



CLINICAL EVIDENCE AND THE ABSENT BODY IN MEDICAL PHENOMENOLOGY:

ON THE NEED FOR A NEW PHENOMENOLOGY OF MEDICINE

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Abstract

The once animated efforts in medical phenomenology to integrate the art and science of medicine (or to humanize scientific medicine) have fallen out of philosophical fashion. Yet the current competing medical discourses of evidence-based medicine and patient-centered care suggest that this theoretical endeavor requires renewed attention. In this paper, I attempt to enliven the debate by discussing theoretical weaknesses in the way the “lived body” has operated in the medical phenomenology literature—the problem of the absent body—and highlight how evidence-based medicine has refigured medical phenomenology’s historical nemesis, “biomedicine.” What we now need is a phenomenology of the embodied subject in the age of evidence-based medicine.

Medical discourse currently manages two broad visionary movements: “evidence-based medicine,” the effort to make clinical medicine more

responsive to the medical research, and “patient-centered care,” the platform for a more humane health-care encounter. There have been strong calls to synthesize the two as “evidence-based patient-centred care” (Lacy and Backer 2008; see also Borgmeyer 2005; Baumann, Lewis, and Gutterman 2007; Krahn and Naglie 2008), yet many question the compatibility of the two competing programs.

This might sound to some like a new version of an old story. Despite the fact that evidence-based medicine and patient-centered care are relatively new programs, the story of their oppositional stances—one for science, the other for humanism—and the negotiation between the two is a familiar one in the philosophy of medicine. For example, in the *Journal of Medicine and Philosophy’s* December 1978 issue on “Medicine and Knowledge,” which chronicled emergent themes in medical epistemology, we find Ian McWhinney (1978) and Sandra Harding (1978) pondering the detriment to patient care that can accompany the rise of technology in biomedicine. Meanwhile, Stan Reiser (1978b) lamented the decline of clinical dialogue, and Irwin Savodnik (1978) called for humanity and holism in medicine. The discussions happening thirty years later regarding “evidence-based patient-centered care” mimic these themes, and even invoke the same antagonistic language of “scientific knowledge” vs. “clinical practice” and “algorithmic procedures” vs. “human judgment” (Wartofsky 1978).

As the 1970s critiques of biomedicine’s inhumanity increased in force, phenomenological themes were invoked in order to overcome those challenges, creating the fledgling study of “medical phenomenology.” This was a promising avenue: Edmund Husserl’s (1970) insight that a comprehensive science requires the synthesis of first- and third-person perspectives seems to capture the problematic of the cold and distanced objectivity that characterized biomedicine as well as the missing empathy that patients so badly needed. The lifespan of this phenomenological effort to unite the art and science of medicine proved to be brief, however; vigorous efforts ended in the early 1990s and related fields like narrative ethics and embodiment studies took off instead. This paper argues for a return to the early efforts of medical phenomenology to unite science and the lifeworld, but to do so within a contemporized context.

This analysis begins with an introduction to evidence-based and patient-centered care platforms. I then review the general themes of medical phenomenology, paying particular attention to how the body and the phenomenological account of illness figure into the general philosophical project. I propose that the “intertwined medicine” that medical phenomenologists drew out of Hus-

serl's efforts to reunite science and the lifeworld captures the health-care goals built into the integrated "evidence-based patient-centered care" program. Yet despite the successes in developing an innovative theory of illness, there are theoretical deficiencies that limit medical phenomenology's philosophical relevance and the extent to which it can respond to the call for evidence-based patient-centered care. I demonstrate that the phenomenology of medicine, with its preoccupation with integrating science and humanism, has been weak on the issue of embodiment in its effort to conceptualize a model of medicine that is responsive to the lived experiences, and premised on the lived bodies, of patients. As a result, a problematic "absent body" has tacitly operated in phenomenological thought. This problem has only been exacerbated by excellent advances in embodiment studies, especially the theorizing of the visceral body, which are not reflected in the medical phenomenology literature. The second problem with medical phenomenology is in its conceptualization of modern medicine. Medical phenomenology's targeted enemy "biomedicine" is now out of date and must be revised to reflect the new "evidence-based" medicine. While medical phenomenology offered impressive theoretical insight—most significantly a rich alternative theory of illness—advances in both embodiment studies and medical research highlight the need for a new phenomenology: a phenomenology of the embodied subject in the age of evidence-based medicine.

Integrated medicine: Evidence-based patient-centered care

Evidence-based medicine (EBM) was introduced into the medical literature only sixteen years ago (Evidence-Based Medicine Working Group 1992, 2420), and it quickly rose to become the largely undisputed standard of best practice in most areas of health care. The program begins with the seemingly simple and defensible goal of basing health-care treatment on the best evidence. Its founders, clinical epidemiologists from McMaster University in Canada, diagnosed the problems and shortcomings of modern medicine as stemming from the discipline's overreliance on intuition, habits, and unsystematic clinical experience in patient care. They established the evidence-based approach as its remedy: a rigorous and methodical approach to clinical decision making that is grounded in the best and most current research evidence. The randomized controlled trial holds pride of place as the gold standard in clinical research, and so it sits on top of the EBM's "hierarchy of evidence."

