthetics and motives, intentions, soul, consciousness, spirit. Experience as such is cast out of the realm of scientific discourse.

3.3.2 Mechanistic medicine - understanding or control?

The scientific quest for understanding and wisdom was replaced by what can be termed the Baconian spirit which sought to control through science. In other words, to develop verifiable experimentation which could provide knowledge aimed at controlling nature, rather than as hitherto, to understanding it through the powers of deduction. E. Gilson and T. Langan (1965:9) note this new start as follows: "Bacon was the spokesman for the new ideal of a scientific view of the world based upon observation and experimental reasoning". Philosophising was to be demolished because of its "...unwholesome mixture of things human and divine" (Gilson and Langan 1965:37) in favour of "...a true and lawful marriage... between the empirical and rational faculty" which was to conquer nature via "...the mind's machine" (1965:38). Rather than following the philosophers who Bacon saw as working from axiom to conclusion (within the realm of speculation), science needed to work from experiments and observations up to axioms.

According to S. Stumpf (1982:213) Bacon advocated that learning had become stagnant:

> Philosophy was still dominated by Plato and Aristotle, whose teachings Bacon denounced as shadows and phantoms. Because he emphasized the utility of knowledge, having said that

> knowledge is power, he was particularly agitated by the uselessness of traditional learning. What made this learning useless was that science had become mixed up with superstition, unguided speculation, and theology. Bacon challenged this approach to science as having no adequate method for discovering what nature and its workings are really like.

And so whilst Bacon set forth an empirical theory of inductive procedure, scientific experimentation was combined with the use of mathematical language to describe nature. Only the essential properties of material bodies which could be measured were to be called scientific (deduction), whilst subjective qualities were to be considered secondary mental projections which had to be excluded from the domain of science.

3.3.3 The medical machine

As was noted in section 3.3.2 above, according to Bacon learning had become stagnant. It came from studying literary texts, and in the field of medicine the qualification for medical practice was an ability to quote the texts of Hippocrates and Galen rather than to understand the experiential and participatory elements involved in human health and sickness. This meant that medical practice was usually undertaken by poets, rhetoricians and clergymen. The discovery of machinery, and in particular clockmaking with its precise automatic moving parts, soon found animals and people likened to living bodies formed with wheels and springs. This view fostered all the potential necessary for Bacon's call to conceive of the universe in mechanistic terms, and furthermore, to join forces with Galileo's mathematical language.

3.4 HUMAN EXPERIENCE: AN ABSENT ENTITY IN THE MECHANISTIC MODEL

It quite naturally followed that to be scientific in the field of

medicine not only required that one think of the body in mechanistic terms, but that one actually had to conceive of human illness devoid of all human experience. This meant that the human aspects of sickness - together with its meaningful experience in consciousness - were discarded in favour of the body as a machine which when broken was mended by the physician as mechanic. In this respect Capra suggests that with the Cartesian revolution the hitherto addressal of the interplay of body, mind and soul was replaced by the Descartian division between mind and body, which led physicians to concentrate on the body machine and to neglect the psychological, social and environmental aspects of human living.

As noted above, Figlio (1987:77) argues that it is in fact "...subjectivity [which] distinguishes a sociological approach to health and illness from an epidemiological one", and he makes clear his point that unless we try to reclaim the subjective element in medical sociology, we will never be free from the medical hegemony to which we seem to have grown accustomed. The claim of this thesis is that intersubjectivity (which this thesis distinguishes from subjective exclusively on the grounds that interaction is not only two way but takes account of all human meaningmaking), has to be fostered if a medical model is to become more humane.

Figlio in arguing that medical sociology has lost its individual subjectivity indicates that people's consciousness or essence is now uninvolved in medical theory, or as he puts it: "...alienated...from the life history of the individual and of the society" (1987:77). This study however, in keeping with the humanist criticism levelled at the mechanistic medical model put forward above (and in view of the humanist tradition towards social reality as laid down in chapter 2), would indicate that Figlio, whilst advancing in the right direction can be extended.

In the terms of humanist theory, human subjectivity has to be replaced with human intersubjectivity as the primary concept needed to avert medical hegemony. (In chapter 4 the theories put forward in chapter 2 will be expanded upon to highlight this point). The primacy of intersubjectivity is noted by Buber in this way:

> ...fulfilment...between men, means acceptance of otherness....The strictness and depth of human individuation, the elemental otherness of the other, is then not merely noted as the necessary starting point, but is affirmed from the one being to the other (1970:112).

Therefore there can be no individual self because subject equals mutual, reciprocal subject. Intersubjectivity develops and is reliant upon the symbolic nature of human living which Buber refers to as We-ness. In noting this, Buber says that man "...will not persist in existence if he does not learn anew to persist in it as a genuine We" (1970:86). Does We-ness manifest itself in medical practice? In seeking an answer to this question the effort will be to point out that in many instances medical science does not successfully (i.e in humanist terms) account for We-ness or intersubjectivity within the currently implemented medical model. This chapter now moves on to consider these concepts in terms of the doctor-patient interaction.

3.5 THE DOCTOR-PATIENT RELATIONSHIP

The doctor-patient relationship is of paramount import in any evaluation of medicine and no study can hope to be fulfilled without the inclusion of Talcott Parsons's (systems theoretical) account of the sick-role. In this section a short account of this theory is offered, both from the patient and doctor point of view. It is argued that intersubjectivity, in humanist terms, does not present within the Parsonian appraisal of the doctor-patient relationship. An indication is then given of how the humanist tradition can afford a more humane way of conceiving the roles of patient and doctor within the medical model, by engendering intersubjective meaningmaking.

3.5.1 Talcott Parsons and the concept of self-interest in the doctor-patient relationship.

Grappling with the notion of self-interest as the principal characteristic of modern industrial society, Parsons could not easily ally on the one hand rational science and on the other the sensitivity of the emotional attitudes concerning patient-doctor relationships. Uta Gerhardt (1987) argues "...the sick role is regarded [by Parsons] as a complementary counterpart to the practitioner's role, and both are ... elements of the social system of medical practice" (1987:115).

Between 1951 and 1958 Parsons developed his theory on roles within the medical profession. His theory on patient illness and the role of the physician suggests that the doctor's task is to confirm the individual in the sick role - a socially sanctioned set of behaviours to which people are expected to conform when sick. Working from a basis of functionalism, Parsons regarded illness as dysfunctional for society because it interfered with the more usual societal roles performed by people when in health. In this way illness can be viewed almost as deviant because it deviates from the role norms of non-sick behaviour which usually apply, and which uphold system equilibrium. Gerhardt (1987:118) makes note of the systematised collectivity in this way:

> ...both the sick role and the physician's role follow a collectivity orientation. ...for the former, it ensures that getting well is seen as accomplishing a common task in co-operation with the doctor.... for the [latter], collective orientation above all [denotes the] motive for all diagnostic and therapeutic action. Thus...the value orientations of universalism, achievement, affective neutrality, functional specificity, and collectivity of spirit, make the sick role and the practitioner's role into a social system [which upholds the whole].

3.5.2 The sick role

In Parsonian theory the patient role is subordinate to that of the doctor who holds an elitist position because of superior medical knowledge in relation to that of the patient. Gerhardt in this respect notes that there is a "...two-way rule-governed acceptance of the one side's claim to dominance and the other side's willingness to comply..." (1987:130). Gerhardt observes that this professional dominance aids an exclusionary and expansionist social control which has an influence upon the interaction of any consultation because the roles of doctor and patient are associated with certain expectations. And, furthermore, in terms of Parson's theory denotes a rationality aimed at system maintenance.

This two-way acceptance denotes the patient as expecting the doctor to diagnose and treat illness from a base of elite specialist knowledge. The patient is required to passively accept the diagnosis and treatment suggested by the doctor without question. Figlio (1987:89) notes that in relation to the medical model and rationality, these expectations "...do not fit the model of rationality that one would expect from ... sociological typifications...". This point was expanded in section 1.4.3.2 of chapter 1 in terms of Schützian theory.

3.6 THE POWER STRUCTURES WITHIN THE MEDICAL RELATIONSHIP

As was noted in section 3.5 of this chapter, Parsons's theory points to a power element within the doctor-patient relationship. For Parsons the authority of the doctor is legitimised by a mechanism within contemporary society which defines illness in terms of anti-social or deviant behaviour. In this way sickness is viewed as a negatively achieved role (which should be righted as soon as possible), because it removes the role occupant from the more important role in terms of the functional prerequisites of the social system. In this respect the doctor's role can be seen as one

of preserver of the social system: a high incidence of illness is dysfunctional for the system as a whole. Gerhardt (1987:119) therefore notes that: "The doctor's role...is to provide the legitimation to enter the sick status as well as to spur the urge to leave it". The power element here points to the doctor as definer of sickness and the patient as mere submissive recipient of a doctor's suggestions.

3.6.1 Medical power as a colonisation of the lifeworld

Other authors too have debated and theorised on the power element in the medical model. Graham Scambler (1986) suggests that Jürgen Habermas views the power structures inherent in medicine as having colonised people's lifeworld "...by means of its power as an expert occupation...(and its) distortion of communication caused by medical expertise in doctor-patient exchanges" (1986:165). Scambler defines the use of the term lifeworld in this way:

> It refers to the distinctive, pre-reflexive form of background assumptions, convictions and relations which function as a resource for what goes into explicit communication...the lifeworld is the medium, or symbolic space within which culture, social integration, and personality are sustained and reproduced (1986:170,171).

Habermas's reference to power as a colonisation of the lifeworld (as discussed in chapter 2 of this thesis), becomes increasingly important towards the end of this chapter when the strength of the intrusion by mechanistic medicine into the meaning structures of people is evaluated. It is noted that Habermas, in calling for a society which is genuinely emancipated, can be seen to argue for a medical profession in which individuals actively control their own lives.

Therefore, by drawing on Habermas's argumentation concerning emancipation and by allowing for intersubjective participation (as intimated in chapter 2 section 2.5.3), this thesis endeavours to go beyond the idea of consensually agreed upon norms to suggest that norms are not unnegotiable, but are rather a debatable entity reliant upon a dialogue of viewpoints in which all participate and make choices.

3.6.2 Medicine as a controlling agent

Another way in which power can be considered within the medical model is in terms of Michel Foucault's argument which suggests that power can be viewed as double sided. This means that power can at one and the same time incorporate welfare with supervision and control. Foucault's theory evolved in relation to his interest in state control, and primarily to state control linked to surveillance of the so called deviants in society (the mad, the sick, the prisoner, etc.). Foucault's argument is that state institutions seem to be organised in such a way as to allow the control of many into the hands of a few - often one person. (He uses the example of the Benthamian Panopticon* to show that in this situation successful control by the few actually results in the controlled controlling themselves).

In this respect Foucault's argument can be utilised to argue that medicine has become a "...closed domain reserved for it alone" (1980:75). By a process of extrapolation this can be seen to suggest that medical personnel exert power over many through an interventionist elitist technology available to, and utilised by, the few.

---

*A prison building which was so designed to enable one guard to effectively observe (control) a number of prisoners at one and the same time. Because prisoners had no way of telling when they were being watched - the guard could be removed and the prisoners controlled themselves in expectation of the mere possibility of surveillance.

In this way it can be argued that so successful has medicine been in infiltrating people's consciousness, it is now "...associated with a general amplification of power which does not curb or limit [its] forces, but rather produces [its] enhancement" (1980:111).

Clearly both Habermas and Foucault criticise the Parsonian view of the legitimacy of physician power because it can be indicated that it occludes an intersubjective relationship in which opposing positions may be expressed in terms of negotiation (this is elaborated upon in the following chapter).

3.6.3 The conflict view of power relationships in the medical model

Yet another way of perceiving the power relationship within the medical model is in terms of a conflictual interaction. E. Friedson suggests that "...the separate worlds of experience and reference of the layman and the professional worker are always in potential conflict with one another" (in Patrick & Scambler 1986:60). By this Friedson means that the doctor's dominant knowledge negates any knowledge which the patient may wish to bring to the interaction, in terms of a superiority of knowledge. Contrary to this view Friedson argues that the doctor-patient role be seen in terms of symmetry rather than division due to elitist powers. And in this way Freidson can be argued to uphold the suggestion put forward by this thesis - that all potentially conflicting areas of social life can be addressed via (symmetrical) negotiation. To negotiate thereby implies an intersubjective arena whereby human interaction can facilitate the views of all parties.

However, Friedson argues that conflict within the doctor-patient relationship can be viewed in various ways. Firstly it is noted that there is often oppositional principles present between the doctors obligation to help the individual patient and their obligation to administer their professional duties on behalf of not only the person but also the state. This problematic can become

compounded by differing evaluations on the part of doctor and patient concerning the seriousness of a condition - viz., the patient may perceive his/her particular illness as important enough to lose time from employment whilst the doctor does not. The humanist thinker would suggest that a truer definition can be sought through the mediation of intersubjective negotiation.

It can be argued that health education and awareness campaigns do aim to equip the individual with as much health knowledge as possible so that the patient can aid the doctor in arriving at a diagnosis. But Patrick and Scambler note that this situation actually places the patient in a double-bind position in that they are expected to have and to offer personal knowledge of illness whilst at the same time accepting unquestioningly the doctor's diagnosis and suggested course of action. According to Friedson (in Patrick, S. & Scamler G.,1986) medical expertise is in part founded upon, and generally legitimised in society, by what Friedson calls a formal knowledge. (Note the difference from Parsons who believes in the legitimation of medical expertise because it is functional for the system, and therefore beneficial to all). By this Friedson means knowledge of a higher degree which is the domain of a few - in this case the medical profession - and which therefore cannot be deemed as beneficial to all. According to Friedson the use of formal knowledge to order human affairs can in this way be seen to constitute an exercise of power, or an act of domination over those who are the object.

In this respect Ralf Dahrendorf's argument referred to in chapter 1 section 1.3.3.2, which locates power within role occupation, can be seen to complement Friedson's concept of power as exercised through elitist formal knowledge. Power is exercised by the doctor over the patient by virtue of his or her priviledged role in having access to more scientific medical know-how. This, however, is not to say that the patient does not have knowledge which can be brought to the consultation and more will be said about this point in chapter 4 to follow.

3.6.4 Critique of contemporary over-medicalisation

Ivan Illich (1977) - whose position was briefly touched upon in section 3.2.4 above - offers a systematic critique of the nature and practice of modern medicine. Illich's critique of the medical model can be used to highlight some of the reasons identified by this study as problematic for human intersubjectivity. He argues that the application and influence of modern medical practice with its scientific character and aspects of control over human lives, is serving not so much to improve health but to advance the medicalisation of life. According to L. Doyle and I. Pennell (1981) it is Illich's proposition that medical techniques can be both harmful and ineffectual and furthermore that medicine, on the whole, does more harm than good. Illich advocates that more and more areas of human living are being brought into the medical sphere of influence and he suggests that not only is immense control exerted upon people's autonomy in controlling their own lives, but that this is the fastest growing epidemic of modern times which irrefutably and unquestionably occupies a position he refers to as a sacred cow.

Illich's theory shows not only how a different view of the power (in other words a view which questions the power structures of the medical model by pointing to their failings) within the scientific medical model can be defined, but also points to the far reaching effects upon the implementation of health care. Health care tends to be seen in terms of the good it provides in keeping the populace free from disease. This study suggests, in line with Illich, that medicalisation has permeated the human being so thoroughly that it has instilled a desire in people for health not at any price, but possibly to the detriment of other areas of human existence.

3.6.5 The increase in medical intervention

Increasing medical intervention and the growing pressure of the medical profession over social life, has led authors like Friedson to speak in terms of monopolisation. Questions of a monopoly, the

professionalising process in terms of growth of knowledge and service, and areas of coercion and control, suffer from what D. De Swan calls "...the same fault: they overestimate the conscious, active part of the individual..."(in Siegel, 1987:66).

De Swan argues that this increase of medical intervention permits the medical regime to exercise more and more power over modern society. He states: "...over some people totally and even permanently, over almost everyone for many aspects of daily life, and at decisive moments in the life-cycle...(and this) involves an authority relation and a hierarchy, a professional ethos and a world-view" (in Siegel, 1987:66). De Swan notes that this increase of medical intervention comes about for two reasons. Firstly the medical profession owe their elitist position to their specialist expertise. This expertise is protected by the profession itself, by its personnel and by technical-scientific knowledge founded upon explicit theories and demonstrable results of research. Secondly, the medical profession are legitimised by the state, whose bodies they permeate through professional organisations and administrative apparatus.

3.6.6 The expansion of the medical regime

Doctors through their professional status are continually opening up new areas within social life which require their specialist intervention, and this intervention can often be seen to impose what can be termed a restrictive influence upon the individual. For example an application for a post within a company is often dependent upon medical clearance of one sort or another. In the case of the elderly within society, entry into sheltered accommodation or an old home invariably rests upon a medical recommendation. In this regard De Swan (in Siegel, 1987:68) notes that: "...personal situations...which once counsellors and pastoral workers had to solve..." are more often than not re-defined as medical problems. He states:

> Whenever social contradictions are involved, also in their individual form as personal conflicts, the reduction to a medical problem is a derivative application of medical knowledge; medical expertise is used to cover for conflict management (1987:68).

This type of intervention is not initially aimed at control and quite often results in the upgrading of the population as a whole. But the benefit to the individual is more often than not overshaddowed when compared to the benefit received by the medical doctor whose services are required in more and more areas of human life. What results is an increasing dependence of patients and potential patients upon the medical profession which excludes other relevant areas of support and aid.

As the areas of medical intervention grow and other support systems diminish, there is a growth in the institutionalisation of certain members of the community who would once have continued to occupy a place within the family unit. The disabled, the terminally ill, the elderly, the feeble-minded are all cases in point. Also the diverse categorisation of mental illnesses - in an effort to afford rehabilitation programmes aimed at improving the quality of life of the mentally ill - label many individuals as in need of specialist treatment and this often relegates them to a life of institutionalisation. Rehabilitation programmes which once offered support mechanisms to equip families for aiding the disabled at home have fallen away, and help is now invariably only obtainable within the confines of the institution or hospital. This requires the services of more and more specialist medical personnel and at the same time removes involvement and responsibility from the private and individual, into the arena of professional medical expertise.