The methodological innovations introduced by EBM are captured in the tenets of “clinical epidemiology.” One commentator has characterized the ascendancy of evidence-based approaches in clinical medicine as the triumph of statistics over clinical common sense based on deterministic reasoning (Polychronis, Miles, and Bentley 1996). Epidemiology is a segment of public health research that investigates disease distribution and frequency in populations. Until “clinical epidemiology” was first introduced in the 1930s to signal attempts by some epidemiologists to move their expertise closer to the bedside, public health and clinical medicine were regarded as very distinct disciplines in the former’s focus on population health, while the latter addressed the individual patient. Clinical epidemiology had a difficult start insofar as it breached well-established oppositional distinctions between public health and curative medicine, epidemiological and clinical knowledge, and population vs. patient care.¹ It only came to prominence in the 1980s when a group of professors of medicine, who shared a conviction that the scientific base of clinical practice should be strengthened, published the first edition of the key textbook *Clinical Epidemiology* (Sackett, Tugwell, and Haynes 1985), which was the precursor to “evidence-based medicine.” That group of physicians later became the famed Evidence-Based Medicine Working Group.

EBM distinguishes itself from pre-evidence-based biomedicine by its orientation toward outcomes research, while biomedicine is more dependent on bench science. Biomedical research entails laboratory science that aims to reveal the mechanisms of medical cause-and-effect in order to determine what ought to be effective, while EBM seeks to generate probabilistic knowledge regarding what is likely to work, for whatever reason (Tanenbaum 1994, 28; Goldenberg 2009, 172). John Wennberg, director of the Center for Evaluative Clinical Science at Dartmouth Medical School, regards biomedical science to be at the service of evaluative science in treatment decision making. The role of the former is to generate ideas and technologies, while evaluative science provides the necessary clinical information linking treatments to outcomes (Wennberg 1992). When some of the doubters challenge that biomedicine had indeed *always* been evidence based—what other kind of medicine could there possibly be?—they are missing how EBM has introduced new standards for what counts as *best* evidence. Such is the significance that clinical epidemiology is now held by some to be a *basic* medical science (Fletcher 2005, 3; Upshur 1999, 320). EBM’s promise of ridding medicine of its faulty intuitions and untested customs and elevating the scientific rigor of the discipline to improve patient care has proved to be

enormously appealing. It spread quickly to all other areas of health care. At this point, it would be difficult to overstate the political and professional capital of this movement, as evidence-based health care is thought to increase professional responsibility and accountability, improve patient care, and make managed care and health research more cost effective by ensuring that only the most promising technologies are funded.

There is, however, an emerging critical view. The minority opinion holds that evidence-based health care manages to create a linear decision-making framework in which evidence can be the *basis* of treatment decision making for individual patients by narrowing the modes of acceptable research methodology and forms of reliable evidence by imposing an overly rigid hierarchy of evidence. To do this is to misrepresent the complexities of clinical decision making. Furthermore, EBM's roots in epidemiology create a "fragmented" picture of medical knowledge that overprivileges aggregate measure and separates "expertise from expert . . . knowledge from knower, and the distillation of medical truth outside the clinical encounter" (Tanenbaum 1995, 102). By giving credibility to the belief that better knowledge of what is efficacious or appropriate medical action is obtained outside the clinical encounter by individuals who have no direct familiarity with the patient (biostatisticians, epidemiologists, etc.),² the evidence-based approach to health care takes authority away from the practitioner and silences any epistemic legitimacy that patients may claim to have pertaining to their illness and treatment. EBM remains noticeably silent on the values, preferences, and other subjective content that inescapably enter into all decision-making schemas.

This critique regarding the erasure of the patient is particularly forceful given the parallel vogue of "patient-centered care" in clinical medicine. Like evidence-based medicine, "patient-centered care" is widely broadcasted on the websites and other media outlets of major health-care institutions with an eye toward instilling public trust and confidence in their institutional practices. Toronto's University Health Network website, for instance, offers this definition of patient-centered care: "Patient-Centred Care is about respecting the patient's perspective on what matters most and then tailoring the care we provide to enhance their experience while in our care. [It] also incorporates other related efforts in pain management, patient education, health care provider-to-provider communication, patient safety, and cultural diversity" (University Health Network 2008).

The academic literature does not offer such a concrete definition. Stewart writes that "patient centredness is . . . most commonly understood for what it is not—technology centred, doctor centred, hospital centred, disease centred"

(Stewart 2001, 444). Against the precision that characterizes biomedical discourse, “definitions of patient centred care seek to make the implicit in patient care explicit” (ibid.). This makes the task of offering a global definition challenging, as it must somehow capture “the indivisible whole of a healing relationship” (ibid., 445).

EBM is implicated in this move to make the patient, rather than the evidence or other possible candidates, central. The calls for patient-centered care challenge at some level EBM’s strong assumption that the evidence somehow dictates best practice. Leaving aside the familiar post-positivist critique that the evidence cannot dictate theory choice (or, if you like, not without considerable interpretive and subjective qualifications; see, for example, Goldenberg 2006), patient-centeredness is certainly supportive of medical research and EBM’s commitment to finding the *best* evidence. However, it rejects the foundational model of an evidence-based medicine. Furthermore, it seems to flip the evidence-based hierarchy of evidence on its head when its advocates (such as Stewart, cited above) suggest that it is qualitative research that will likely illuminate the intrinsic holism of the therapeutic relationship that is so central to patient-centered care.