As diagnostic techniques have improved, so more and more people have found their lives invaded and taken over by **medical expertise**. Thereby, society is faced with a medical model which recommends the worth of modern technology and at the same time encourages the

conditioning of a population who accept this **worth** unquestioningly. This means that ethical and moral considerations are of much import and although this topic will be elaborated upon in the final chapter of this thesis, a brief resume is offered here in terms of ethical considerations relating to medicine as a mechanistic model.

3.7 AN ETHICAL VIEW OF THE MECHANISTIC MODEL

It will be noted in chapter 5 of this thesis that one of the most crucial areas of medical ethics is the question of rightness or wrongness of medical action. It is not only about the good to be obtained in either medical care or medical investigation, but rather what constitutes right action in medical practice. And furthermore, it is concerned with whether or not there exists a reasonably free and adequately informed consent (which consent has of course to be founded upon intersubjective negotiation as a basis for the interaction necessary) between patient as subject, and the person instigating the medical procedure.

When discussing the principles involved with informed consent Paul Ramsey (1987) argues that:

> ...the common cause is some benefit to the patient himself; but this is still a joint venture in which patient and physician can say and ideally should both say "I cure". Therefore, I suggest that men's capacity to become joint adventurers in a common cause makes possible a consent to enter the relation of patient to physician or of subject to investigator. This means that partnership is a better term than contract...(in Siegel, B., 1987:105).

Ramsey's "joint adventure" can effectively make provision for the medical model to become more humane in that choices are initiated from a platform of humanist **status shift** (see general introduction to this thesis). This would involve the doctor making his/her scientific specialist knowledge available and the patient making his/her ideas and beliefs known.

But it is not at all certain that this way of involving both doctor and patient in decisionmaking is actually taking place. Rather, the medical model appears to operate in terms of its irrefutable scientific framework which promotes scientific "right" answers in opposition of negotiated decisionmaking. In this way medical science can be seen to argue that it, and it alone, has the best answers to illness. And, furthermore, that questions concerning illness and treatment can only be answered in terms of science.

In chapter 5 it will be shown, by referring to the theories of Illich and others, that the medical profession (in denying what this thesis suggests is the very human need to participate in an experiential manner towards the defining of illness and diagnosis) does not come to terms with the "essence" of human social reality. Rather the medical model in offering medical truths and denying choice, stunts the very frames of human reference by its medicalisation of people's lives.

In this way it can be argued that formal specialist knowledge infiltrates human consciousness to the point where the patient believes **unquestioningly** in the value of scientific medicine. Medical decisions become accepted as no choice situations. People come to believe that there is only one way and that one way **must** be the **right** way because the medical profession convincingly promotes the idea that medical science is irrefutable. In these terms the medical answer to ethical questions is "more scientific medicine". This is what Peter Berger means when he suggests that institutions like the medical profession appear to be unquestionable. What needs to take place is a "healthy" reconsideration of the medical model in the knowledge that people-made institutions can be redefined, or to use Mead's term de-institutionalised. In this way ethical questions in medicine can be taken up within a more humane framework which does not acquiesce to scientific medicine in terms of non-accountability.

3.8 CONCLUSION

In chapter 2 of this dissertation the theoretical foundations of

humanist intersubjectivity were traced, in order to provide a framework with which to investigate the medical model. In this chapter the extent to which the contemporary mechanistic medical model can be seen to have colonised human lives has been searched in order to highlight the overmedicalisation of modern living.

In the chapter which follows the mechanistic medical model will be brought together with a humanist critique, in order to suggest that intersubjectivity and the framework of the medical model are incompatible. And, thereafter, an attempt will be made to offer a more humanistic framework, a framework which may serve to bring "new life" into matters of human health and healing.

CHAPTER 4

THE HUMANIST CRITIQUE OF THE MECHANISTIC MEDICAL MODEL

4.1 INTRODUCTION

In the preceding chapters, the theoretical tradition of humanist intersubjectivity was outlined as being the way in which people give meaning to their lives by participating together with their fellow human beings. The mechanistic medical model was shown to adhere to a scientific framework which for the most part does not involve people's meaning structures as the humanist would define it.

The argument in this chapter is that there exists a discordance between the humanist sociological view of intersubjectivity and the practical application of the medical model in relation to issues of human health. Because the scientific medical model does not offer theoretical provision for intersubjectivity, the aim of this fourth chapter is to apply some of the concepts developed in chapters 2 and 3 (theory and the medical model respectively) in an effort to evaluate the practice of medicine in humanist terms. In this way it is hoped to develop an alternative model which addresses human health in humanist terms.

Firstly the chapter utilises the theory of George Herbert Mead and then moves on to examine other theorists from the preceding chapters in not quite so much detail. The theoretical arguments thus taken up will be systematically applied to the medical model in order to show their relevance for intersubjective meaningmaking within the medical framework.

4.2 THE MEDICAL MODEL AND TRUTHS

In chapter 3 it was indicated that the scientific medical model

appears to offer truths to which the doctor has access but not the patient. This situation arises because medicine entertains a knowledge which it is not the prerogative of patients to question. However, attention was also drawn in chapter 3 to what might be called Martin Buber's more humanistic ideal, that truth is not so much the content of knowledge, but something which can only be related to human existence and to the experience thereof. Therefore, it was indicated that this leaves the humanist with a question about what truth in human terms might be rather than an answer which can be simply provided by science.

4.2.1 Medicine, truths and Mead

As noted in chapter 3, the medical model purports to offer cures for human illness in the form of scientifically testable treatments. The doctor's role within this model is one of **knower** and **fixer** and the patient's role is often perceived to be one of passivity. Furthermore, it was noted that these role prescriptions can be seen in mechanistic terms: the doctor as the mechanic, the patient as the machine to be repaired. This in Meadian terms means that both role prescriptions operate in purely "Me" type areas. The doctor offers predefined remedies which do not involve the "I" component of the self of either interlocutor, and this in turn stifles the **otherness** of both.

What this means is that people are seen only as objects who passively accept the rigidified generalised expectations imposed by the accepted norms of the societal institution of medicine. In so doing they become what in Mead's terms is a moron. The scientific medical model by not making provision for an operative "I" does not aim to foster negotiation between doctor and patient, and because of this any interaction which does take place is not undertaken intersubjectively. What rather seems to be occurring is a rigidified interaction which far from leading to a freedom of human spirit by involvement of the Meadian "I", reduces people to a condition of pure **object**. (Chapter 1 section 1.4.2.2 refers).

This study suggests that because there appears to be no interplay between the self of doctor and the self of patient (except in terms of a required conformity to the expectations relative to their positions), these rigidified interactions reduce other to an objectified state which is not conducive to the healthy mix of "Me" and "I" which Mead advocates is necessary if humans are to reach their full potential.

4.2.2 More science, more objectivity

The medical model, in striving to become more scientific rather than less, can be seen to deny the existence of any other way of seeing, or at least does not encourage any mode of action which does not measure up to its scientific framework. This means that the doctor may employ an impersonal attitude which aims not to involve the patient's knowledge of a possible diagnosis but to control the interaction. Uta Gerhardt (1987:117) notes this point by stating:

> The physician is expected to treat an objective problem in objective, scientifically justifiable terms. For example, whether he likes or dislikes the particular patient as a person is supposed to be irrelevant...affective neutrality in the doctor's role is the necessary corollary of the fact that medical practice is applied science...

Ivan Illich (1977:252) also sounds a word of warning in this respect by noting that: "As a science, medicine lies on a borderline. Scientific method provides for experiments conducted on models. Medicine, however, experiments not on models but on subjects themselves". By adhering to scientific objectivity when dealing with patients the doctor conducts diagnosis as if patients are specific cases rather than autonomous persons. Thus rigid adherence to institutionalised patterns are observed with the patient almost expected to be no more than a puppet who does not take part.

4.2.3 The doctor as dominant role prescription

In this way the doctor is seen to be in charge of the interaction and the conversation which takes place during the consultation. Should the patient try to take part by stepping out of the role prescription previously noted as passive, for example to question the doctor's diagnosis, this behaviour may be seen not only as unconventional but is often considered by the doctor in a light of interference rather than of a shared responsibility for illness as the humanist would prefer to define it.

It is possible that the doctor in this situation will attempt to control the interaction in such a way as to discourage its happening again. This type of discouragement would seem to be legitimated by the medical model and in this respect Illich (1977:41) suggests that one of the reasons for this is a "...professional autonomy [which has] degenerated into a radical monopoly [whereby] people are rendered impotent...". Because of this, sick people have grown used to accepting control from the doctor and rather than appear deviant to what is seen as acceptable societal norms, patients comply with the institutionalised patterns unquestioningly.

4.2.4 The dominant role of doctor and truth

In relation to medical truths this means that the doctor holds the key. He/she can proffer scientific regimes which will right the sick machine and which, even more to the point, are often advocated to be failure proof when in fact they are not. As noted in chapter 3 Illich has much to say about the medical model which offers truths in this fashion. In arguing that the scientific medical model is often shown to cure one illness whilst at the same time inducing another, Illich is able to propose the idea that to give medication or to attempt diagnosis without involving the sick person, is tantamount to saying that medicine and only medical personnel have the truth of illness.

4.2.5 A more humane sharing of knowledge

This study would suggest that specific knowledges come together at specific times in consultation, due in no small part to the interaction between specific individuals. If the doctor is a particularly good communicator, or if the patient is particularly intelligent/interested (or vice versa), the interaction which takes place will be far different from an interactional situation where neither party is intent upon involving the other intersubjectively - or even a situation where a particular patient finds difficulty in explaining symptoms, etc. All of these areas can be of much importance to the outcome of an interactional situation. There is no way of knowing before hand how that interaction will proceed, what knowledge will be imputed into it and therefore what decisions will come out of such a meeting.

With this in mind it is suggested by this thesis that scientific theories of illness need to be seen as approximations (likewise diagnosis and treatment) in the knowledge that **reality** is always re-definable. Thus, rather than being seen as complete definitions, the terms illness, diagnosis and treatment should be seen as symbolic and provisional, serving only insofar as they offer an invitation for dialogue which takes up the re-definability of the meaning of the terms. The section which follows will indicate that all information should be seen in terms of a re-definability which can only be **validated** contextually through a process of social discourse.

4.3 THE MEDICAL MODEL, SYMBOLIC INTERACTIONISM AND TRUTH

4.3.1 The patient

The medical model seems to befit a process of invitation to communicate between doctor and patient. The patient explains to the doctor the symptoms he/she is experiencing and the doctor applies

his/her specialist knowledge to the symptoms in order to effect a cure. In Meadian terms this means that the "Me" component of the self is operating here according to prescribed institutionalised patterns. The patient by responding to questions set by the doctor concerning symptoms, and the doctor in initiating the questions asked, can be seen to conform to the role pattern variables highlighted in Mead's theory within chapter 1 section 1.4.2.2.

In this respect the patient may perceive of the doctor in elitist terms (the doctor has knowledge and they do not), they may be frightened of the knowledge they think the doctor has about them and their illness. They may indeed be afraid to tell the doctor the complete details - this may be due to embarrassment or fear of prognosis, etc. - and they may even be trying to influence the doctor's decision on their illness to ensure a sick break from employment. Whatever the reason, the interaction which takes place bears very little resemblence to the health mix of Mead's "Me and "I" and, therefore, to the elements of intersubjectivity and truth discussed in chapter 1, which are thereby not provided for. Intersubjectivity seems to be stifled by what can be termed the "normative" role prescriptions to which each party adheres.

4.3.2 The doctor

The doctor as a busy professional allows only a certain amount of time to consult with each patient. When the doctor lived and worked in his own particular community diagnosis was given from a base of not only the reported symptoms, but also the personally known social aspects of the patient's life. The doctor, as a friend and neighbour, would often be aware of any personal problems which may or may not be affecting the patient's health and would take this into account when trying to address an illness.

Today with more and more areas of life becoming medicalised and therefore additional numbers of people seeking the professional help

of a doctor, less and less time is allocated for the patient to give the doctor full information about her/his condition. Added to this is the problem mentioned above that the doctor probably does not know the patient personally and thereby has to rely more and more on the small amount of information the patient is able (or is willing) to give in the restricted time limit. Illich maintains that this lack of time and knowledge can often result in the prescribing of unnecessary drugs. In this respect it can be suggested that to give an anti-biotic when one is not sure of diagnosis not only affords the patient what the doctor believes is **protection** medication, but at the same time can be construed as protection for faulty diagnosis or even promotion of drugs for promotion sake.

4.3.3 The doctor and prescription drugs

In this respect Illich (1977:65) discusses the drug Chloramphenicol as a good example of how such a reliance on prescription drugs can be useless in the treatment and protection of patients when prescribed indiscriminately, and thereby can be seen to promote abuse. Chloramphenicol, Illich explains, was developed for use against Typhoid (interestingly, in line with Illich's argument, this drug increases the risk of dying with aplastic anemia), but has been prescribed - due to the success of the manufacturer (Parke Davis) in promoting their product, for diseases as far apart as acne, sore throat and hangnail. Illich says that "Since typhoid is rare... no more than one in 400 of those given the drug needed treatment" (1977:66).

This means that the doctor is not only treating the patient from a stock of pre-defined knowledge, but it could be argued that he/she is employing the use of modern scientific drugs to compensate for what this study sees as a lack of intersubjectivity within the consultation setting. Furthermore this also means, in terms of Meadian theory, that only the "Me" part of the self is operant with neither doctor nor patient entering into a communication which seeks to employ the full self of both parties. Both doctor and patient, as noted for a variety of reasons, often stick to what they see as the

rigid and unquestionable institutionalised patterns of their individual roles. And again there is little here which resembles intersubjectivity and truth in the humanist sense. This is so because if diagnosis were to be discussed in terms of the argument put forward in this thesis for intersubjective living, negotiation between doctor and patient might more successfully be able to address the problem without the need of scientific drugs.

4.3.4 The dominant "Me"

As indicated from the reading of Mead chapter 1 section 1.4.2.4, what prevents human beings from becoming morons is their capacity to think out choices between alternatives. In this respect it should be noted that even given the same stimulus, the response will be different time and time again. As indicated in chapter 1 this happens for a variety of reasons amongst which is noted the differences in biographical background (attributes of the unique human being) and the contextualities of the interactive process.

When humanist intersubjectivity is employed it should give rise to a continuous interpretation and negotiation in the area of meaningmaking, thereby affording a symbolic reality which is humanly meaningful in the sense that it allows for dialogue concerning what things mean for people.

It is the contention here that having applied the concepts of the scientific medical model to the interaction which takes place between doctor and patient, there appears to be a rigidity which restricts communication to a pure Meadian "Me" interaction. This, it is argued, forces the "I" to remain dormant and fosters the operation of a form of concensus. For the patient this means that the doctor has the **best** knowledge or truth of the situation and the patient merely accepts the definition offered by the professional believing they have no knowledge to bring to the interaction.

The conceptualisation of thinking and communicating in the consultative model laid down here, does not allow any focus on human

intersubjectivity. As noted previously it can be argued that, given the rigidified situation noted above, communication between doctor and patient does not incorporate the full selfs of both doctor and patient. In Meadian and humanist terms, only when these areas are addressed will communication lead to a more humane definition of truth and human reality within medicine which in Buber's terms is not knowledge alone, but the experience of living.

Humans do not live by law like facts. Rather, as noted in chapter 2, the humanist way of thinking suggests that it is not possible to know anything outside of the individual consciousness, and therefore human consciousness has to enter into, and to **participate** in, any negotiation which takes place. This indicates that the symbolic experiential nature of meaningmaking allows people to continually revise their lifeworlds in the light of new alternatives. With regard to the institutions of society (the medical model is one), this means that people are capable of de-institutionalising them by an ongoing reconsideration in the light of these new alternatives. For instance, the institution of medicine as a **treating machine** can be questioned.

In this way new ideas as to what the role or role performance of both doctor and patient may be, can be seen as open to choice between all alternatives. Here is how and where people are able to avoid a moronic type of existence by choosing to live to the full in the exercising of one's whole self; not to live subjectively (where either doctor or patient as exclusive subject imposes his or her will on the other), but intersubjectively. This would mean that both parties do not become estranged from life and the difficulties of choice; they enter into choicemaking in the knowledge that only in participation do humans take up the challenge to live to their full potential.

4.4 HUMANISM, SYMBOLIC INTERACTIONISM, TRUTH AND THE MEDICAL MODEL

4.4.1 The patient

When patients visit the doctor they are armed with many ideas

and much knowledge about their own situation, and from a reading (interpretation) of Meadian theory, it may be suggested that the patient knows quite a lot about the doctor also. Not about specific or personal areas of the doctors life, but from their ability to take the role of the other the "Me" component of the self allows for a generalised knowledge of other. There is already in existence, before communication begins, what may be called a typified shared arena of symbols whereby humans utilise a knowledge of each other (sameness). In Mead's terms, this knowledge is coupled with an awareness of the possibility for uniqueness (otherness in terms of the "I" component of self) and novelty denoting any interaction in terms of a mediation which does not revert into the mere following of recipes for "expected" conduct.

The information which the patient gives to the doctor is in the form of significant symbols, and as noted in chapter 1, Mead argues that these symbols themselves impart information in specific ways. This means that within the interactional arena the information the patient is giving is always subject to interpretation by the doctor. After all the doctor is making sense of the stimulus offered from a base of different biographical meaning structures.

The humanist makes allowance for this by arguing that significant symbols, far from relaying truth, actually should be seen as starting points for negotiation - a sort of hypothesis which recognises the so called "symbolic space" within interaction. Once this is realised it becomes apparent that to operate from a purely "Me" type component of self does not lead to the negotiation of human truth as an ongoing dialogue between different positions.

In telling the doctor the symptoms of illness the patient actually opens up a communicative area which should become an invitation for both the doctor and patient to explore the "good" and "bad" news (the options between alternatives) of various ideas for both diagnosis and treatment of illness. Within the shared platform of "good" and "bad" news both the Meadian "Me" and "I" become operational and the doctor

is placed in better stead to understand the patient's illness through what can be termed the experiential elements of the shared platform.

4.4.2 The doctor

Likewise, the doctor faced with a patient who is communicating information should be capable of responding to such stimuli in reciprocal manner. Rather than to make a diagnosis on the initial information offered by the patient, the doctor also needs to invite the patient's knowledge of possible diagnoses and possible treatments, and to explore the "good" and "bad" news of these alternatives in order to raise the consciousness, not only of the patient but also of him/herself. In this way the interaction proceeds in terms of what was noted earlier as Veronica McKay's (1990) **status shift**. In other words there is a shared arena of generating knowledge of the case which is not just one way - from doctor to patient - but a truly intersubjective arena where both parties share knowledge - each to their own capabilities. Through corroboration and the ethical principle of enlarging the choice making process, an **equalising** of knowledge takes place. In this way Meadian theory is operating fully, both doctor and patient self is active and there is now much more chance that something nearer the humanist truth - as a product of dialogue - might be found. Any information which is taken into consciousness, and thereby becomes part of the individual's meaning structures has become experienced and therefore even in Buber's terms can be considered to be something akin to truth.

4.4.3 The "Me" and "I" in the shared arena

It has been shown that the self as a product of the relationship between the "Me" and "I" provides for the individual to take account of all meanings in society. Applied to the institution of medicine and the treatment of illness this calls for the recognition of a shared arena in any communicational setting and by this is meant that both doctor and patient spend time elaborating on the feelings and meanings concerning alternative courses of action.

If the doctor prescribes a pill as a cure he/she should ensure that all alternatives are fully discussed with the patient. The patient needs to know why the doctor feels the pill should be prescribed, and what the doctor believes will happen when the pill is or is not swallowed. Then from the patient's side, the doctor needs to know if the patient's ideas concerning the prescribed treatment are in harmony with his/her advice on treatment.

In other words: is the patient worried about the treatment offered, is there a problem with swallowing pills, is the patient worried about side effects, etc? All of these areas and probably very many more need to be addressed. On the other hand not every patient has a need to have questions answered, some patients do prefer the doctor alone to take the responsibility for their illness so the doctor is not always required to offer information: but doctors should be open to offering their knowledge if the patient requires it.

What this dissertation wishes to highlight is the idea that choices exist in every situation and that it should be the prerogative of all human beings in all situations, not only medicine, to be able to take up these choices should they wish to do so. Justification for this ideal in medicine is offered by Mark Chesler and Oscar Barbarin (1984), and it is suggested that this idea be borne in mind when the study moves on to consider the areas of human choice and responsibility, a) in the existing model of scientific medicine and b) in humanistic terms, making note that according to Chesler and Barbarin:

> ...satisfaction...correlated significantly with...ratings of communication with [the] physician...in addition, patient/physician rapport may play an indirect role in effective treatment...[and] the quality of these relationships may also affect the patient's emotional status and the patient's and family's ability to cope [with illness]...(1984:49).

4.4.4 Sharing of responsibility

Chesler and Barbarin (1984) further note that there is often an

intense need to know a great deal about one's condition and suggest that this can be seen as a sort of "...intellectual mastery to gain some sense of control" over the situation. They also indicate that this need to "know" is often not forthcoming because "...professionals expect passive acquiescence rather than active participation from powerless clients" (1984:51). It does appear however, according to Chesler and Barbarin, that patients are often willing to take up the potential to choose and also to accept responsibility for their own illness. This has a great bearing on the humanist idea of truth because it actually detracts from the medical concept of the doctor as the only possessor of that truth and highlights the need for possible shared accountability.

In the next section it will be indicated that according to Jean-Paul Sartre, responsibility and choice are not just individual, or even mere intersubjective concepts, but "wholly" joint concepts which involve a co-responsibility for all humanity. Such ideas are akin to Mead's view on the formation of self which rejects the idea that there can be individual selfs: humans need each other if they are to exist as humans at all. These ideas can be seen to accommodate Chesler and Barbarin's suggestion that satisfaction within doctor-patient communication is related to having the choice to take part on reciprocal terms.

4.5 THE MEDICAL MODEL, CHOICE AND RESPONSIBILITY

As was shown in chapter 2 section 2.2.2 the idea of a shared communication proceeds with each party taking what Sartre (1973) argues is a co-responsibility towards each other. This co-responsibility for oneself and for others is intimately linked to human action and choice and provides, in Sartre's terms, the only opening for human freedom. Human beings have to act to live and that action means to take up the responsibility to exercise choice. In choosing humans do so not just for personal freedom, in other words not just individual human freedom, but in fact for multi human freedom.

It was noted in chapter 2 that for Sartre existence precedes essence, and therefore people cannot avoid the responsibility of making choices because the self cannot exist alone devoid of the interaction with other selfs. This intersubjective interaction, which by its very nature requires that people make choices on the basis of a shared reality, does not mean that the parties aim at concensus, or for that matter that they assume agreement, but rather that in taking part people aim to become involved each to their own ability in a process of negotiation. In this way Sartre argues that a shared reality impinges intrinsically upon what can be termed the shared realities of others.

This obviously means that people have to act to live and that that living calls upon human beings to invent themselves and at the same time to take responsibility for the choices they make during those acts. The idea argued by Sartre that I think, therefore I am, identifies people as subjects - at the same time identifying the other as indispensable to one's own existence and vica versa.

4.5.1 The doctor, the medical model, choice and responsibility

What this means in terms of the existing medical model as it equates to legitimation within that model (and to the areas of institutionalised practice and the interaction between doctor and patient), is as follows. The doctor, in control of the interaction, will define **diagnosis** and **treatment** on the basis of the questions put to the patient - this can restrict the patient's choice of reply. Therefore although the aspect of choice appears to be exercised by the patient, such choices are made within a rigidified situational interaction which does not spring from a dialogical exploration of options.

Sartre would argue that this situational interaction does not allow for the taking of co-responsibility for the choices we make in the knowledge that such choices indirectly affect everyone. And by making note of this problematic within the interactional sphere, it can be

argued that if this type of (rigidified) interaction is allowed to take place, all such interactions will continue along similar lines because role prescriptions continue to be seen as un-negotiable. Doctor and patient will merely take up the role prescriptions inherent within their situations and consensus will rule. What the doctor should attempt to engender is a situation in which the fors and againsts of various ways of seeing the symptom, diagnosis and treatment is tantamount to raising the consciousness of the patient concerning various alternatives. The relevance which the doctor assumes when putting forward these for and against alternatives, need be recognised as negotiational areas rather than explicit forms of action.

By consulting in this way the doctor is offering a form of responsibility to the patient in regard to the illness definition and taking responsibility for the development of a knowledge of the case. By operating in this way the doctor may serve to facilitate a status shift. This means that the consciousness of both doctor and patient is raised as medical knowledge is negotiated, re-interpreted, re-defined and re-thought out, etc.

4.5.2 The patient, the medical model, choice and responsibility

In the same way the patient must also accept responsibility for the type of communication which takes place with the doctor. Here Mead's theory is applicable because even though both parties may not be equal in terms of knowledge, social position or even intelligence, both are nevertheless armed with a generalised knowledge of the other. Even if they are akin in these areas, their biographical backgrounds - their stock of past knowledge - is different. Whatever the position concerning initial equal status, by applying the humanist ideals of choice and responsibility to the medical model, a sharing of both common ground and unique understanding is possible. As noted earlier in chapter 2 section 2.2.1, Sartre argues that human freedom is linked to responsibility and choice. Such freedom of choice means that both doctor and patient are free to participate in defining any so called solution and this situation

cannot, indeed should not, be suppressed. Norman Green notes why in this way:

> The other's freedom...is the limit of my freedom...It is given to me as burden which I carry without ever being able to turn back to know it..."(1966:20).

The common ground which exists between doctor and patient actually seems, in terms of Sartre's argument, to be that any one reality is mediated through and by the realities of others: **being-in-the-world** is very much tied to the idea that the **other** makes us what we are. The patient then must not sit back expecting the doctor to make individual decisions on their health because such decisions are actually already mediated by their very joint being-in-the-world.

The only way to solve this situation, in other words to make choices which are purposefully taken, is to participate in the negotiation which addresses the looking for answers. When the doctor asks what symptom has brought the patient to the surgery, any answer given should form part of negotiational mediation rather than a factual account. The aim thereby is to further discussion with a view to finding terms of tentative agreement. Likewise, with diagnosis and treatment the same facilitating platform should be employed: to act in any other way is to try to avoid the **total** responsibility which Sartre maintains is part of the very act of living. If this does not take place the individual as a social being becomes alienated from what should be a social reality which is purposeful, meaningful, creative and experiential.

Sartre (1956) considers the stresses and strains attached to such responsibility in social life and comes to the conclusion that "...the social nature of man appears unpleasant and at the same time inevitable" (1956:566). This mutual inevitability concerned with choice and responsibility can cause a conflict of interests. In the

medical field doctors are called upon to give loyalty to many, not only the patient, themselves and other medical doctors (in fact the whole medical institution/profession), but even the state.

This thesis does not refute conflictual situations, but suggests that when conflict is present it is negotiable. When conflictual situations are addressed in humanist terms the negotiational platform provided allows for all parties to express their opinion rather than one party to impose its views upon the other. This is an important point and in the light of Sartre's argument concerning responsibility, will be taken further in the following section.

4.5.3 Modern medicine, choice, responsibility and control

The contemporary medical model because of its vast advancement along scientific and technological lines, has become an enormous finance revenue maker. This applies to the medical model in all its service areas, but for the purpose at hand the investigation will be confined to the role of the medical operative (doctor/physician). In terms of the modern doctor, and working from a purely scientific medical model (non-humanist form), not only the patient's health but the patient's financial situation is in the hands of the doctor. Should the doctor so decide, the sick may find themselves faced not only with a high consultation fee, but also the cost of various diagnostic examinations which are reliant upon modern technology: blood tests, X-rays, radiological scans and a whole array of invasive techniques which may or may not be really necessary.

Added to the cost of a doctor consultation fee and possible specialist exploratory examination, will be the cost of medical treatment itself in the form of medicine. If this situation is handled in a humanistic fashion then negotiation will have taken place between doctor and patient and some sort of mediated agreement (never consensus) concerning diagnostic need and required treatment will have been made. If not, then it is possible that many of these procedures will have been effected because either the doctor truly

believes they are necessary, or perhaps having been given such a hazy picture of symptoms from a non-communicative patient, feels that further investigation is advisable for protection of both parties alike (doctor and patient).

4.5.4 Choice as co-responsibility

In terms of Sartre's argument the decision to investigate a medical problem, taken in a context of co-responsibility, means taken in an attitude of what can be called humility. This means in the knowledge that such decisions and choices are actually made not only for the patient at this time, but bearing in mind Sartre's concept of co-responsibility, possibly for the doctor also at some time in life. Such decisions, according to Sartre, affect not only the patient and doctor of this interactive situation, but in effect possibly all of humanity. If diagnostic examination becomes the "norm" for certain conditions there is the possibility that decisions of this sort become routinely necessary, and thereby are rigidly applied to the exclusion of intersubjective negotiation in terms of necessity rather than need.

Doctor protection, as considered earlier in Section 4.5.1 of this chapter, very often leads to far too many investigatory procedures and the over use of modern drugs, not for medical reasons, but because it has become the "norm" within certain set conditions or circumstances. Therefore, decisions taken to investigate in one situation will invariably have an impact on the choices and responsibilities taken or withheld concerning other human beings and investigatory procedures. Doctors will find themselves in the position of patient at some time during their lives and they too will be at the receiving end of procedures they helped to initiate by their professional involvement and adherence to purely scientific regimes.

It has been noted that in terms of Sartre's argument, there is no way out of taking up the responsibilities and choices which present during life. In terms of the medical model it can be argued that

there is an unequal distribution of power and authority operating within medicine and that this power is more often than not held by the doctor due to his/her "superior" knowledge in terms of scientific irrefutability. Within this context, to have power and authority means that one individual is able to act at, or against, another person's will. This happens within medicine not so much in the form of coercion as we might see in state structures, but in terms of not facilitating the involvement of people in the intersubjective process of negotiation and decisionmaking which allows for personal participation. This Jürgen Habermas refers to as a suppression of voices (chapter 2, section 2.5.3).

4.6 CO-RESPONSIBILITY VERSUS COERCION

It can be argued however that a form of coercion does exist in the medical condition of childbirth if for example a doctor resorts to manipulative language to ensure that a mother delivers her child in hospital. (In terms of scientific medicine, to deliver within the confines of the hospital delivery room is considered by medical personnel to be the safest place for both mother and newborn.) The doctor bases his/her advice to enter hospital for the birth of the child upon a belief in scientific care as being the right way to handle the condition of giving birth. But it can be suggested that verbal manipulation might be seen in terms of a form of violence when seen from the perspective of a mother to be who requests to give birth somewhere other than in a hospitalised environment. The scientific doctor, because of his/her belief in scientific care, may perceive this request as oppositional not only to the accepted "norms" of the medical model, but also in terms of the doctor-patient hierarchical relationship.

However, in terms of the humanist framework advanced by this thesis, if the doctor does not facilitate the mother's own meanings/feelings concerning whether she wishes to deliver her child in hospital or at home, within an intersubjective arena - if he/she gives only the "good" news of hospital delivery and does not offer the "bad" news also (for instance that the birth atmosphere is clinical, that she may be required to accept medication she does not really want, or

that her husband and family may not be allowed to be present, etc.), then this can be argued to be a form of violent coercion which functions in terms of Jürgen Habermas's distorted communication/ intersubjectivity.

In the case of childbirth, the medical model in transforming people into patients, pushes the mother-to-be into a potentially violent situation. It may also be argued that hospital delivery brings to the fore the over use of drugs and induction birth which can be considered in terms of violence done to the unborn child. It can be argued that a child may be born more quickly within the hospital environment in order to facilitate the hospital/doctor's timetable, and also may have been subjected to heavy doses of synthetic drugs running through the placenta before and during the birth process. Although this point is not fully expanded within this thesis it should be seen as a relevant factor when considering a doctor's use of manipulative language in order to promote scientific regimes. It can also be seen to highlight how Sartre's idea of co-responsibility operates, even on what might be termed a secondary level: responsibility for the mother to be and the unborn child. The doctor involved should not take responsibility for deciding what is best for mother and unborn child in terms of his/her belief of having access to the right decisions.

Right decisions, in humanist terms, can only be accessed if decisions are recognised as not being clear-cut. Otherwise what exists is the situation whereby the doctor makes a decision and takes responsibility for that decision. In terms of humanism this type of decision equates to rigidified choice, because it does not involve the mother within an interactional intersubjective framework where the "good" and "bad" news of various alternatives are mediated in terms of a co-responsibility for decision making. This thesis now moves on to consider Ralf Dahrendorf's theory of power within role statuses, initially addressed in chapter 1 section 1.3.3.

4.7 THE MEDICAL MODEL - RALF DAHRENDORF'S CONCEPTS OF POWER AND AUTHORITY

4.7.1 Power/authority defined by role

The concept of role plays an important part in analysing the medical model/profession from either a functional or conflictual perspective. In section 3.5.1 of chapter 3 it was noted that Talcott Parsons saw the role of doctor and patient as separate; regarding the sick role as complementary to that of the practitioner's role. It was earlier indicated that as a functionalist, Parsons viewed sickness as dysfunctional for society because of its interference with the roles people normally fulfil within the social structure when in health. Therefore, sickness in Parsonian terms can be seen as deviant because it deviates from the role norms which usually apply. It can furthermore be argued that in accordance with Parsons's theory, the role of patient is subordinate to that of doctor because of superior elitist knowledge held in the hands (or role) of the doctor in relation to that position.

It was noted that Dahrendorf, rather than locate power and authority in terms of systems maintenance (Parsonian theory), or within a dialectic conflictual tension between the haves (the doctor) and the have nots (the patient) as Marxian theorists would do, preferred to argue that power and authority are intrinsic within the role taken up. Here it should be stated that the concepts of power and authority are used by Dahrendorf interchangably to suit his arguement, and in both cases refers to the stratifying elements within roles in society. Chapter 1 section 1.3.3.2 indicated that seen in terms of Dahrendorf's theory a person can have power within one role in society, i.e. in the role of doctor, and have no power at all in another role, viz., as a mere congregation member in the church.

4.7.2 Power/authority - the doctor's role

By applying Dahrendorf's theory it can be argued that the doctor can be seen to exercise power over the patient in terms of the authority inherent within the doctor role. The patient passively accepts this power division believing that their own role is devoid of both knowledge, in terms of medicine, and power in terms of role status.

As noted in Chapter 1 section 1.3.3.2:

> ...here it is not voluntary cooperation...some positions are entrusted with the right to exercise control over other positions...in other words that there is a differential distribution of power and authority (1969:165).

Dahrendorf indicates that it is this differential in the distribution of power and authority which causes conflicting areas in social life. The doctor can use his or her influence to convince a patient to swallow the recommended pill or to accept a recommendation for invasive diagnostic investigation, etc. In the example of childbirth discussed earlier, the **resolving** of different ways of seeing particular options is more often than not in the form of the doctor exercising his or her authority over the mother in such a way as to cause her to acquiesce. What this type of interaction promotes is in effect the medicalisation of the **natural** condition of childbirth into a condition which is now almost conceived of in terms of an illness.