In efforts to overcome the criticism, more recent iterations of evidence-based health care have lost the early polemical language of “new paradigms” and “revolutions” in health-care education and practice. The matured accounts have also introduced more varied research and data synthesis methods in order to overcome the early charges of “cookbook medicine.”³ Additionally, supporters have admitted that “evidence is never enough” in clinical decision making (Guyatt and Rennie 2002, 6), as research data cannot be applied to actual patients without a fair degree of clinical judgment or “know-how” by the practitioner, and because patients’ values must be taken into account. In a 1996 response to the critics, the Evidence-Based Medicine Working Group redefined EBM, shifting it from the original narrow focus on using the best evidence to the more encompassing “*integrating individual clinical expertise and the best external evidence*” (Sackett et al. 1996, 71–72; my emphasis) and then characterizing it as “the integration of the best research evidence with clinical expertise *and patient values*” in the 2000 edition of the authoritative textbook *Evidence-Based Medicine* (Sackett, Straus, and Richardson 2000; my emphasis). Just a few years later, however, that same group conceded that despite evidence-based health care having “come a long way,” the “incorporation of evidence and patient values into all clinical decisionmaking remains a distant goal” (Guyatt, Cook, and Haynes 2004, 990–91).

The philosophical contributions of medical phenomenology offer considerable insight into why it might be that the integration of research evidence and contextual clinical considerations prove to be so challenging. The literature emphasizes a conceptual schism between the distanced objectivity of science and the lived experience of the particular patient that helps explain the problem of actualizing an integrated medicine. Furthermore, the efforts to reconcile science and the lifeworld seem to parallel the attempt to integrate EBM and patient-centered care as “evidence-based patient-centered care.”

Medical phenomenology

Phenomenology is the study of phenomena (“that which appears”) as they present themselves to consciousness (or how they appear to us from a first-person perspective). This philosophical approach is grounded in Edmund Husserl’s belief that the objectivism of science precludes an adequate apprehension of the world (Husserl 1970). Phenomenological methodology involves radical reflection on everyday objects and events—phenomenologists take on a “phenomenological attitude” that suspends one’s taken-for-granted presuppositions about the nature of “reality” and one’s commitments to certain habitual ways of interpreting the world.⁴ In particular, phenomenologists will set aside any theoretical commitments derived from the natural sciences in order to describe features of the natural world. All empirical sciences begin with the presumption of the lifeworld as already “given” and amenable to their methods and theories. Therefore, they presuppose the kind of thing phenomenology tries to elucidate—namely “the meaning structures through which our ‘coming to know’ objects in the world is first of all made possible” (Toombs 1993, 123). This gap between lived experience and scientific explanation is disclosed in phenomenological analysis, and such was the significance of this gap that Husserl attributed it to “a crisis of meaning” in the sciences, where despite impressive technique in controlling nature, science cannot address questions of human self-understanding (Husserl 1970).

With the advent of “medical phenomenology,” biomedicine was charged with suffering from a similar “crisis of meaning” as that described by Husserl. Drew Leder captured this in the opening lines of his editorial introduction to the wonderful anthology *The Body in Medical Thought and Practice*:

A critique has been levelled at modern medicine which goes something like this: Medical practice, though it has gained much of the last century in clini-

cal efficacy, has lost something as well. Most importantly, it has progressively lost the human touch. Patients are often treated in a depersonalized, even dehumanized fashion within the modern health-care system. Their suffering is not heard and responded to; their wishes are not incorporated fully into treatment decisions; their resources for self-healing are not called into play. (Leder 1992b, 1)

Richard Zaner recounts the topic of the technically adept but unfeeling physician being “on the agenda” of the first meeting of the Society for Health and Human Values (a precursor to the current American Society for Bioethics and Humanities) in 1972.⁵ The problem was that “physicians’ attention had become too focused on diseases and organs, diagnostic capabilities and treatment protocols, and too little on the persons receiving them” (Zaner 1988, 3). Zaner voiced what was becoming a familiar concern regarding the technically proficient physician in post–World War II specialized medicine:

Staying abreast of the new developments often meant that while physicians were obliged to be and to remain technically competent, they rarely had the time or inclination to be alert to moral issues, religious values, or social concerns. (Zaner 1988, 4; see also Cassell 1973; Pellegrino 1979)

In addition to challenges to its moral standing, the very goals of medicine have been contested in light of this depersonalized treatment of patients (Toombs 1995).

Medical phenomenology writings emphasize the experience of illness—the patient’s first-person perspective—as the missing component of biomedical thought and practice. Eric Cassell (1991), Kay Toombs (1993), and Richard Zaner (1988) often directed their philosophical writing toward medical practitioners, challenging them to really listen to their patients. Richard Baron published an introduction to medical phenomenology in the *Annals of Internal Medicine*, a seemingly unlikely venue for phenomenological research. In it, he captured the general themes and direction of the burgeoning philosophical program:

A great gulf exists between the way we think about disease as physicians and the way we experience it as people. Much of this separation derives directly from our basic assumptions about what illness is. Our medical world view is rooted in an anatomicopathologic view of disease that precludes a rigorous understanding of the experience of illness. What we need to remedy this problem is not just the admonition to remember that our patients are people, but a radical restructuring of what we take disease to be. The philosophic discipline of phenomenology is used to present a vision of disease that begins with an understanding of illness as it is lived. “Nonmedical” descriptions

of illness show how we can reorient our thinking to encompass both our traditional paradigm and one that takes human experience as seriously as it takes anatomy. (Baron 1985, 606)

In this illustrative excerpt, the patient narrative is revalued—no longer merely a superficial cover or entry point for the true pathophysiological cause of illness and disease, but rather a legitimate and relevant source of medical knowledge.