4.7.3 Power/authority - the patient's role

In the light of the foregoing section it may appear as if the patient has little to offer in the way of power/authority in the doctor-patient interaction. But the reverse can be argued if one considers that it is possible for the patient also, by withholding information from the doctor or by the manipulation of knowledge/information proffered during the interaction, to manipulate the doctor in terms of the same distortion of communication discussed above. One can also argue that by adding or falsifying "phantom" symptoms, etc., the patient may be successful in acquiring unnecessary medication or a doctor's certificate to secure sick-leave from employment. But nevertheless the doctor does appear to hold an authority within his/her position which is dominant to that of the patient situation and therefore can use the power inherent within his/her role to say no to both manipulative patient examples given above.

It is possible, if the patient is a forceful type of person and the doctor is more reserved or intraverted by nature, that the so called

power structures operating within the interaction may be distributed a little differently. But whatever the case, it does appear that the differentials of power and authority in the medical situation is what Dahrendorf refers to in terms of domination and subjection. This can give rise to conflicting interests when a patient does indeed wish to participate in the defining of a condition and the rendition of this condition to their satisfaction.

4.7.4 Power/authority - Humanist terms

The situation of doctor and patient roles in relation to stratification, invested power and authority, are also tied to the concept of status. Some roles carry status (the doctor) and some do not (the patient), and the concept of status can either enhance or decrease the amount of power within particular roles. Therefore the concept of status, in terms of role, is of concern to both Mead and Sartre in relation to human society/social reality. It has been noted that both authors argue that people do not exist in isolation because, in Mead's terms one's own self is very much a part of the others self, and in Sartre's terms similarly, personal being is nothing without other. In this way it can be argued that status is very much determined by the manner in which a person is regarded by others, or in other words people's role status in part becomes that which is bestowed upon them by others. Interestingly Norman Green (1966) notes Sartre as suggesting that "...status is associated with profession but cannot be reduced to it" (1966:42). And furthermore that:

> The status of a particular individual will vary from group to group, and supposedly even from person to person, although one can speak loosely of an individual's social status. The individual finds that in order to act in society he is obliged to assume the roles which others set for him by their expectations...(Sartre in Green, 1966:42).

By using the authors referred to above and extrapolating their theories, the urgent need for intersubjectivity within the medical model is highlighted. In humanist terms any situation calls for

interactional skills which take account of both "sameness", "otherness" and shared responsibility of choice. This takes cognisance of the idea that the unequal distribution of knowledge and power within the doctor patient role can reach potential equalisation if each party accepts the participatory elements necessary for human existence. Therefore by accepting responsibility and taking up the potential to act whilst expecting others to do the same, leads to a rendering of human life in terms of experiential participation.

How people take up the potential to take part, to live within an experiential framework of meaningmaking, is according to Richard Brown (1978) a matter of taste (to make choices) and to Cornie Alant (1990) the way in which people enter into society dialogically (to choose between alternatives), and this in turn denotes a specific way of "seeing" social reality. It is to these two authors and their conception of social reality which this chapter now turns.

4.8 NEGOTIATED REALITY - RICHARD BROWN

4.8.1 Richard Brown - Medicine as aesthetics

As noted from the reading of Brown's theory in chapter 2 section 2.4, social reality is usually conceived of by theorists in terms of structure, or a meaningfully making sense of the world through experiential participation. Brown manages to build what might be called a pontoon between societal structures and people's understanding or meanings thereof. He achieves this by suggesting that the two camps, in his terms science which stresses logical deduction and controlled research, and art or intuitive knowledge which stresses insights and subjective understanding, can be fused by applying what he terms cognitive aesthetic theory. Basically Brown's proposition is that societal structures can only be understood in human terms when they take on board cognitive experience - in other words, when they are taken into human consciousness.

This argument applied to the medical model becomes substantiated when one accepts that the scientific regimes offered by the medical profession have no way of becoming relevant in human terms unless the

experiential elements of people become involved. As noted in the previous chapter Norma Romm's (1991) reading of Jürgen Habermas points to human validation in terms of a truth-content which initiates a "process of self-reflection on the part of the subjects in society" (1991:139). To be self-reflexive can only come about when people come to recognise their own power to overcome constraints which appear given or unalterable. This, Romm notes, means that:

> ...so called facts and laws and cultural traditions in society - which had been regarded by people as incapable of alteration - will become recognised to be, on the contrary, alterable constructions (1991:139).

When the doctor provides treatment, in the form of pills or advice to a patient, the success of such is dependent upon the patient being able to accept into consciousness (becoming reflexive) the background knowledge from which this advice stems. Unless this happens the mother-to-be will be just as unhappy and unaccepting at being "coerced" into hospital for the birth of her child as will an elderly person "forced" to accept diagnostic investigations which they themselves view as unnecessary.

According to Brown's argument for cognitive aesthetics, both medical science and intuitive elements of experience are part and parcel of the one rationale or continuum. Both must be accommodated in consciousness if knowing is to be constituted. Brown therefore argues that in this context the presupposition that science itself constitutes a commitment to values and that the appreciation of art does not, becomes nonsense when evaluated in terms of his aesthetic criteria of rationality. What this means for the medical model is that the science of diagnosis and the patient's meaning structures are all part and parcel of the one same thing (science and art in Brown's terms) and as such both are constituted in consciousness and both warrant like emphasis.

4.8.2 Aesthetics as symbol

The word pontoon used earlier to depict Brown's bridge building

between art and science was chosen in order to highlight the symbolic nature of social reality. By choosing this word, which means flat bottomed boat used to support a temporary floating bridge, it is possible to refer Brown's reference to a cognitive bridge with symbolic social reality as precarious (just like the floating bridge support). The negotiational aspects inherent in all symbolmaking, can be likened to the semi-permanence of the bridge-like structure. Both rely for their continuance upon human reconfirmation/ maintenance. If successful, this chapter has placed human living firmly in an arena of symbolic reality which leaves little doubt that human enterprise, in terms of humanistic sociology, is one of an intersubjective reality which functions dialogically.

4.8.3 Mead's symbol (language)

As noted in Meadian terms, it is this ability of people to acquire language and to use this language in the form of symbols, which sets people apart from other forms of life. The modern day doctor knows much about symptoms, but unless both doctor and patient are prepared to interact in terms of an intersubjectivity as defined by the humanist model, it is impossible for either doctor or patient to share knowledge, and thereby to co-look at alternative meanings of symptoms. If **co-looking** at the alternatives of diagnosis and treatment does not occur it is suggested by this thesis that the patient may feel less inclined to follow the advice or treatment offered by the doctor because personal meaning patterns did not become involved through dialogical participation.

4.9 DIALOGICAL REALITY AND THE MEDICAL MODEL - CORNIE ALANT

Alant's theory, as noted in chapter 2 section 2.5, rests firmly upon the premise that human beings live intersubjectively in a social matrix which operates dialogically. By this is meant that people's shared world accommodates both the taken-for-granted aspects - the invention of culture - and its possibility for re-definition in unique ways (or otherwise stated, what Alant refers to in section

2.5.1 of chapter 2 as to accept tradition or to revise it). In the humanised medical model it could be argued that there is an acceptance of the doctor's medical knowledge not in terms however of an objectively specified truth, but rather as vehicles of communication for continuing dialogue. Spelt out in this way it can be argued that the truth offered in terms of medical diagnosis by the doctor need actually be seen as the starting point for an "open" reconsideration by all parties. Dialogue within such a defined medical field throws light upon the precarious and ever changing nature of the medical model as applied in practice because it continually throws into question its validity. The doctor and patient raise each other's consciousness with the "good" and "bad" news of alternative meaning patterns and in so doing it becomes possible to reach the ongoing flux invisaged by "status shift" effectively equalising specialist knowledge and laymen concerns.

The mother-to-be in the example cited earlier in section 4.6 of this chapter, through intersubjective dialogue with her practitioner, may decide that it is preferable to deliver her child in hospital rather than at home. In entering into dialogue as to how the doctor sees her medical condition, it is quite possible that she will understand his reasons for offering this advice and accept them (tentatively), and act on this basis. On the other hand, it is also quite possible that such dialogue will enable the doctor to understand her feelings on the matter. It may be that the patient's fears of hospital confinement are found to have some relevence after all and through negotiation the doctor may come to see that the patient's fears of hospital confinement could be detrimental to a successful hospital birth (or at least that they do deserve recognition).

Even if no decisions are changed concerning the medical arrangements for birth, a decision will at least have been taken from a platform of intersubjective debate which required that both doctor and patient consider the alternatives involved with any decision, and furthermore, in the knowledge or recognition, that there is no one and only right answer or solution. In this respect Alant notes that intersubjectivity is not to be seen as a <u>formula</u> but rather as a

means of choice which at one and the same time requires people to make their own reality and to take responsibility for their choosing. This dialectic relationship is referred to in the work of Peter Berger to whom this chapter now turns.

4.10 THE BERGERIAN DIALECTIC WITHIN THE MEDICAL MODEL

As noted in chapter 2 section 2.3, Peter Berger considers human social reality to be dialectic by nature. Arguing that society is a product of people and that people are a product of society Berger highlights the paradox inherent in human living. Related to the medical model it can be suggested that people having formed the scientific medical model must now answer to it. Berger argues that to live merely by the existing structures (answering to what appears to be objective reality which cannot be questioned), is to live in a condition of alienation. People-made institutions like medicine can and must be questioned if people are to exercise their full potential for human living. Seen in this way the medical profession, far from being an objective structure which is unquestionable, is actually an ongoing debate, part and parcel of what Alant considers is merely a vehicle for communication.

For the institution of medicine this means that patients should not just accept the status quo (status quo here refers to the doctor's ideas on diagnosis and treatment) of any situation, and doctors need not try to offer pure truths of treatment to their patients. When the doctor suggests a particular type of treatment the patient should take up his or her capacity to question the validity of such, and thereby take part in what Berger suggests is a participation in the co-production of reality.

Berger further argues that there has been a rise of science as an autonomous secular perspective (note this point in chapter 3 section 3.2.2 with regard to Fritjof Capra's argument) and he suggests that unless people exercise their human ability to make choices the ready-made-world of medicine will come to be seen and accepted more and more as a field which becomes validated in terms of people as

machines rather than as human beings. What happens is that we begin to see the world as a world of predetermined institutions and the people who staff those institutions, and ourselves included, in terms of what Alfred Schütz calls typifications. It is to Schütz's theory of social typification that this chapter finally turns.

4.11 THE MEDICAL MODEL AS SCHüTZIAN TYPIFICATION

Within the theory of Schütz, as laid down in chapter 1, it is noted that the field of phenomenology is primarily interested in the way in which interpersonal interaction becomes meaningful to actors. In line with many of the other theorists applied to the humanist medical model in this chapter, Schützian theory argues that the social world is experienced by people as common and shared. What this means is that the world manifests itself as having an out-there existence which humans assimilate into their consciousness in terms of a commonsense knowledge or, in typification form. Reciprocity of this commonsense view of the world ensures that people become confirmed in their actions and views because others too take-for-granted the same aspects of the world.

4.11.1 Medicine as shared expectation

Applied to the medical model this means that our expectations of the medical doctor are shared by everyone else in our own particular culture. This means that if the medical profession is seen as irrefutably scientific and therefore unquestioningly sound, it becomes increasingly difficult to suggest even in our own minds that this is not so, because everyone confirms it. However, by expanding upon Schütz's concepts further it becomes clear that people do not live by typification alone.

4.11.2 The pure "We" relationship and medicine

Schütz's way of addressing the more humanist theory of social reality suggests that the pure "We" relationship (the face-to-face interaction whereby two people enter into the consciousness of the

other - explained more fully in chapter 2) can fend off typification living by revision and modification of thoughts and actions in reflexive consideration. For our medical model this means that although we enter into the consultation armed only with anonymous typification knowledge of the other, as the interaction proceeds, both role occupants (doctor and patient) rewrite their typifications in order to make sense or make meaning of what takes place. What takes place of course is an intersubjective encounter during which typification knowledge, as indefinite recipes, become starting points (or vehicles) for negotiation.

4.11.3 Medicine as mediated understanding

In this way understanding of a particular medical condition becomes a mediated understanding and the doctor as expert has to become a negotiated expert in as much as expertise needs to be defined and confirmed through intersubjective dialogue. At the same time the meaning of his or her expertise can become altered and shifted through the actual interaction. Mediated expertise does pose moral questions as to how much or how little patients should be told about the doctor's perception of their illnesses, especially in the case of the more serious illnesses of our time like Cancer and Aids. (For this reason medical ethics forms the basis of the final chapter of this thesis and will therefore be developed fully later). For the time being, mediated understanding need be seen in terms of a partnership between the medical profession and its patients.

4.12 HUMANISTIC MEDICINE - A ROUND UP

In Meadian terms this partnership indicates that selfs need other selfs to survive. In Sartre's terms such a partnership means that in order to live freely everyone has to make choices and to accept the anguish that choicemaking brings.

In this respect Sartre argues that choicemaking encompasses an acceptance of co-responsibility for human social reality and this co-responsibility in terms of Brown's and Alant's theories, indicates an intersubjective dialogue which provides for the symbolic nature of human living.

For Berger and Schütz the partnership takes account of the dialectic tensions within society which need constant addressal if alienation and rigidified typification (uninterpreted by human involvement), is to be avoided or prevented. This indicates that humanist authors can be seen to unite in many areas of their individual theories. It furthermore points to the conceptualisation of social reality as a concept which promotes the ideal of there being no one and only right way of making sense of human existence.

With this in mind it is here argued that humanist sociology in providing for the participatory experiential essence of people to make choices, provides for an arena of creativity which is not given due credence either within other sociological perspectives, or within the contemporary scientific medical model.

4.13 CONCLUSION

In this chapter the opposing poles of humanist intersubjectivity and the medical model have been brought face-to-face in order to highlight their lack of accommodation. The work of theorists introduced in chapter 2 and the ideas propounded about the scientific medical model in chapter 3 have been systematically applied to areas within the medical framework.

The theory of George Herbert Mead gave an indication of how, through the utilisation of symbol and self, the human being both makes and revises personal social reality. In the medical field this was shown to mean that diagnosis and treatment cannot be defined as having truths or the correct and only answers to medical problems. Correct answers would mean that people interact in purely "Me" type mode and Mead's theory actually points to the simultaneous interactive

qualities of the self through both the "Me" and "I" interplay.

Jean-Paul Sartre's theory of co-responsibility was shown to address illness in terms of choices which when made affect not only the choice maker, but all humanity.

Ralf Dahrendorf's theory of power within role occupation indicated the inequalities inherent in the power distribution within the medical consultation. It was noted that the doctor has access to elitist knowledge and that this superior knowledge locates both power and status within the doctor's role and within the doctor-patient relationship.

The work of Richard Brown (cognitive aesthetics) and Cornie Alant (dialogical social reality) were shown to argue that all meanings (scientific or otherwise) are taken up in consciousness via the vehicle of dialogue. It was suggested that only in this way can social reality be seen to provide human freedom. This was shown to mean that people are seen as free to either confirm or redefine symbolic meanings. Applied to the humanist medical model it was indicated that confirmation or redefinition of illness, diagnosis and treatment are primary for a humane medical model.

Peter Berger's theory of the medical institution as people-made, and therefore revisable by people, was shown to pinpoint the dialectical nature of human living.

Finally, Alfred Schütz's concept of typification (meaning that actors conceptualise the world as taken-for-granted) was used to show that although typification allows for commonsense understanding, interaction via the "pure We" face-to-face relationship can provide an alternative way of seeing social reality. Applied to the medical model Schütz's theory pointed to the ability of intersubjective interaction to re-write anonymous typified knowledge.

In the next chapter this thesis moves on to consider in more detail how medical ethics can be utilised to facilitate personal autonomy

when considering health, illness and treatment. This ideal is motivated in terms of what can be called a more humane interpretation of medicine through the mediatory facilitation of intersubjective dialogical living.

CHAPTER 5

HUMANISM AND ETHICS IN PRACTICE

5.1. INTRODUCTION

In the previous chapter the humanist tradition was brought face-to-face with the scientific medical model. It was indicated that the scientific medical model is at variance with the humanist tradition in terms of intersubjective living because it fails to address what has been termed elsewhere in this thesis "the creative and meaningful construction of the human lifeworld". (See chapter 1, section 1.4). It is thereby suggested that if people are not invited to take part in the defining of illness, diagnosis and treatment, a block is effectively created which prevents intersubjective meaningmaking.

In this respect, it was suggested that people who subscribe to the medical model, use its scientific character to define the terms illness, diagnosis and treatment without the involvement of people's meaning structures. It was shown that pre-definition of human illness can occur within contemporary medicine for several reasons. For the most part, people within the medical profession rely on elitist skills and knowledge (patients are often considered knowledgeless), and it was argued that there appears to be a power element at work within medicine which seems to uphold the profession's seeming **right**, or sole prerogative, to provide the only answers to medical problems, etc. It was indicated that the "profession" has so successfully infiltrated the human consciousness with its scientific irrefutability, that people have come to accept, expect and believe in the medical fraternity as sole definer of their medical ills.

In terms of the humanist perspective defined within this thesis, this was shown to mean that most personnel within the medical

model appear to function in a mode which can be likened to the Meadian "Me" component of the self, to Schützian typification and Bergerian social reality as a pre-defined facticity (see chapter 4). In these terms, what takes place is according to Jürgen Habermas (1987) that the power structures within medicine successfully "colonise" people's lifeworld through a distortion of communication caused by medical expertise in doctor-patient exchanges (see Chapter 3 section 3.6.2) This prevents human discourse from occurring.

In this chapter the concept of medical ethics will be searched in order to try to discover how far there is an allowance for shared (intersubjective) definition in medical decisionmaking in terms of humanist theory. This means that the chapter will not be looking at the reasons for why particular moral decisions are taken, but rather at the way in which decisions are made in terms of human intersubjective communication through a shared arena. In other words not at whether moral decisons can be considered good or bad, because such decisions in humanist terms are symbolic and therefore open to multi definition. Decisions made in terms of humanist communication, involve what is termed a "co-responsibility" and a willingness to face what have become reified meaning patterns within society.

In this respect certain aspects of communicative interaction will be of import. For example, what effect does an unequal knowledge and power relationship have on the type of interaction which takes place between medical personnel and patients? Do doctors consider patients as knowledgeless? Is there an attempt by the actors involved to equalise the interaction which takes place? Are patient-doctor consultations normally conducted in terms of "closed" interaction, or does the potential for "open" interaction exist?

In the previous chapter the theories of George Herbert Mead, Alfred Schütz, Richard Brown, Cornie Alant and Peter Berger were read, to highlight the failure (in humanist terms) of contemporary medicine to address human participation and meaningmaking. In this chapter Jürgen Habermas's theory of distorted communication - leading to distorted intersubjectivity - will be utilised to address the areas noted above, and to try to initiate what can be termed a more humane platform from which to consider human worldconstruction and meaningful reality within the medical model. The work of other humanist authors will be integrated where necessary to elaborate upon the argument at hand.

Finally, it is necessary to document the fact that this chapter on ethics is limited in terms of particular selected aspects. The field of medical ethics is vast. It extends into many and varying areas of human life which cannot be fully addressed here. Questions of moral concern between people and medicine begin even before life itself (as will be indicated later in this chapter when genetic engineering is considered), and extend far into the realms of death. It will be shown that in relation to death and transplant surgery, the pressure upon the dying and their families to agree to donate organs once death has taken place, is great. At times the wellmeaning concerns of the organ transplant team can be argued to preempt the use of life-support machines in order to prolong the death process and thereby allow medical science time to preserve organs and save the life of others. This in turn can be seen to deny the dying and their family what can be termed the dignity of dying under natural circumstances. The moral issues involved become complicated when one realises that this type of decisionmaking has equally as much to do with the rights and dignity of the dying, the donor recipient requirement for new organs, the medical professions need to further its scientific involvement and state provision in terms of medical facilities and financial backing for transplant programmes.

Also of import is the point of view from which questions of medical ethics are approached. The philosophical view, in relation to the

writings of various authors within chapter 1 of this thesis, offers a far different account of human meaningmaking than the account proffered by the medical model. Philosophy thrives upon self doubt and questioning whilst medical science has to do with the achievement of success, linked to more and more technological advancement in the ability to heal, cure, prevent disease and preserve life, in terms of the unquestionability of scientific regimes. But this achievement and success also involves power, and power brings with it both responsibility and anxiety. In this respect according to Samuel Gorovitz (in Moral Problems in Medicine 1983), this is the urgent area of medical ethics today, and should be seen as a "symptom" of the success of contemporary medicine. Whatever one's personal belief concerning modern medicine (as noted earlier, it is not the prerogative of this thesis to make any form of moral judgement in this respect), one has to acknowledge that the field of medical ethics is both extensive and pervasive. As mentioned above, for this reason the ethical issues read within this chapter have to be perused in limited fashion in order to facilitate and utilise the primary concern of this work, which is to search humanist intersubjectivity in terms of ethical considerations.

5.2 MEDICAL ETHICS RELATED TO HUMANIST THEORY

Initially an attempt will be made to locate medical ethics historically in order to give brief consideration to the area of growth in technological medical intervention, and thereby the increase in what can be termed an ethical dilemma within the contemporary medical model. This in turn will be related to the rise of moral decisionmaking within contemporary medicine, and defined by this thesis as due in no small part to the growth of the so called scientific "regime". The chapter then moves on to discuss "operational" ethics within both the doctor-patient consultation and within the wider concerns of public debate.

To achieve this aim certain concepts within the area of medicine relative to medical ethics will be highlighted. Some of these areas

are: confidentiality, decisions on how much or how little to tell a patient about their condition, what to tell patients to expect from particular therapies and drugs, etc., - in other words, how far to involve people in the decisionmaking process concerning medicine and its scientific procedures. Interaction in these areas is indicated to be two-way and "shared", and it will therefore be argued, cannot be considered merely in terms of an issue where the doctor takes autonomy to inform or decide procedure. Therefore the point at issue here is, if the patient requests knowledge how does the doctor handle this enquiry for more information?

Does he/she merely answer the questions and then feel that the patient has taken part in deciding (in other words that the patient's cognitive structures have become involved). Or are his/her actions "humanistic" enough to involve the patient's real feelings and meaning structures through a truly shared arena of **all knowledge** available - rather than avoid contradiction between the interests of those exercising power (the doctor) and the interests of those they exclude (the patient)? It will be indicated that in many of these areas there exists the possibility on the part of medical personnel to impart only the "good" news of possibilities in order to retain scientific autonomy. In this respect this chapter argues that intersubjective living - to impart both "good" and "bad" news of decisions/possibilities - is blocked by the medical profession's adherence to its own scientific morals rather than to what Jean-Paul Sartre in Chapter 4 section 4.6 of this thesis refers to as co-responsibility for decisionmaking.

5.3 MEDICAL ETHICS - FROM HIPPOCRATIC OATH TO CONTEMPORARY MEDICINE

The idea that medicine involves both ethical and moral dimensions has been evident since the Oath of Hippocrates. It was the Greek physician Hippocrates who, around 400 B.C., became instrumental in formulating principles of health which relied upon the rejection of so called supernatural phenomena (see chapter 3, section 3.3.1).

Hippocrates argued that medical knowledge should be derived not from a total belief in the dominance of God, but from an understanding of the natural sciences and the logic of cause and effect relationships.

W. Cockerham (1989) notes that it was Hippocrates who first pointed out that human well-being is influenced by a totality of environmental factors - living habits, climate, topography etc. It was these ideas, combined with an approach based upon thorough observation of the patient's symptoms and a logical plan of treatment according to proven procedures, which laid the foundations for the "Hippocratic Oath" which medical personnel still swear to uphold today on completion of medical training. Therefore, the Hippocratic "system" considered the "whole" person to be an important factor in the understanding of illness and it was, according to Cockerham (1978), the Roman Catholic Church who preserved this belief in knowledge and intellectual orientation after the fall of Rome.

Within the Oath of Hippocrates lie the elements relative to medical morality and ethics: medical personnel swear to refrain from intentional wrong-doing or harm, to keep confidentiality in all matters pertaining to the doctor-patient relationship and to do all that can be done to search out the reasons for illness. In all these areas there is an element of choice which is not always extended to the patient concerned because, as argued within this thesis, medicine believes it has the right answers. In this respect Gorovitch (1983) notes that the concerns of the Hippocratic Oath to "do no harm" are often quoted haphazardly in that, "...the maxim is abruptly cited, as if its import is quite obvious...", whilst most physicians who quote the venerable text "...know little of its origin and are unaware of the range of possible meanings it might have in arguing a case in medical ethics" (1983:99).

Humanism also refutes belief in the "venerable text" if it is seen in terms of "set" unquestionable criteria, because humanism argues that content/meaning is only "understandable" when taken up within

the framework of the human consciousness. This means that all things are questionable and redefinable - even science and the Oath. Therefore the areas mentioned above do not have clear-cut answers (definable by science), and in this respect the humanist would ask, what does "intentional wrong doing or harm" in the scientific context mean? Who should the physician keep confidentiality with and how do physicians "search out the reasons for illness" without at times "stretching" the goals of their Oath? K. D. O'Rourke and D. Brodeur (1987) note in this respect that these crucial elements between doctor and patient can become severely pressurised when a team of healers become involved with a patient. They note that reductionist contemporary medicine has to find a balance between the call of medical science and the "patient's rights...and need for information" (1987:62,3).

This called for "balance" in itself would seem to uphold the humanist ideal for a shared intersubjective arena, which according to O'Rourke and Brodeur now has increased relevance because modern medicine equates "...quality care [as] ensured only through a larger number of people having access to a patient's [personal medical knowledge]" (1987:63). Therefore, if personal information is not "humanistically" delineated between the "team" and the patient concerned, conflictual elements may easily arise in the treatment of patients which actually prevents success rather than enhance it. This "cleft-stick" situation is now taken up.

5.4 HIPPOCRATIC IDEALS APPLIED TO CONTEMPORARY MEDICINE

As noted above, the situation concerning ethics within medicine now seems to encounter difficulty in keeping pace with the technological advances and changes taking place within contemporary medicine, and at the same time remain true to the ideals contained within the Oath. More and more ethical decisions seem to promote scientific medicine in opposition to human enterprise and this thesis argues that this can cause harm in human terms. Within the realms of doctor-patient consultation the elements contained in the Oath can

be noted as not so clear-cut because they often embody decisions being taken on behalf of the patient (as noted earlier, patients may indeed be asked on certain issues - but asked in such a way as to merely elicit the response that science requires, to coalesce), without their **truly** becoming involved.

Medicine has advanced so far in technological terms that it is often difficult for medical personnel to impart to patients and their families what certain medical decisions entail. Because of this difficulty - bridging the gap between medical scientific regimes and laypeople understanding - medical personnel make what they consider to be the best "scientific" decision under the circumstances which prevail. But at times this can be seen to leave the patient unknowledgeable about the **true** (or viable) choices involved in certain treatments. And this means that the rigidified meaning structures within society - and in this case the medical model - are not addressed. They are "skirted" by both doctor and patient alike as decisions are discussed and taken from a reified set of meaning structures. This point is taken up further in section 5.7 of this chapter where it is indicated that ethical decisionmaking in contemporary medicine involves both the well-being of the person and the concerns of this thesis: that **real** choices be made available to people in order to prevent stagnation of medicine in humane terms.

This is not to say that the medical profession restricts or eliminates personal choice on purpose. On the contrary, it will be noted later that the medical model does believe it offers choice of alternative options to its clientele. It does ask questions about what people want but in the terms of this thesis it does so in what can be called a form of set agenda, or in the case of medicine, a set policy which utilises both scientific irrefutability and reification in its planning. This means that decisions are made in terms of its (medical science's) own scientific irrefutability, in a belief that science has the right and only answers to human illness.

It will be indicated that part of this reification is due to the social context (i.e. social and economic elements which involve the population at large and the state apparatus), and the "problem" of people having become used to operating within set conceptualisations or categories within society. This point is expanded in section 5.7 to follow, where it is suggested that medical policy is framed in restricted reified terms. In this way medical ethics as a set of written and unwritten rules (unwritten rules relates to decisions made from a basis of what could be called "normalised" procedures within a set situation), regulate and prescribe behaviour which reflect scientised values and attendant norms rather than the well-being and worth of human existence.

5.5 ETHICAL DECISIONS IN MEDICINE RELATED TO THE HUMANIST TRADITION

Ethically (within the terms of the Hippocratic Oath), medical personnel are required to advise patients on various courses of action which may be taken. However, if that advice is given from a base of so called scientific irrefutability - a base which answers questions with routinised answers - this can be shown to hold the possibility of coercion (on the part of the doctor), through what Habermas calls distorted communication (see Chapter 2 section 2.5.3), leading to distorted intersubjectivity.

In this way, if a patient questions the medical practitioner's decision - rather than accept his/her "expert" advice - the doctor will either provide answers which he/she believes to be correct in terms of his/her scientific background (and therefore offer no real choice to the patient in humanist terms), or perceive the patient's behaviour as deviant because what is taken to be the accepted "norm" is seen as violated. The patient is expected to listen passively or acquiesce, and therefore does not embark upon a search for participation in the construction of a meaningful reality. This is not to say that the patient becomes unhappy (it was noted earlier that due to the successful infiltration of medical science into

human consciousness, people have become used to operating in set categories - which in this case uphold the so called "superior" knowledge of medical science). Therefore unhappiness does not feature because both scientific doctor and patient alike operate in terms of "colonised" meaning structures which appear to be correct (see chapter 2, section 2.5).

But in effect this lack of participation leads to a process of dehumanisation in humanist terms because the scientific medical model seems to offer "correct" answers to ethical questions which present themselves without the involvement of people's true meaningful participation, and which thereby do not provide for **real** choicemaking.

5.6 THE POWER ELEMENT INVOLVED IN MEDICAL ETHICS

When medical ethics is seen in the wider setting of social and economic concerns the situation becomes more complex because a power element becomes apparent. For example, if consideration is given to the area of moral decisionmaking concerning the postponing of death - or the prolonging of human life - it is apparent that both involve personal values and norms regarding the treatment of the individual which impinge upon both the personal well-being of that individual and his/her family. Whilst to withold medical assistance and allow death to take place "naturally" may appear the best course of action in terms of the people concerned, such action could be argued to run counter to the medical code of ethics which is directed at saving/prolonging life for as long as possible. Also, in the broader context of this thesis the decision to allow death to take place "naturally", has to involve intersubjectivity in terms of not only the actors involved in this particular "scene", but also in terms of a consideration of what such decisions mean for everyone living in the same society. As Alant (1990:46) notes:

> From the outset, we the actors on the social scene, experience the world we live in...not as a private but as an

> intersubjective one, that is, a world common to all of us, either actually given or potentially accessible to everyone.

This means in effect that our thoughts and actions - being non private entities - are affected and indeed have an effect upon fellow human beings. As noted in chapter 2, section 2.2.3, Sartre argues that "Whether I desire it or not, my choice of a situation involves others about me, and mankind in general (1973:374). In this way the choices made within any situational arena automatically involve everyone and carry the responsibility of knowing that people's experience of social reality is the only definer of human action.

It may also be argued that such decisions (due to technological achievement in the field of life-support machines) conflict with, (a) the Hippocratic Oath which aims to preserve life (as noted above), (b) the concerns of medical science in the field of scientific advancement (transplant surgery), and (c) the wider concerns of public accountability. In this way, to preserve life "scientifically" may facilitate a life for someone else in the form of a healthy kidney, but at the same time has to balance the responsibility to utilise scarce resources in the form of public/state funds and medical expertise/technology (thereby embodying decisions of both a financial and ethical nature which concern public debate), with the emotions of the individual and his/her family.

This type of decision can further be related to the debate on euthanasia and involves not only decisions being made with regard to painless death versus an existence compatible with human dignity. But also to the above mentioned concerns of scarce state resources in the form of medical personnel, medical costs for machinery and drugs, and the question of decisionmaking in terms of the broad intersubjective rationale debated above. In this area procedural courses of action have had to be effected (see endnote 1), in order

to rationalise medical procedures and thereby "routinise" and protect human decision-making. B. A. Rix (1990:5) states in this respect that "... new medical technology, for example the respirator, has affected the process of death...and raises new ethical questions of very practical import" which involve the human emotions. If these emotional elements can be removed through rationalised procedures (a systems approach rather than a humanist), Hans-Martin Sass notes what he terms one of the advantages of brain-oriented definition of death in this way,

> Human life that can no longer communicate or feel pain need no longer be supported; severe moral, emotional, cultural, social, and economic costs that would have been associated with the artificial extension of the life of such entities are thus avoided. Organs then become available for patients who would otherwise die or face severe suffering..." (1989:49).

But Rix argues against this so called "advantage" by pointing out the dilemmas involved with any definition of death. He notes:

> Though certain legal and medical dilemmas are solved by the brain death criterion, questions such as what is death and what conditions should be provided for the dying cannot be summarily answered [because] our experience of death transcends the medical and legal purviews, and relates to our most fundamental beliefs, attitudes and practices. The new medical technology necessitates a practical and precise definition of death, but this definition cannot be arrived at without a consideration of deep-lying human values (1990:5).

In this respect the concern with public accountability is taken up by Rix (1990) who quotes The Danish Council of Ethics as stating that "...a change in the criterion of death is an event of such significance that it should not be permitted without a major public debate" (1990:5). This would involve consideration of scarce public

(and health profession) resources, and furthermore in the terms of this thesis, although it still does not involve real choicemaking on the part of the patient and his/her family, it does highlight the growing complexity of the ethics debate within the contemporary medical model.

In Chapter 3 section 3.6.2 Foucault's argument concerning control versus power highlighted this double sided controversy. Here it was noted that medicine can sometimes be regarded as a "closed domain" whereby life and death decisions are taken by medical personnel from a platform of power which is backed by elitist knowledge. There is an apparent dilemma between the doctor's position of power in such situations and also his/her handling of the elements of confidentiality and belief concerning how much patients and their families need to know - and furthermore, to the public debate surrounding medical moralising. This thesis adds a third area of concern to Foucault's double sided controversy by calling for the recognition of people's potential to take part in this negotiational arena. In this way the very definition of death becomes ongoingly debated and takes into account not only people's meanings of the concept death, but also a "consideration of [the] deep-lying values" pointed out by Rix above.

In the case of death, the prolonging of life through the use of a life support machine involves the medical profession in offering its "expert" scientific advice to the patient's family on the fors and againsts (presuming in this case that the patient is unable to understand the position for him/herself). But as noted earlier, due to a concern for scientific advancement, the medical profession may have its own reasons for seeking permission to prolong life.

Again, according to Hans-Martin Sass, the moral options which such decisions involve often become confused between ethics and emotion. Sass notes that: "The first heart transplant a generation ago and

the actual debates [involved with prolonging the life of someone through technical means] serve as examples of emotional rejections of morally acceptable or even desirable new options" (1989:45). The public obviously wishes to exercise its right to enter into the debate surrounding "improved" medical technology. This debate centres around the so called "good" news for the patient and the so called "bad" news for many who are called upon to fund expensive technology which it may consider undesirable.

On a different level, the debate and choices involved with improved medical technology are not always spelled out to patients. Where the situation of "repair" to the body is concerned the "good" news may be that life can be supported until a kidney improves or a heart becomes stronger, etc. In these terms medical science can achieve great success. But humanism's problem is that the "bad" news may not always be given to the patient and/or his/her family, i.e., the bad news that even when the heart gets stronger it may not return to full strength and the patient may thereafter have to accept a life of semi-invalid. Or the transplanted kidney may not be accepted by the host body and the patient may be placed in an even more critical position.