The body in medical epistemology

While sociologists have attributed the dehumanized style of modern medicine to such causes as capitalist economics, bureaucratization, and overspecialization in medicine, medical phenomenologists instead take these compelling phenomena to be manifestations of a problematic metaphysics that is captured in how biomedical science regards the body. Biomedicine is argued to rely on a vision of the body as machine⁶ that undercuts the subjectivity of patients. The mechanical body was a feature of the mechanistic philosophy that marked the Scientific Revolution, where Cartesian thought replaced the scholastic teleological view of nature with the materialist *res extensa*. The body was similarly desouled, depurposed, deanimated, and understood instead to be driven by mechanical forces. Michel Foucault points to the historically significant conceptual mechanization of the body that took place in late-Renaissance European human medicine as the study of anatomy and pathology flourished (Foucault 1994, 122). This cognitive shift permitted a necessary relaxing of social and religious taboos regarding autopsy. Medical historian Stan Reiser has characterized modern diagnostic technologies like the stethoscope, ophthalmoscope, and X-ray as furthering this regard of the body as a mechanical object by permitting a kind of dissection of the living body, where the body could be opened and its component parts revealed for analysis (Reiser 1978a).⁷ Structures could be exposed as these technologies probed the body cavities and microscopes showed the fine details of tissues and the bacteria living inside of us. Other instruments served to represent body function through quantification: measuring lung capacity, heart rate, temperature, and blood pressure (*ibid.*). With the addition of chemical testing of body fluids, physicians could diagnose and chart the course of an illness almost without talking to the patient.⁸

Drew Leder has argued that “given this reductive vision of embodiment underlying our disease categories and diagnostic methods, it is not surprising that the process often culminates in mechanistic forms of treatment” (Leder 1992a, 22). There has, of course, been considerable success in regarding and

treating the heart, for example, as a muscle pump, a hydraulic system, or as an electrical system. When drawing from the therapeutic arsenal of pharmaceuticals, exercise regimes, dietary changes, or surgery, “the doctor uses means which will alter the body as one would fix a mechanical thing, substituting parts, alternating inputs and outputs and regulating processes” (ibid., 23). At the core of modern medical practice, Leder explains, is “the Cartesian revelation that the living body can be treated as essentially no different from a machine” (ibid.). Although any good clinician also engages the patient as a person too, “the predominant thrust of modern medical therapeutics has been upon such mechanistic interventions” (ibid.). Yet despite the marvelous advances and achievements, the overlooked humanistic variables continually peek through the cracks of mechanistic medicine. It is because a machine is not an existential being that its misperformance or breakdown can be properly explained solely in terms of mechanical forces. With human disease, however, experiential factors like desires, perceptions, and expectations figure in significantly. Illness and disease expression are known to differ based on personality styles (Type A vs. Type B) or lifestyle situations. Emotional stress can bring about illness, while patients with supportive interpersonal relationships tend to have better responses to treatment (ibid.).

**The phenomenology of illness
and dis-ease and intertwined medicine**

Rather than being defined by its disease category or symptomology, illness is reconceived from an experiential perspective. Illness, phenomenologists explain, is experienced as a sense of disorder (Baron 1985, 609) and is a distinct way of being in the world “characterized not simply by bodily disfunction but by a concurrent disruption of self and the surrounding world” (Toombs 1992, 127; see also Toombs 1988). Pain, dis-ease, and disorder oblige a loss of the taken-for-grantedness of our bodies and disrupt the previous ease and “everydayness” of things (Scarry 1985; Toombs 1992). The concept of health is thus recast not as the absence of disease, but rather as “a state of unselfconscious being that illness shatters” (Baron 1985, 609; see also Toombs 1992, 127). Illness is a problem of embodiment, as the usual effortless and unself-conscious unity of the body and the self is disrupted, making one pay explicit attention to the body as suddenly problematic (and separate or alien from the self).

Kay Toombs draws on this embodied theory of illness, which is predicated on the lived body rather than the body scientifically described, to educate physi-

cians toward more humane and patient-centered practice. She argues that as a result of their training, physicians frequently slip into the “third-person” analysis of illness, and so they may fail to meet the emotional and information needs of their patients, who understand and interpret their illness largely from a first-person perspective. The physician must work to understand what illness *means* to the patient (Toombs 1993). In the therapeutic context, the physicians must not dialogue with the patient while harboring an understanding of disease as a breakdown of the objectified body-machine. Instead, the physician must try to approach illness as a disturbance in the patient’s ability to relate to and function in the world, as it is one’s embodiment, one’s capability of interacting with the world, that is damaged in the event of illness.