The medical model answer to such questions is always scientific, i.e. if this happens then there is much that can help the patient technically. But this thesis argues whatever the decision made all parties within particular situations should be offered both the "good" and "bad" news from which to decide, not merely the scientific "good" news. In this way real participation becomes accounted for and more humane ethical decisions are taken because they involve the meaning structures of **all** concerned. The concept of confidentiality has much import to what has been said so far and for this reason it is now taken up in more detail.

5.7 CONFIDENTIALITY AND THE DOCTOR-PATIENT RELATIONSHIP

In terms of confidentiality there are always decisions to be made in

the area of how much knowledge a patient and his/her family should be given, or need to be given, concerning courses of action. The dilemma noted earlier is directly related to what can be called the unequal elements within the doctor-patient relationship. The doctor's interest is primarily professional and his/her skills underwrite an authority over the patient. This means that for varying reasons the doctor may decide to withhold important information concerning illness - e.g. the doctor's possible need for an unemotional involvement with a patient in order to offer the best scientific/objective advice, or a belief that patients require, or are entitled to protection from unnecessary worry or distress. Todd and Still (1984), discussing impending death, note the dilemma involved in this type of situation in this way:

> There is conflict...between the doctor's not telling his patients because it is better if they don't know, and his recognition that in fact they do know either through their experience of the illness or through talking about it with...[others]...the doctor experiences a conflict between his role as a doctor and what he faces...(1984:669).

This conflictual aspect is understandable in the situation of death (although the humanist would argue that even in this situation choices need to be made which should involve all parties), but in humanist terms conflict can be shown to exist in other areas of decisionmaking involving ethical consideration within the doctor-patient arena. For example, a doctor who calls for extensive X-rays to aid diagnosis may offer only the "good" news of this decision. The X-rays will probably show what is wrong. In this situation, withheld from the patient is the "bad" news of the situation. Too many X-rays can involve the body in overdoses of radiation - leading to what Ivan Illich notes as medicine which does more harm than good.

The same can be said of drug therapy. Many drugs can be seen to cure one thing and at the same time induce another problem. In this respect Illich's argument (Chapter 3 section 3.6.4) indicates that medicine causes as many medical problems as it solves and points to the medical model in terms of a radical monopoly. This argument has a direct bearing upon confidentiality and a doctor's willingness or ability to provide both the "good" and "bad" news of various options. It also has a direct bearing upon the way in which medical ethics can be seen to operate within the communicative arena because it stifles certain information in order to promote the "good" news.

R. M. Veatch (1989) suggests that confidentiality is basic to the physician-patient relationship and is "...closely linked with basic human dignity and respect for persons, just as with lucidity" (1989:83). He indicates that to keep confidentiality does not only have to do with keeping one's mouth shut about a patient's private affairs because in some cases "...where physicians think that violating confidentiality would benefit the patient in some way, they would be encouraged to seek that benefit at the expense of patient privacy" (1989:83). But confidentiality also has to do with threatened harm towards others, for instance a patient who discloses to a doctor that he/she intends to help a terminally ill patient to end his/her life. Therefore Veatch maintains that deciding when confidentiality may or may not be overridden is one of the most difficult problems in medical ethics, and furthermore in these terms, highlights the humanist argument that symbolic concepts are not clear-cut and predefined within the operational area.

Along these lines Veatch indicates that the family physician may encounter a double-bind situation. He notes that, "...[physicians in the terms of their oath of confidentiality] owe a duty to respect the privacy of a patient, but [can] also feel a duty to other family members of that patient, who are also members of that physician's practice" (1989:86). He cites the situation where an adolescent asks for birth-control pills and does not want her family to know.

In terms of the argument put forward by this thesis, the doctor who assumes his/her role to be one of deciding for the patient by allowing only "surface" choicemaking (for example, this is my recommendation do you agree? [the "good" news]), in humanist terms negates the integrity of the personal lifeworld through the possible withholding of certain information/knowledge in order to further what the doctor thinks is the best course of action in terms of his/her scientific background/belief. What this may mean in terms of the above example is that the doctor either advises the adolescent to tell her parents first, or takes the authority and prescribes the birth control requested. C. J. Todd and A. W. Still make note that this type of situation causes "...deliberate barriers to overt communication" (1984:667).

What humanism calls for in answer to the above examples is that "real" choices be availed. Not only that the patient's point of view be discussed, but that the doctor's point of view and situation concerning confidentiality also be confronted in a negotiational setting. In this way, even the patient who admits to something untoward (i.e a patient who confesses to a wish to aid the death of a terminally ill family member) should through consciousness raising and a discussion of the "good" and "bad" news (various options and alternatives) be able to see not only his/her own appraisal of the situation, but also the physician's difficulty in being expected to keep confidentiality in a situation which in this sense is illegal.

This means that the physician is no longer seen in terms of a power position, or in this case, in terms of a listener who is expected to listen (in confidence) and make no moral judgement because of the patient's expectation of confidentiality. The doctor does have personal moral ideals and in the case of the adolescent and birth control, may even be prejudiced for or against. Humanism allows for all of these conflictual elements to be mediated through the platform of "good" and "bad" news negotiation.

By not attempting to mediate both doctor and patient "knowledge" highlights the way in which medical expertise legitimates its action in terms of set criteria (patient confidentiality). It achieves this by deriving power from its roots in formal knowledge (science and technology), thereby effecting what was referred to in terms of Habermas's theory as a colonisation of the lifeworld (see chapter 2 section 2.5.3). This can be seen to place both patient and medical personnel into an area of what might be called "illusionary" communication. The expectations contained within the concept of confidentiality are now taken up using Habermas's theory of distorted communication.

5.8 CONFIDENTIALITY AND JÜGEN HABERMAS'S THEORY OF DISTORTED COMMUNICATION

In Jürgen Habermas's theory of communicative action it was noted that the lifeworld is seen as a sort of "symbolic space" within which mediation between differing (and sometimes opposing) standpoints takes place. In terms of humanism, and the concept of confidentiality, this means that what takes place within that space is very much open to definition by the particular actors who take part and, therefore, to their particular meaningful understanding of the situation. However, due to what was noted earlier as an unequal distribution of knowledge, power and skills, the symbolic nature of communication becomes distorted within the medical model in terms of the scientific frame of reference. This thesis suggests that rather than an acceptance of medicine in terms of unquestionability, the symbolic space in medical interaction be recognised in a light of revisability and of choicemaking on the part of all involved.

What this means in terms of ethical decisions within medicine is that medical decisions should not be presented as "technical" and "scientific", as unrevisable and unquestionable, because this type of presentation involves the necessary use of one best method. In

this respect Habermas is noted by Patrick Scambler (1986:174) as suggesting that this gives rise to a critique of modern medicine in terms of its "...medical expertise [which] has become increasingly technocratic and un-accountable...involving a progressive medicalisation of everyday life".

In these terms the meaning of ethical decisions is provided through what can be termed abstract rules which successfully decontextualise events and remove them from particular personal experiential contexts. Rather what needs to take place is what J. Mishler (in Todd and Still, 1984) argues to be the need for a more symmetrical power relationship between physician and patient. In this way the sharing of knowledge between doctor and patient can achieve a humane empowering of patients by inviting patient entry into the experiential area of decisionmaking.

This effectively draws upon Habermas's theory of communicative action because it is oriented to understanding rather than the mere acceptance of reified knowledge, to "...symbolic structures [which] remain restricted to a language in which conscious intentions are expressed (1971a:216). If this does not take place, then the communicative arena is set in terms of a distortion of communication/intersubjectivity. Medical knowledge is thereby denoted in terms of a formal knowledge which affords the medical profession the only true expertise. This relegates laypersons into the realms of unknowledgeablility and limits choice relative to a doctor's suggestions (backed by scientific accountability). In humanist terms, limited choice has to be seen as no real choice because it does not involve all people and all possible knowledge.

In the next section of this chapter, the argument presented here is applied to various ethical debates within contemporary medicine. Here it will be shown that medical ethics often function in a framework of "good" news only, which does not always identify the real choices to be made as open for debate between patient and doctor. As noted earlier, in promoting the "good" news of scientific medicine the patient is often not made aware of the "bad"

news of various decisions or of the real choices to be made, because choice is offered from a reified base. Therefore, options and alternatives become relegated to an area of what Arie Brand calls the "steering media" of power and elitist knowledge (in this case scientific accountability), which in turn stifles the symbolic space within communication (Chapter 1 section 1.3.4). The identified areas of confidentiality - how much or how little to tell patients - will be drawn through the section to follow in order to highlight that distorted communication is "alive and well" within medicine and its many areas of ethical concern.

5.9 ETHICAL DEBATES RELATED TO THE HUMANIST TRADITION

The advancement of medicine along technological lines, whilst it can be argued to have improved many areas of human health, can also be seen to have achieved this improvement at the expense of human meaningful intersubjective living. Medical autonomy can often be seen in terms of a "closed" authority (backed by scientific irrefutability) which operates through an adherence to the training of medical personnel to deal with illness in purely scientific terms. This means that human disease is addressed in terms of objective criteria which takes precedence over a humanistic concern for people, their well-being and their ability to make sense of the world.

Medical students are thereby encouraged to take a detached view of patients and their illnesses, to concentrate upon physical/ pathological conditions, and to endeavour to remain apart from emotional involvement. According to the medical model, this type of treatment affords the patient the most objective/scientific handling, and thereby what the medical profession consider to be the most effective addressal of the problem at hand. In this respect Robert Coombs and Pauline Powers (in Cockerham 1989:8) note that "...physicians would intellectually dissect their patient into physical parts...known as the fragmentalisation method...[which allowes] the doctor to deal only with the parts and not with the

whole". Training in this way places medical education into what William Cockerham calls "trade schools", forcing doctors to be little more than "technicians" who work on the body, and causing what J. McKinlay amusingly calls, "...thought processes [which suffer] from excessive hardening of the categories".

According to Mark Chesler and Oscar Barbarin (1984) this type of relationship between patients and medical staff, in calling for unemotional scientific involvement which "trades" in passive physical parts, can lead to dissatisfaction on the part of patients. They note that:

> Professionals [who] expect passive acquiescence rather than active participation from powerless clients...correlated significantly with patients ratings of communication with their physicians and with their doctor's interpersonal style (1984:49-51).

It was indicated earlier in this study (Chapter 3 section 3.2.3) that dissatisfaction on the part of patients can arise when they are not invited into a two-way interactional undertaking which takes account of the intersubjective elements of human living, and therefore the creativity involved in true choicemaking. This calls for a process of participation between doctor and patient in arriving at an "account" of illness and furthermore, for making decisions on how to explain and deal with particular situations. The way in which this "arrival" is achieved in the terms of this thesis is at the very root of the ethical debate addressed in this chapter. Therefore by looking at particular ethical concerns within medicine, it should be possible to highlight the humanist argument.

5.9.1 Genetic engineering

In the field of genetic engineering medicine has made great strides.

Related to childbirth, the "good" news in this field of medicine has brought much joy to childless couples by offering them the chance to become parents through technological intervention. But controversy does exist in this area because questions and choices exist, which by their very nature involve not only the parents to be and the doctor involved, but the general public at large. Kevin O'Rourke and Dennis Brodeur (1987) note in this respect that medical technology has moved from being able to repair the human body to an area of actually being able to make human bodies. This they indicate prompts the situation where people must face the question: "Is it right for us to become our own creators"? It is to this area of genetic engineering that this discussion now turns.

5.9.2 The test-tube baby debate

Genetic engineering has made it possible to artificially "mate" multiple egg and sperm in a culture medium outside of the mother's body under controlled laboratory conditions. Thereafter choice is involved in deciding which, and how many, of the mated embryo should be implanted into the mother to run to full term conception. The medical model assumes that it has the right answer to this choice and it uses its scientific code of ethics to decide which embryo should live and which should die. In terms of the humanist argument this would not be problematic once certain ways of making such decisions are made available. In this respect humanism calls for decisions of this nature to involve not only scientific choice, but also the meaning structures of the parents to be and the concerns of the wider society. This denotes an intersubjective forum of ideas.

However, this is not to presume that the parents were not involved in making the decisions. They must have been involved to have supplied the egg and sperm necessary to begin the process. But were all the options discussed fully with the parents or were only so called "surface" choices involved? For example if the doctor merely

discusses the fors and againsts involved with "test-tube" birth from a basis of personal belief in scientific proveability, this is not real choice, but "surface" choice. This approach invariably advocates the benefits of scientific irrefutability ("good" news), and although it will be successful in putting the parent's minds at rest, it in no way involves an intersubjective forum which will promote the negotiation of both the "good" and "bad" news of the situation.

Because of the way in which the parents to be frame their questions (from a base of little knowledge), and the way in which these questions are answered (from a belief in science), the couple feel secure in the knowledge that scientific medicine can address and quell their worries. The doctor feels happy that he/she has managed to set the couple's mind at rest. In humanist terms what has been achieved here amounts to a meaningless jumble of rigidified/reified "regime" jargon, whereby medical science has offered only the "good" news: the childless couple can become parents. But dangers do exist in this procedure because it involves the necessity to implant more than one embryo into the recipient womb to ensure success.

The reality when multiple fetuses are conceived often leads to the birth of underweight babies who experience respiratory problems and die soon after birth (baby Brandon who died at birth here in South Africa in 1990 is a case in point). Brandon was the smallest of five babies, three of whom suffered respiratory problems - two survived, but the third, Brandon, died. All four surviving babies have impaired vision and face years of, "hopefully", corrective intervention by medical science.

5.9.3 The humanist way of choice

Following on from the examples discussed above it can be argued that the medical profession has utilised its professional confidentiality to bring only "good" news of its scientific achievement into the communication arena. And by functioning in these terms only,

it can be suggested that medicine operates through a form of distorted communication because the "bad" news (or the real choices) are omitted. To the scientific medical model the answer to such a dilemma is simple: the answer lies in scientific advancement. To the humanist this answer is not so clear-cut because it involves options and alternatives which need ongoing debate in order to define what answers mean. All such debate has to come from a truely "open" forum which includes all alternatives and all options, not merely routinised or reified options and alternatives. Human involvement requires that people intersubjectively participate with medical science in defining what choices exist, and this implies a right to become involved in deciding on medical and ethical issues.

If this does not take place, then medical technological advance can be seen in conflictual terms because it promotes science at the expense of a humane meaningful existence - thereby devaluing human existence whilst seeking to improve it. This is not only disastrous for the very people the medical model purports to serve, but to its own Oath of allegiance which calls for medical personnel to do all in their power to address human well-being.

Even seen in this light it is still more than likely that prospective parents of a test-tube child (i.e. armed with the "bad" news and the real choices involved), will decide that their need for children is of uppermost importance (the actual decision in terms of this thesis is academic - see introduction to this chapter) and therefore will perceive even the discarding of "surplus" embryo as a small problem relative to their need. Alternatively, they may decide that they cannot continue with the process. Whatever decision is made, when humanistic values are involved the decisions taken will have evolved from a truly humane platform which takes into account both the "good" and "bad" news of the situation. If this type of interaction does not take place then the medical model can be seen to have functioned in terms of what Jan K. Coetzee (1989b) refers to as a "monopoly of knowledge" which robs people of their personal dignity because it does not allow for cognitive

participation. This utilises the principle which informs humanism's call for the preserving of people's rights to participate in defining and constructing a world of meaning. And this, Coetzee notes, means:

> To live in a world containing meaning [which] does not imply a static conception of social reality; [because] it presupposes an active dialogue between people and their overall reality (1989a:6).

5.9.4 The distortion of the lifeworld through "colonisation"

In Chapter 2 section 2.5.3, it was noted that Habermas's argument for communicative action involves knowledge as guided by particular interest or purpose. It was indicated that particular interests or purposes can, through a process of distorted communication, effectively hide the possibility for alternative ways of "seeing". With reference to the ethical considerations discussed above, this can be argued to mean that the scientific dominance of the medical model is capable of distorting communication to hide the "bad" news of its scientific regimes. Norma Romm (1991:134) argues that unless people "...account for the interests underlying the logic of... scientific analyses...it will operate behind our backs and control us".

In this way it can be suggested that the medical profession in offering scientific "answers", may be seen to place people at its mercy by impressing its scientific ideology upon them. This causes a distortion of intersubjective living through what can be termed the medical models ability to make the interaction which occurs within the symbolic space appear rigid and unquestionable, and the meanings therein non-revisable. If people's consciousness is stifled in this way then they are effectively unable to think in any other categories.

This amounts to a colonisation of the lifeworld by the medical model. Ethical decision rests not upon the potentialities possessed by human beings themselves to achieve shared understanding, but upon the scientific ideology of achieving a result. Habermas argues that it is the function of critical theory to expose this hidden exercise of domination. Such an exposure can effectively provide for other ways of "seeing", by highlighting the "interests" underlying scientific logic and providing entry to a more meaningful construction of social reality within the concerns of medicine. Romm (1991:146) argues in this respect that humanism calls for a widening of the scope of humans to make choices by affording them a knowledge of the viable options. In this way the humanist argument alludes to an enriching and equalising of the conditions of human existence.

5.10 MEDICINE AND HUMANIST IDEALS IN ETHICS

What the humanist argument, and the argument presented in this chapter calls for, is quite clear. All concepts within the field of medical ethics namely, confidentiality, accountability, shared responsibility, ethics itself and the defining of illness, diagnosis and treatment regimes, etc., are open to continuous ongoing re-definition. In the medical communicative arena, definition and decisionmaking should be shared between all parties concerned in the interaction, and seen in a light of dual accountability which adheres to a co-responsibility for decisions taken.

Responsibility in these terms does not imply that the doctor makes a decision for a patient and then takes responsibility for that decision. Rather it implies that the responsibility for making decisions, or taking account of various options, or applying confidentiality, is debatable, questionable, re-definable, between all parties involved in specific contexts. This involves what Coetzee (1986:8) indicates is an esteem which goes hand in hand with freedom in the humanist tradition. In this sense humanism implies the opportunity to realise one's human potential.

Or as otherwise stated, leads to what Veronica McKay (1990) calls a status shift through the delineation of all knowledge pertaining to the situation. Therefore doctor-patient interaction should not take place from a platform of pre-defined policy, but from an understanding of the need for participation on the part of all people if freedom and meaningfulness is to be obtained through the realisation of human potential.

5.11 BERGERIAN ETHICS APPLIED TO THE MEDICAL MODEL

Earlier in section 5.9.2 the idea of choice undertaken in terms of a set agenda or policy was discussed. This form of choicemaking was noted not to be real choice in humanist terms, but choice made from a predefined reified set of meaning patterns. In this respect Peter Berger indicates that any policy (political or medical) invariably implies problems of values. He argues that if human beings have the right to live in a meaningful world, then respect for this basic human right should provide what he calls the moral imperative for policy decisions. In this respect he notes that: "Sooner or later, avowedly or covertly, all policy considerations involve choices between values, and all policy decisions are value-charged" (in Berger, P.L. & Luckmann T., 1976:64). He notes that policy decisions involve either "...the active inflictual or the passive acceptance" on the part of people and that this should require "...a justification in terms of moral rather than technical necessity" (in Berger, P. L. & Luckmann T., 1976:165).

In the case of medicine it was noted that the "policy" inherent within the medical framework is one of what can in humanist terms almost be called "non-involvement". In order to uphold the scientific regime and its professionalisation, medical science offers what it sees as the best treatment for patients. When involvement does take place - doctors and patients meet, discuss the patients' problems, make decisions upon diagnosis and treatment, etc. Berger agrees, but indicates that both engagement and detachment

within any setting carried to excess can be dehumanising. He notes: "The...fanatic is no less a repulsive figure than the theoretician to whom human anguish is nothing but an occasion for intellectual exercises" (in Berger, P.L. & Luckmann T., 1976:245). Arguing that it is impossible for humans to maintain a disengagement, he indicates that "...engagement is always in terms of and out of...a specific location...and therefore must imply a sensitivity..." (in Berger, P.L. & Luckmann T., 1976:247).

Applied to the ethics of medicine and the doctor-patient interaction, it can be argued that the doctor tries to detach from the consultation far enough to maintain a professional scientific relationship. But, according to Berger, in the very act of engagement there arises an intersubjective arena which can only be in the form of a sensitivity one to the other.

The aim therefore, should be to engender a "consciousness raising" platform wherein the knowledge of **both** parties has **equal** weight within the interaction. The doctor's imput is from a scientific standpoint and the patient's imput is from his/her understanding of the condition in question. Such interaction should be seen, in principle, as an interaction between equals. When seen in this light there is always the possibility that intersubjective communication will take place (that medical science will not organise on behalf of people), and therefore, that real choice in humanist terms is potentially possible. But what happens in cases where people cannot enter into communication concerning choice between alternative options? How would the ethical dilemma of say an unconscious road accident victim fare when faced with humanism's argument for involving people in deciding? How would the argument evolve concerning a baby born with severe spina bifida, or even the case of a new heart for old? The following section considers a number of medical conditions as seen from a humanist perspective.

5.12 ETHICAL CASE STUDIES AND THE HUMANIST TRADITION

5.12.1 Case 1: the road accident victim

In this first situation, and for the purposes of the argument at hand, it is necessary to consider the accident victim to be badly injured and unconscious before medical intervention. The patient cannot be asked because he/she cannot communicate, family have not yet been informed so they cannot help decide. It is up to the medical personnel to employ scientific medicine to "save" this particular individual. In line with their medical Oath - to do all they can to preserve life - and in line with their belief in science as having the right answers, the medical personnel employ all the scientific technology they can muster, and either save or lose the patient.

The outcome of whether this particular person lives or dies is academic, and so it may seem is the humanist argument to present choices, "good" and "bad" news, etc., from which to make decisions, because the patient and his/her family were not able to make these choices. But this is not the case. The hospital personnel will have debated with the "good" and "bad" news of the situation before the decision to use scientific know-how was invoked. Questions like, how badly are the kidneys injured, i.e. is there enough function left to allow a continuance of life should the patient recover, etc., will have been considered. Specialists, radiologists, nurses, other doctors, all will have made an input into the decisions made concerning this accident victim.

In one respect the choices offered and made will have been fairer in that the people making the choice, were all equipped to recognise the "bad" news involved from a position of being medically trained. On the other hand this does mean that this medical training, if the argument advanced elsewhere in this thesis is accepted, does predispose such people towards scientific regimes. But at least operating here is the aspect of Sartrian co-responsibility which does mean that the people making choices will have done so in terms

of a humility and care for their fellow human being. For the purposes of the argument at hand, what seemed to be a no choice situation is actually not correct. Science is called upon at times to take over the choicemaking process, but medical personnel are human also and therefore real choices can still made.

5.12.2 Case 2: The spina bifida baby

In this case a child is born into the world with severe spina bifida. Without going too deeply into what this sad condition involves (the back of the child is open, exposing the spinal cord and the nerves - repair always leaves the child impaired in some way: either spastic or paraplegic with the only unknown being, how badly), a decision has to be made quickly about what to do. If an operation is not performed to close the back the child will very soon die. If an operation is performed the child is faced with a life of restricted ability and life span. Samuel Gorovitz (1983) notes just exactly what this means:

> As a consequence of the spinal cord deformity, the child is paralyzed below the level of the lesion. This always involves loss of bladder and bowel control...the kidneys may also be dysfunctional...impairment of circulation of cerebrospinal fluid [causing] an accumulation of excess fluid in the brain which can result in mental retardation. Treatment...involves immediate closure of the defect to prevent infection....Even with vigorous therapy, the results are seldom very good...most live pitiful lives. (1983:402,3).

Again, it is not for this thesis to consider the right (see endnote 3) or wrong of decisions of this type, but to consider the way in which the choices involved are put to the people around the child - those who have the unenviable task of deciding the fate of another human being. In this situation the medical personnel will probably want to use their life saving techniques to save the child. They

will rely upon the irrefutability of scientific technology and their personal belief in its techniques, to persuade the parents to sign for the operation. In answer to the parents's questions science will probably offer technological answers - like, things are getting better in this area all the time, life for these children is improving, etc.

But in humanist terms this is merely offering the "good" news of the situation and as such offers no real choice. From what the parents are told, only ill-feeling people would decide not to sign the consent form for the operation (endnote 2 concerning signed consent refers). On the other hand if the parents are told both the "good" and "bad" news of the situation, their decision may be different. This is what Habermas means when he refers to knowledge which is guided by particular interests (in this case scientific medicine). And this is what he means by distorted communication leading to distorted intersubjectivity. The parents are almost coerced into accepting treatment for their child through the distorted communication which offers only "good" news. Only "good" news, equals distorted intersubjective living, because people have been required to choose an option from a set of reified meanings.

Richard McCormick (in Gorovitz 1983) suggests that there are "either-or" extremes at work in this ethical area, linked to the criteria of "meaningful life". The concept of "meaningful life" is used to measure what doctor and parent consider to be a child's chance to live a reasonably useful and happly life. Where the consideration is that "meaningful life" is extremely poor or hopeless, this yardstick is used to decide for or against further treatment. McCormick notes that:

> The awesome finality of these decisions, combined with a potential for error in prognosis, made the choice agonizing for families and health professionals. Nevertheless, the issue has

> to be faced, for not to decide is an arbitrary and potentially devastating decision of default (1983:396).

Here we note the Sartreian notion of co-responsibility which eminates from a responsibility to act. Sartre maintains that there is no reality except in action, and furthermore that people accept not only the responsibility of such action in the knowledge that the weight of their choices is hard to bear because it often brings anxiety. But also, that only by acting in the world can people obtain any self-respect at all. They must take up the potential for decisionmaking however devastating this may be because human dignity is very much intertwined with people as interacting subjects. (See Chapter 2, sections 2.1 and 2.2).

But this study argues that there is a middle course between "either-or". According to McCormick such a middle course runs within the development of "substantive standards to inform parents and physicians" (1983:397). This indeed may be one way to offer guidelines for acting, but these guidelines rely on medical expertise. There are other criteria to be taken into account and J. M. Gustafson (in Gorovitz, 1983:398) notes what these might be. He begins: "Why would I draw the line on a different side...than the physician ..."? (This the writer interprets as on a different side to that of scientific knowledge). And in answer to this question states:

> While reasons can be given, one must recognise that there are intuitive elements, grounded in beliefs and profound feelings, that enter into particular judgements...

In the case of spina bifida these areas can only be taken into the negotiational arena when and if all concerned in decisionmaking are invited to share the "good" and "bad" news of the situation. Only then can "meaningful life" get anywhere near to being meaningful in humanist terms. Because as McCormick (in Gorovitz, 1983) notes:

> The trouble with slogans is that they do not aid...they co-opt..., often only thinly disguising a good number of questionable value judgements in the process. Slogans are not tools for analysis and enlightenment; they are weapons for ideological battle (1983:397).

5.12.3 Case 3: the new heart for old

In case three the patient has a condition which, if allowed to run its own course, will culminate in an early death because the heart is unable to continue, due to disease. The patient is fully aware of his/her condition and seems to be in a situation where little choice is available if they are not prepared/ready to die. But the scientific medical model is able to offer this patient a choice: the removal of the old heart and its replacement with a new. Both "good" and "bad" news is discussed with the patient, all options and alternatives are thoroughly searched. The patient is told that the new heart may work or it may fail. He/she is told he/she may die on the operating table because of the seriousness of such an operation He/she is told he/she should expect to feel very ill during the recovery period, etc. All of these areas are discussed in an open forum which includes the meaning structures of all parties involved in the interactional arena: the patient, the doctor, wives, husbands, children etc., and a decision is made which can be conceived of in what might be called truly humanist terms.

E. Friedman (1986) notes that even under these circumstances there are still very many problems which impinge upon ethical areas of a different nature. For instance, the questions which are asked of the recipient automatically seem to assume that the quality of life will be better after a heart transplant. Friedman notes that this is not always the case because quality of life is not easily measured due to its subjective parameters. She notes in this vein that many heart transplant recipients "...are disabled primarily from the side effects of immuno-suppressant drugs, the most common

of which are decalcification of bones and secondary infection" (1986:116).

Another major problem noted by Friedman is recipient selection and she asks who should make the decisions in this regard and with what criteria? Friedman argues that decisions in the area of transplant recipient selection - as experimentation moves into the realms of clinical practice - will have to be "standardised" if they are to succeed in terms of choosing the best patient in relation to a successful recovery. In terms of the humanist perspective, to standardise is, however, not to set in terms of finality (as Friedman appears to advocate) because what "success" is and who the "best" patient is is not so clear-cut. As noted earlier in section 5.6 above, patients do not always react in the way in which the medical profession expect, or indeed, they themselves expect to react. Therefore, seen in terms of symbolic mediation the criteria for a standardisation of recipient selection does not make sense because it is open to negotiation in terms of the "good" and "bad" news of various options concerning recipient suitability.

Humanistically taken decisions are made on the basis of a choice between options at a certain moment in time. Humanism makes note that choice, as a hypothesis or tentative agreement, denotes the precarious nature of symbolic reality. Human decisions are thereby precariously tinged with a non-finality which calls for continuous ongoing debate and reconsideration. In this regard it may be that the patient whom the doctor thought could handle such a serious operation may not handle it well after all. The family who appeared confident may crumble under the strain and trauma of seeing a loved one in such distress. The scientific regime may fail the patient, i.e a heart may not become available in time and the patient dies anyway. Whatever the outcome, the strength of the humanist perspective lies in the fact that decisionmaking is a shared experience which, in relying upon the intersubjective participatory aspects of negotiational communication, engenders the possibility for all to take part in real choicemaking.

This is what Berger means when he speaks of the basic human right which should provide moral imperatives for policy decisions, or otherwise stated, a justification in terms of moral rather than technical necessity. In case 3 there was definitely a technical necessity involved - the patient would die if the new heart was not implanted. But the justification for placing on the agenda all "good" and "bad" news relative to the situation (even in this case where the patient seems to have little choice, except to choose to die) is according to humanism, that to be morally correct the patient should be meaningfully involved and not scientifically "pressed".

Otherwise what happens is that the technical approach, as an ideological approach, rules the day, and further more as Romm noted in section 5.9.4 of this chapter "operates behind our backs". People are no longer in control of people's interests - the ideology or the technology is. This can be argued to mean that people are no longer in charge of their own welfare, the technological medical model is. Cornie Alant has something to say about this area of medical ethics and it is to his work that this chapter finally turns.

5.13 CORNIE ALANT'S THEORY IN RELATION TO MEDICAL ETHICS

Cornie Alant maintains that people can only realise their true self, "...insofar as [they] have a choice, or...insofar as [they] actively participate in contributing to [their] own welfare" (1990:132). In terms of the argument put forward here, this means that people should be offered the choice of alternatives rather than being presented with only the "good" news of science which appears unquestionable. According to Alant this type of "good" news relates not to active contribution on the part of people but upon their passive acceptance of **given** scientific truth. In this respect he argues that we have all become slaves of the technological society

which "produces" us. Concerning medicine he suggests that this is a myth of professionalism because it:

> ...predefines the attitudes and conduct of patients, [in that] they swallow pills unconditionally, or let themselves be cut up without questioning the decision of the surgeon, because health...has become a technological matter - for experts only. This kind of elitism denotes health care to a mechanism of alienation whereby society loses its creative imput (1990:132).

In arguing for a medical profession which stresses the level of consciousness, Alant calls for people to act with an awareness of the physical and clinical effects of treatment, as well as being aware of the influence which the so called treatment can have upon the total self-conception and construction of reality of patients. He argues that if this does not happen, then medicine may become an indicator of dehumanisation because it just may lose sight of its hermeneutic existence. Alant draws upon Alvin Gouldner's definition of hermeneutic existence as the idea that every interpretation is mediated by consciousness, in other words through people's interpretative faculties. Therefore, anything less, would in terms of humanism denote an alienated existence.

5.14 A HUMANIST ROUND-UP

For the argument which has been put forward here, to lose sight of our hermeneutic existence relates to medical science as having the only right answers to human illness. But as noted in section 5.13 of this chapter, if this happens then technology controls people, rather than the other way around. In this respect Alant suggests that concerning the medical institution and its application of an ethical code, this idea of interpretating in "right" terms can be argued to uphold not only the institution's belief that it has the only right answers to health and illness, but that these right

answers should be accepted as irrefutable because they are backed by scientific provability.

Furthermore, it is noted by A. Buchanan (1985) that ethics in these terms is untenable if it fails to reflect critically upon the presuppositions which underlie its approach. He notes: "The adoption of...purely technical notions of efficiency that prevail...rest upon controversial [in humanist terms] moral assumptions" (1985:2). For the humanist, this controversy can only be answered when people are involved in its initial defining.

This thesis, in arguing that there can be no right answers to illness in humanist terms, points to the problem inherent in believing that "right" can be rendered without presuppostion. Science presupposes its irrefutability and this means that the human element of choice is not made available because the "good" news of its right answers do not offer alternative options.

But humanism argues that this is not the case. Medicine, like all the other institutions in society, functions through what can be called a co-authorship involving a co-responsibility towards others who co-inhabit the world. Social reality in terms of a meaningful human reality, has to be seen as revisable and therefore to recognise discourse as an integral part of living. Idealised "dogma" has a closing off effect which is dehumanising; whilst symbolic negotiational participation contains an invitation of openness and an inherent potential to be more.

Therefore contemporary medicine has to involve the true meaning structures of the people it is there to serve, and this means not just providing patient answers from a set agenda (or policy) of predefined, reified meanings, but by offering real choices between the alternatives of "good" and "bad" options. True choice involves All meanings, All options and All alternatives, even if they do not

seem so attractive, because it is only in this way that medicine can hope to reinstate and retain the humane element within its framework.

5.15 CONCLUSION

In this chapter an attempt has been made to use the concept of medical ethics, to highlight the complex interplay between people and the institution of medicine. The historical concerns of medical ethics were shown to have changed from a concept which was subsumed under theology and supernatural power, to a contemporary concept which in itself seems to provide the answers to human life and death situations.

The theory of Jürgen Habermas was utilised to highlight the humanist argument in terms of distorted communication leading to distorted intersubjectivity. It was shown in this respect that medical personnel sometimes invoke their superior elitist position to provide only the "good" news of various situations which in turn, leads to a suppression of voices and a blocking of discourse. This argument was then linked to various ethical debates within society and an attempt was made to show where and how the humanist tradition might provide a more humane way of "seeing" medical ethics in human terms.

Finally Alant was read to indicate that this more humane way of "seeing" actually provides for the well-being and welfare of people because only through involvement, in making choices in the light of various alternatives, can people realise their true self - a self which is always in the process of becoming.

CHAPTER 6

CONCLUSION: Synopsis and recommendation

In this thesis entitled, Illness as intersubjectivity: a sociological perspective, the hypothesis that the scientific mechanistic medical model - by adhering to reductionist technology - is unable to facilitate the personal ongoing meaningmaking necessary for intersubjective living, was searched. The ideal of continuous intersubjective interaction was shown to form the bedrock of the humanist tradition and to be derived from the belief that human life, to be meaningful, can only become **understandable** in terms of an experiential nature.

The term "intersubjective living" was indicated to mean that the lifeworld of people is a shared reality which promotes a style of living which is not private, but is ongoingly "fashioned" by people through the experiential creative process of interaction. This was shown to mean that people take cognisance of their own position within reality and at the same time acknowledge that other's do the same. In taking as its starting point the idea that people construct a social reality which is meaningful to them, intersubjective living was indicated to suggest that all understanding of meaning is inherently linked to choice making, and to the taking account of alternatives and options which present in interaction. It was argued that for anything to be "known" by people, understanding has to involve the human consciousness through an experiential taking part therein. Therefore, in humanist terms, meanings within the human lifeworld are not "given", they experientially **evolve** through a process of participation.