And so, this phenomenological reunion of science and lifeworld importantly offers a rich theory of illness that is appealing in its abilities to both highlight the suffering often endured by patients and to effectuate several desirable moves toward humanizing biomedicine: (1) it serves to rehabilitate the patient-as-embodied subject, to bring her back into view, and to deny her reduction into machine or corpse; (2) it provides an embodied account of illness that gives patients voice in their diagnosis, treatment, and treatment objectives; (3) it makes medicine more responsive to the needs of patients; and (4) it validates qualitative research. This general alignment with patient empowerment strategies fits well with numerous patient advocacy movements’ liberatory programs.

The phenomenological theory of illness has been further developed into an alternative model of medicine: an “intertwined medicine”—built on physiology *and* intentionality, empiricism *and* phenomenology. Much like the proposed integration of the evidence-based and patient-centered platforms, intertwined medicine is supposed to synthesize the specialized experiences and perceptual insights offered by scientific medicine with the lived experience of illness, and manage to do so without overwhelming the humanistic variables of health care. Science perspectives are understood by phenomenologists to reveal aspects of corporeality unavailable to ordinary vision and to clarify the structural correlates to intentional capabilities. Thus rather than replace the scientific perspective, phenomenologists instead challenge its monolithic status.⁹ The scientific account should not be taken as the only correct interpretation of the nature of things. Rather it must be intertwined within a broader phenomenological framework, where scientific references contribute to rich experiential understandings. For science arises out of lived experience, although a highly specialized sort.

The absent body in medical phenomenology

This theory of illness as rupture of the previously taken-for-granted body and self is phenomenological in its use of the experiential center as the conceptual starting point. In trying to understand what *is* this “lived body” on which an intertwined medicine would be premised, however, one still has a better sense of what it is *not* rather than what it is. Similar to the way in which patient-centered care was defined earlier largely by what it is not, the lived body is similarly captured in its opposition—*not* anatomically or physiologically described, not a machine, not a corpse. While this insight amply challenges many of the deficiencies identified in scientific medicine, we have yet to see a phenomenology of the embodied subject.

Drew Leder is one of the few medical phenomenologists to have significantly addressed the workings of the “lived body.” And it is here that problems arise with what had seemed so far to be a rich theory of illness and intriguing alternative medical model. In his influential book, *The Absent Body* (1990), Leder details the phenomenological lived body, which he takes to be paradoxical in nature. On the one hand, the existential and experiential body, as the site of subjectivity, is characterized by presence. He illustrates:

My legs carry me toward a desired goal seen across the distance. My hands reach out to take up tools, reconstructing the natural surroundings into an abode uniquely suited to my body. My actions are motivated by emotions, needs, desires, that well up from a corporeal self. Relations with others are based upon our mutuality of gaze and touch, our speech, our resonances of feeling and perspective. (Leder 1990, 1)

At the same time, however, the body, as the *grounding* of experience, tends to *recede* from direct experience. While in one sense the body is the most abiding and inescapable presence in our lives, it is also essentially characterized by *absence*. One’s body is rarely the thematic object of experience. Leder explains:

When reading a book or lost in thought, my own bodily system may be the farthest thing from my awareness. I experientially dwell in a world of ideas, paying little heed to my physical sensations or posture. Nor is this forgetfulness restricted to moments of higher-level cognition. I may be engaged in a fierce sport, muscles flexed and responsive to the slightest movements of my opponent. Yet it is precisely upon this opponent, this game, that my attention dwells, not on my own embodiment. (Leder 1990, 1)

Strong support for the “absent body” thesis comes from the seeming experiential sway of the theory of illness as a rupture of the taken-for-grantedness of our bodies, or a sudden awareness of what was once absent. Toombs powerfully describes her onset of disability due to multiple sclerosis with a compelling experiential narrative:

The malfunctioning body intrudes itself into our everyday existence, becoming the focal point and object of attention. In particular, the body presents itself as an oppositional force which curtails activities, thwarts plans and projects, and disrupts our involvements with the surrounding world. In various and varied ways, the body is experienced as essentially alien, as that which is Other-than-me. (Toombs 1992, 127)

The converse of the problematically present body in illness is the absent body in health. And so we see the absence/presence dualism articulated by Leder in Toombs’s phenomenological characterization of health and illness.

An important consequence, vis-à-vis the history of ideas, of this empirical-experiential support for a phenomenology of bodily absence and presence is an *experiential affirming of the mind-body dualism*. Indeed, Toombs uses language of separation of body and self in the bodily otherness that her progressive disability invokes. The Cartesian dualist paradigm is frequently argued by its critics to prevail in our cultural imaginary due to rigid ontological commitments at the expense of lived experience. The “experience” of illness as rupture of the absent body instead offers a deep-rooted experiential basis for Cartesian dualism.

This maligning of the body in the mind-body binary will raise concern for the numerous philosophical schools that variously deny binary thinking. For feminists, for instance, this phenomenology of illness reinforces the dualistic thinking and again privileges the mind and other “male-coded” binaries (culture, reason, abstract) over their “feminine” counterparts: body, nature, emotion, concrete.