In chapter 1, a narrative account of intersubjectivity was built-up using three sociological perspectives. The perspectives utilised were: systems perspective, conflict perspective and humanism. Three author's defined as systems theorists were read: Emile Durkheim, Talcott Parsons and Jeffrey Alexander.

These three author's theories were shown to indicate that intersubjectivity in humanist terms is not apparent within the systems perspective, and that the only indication of interaction in terms of a "shared" intersubjective reality is through what the thesis defines as "consensual overlap". Within the conflict perspective, the work of Karl Marx, Ralf Dahrendorf and Jürgen Habermas was read. Here, in the case of Marx and Dahrendorf, it was noted that the conflictual nature of social reality is related to class differentation and role authority. It was argued that where interaction takes place within the conflict perspective, it does so within the confines of either class or role prescription rather than an ongoing dialogical process of interpretation and negotiation. This was shown to mean that alternative viewpoints are not recognised as expressions of meaning which lead to a meaningful social reality in humanist terms, but rather, the expression of roles. Therefore humanist intersubjectivity does not present because choice is mediated by class and role interests.

Conversely Habermas's critical Marxist stance was indicated to incorporate the phenomological bent for meaningmaking by showing that communicative action is able to take account of varying viewpoints in the world. Habermas was noted to indicate that when these varying viewpoints are stifled by the power mediums operating in society (as with the oppression of Marxist class differentials and Dahrendorf's dominantion/subjection within roles), then a form of distorted communication is operating which leads to a distortion of intersubjectivity. Habermas's theory, therefore, forms the springboard for the thesis' entry into humanism.

Finally the theories of two humanistically defined authors were read in order to lay the foundations for chapter 2 which considers the work of contemporary humanist theorists within the humanist tradition. In this respect the Symbolic Interactionist theory of George Herbert Mead was utilised to define humanist social reality as symbolic, and the theory of Alfred Schütz took up the idea that social reality in humanist terms, is a reality of interpretation.

There followed a comprehensive exposition of humanist theory in Chapter 2. The chapter began with a resume of the humanist tradition, building what can be termed a "flavour" of the ideals of humanism: that society is meaningful, that social reality relies upon human participation and that human life functions dialogically. The theories of variously defined humanist authors were thereafter utilised to highlight how these concepts fit into the conceptual framework of the humanist perspective. The work of inter alia, Peter Berger, Richard Brown, Jean-Paul Sartre, Cornie Alant and Norma Romm were interlinked with the theories of George Herbert Mead and Alfred Schütz (from chapter 1), to form a narrative account of intersubjective living as defined by humanist thinkers.

In chapter 3 the argument for the medical model seen in terms of a scientific reductionist regime was laid down. The roots of this mechanistic medical model were historically located and then brought up to date to highlight the "form" of contemporary medicine in terms of the thesis definition. To augment this debate, various authors from the theory chapter (chapter 2) were re-read to indicate that scientific contemporary medicine is mechanistic rather than humane, and through its elitist professional knowledge, has successfully colonised people's meaning structures through an infiltration of human consciousness. This was shown to mean that medicine operates in conflictual terms: both as an institution of care and control.

In chapter 4, the juxtaposed positions of the scientific medical model and the humanist tradition were brought face-to-face. In this way the areas of conflictual "belief" structures were shown to be at variance with humanism's ideal of meaningful worldconstruction. The theorists previously identified within the humanist sociological literature were utilised to highlight the colonisation of people's meaning structures, and to show that: a) the medical models infiltration into human consciousness does not provide for intersubjective living and b) that it achieves its autonomy - its scientific irrefutability - at the expense of human participation.

In chapter 5 the concept of medical ethics was discussed in terms of variously defined areas within the field of medicine. The concepts of confidentiality, accountability, shared knowledge and participation were related to various topical ethical debates within contemporary medicine. The work of earlier defined humanist authors was drawn through the ethical considerations taken up, and an indication was made at various points to highlight how the medical model might successfully reinstate the humanist ideals of choice, dialogue, creativity and construction of a meaningful life world into its scientific framework. If this has been achieved, the study will have successfully introduced "real" choice into medicine by providing for health, illness, and treatment to be seen in intersubjective terms: not in terms of "given", unquestionable **facts**, but rather in terms of a "healthy" (humanist) reconsideration.

Recommendation

In this thesis the humanist tradition, and in particular the concept of intersubjectivity therein, was theoretically applied to the so called scientific medical model. This study was undertaken in order to test the hypothesis:

> That the scientific mechanistic medical model (with its adherence to reductionist technology), is unable to facilitate the personal ongoing meaningmaking and worldconstruction necessary for intersubjective living and healing.

The concept of intersubjectivity was systematically applied to various areas within medicine and suggestions were proffered as to how the medical framework might become more humane if scientific

medicine were to incorporate the human potention for experiential participation in the defining of health, illness and treatment regimes.

It seems natural, having laid the foundations for humanist methodology and research in this work, to proceed to "test" the methodological relevance and accountability of humanism "in the field". With this in mind it may prove pertinent to embark upon a practical comprehensive study/search for intersubjectivity in medical practice. Such an empirical study would be based on the critical reflexive epistemological tradition and brought to fruition through the methodological conception of intervention research. In this way it should prove possible to draw some kind of parallel between theoretical positions concerning scientific medicine, and the position of humanist theory seen as a radical alternative.

ENDNOTES FOR CHAPTER 5

1. The decision of whether to sustain life on a life support machine, or to continue life through the use of this aparatus, has been removed from the personal decisionmaking arena of medical staff. In other words there now exists a procedure which involves various medical personnel. No longer is to sustain or continue life support linked to the beating of a heart, but to the procedural process of "brain death". Various tests are carried out at set intervals, over the course of 24 hours, to determine how much brain and muscle function remains within the body. Below a certain reading, even when the heart continues to beat, a person is considered to have died and life support is either denied or withdrawn.

2. Decisiontaking can be handed over from patient to doctor by the signing of what is known as a "form of consent". The patients who sign such a form relinquishes their own autonomy over their health and treatment and in so doing empower a doctor to make whatever decisions may be deemed necessary for the good of their (the patient's health). This "contract" is entered into by both parties under terms of fidelity and faithfulness. This means that both parties are bound a) for the good of the patient and his/her health, and b) for the doctor and his/her profession. There is little doubt that this is the case. No physician would abuse such a contract. Even in humanist terms, as long as all options and alternatives were made quite clear to the patient and the patient made the choice to sign a "form of consent" from a platform of full knowledge of what this means, then this type of decision is and must be considered meaningful in human terms.

3. From a humanist point of view, any decision made in a nonparticipatory way is "wrong".

BIBLIOGRAPHY

Aggleton, P. 1990. Health. London: Routledge.

Alant, C.J., Lamont, A.M., Maritz, F.A. & Van Eeden I.J. 1982. On societies and societal existence. Johannesburg: McGraw-Hill.

Alant, C.J. (ed.) 1990. Sociology and society. Johannesburg: Southern.

Alexander, J., Gilson B., Munch R. & Smelser N.J. 1987. The micro-macro link. London: University of California Press.

Alexander, J. 1989. Structure and meaning. New York: Columbia University Press.

Atkinson, J.M. 1989. To tell or not to tell the diagnosis of schizophrenia. Journal of Medical Ethics 15: 21-24.

Berger, P.L. 1967. The social reality of religion. Middlesex: Penguin.

Berger, P.L. 1969. The sacred canopy. Garden City: Anchor Books.

Berger, P.L. 1974. Pyramids of sacrifice: political ethics and social change. Harmondsworth: Penguin.

Berger, P.L. & Luckmann T. 1976. The social construction of reality. Harmondsworth: Penguin.

Blackledge, D. & Hunt, B. 1985. Social interpretations of education. London: Croom Helm.

Blaxter, M. 1990. Health and lifestyles. New York: Routledge.

Blythe, P. 1973. Stress disease: the growing plague. Birkenhead: Arthur Barker.

Brand, A. 1990. The force of reason: an introduction to Habermas' theory of communicative action. Sydney: Allen & Unwin.

Bouchard, D. (ed.) 1977. Michel Foucault: language: counter-memory, practice. New York: Cornell University Press.

Boyd, K.M. 1990. HIV infection: the ethics of anonymised testing and of testing pregnant women. Journal of Medical Ethics 16: 173-178.

Brediau, P. 1988. Would it have been better had he died? A case conference. Journal of Medical Ethics 14: 42-43.

Brown, H. & Stevens R. (ed.) 1982. Social behaviour and experience. Sevenoaks: Hodder and Stoughton.

Brown, R. & Lyman S.M. 1978. Structure, consciousness and history. Cambridge: Cambridge University Press.

Brown, R.H. 1978. A poetic for sociology. London: Cambridge University Press.

Brown, R.H. 1989. Social science as civic discourse: essays on the invention, legitimation and uses of social theory. Chicago: University of Chicago Press.

Buber, M. 1970. I and thou. New York: Scribner.

Buchanan, A. 1985. Ethics, efficiency and the market. Totowa, NJ: Rowman & Allanheld.

Byrne, P. (ed.) 1988. Health, rights and resources. London: Oxford University Press.

Byrne, P. 1990. Comments on an obstructed death. Journal of Medical Ethics 16: 88-89.

Capra, F. 1987. The turning point. Glasgow: Collins.

Chesler, M.A. & Barbarin, O.A. 1984. Relating to the medical staff: how parents of children with cancer see the issues. Health and Social Work 19: 49-65.

Cockerham, W. 1989. Medical sociology. Englewood Cliffs, N.J: Prentice-Hall.

Coetzee, J.K. (ed.) 1986. Development is for people. Johannesburg: Macmillan.

Coetzee, J.K. (ed.) 1989a. Development is for people. 2nd edition. Johannesburg: Southern.

Coetzee, J.K. 1989b. The quest for a more human society - a different sociology? Inaugural lecture delivered at Rhodes University on 17 May 1989. Grahamstown: Rhodes University.

Collins, R. (ed.) 1983. Sociological theory. London: Jossey-Bass.

Cuff, E. & Payne G. (ed.) 1984. Perspectives in sociology. London: Allen & Unwin.

Dahrendorf, R. 1969. Class and class conflict in industrial society. London: Routledge & Kegan Paul.

Dallmayr, F.R. 1980. Heidegger on intersubjectivity. Human Studies 3: 221-246.

Dews, P. 1984. Power and subjectivity in Foucault. New Left Review 144: 70-95.

Doyal, L. & Pennel, I. 1981. The political economy of health. London: Pluto Press.

Evans, M. 1989. Organ donations should not be restricted to relatives. Journal of Medical Ethics 15: 17-20.

Faberga, H. Jr. 1990. An ethnomedical perspective. Journal of Medical Ethics 15: 594-595.

Figlio, K. 1982. The problem of medical knowledge: examining the social construction of medicine. Edinburgh: University of Edinburgh Press.

Figlio, K. 1987. The lost subject of medical sociology. Sociological Theory and Medical Sociology 4: 77-109.

Forrow, L. Arnold R.M. & Frader J. 1991. Teaching clinical ethics in the residency years: preparing competent professionals. The Journal of Medicine and Philosophy 16: 93-112.

Foucault, M. 1973. The archaeology of knowledge. London: Tavistock.

Foucault, M. 1977. Language, counter-memory, practice. New York: Cornell University Press.

Foucault, M. 1980. Power/knowledge. Brighton: Harvester Press.

Friedman, E. (ed.) 1986. Making choices: ethics issues for health care professionals. Baskerville: American Hospital Publishing.

Gerhardt, U. 1987. Parsons, role theory, and health interaction. Sociological Theory and Medical Sociology 5: 110-133.

Giddens, A. 1979. Capitalism and modern social theory: an analysis of the writings of Marx, Durkheim and Max Weber. Cambridge: Cambridge University Press.

Gilson, E. & Langan T. 1965. Modern philosophy: Descartes to Kant. New York: Colonial Press.

Goldmann, L. 1969. The human sciences and philosophy. London: Jonathan Cape.

Gorovitz, S. (ed.) 1983. Moral problems in medicine. Englewood Cliffs, NJ: Prentice-Hall.

Gouldner, A.W. 1975. For sociology. Harmondsworth: Penguin.

Gouldner, A.W. 1980. The two Marxisms: contradictions and anomalies in the development of theory. London: Macmillan.

Green, N. 1966. Jean-Paul Sartre: the existentialist ethic. Rexdale: Ambassador Books.

Grinnel, F. 1983. The problem of intersubjectivity: a comparison of Martin Buber and Alfred Schutz. Human Studies 6: 185-195.

Habermas, J. 1971a. Knowledge and human interests. Boston: Beacon Press.

Habermas, J. 1971b. Toward a rational society. London: Heinemann.

Habermas, J. 1982. Critical debates. London: Macmillan.

Habermas, J. 1987. The theory of communicative action. Cambridge: Polity Press.

Haralambos, M. 1989. Sociology: themes and perspectives. 2nd edition. London: Unwin Hyman.

Hass, J.E. & Drabek, T.E. 1973. Complex organizations: a sociological perspective. New York: Macmillan.

Hughes, J.A. 1981. Sociological analysis: methods of discovery. London: Thomas Nelson.

Illich, I. 1977. Limits to medicine, medical nemesis, the expropriation of health. Harmondsworth: Penguin.

Joas, H. 1985. G.H. Mead: a contemporary re-examination of his thoughts. Cambridge: Polity Press.

Korotkikh, R.V. 1989. Medical ethics: problems of theory and practice. The Journal of Medicine and Philosophy 14: 269-282.

Krulik, T. 1982. Helping parents of children with cancer during the midstage of illness. Cancer Nursing 16: 441-445.

Lachowska, D. 1980. Alfred Schutz's theory of intersubjectivity. The Polish Sociological Bulletin 3: 41-49.

Laing, R.D. 1965. The divided self. Harmondsworth: Penguin.

Maykovich, M. 1980. Medical sociology. Palo Alto: Mayfield Publications.

McKay, V. & Romm N. 1991. People's education in theoretical perspective. Cape Town: Maskey Miller Longman.

McKinlay, J.B. (ed.) 1982. Technology and the future of health care. Cambridge, MA: MIT Press.

Mead, G.H. 1934. Mind, self and society. London: University of Chicago Press.

Mechanic, D. 1978. Medical sociology. New York: Free Press.

Musgrove, F. 1977. Margins of the mind. London: Methuen.

Natanson, M.A. 1973. A critique of Jean-Paul Sartre's ontology. The Hague: Nijhoff.

O'Rourke, K.D. & Brodeur D. 1987. Medical ethics: common ground for understanding. St. Louis: Catholic Health Association of the United States.

Parsons, T. 1951. The social system. London: Routledge & Kegan Paul.

Patrick, S. & Scamler G. 1986. Sociology as applied to medicine. 2nd edition. London: Bailliere Tindall.

Potter, D. & Sarre P. 1978. Dimensions of society. London: Hodder & Stoughton.

Reason, P. & Rowan J. (eds.) 1981. Human inquiry: a source book of new paradim research. Chichester: Pitman Press.

Ritzer, G. 1983. Sociological theory. New York: Knopf.

Rix, B.A. 1990. Danish ethics council rejects brain death as the criterion of death. Journal of Medical Ethics 16: 5-7.

Rogers, M.F. 1983. Sociology, ethnomethodology and experience. Cambridge: Cambridge University Press.

Romm, N. 1991. The methodologies of positivism and Marxism: a sociological debate. London: Macmillan.

Ruszkowski, P. 1980. Critical evaluation of Mead's conception of the self: an attempt at reinterpretation. The Polish Sociological Bulletin 3: 51-59.

Sartre, J.-P. 1956. Being and nothingness. New York: Penguin.

Sartre, J.-P. 1973. Existentialism and humanism. London: Methuen.

Sass, H.-M. 1989. Brain life and brain death: a proposal for normative agreement. The Journal of Medicine and Philosophy 14: 45-59.

Scambler, G. 1987. Habermas and the power of medical expertise. Sociological Theory and Medical Sociology 16: 165-193.

Schütz, A. 1967. The phenomenology of the social world. London: Biddles.

Schütz, A. 1973. Collected papers 1: the problem of social reality. The Hague: Nijhoff.

Schütz, A. 1982. Life forms and meaning structures. London: Routledge & Kegan Paul.

Siegel, B. 1987. Love, medicine and miracles. London: Rider Publishing.

Skidmore, W. 1979. Theoretical thinking in sociology. London: Cambridge University Press.

Smart, B. 1983. Foucault, Marxism and critique. London: Routledge & Kegan Paul.

Sorokin, P. 1941. The crisis of our age. New York: Dutton.

Strong, C. & Anderson G. 1989. The moral status of the near-term fetus. Journal of Medical Ethics 15: 25-27.

Stumpf, S. 1982. Socrates to Sartre. New York: McGraw-Hill.

Thompson, K. & Tunstall J. 1979. Sociological perspectives. Harmondsworth: Penguin.

Todd, C.J. & Still A.W. 1984. Communication between general practitioners and patients dying at home. Social Science and Medicine 18: 667-672.

Tuckett, D. & Kaufer J. (ed.) 1978. Medical sociology. London: Tavistock.

Twaddle, A.C. 1979. Sickness behavior and the sick role. Cambridge, MA: Schenkman Publishing.

Veatch, R.M. 1989. Medical ethics. Boston: Jones & Bartlett.

Wardell, M.L. & Turner S.P. (ed.) 1986. Sociological theory in transition. London: Allen & Unwin.

White, B.C. 1989. Overview of the Ota report on infertility: medical and social choices. The Journal of Medicine and Philosophy 14: 493-496.

Wilson, J. 1983. Social theory. Englewood Cliffs, NJ: Prentice-Hall.