Leder leaves us with weaker “strategic” reasons to reject binary logic: upon recognizing this experiential support for the mind-body dualism derived from the absent body, he insists that we should still dismiss dualist thinking *because* of negative social consequences. This strategy is not only weaker but it also seems anti-phenomenological, which Husserl and his disciples proposed, is supposed to reveal important philosophical truths. This is presumably why Leder engages in phenomenological analysis at all!

Denying the absent body

The theoretical developments in feminist theory and women's health research provide good reason for rejecting the "absent body" as properly characterizing the experiential body. Against Leder's total cognitive immersion in the experience of playing sports, girls often "hold back" when engaged in physical sport. In the 1990 essay "Throwing Like a Girl," Iris Young proposes that the way women use and regard their bodies is markedly different from the way men use theirs. While the masculine body moves fluidly and confidently, the feminine body uses limited movements. To "throw like a girl," according to Young, is to fail to make use of a "body's spatial and lateral potentialities" (Young 1990b, 145). This described ill-ease that girls and women frequently have with their own bodies is, of course, a socialized trait—a somatic manifestation of sexist attitudes toward female bodies—that is in no way natural or acceptable in Young's feminist framework. A counter-example to bodily absence comes from feminist bioethics theorists' employment of Foucault's term "the gaze" to describe the health-care experience of women (see, for example, Lupton 1997). Female patients are encouraged to submit to a regime of self-surveying, routine testing, and various other forms of monitoring, in times of illness and health, to keep their volatile bodies "in order." The constant threat of women's reproductive dis-order serves to grossly differentiate the health-care experience of, say, a healthy twenty-year-old woman from a healthy twenty-year-old man.

What these examples amount to is a *very* present body—one that is constantly monitored and examined for fear of immanent breakdown. Bodily absence appears to be a luxury bestowed to only some privileged men. Women, people of color, people who do not meet heterosexist norms, and people with disabilities experience a bodily presence in part because their bodies mark them as vulnerable to violence. The phenomenology of illness rightly acknowledges the "able-ist" dimensions of the absent body: people with pain, mobility and motility issues, and acute or chronic illness have a present body. But bodily absence is not the shared experience of health and functionality. In sum, we see that what began as an intuitively appealing theory of illness—the experience of problematic bodily presence—suffers in its healthy converse: the alleged experience of bodily absence.

Leder briefly acknowledges feminist criticisms (1990, 89–90) but is unsuccessful in his hurried attempt to bring them into the fold of his model of bodily absence. Addressing Young's (1990a) phenomenology of pregnant embodiment, he points out that *aspects* of the "heightened body awareness" that comes with

a rapidly changing body fit with his notion of bodily *dys*-appearance (or presence). He argues that

while bodily states of rapid change need not be dysfunctional, they are indeed problematic. This might be seen as analogous to the time of mastering a new skill. The pregnant woman must attend to her body as its new functions and shape require alternations in patterns of movement, diet, sleep, etc. The very temporal and spatio-functional unity of her body are called into question. (Leder 1990, 91)

While Leder is certainly correct in his suggestion that the experience of the pregnant body will likely require heightened attention to the body—including the negotiation of such uncomfortable states as morning sickness, increased bulk, and finally, labor pains—Leder’s defense does not address his reliance on a supposedly previously absent body. In his words, “the assumptions of a novel body render problematic *what was previously tacit*” (ibid., 91; my emphasis). Therefore, the charge that feminine comportment is more fundamentally “present” is not taken up in Leder’s response.

An objection

My reading of the absent body will surely strike some as controversial, as phenomenology posits the phenomenal body as distinct from the object body, and my reading corrupts this distinction. A supporter of Maurice Merleau-Ponty’s phenomenology of the body will likely object that the challenges that I have mounted against the absent body amount to a (mis-)reading of the lived body as the Foucaultian discursively shaped body: Foucault theorizes the body as the site of discursive inscriptions of power—never authentic or free from regulatory control (see 1990; 1995). The lived body, in contrast, differentiates the phenomenal from the object body, and suggests that only the latter is socially discoursed.

It is the object body that is reflected back to women when they are objectified. It is also the strange and present body experienced by people in pain. The phenomenal body is our primordial openness to the world and to others and is the (bodily) *basis* of experience. This openness tends to shut down when we are ill and our world closes in. At this point, the object body comes to the fore. The phenomenal body can never disappear entirely, however, as it is our phenomenal openness to the world that underlies our embodied being. This ontology explains the concept of “bodily absence,” the body’s disappearance when we are engaged in the world, without the gendered problem of the privileged body. The experi-

ence of illness as rupture of absent body is also explained: when we are ill, we are reminded deeply of the object aspect of our bodies, yet this reminding is possible because we are fundamentally open and experiential.

However yet this ontology warrants critical questioning. Phenomenally unthematized, and thus prior to subjective and socially situated identities, the lived body seems to be immune to discursive appropriation (and the sorts of gendered critique that I have offered). As the concrete material ground of experience and discourse, the lived body is also said not to essentialize transcendental subjectivity. And so, the lived body seems to evade the problems of transcendental subjectivity while remaining untouched by discursive usurpation. I am not the first to notice that the metaphysical details remain unclear as to how it is that the body manages to be so successfully liminal: material, but not merely organic matter; prior to culture and the ordering powers of political and discursive regimes, but not defined by pure consciousness.¹⁰ Chris Shilling, for instance, concedes that the phenomenological approach “has no developed conception of how the body can be shaped by social relations and contexts, or how its somatic experiences provide a means through which particular body–society relationships can serve to attach people to or alienate them from their social milieu” (2005, 56; see also Nash 2007). There have been efforts, she writes, to develop these theoretical deficits by integrating phenomenology with other theorists more engaged in the examination of social structures and contexts, while others have suggested that phenomenology’s valuable concern with the body as the source of self and society ought to be engaged and appreciated in itself, without the sociological concern with the flesh as a location for the social (Shilling 2005, 56).

It seems that phenomenological sources could account for those so-called “sociological concerns” of feminists regarding how bodies engage in society with careful ontological detailing of the relationship between primordial phenomenal openness and the objectified self in society. Some groundwork has already been laid in the recent feminist literature on Merleau-Ponty. Johanna Oksala, for instance, finds the beginnings of feminist emancipation in the perpetually incomplete cultural construction of the body and the constant rearticulation of the intersubjective horizon of meaning. She concludes her analysis of “female freedom” with the claim that “the undefined freedom of the lived body opens up a space where defined political freedoms can be sought” (2006, 226). While this offers an encouraging start, I suspect that the devil is in the details and I welcome further analysis into the question of female emancipation.

It should be no surprise that feminist theorists may resist the phenomenologist's insistence that the experience of an ever-present body by so many women is merely a statement about the body object and not a phenomenological point.¹¹ The suggestion that the phenomenological body is prior to gender flies in the face of considerable feminist and critical race theory research that has multiply concluded that gender and race are not separable categories from human experience. The further insistence of psychic priority and primordiality of the phenomenal body will not placate those feminist reservations easily.¹²

A further point to consider is that charges of masculine bias in Leder's phenomenological analysis do not necessarily disappear even if we agree that the concept of the absent body describes the basis of human experience and is not offered as an analysis of the universal features of embodiment. Even with that understanding in place, Leder has still been charged with partiality and androcentrism. Shilling (2005) offers one such reading. She interprets Leder to be normalizing a phenomenology of purposeful, instrumental, and rationalized action. Specifically, the body only fades for Leder when it becomes sufficiently rationalized to engage in instrumental action. Leder therefore offers "an ethically worrying explanation" of what happens to bodies when they become locations for the effects of a highly rationalized society (Shilling 2005, 59). Leder, Shilling writes, suggests that bodies become visible only when socially or physiologically pathological. This appears to project the logic of instrumental rationality onto the experience of embodiment. Our bodies only become prominent when illness or other malfunctions disturb that purposeful action prized by modern social systems. They fade from experience when they have become a location for the effects and normalized practices of a rationalized social system. Shilling proposes that "if Leder's account of experience is indeed becoming more widespread within modernity, then it can be seen as a damning indictment of the fate of embodiment in that current era" (ibid.).

The charge of androcentrism arises because Leder's vision of the latent body models itself upon the bodies of those whose capacities display the greatest affinity with a highly rationalized society: "those healthy males in their middle years not subject to the bodily processes involved in menstruation, pregnancy, ageing, illness and decay" (ibid.). This charge is reinforced by Young's influential account of the three modalities of feminine motility: instead of being characterized by intentionality, bodily unity, and transcendence, the typical modalities of feminine movement exhibit an *inhibited* intentionality, a *discontinuous* unity, and an *ambiguous* transcendence (Young 1990b, 147). Young wrote:

According to Merleau-Ponty, for the body to exist as a transcendent presence to the world and the immediate enactment of intentions, it cannot exist as an *object*. . . . As subject, the body is referred not onto itself but onto the world's possibilities. "In order that we may be able to move our body towards an object, the object must first exist for it, our body must not belong to the realm of the 'in-itself.'" (Merleau-Ponty quoted in Young 1990b, 150)

The three modalities of feminine existence are therefore "contradictory," according to Young, because of their inhibited, discontinuous, and ambiguous natures. Furthermore, these contradictions in feminine embodiment arise precisely because the phenomenal and object body are not easily separated:

[F]or feminine existence the body frequently is both subject and object for itself at the same time and in reference to the same act. Feminine bodily existence is frequently not a pure presence to the world because it is referred onto *itself* as well as onto possibilities in the world. (Young 1990b, 150)

By offering grounds for challenging the phenomenologically presumed separation of phenomenal and object body, the concept of absent body can be charged with upholding a tacit masculine bias. Much like the medical scientists have been indicted for holding the male body as the norm—a move that underscores such widespread objectionable practices as the testing of most new medical interventions only on male subjects in clinical trials (see Dresser 1992; Marshall 2005a, 2005b; Holdcroft 2007)—medical phenomenology must employ theoretical concepts that recognize and respect difference.

Gender and the visceral body

A further problem with the combined theory of the lived and absent body in medical phenomenology is that the medical body needs further theorizing in order to properly challenge EBM as a scientific philosophy of medicine. We see that the appropriation of the lived body into medical phenomenology highlights the existentiality of illness, thus offering a theory of illness that is rich in its emphasis on the suffering often endured by patients. While one should not belittle the philosophical significance of this work, the medical body that needs theorizing is not *just* missing an existential component. The viscera or internal corpus also needs to be theorized in order to speak to the questions and concerns of health care and health research.

Merleau-Ponty's most significant philosophical writing was the *Phenomenology of Perception* (1945), in which he challenged the idea that subjectivity

resides in the mind by arguing that perception (*comportement*) is a behavior effected not by consciousness but by the lived body. The lived body initially grasps the world via sensorimotor intentionality, and the workings of perception—widely understood to encompass the “I can” of voluntary movement, the expressiveness of language, and the site of sexuality—are localized at the surface body (Leder 1999, 200). His existential-phenomenological research interests lead him to limit his research to the outer surface of the body and to leave the visceral body largely untheorized. This limits his appropriateness as a figurehead in contemporary medical phenomenology, as a comprehensive philosophy of medicine cannot operate without some accounting of the workings of our inner organ systems and metabolic structures. A few phenomenologists have recognized the particular phenomenological significance of the visceral dimension of our embodiment, particularly Drew Leder, Cathy Waldby, Elizabeth Wilson, and Elizabeth Grosz. All of these theorists find deficiencies in Merleau-Ponty’s project and instead emphasize the interdependence of our biology or viscosity with the technocultural inscription of embodiment (Leder 1990, 1999; Waldby 2000; Wilson 1999; Grosz 1994).

The body has largely figured in the medical phenomenology literature, as well as feminist cultural analyses, as purely exosomatic—“as a surface for inscription and representation” (Richardson and Harper 2006, 2). Wilson challenged feminism’s tendency to retreat from biology in favor of social constructivist frameworks in her 1999 paper “Somatic Compliance: Feminism, Biology and Science.” Here, she introduced visceral embodiment theory through a feminist critique of female hysteria—a popular topic within feminist *cultural* critique—that engaged the biological and somatic detail of the condition. The body, she argues, must be treated as more than a “shell” or as a surface for social inscription. To do so is to mischaracterize biology as inert, and it is these static conceptions of the soma that can be manipulated into oppressive ideologies about women (Wilson 1999, 9–10). Her later publication of the book *Psychosomatic: Feminism and the Neurological Body* (2004) aimed to demonstrate that “feminism can be deeply and happily complicit with biological explanation” and that “exploring the entanglement of biochemistry, affectivity, and the physiology of the internal organs will provide us with new avenues into the body” (Wilson 2004, 13–14).

Leder draws attention to Merleau-Ponty’s use of the term *flesh*, which, he notes, commonly refers to the “superficial and fatty tissue” of the body surface (Leder 1999, 204). The term thus already suggests phenomenology’s tendency

to privilege the sensorimotor surface of the body (ibid.).¹³ He writes that the “primacy of embodiment and the primacy of perception that Merleau-Ponty advocates are usually understood as one and the same thesis,” yet the visceral foundation remains unacknowledged (Leder 1999, 200–202). Leder offers a corrective replacement of *flesh* with *flesh and blood* in order to account for both exterior body and the previously suppressed interior. The term *blood* serves as a metaphor for viscosity and *flesh and blood* expresses the “chiasmic identity-in-difference of perceptual and visceral life” (ibid., 205).

This theorizing of the inner corpus is particularly fitting for critiquing EBM and scientific accounts of medicine because the viscera are *precisely* the corporeal features that seem to lend themselves so readily to quantification, reduction, and generalization among populations. The existential-phenomenological analysis of the sociality of the exosomatic lived body does not sufficiently address questions regarding the production of medical knowledge and evidence that have arisen in debate over EBM.

The body that needs to be brought back to medicine, therefore, is not merely the “lived body,” but the corporeal viscera—the wet, organic inner corpus that is so readily quantifiable in evidence-based practice, yet is damaged in this reductive erasure of the patient as person. In an interesting turn, however, the focus on the viscera seems to *strengthen* the case for the absent body that I have already argued against. This is because while the experiential or lived exosomatic body may recede differentially from different people’s conscious awareness due to various social identifiers like gender, race, and ability, the inner visceral body is largely absent from conscious experience. Regardless of one’s awareness, the organs, organ systems, and biochemical reactions operate with admittedly machine-like regularity.

It would be mistaken, however, to think that the previous gendered critique of the absent body no longer applies and that the concept of bodily absence is therefore redeemed. Leder’s absent viscera can be similarly criticized for failing to capture the gendered experience of women. His account of visceral absence rests on a flawed dramatic distinction between our experiences of the exosomatic and endosomatic, where we can have direct conscious awareness of the former, but only oblique awareness of the latter. The endosoma, Leder explains, “rarely makes an appearance in our life-world” (Leder 1990, 111), and so the viscera are defined as the part of the body that is concealed from our lived embodiment. This negative relation between viscera and perception is problematic, however, in that it fails to capture the entanglement of the visceral within the

lived embodied experience—what Julia Kristeva (1982) called the *abject*: the external surfacing of blood, mucus, and feces. Fluidity and flow have figured prominently in feminist embodiment theory precisely because the out-of-control “leakiness” of women’s bodies has been so significantly tied to historical accounts of female biological inferiority (see Douglas 1966; Martin 1987; Kristeva 1982; Grosz 1994, 192–208; and Shildrick 1997, 16–17, 34–35. Irigaray [1985] reclaims the fluid; see especially “The Eternal Irony of Community,” 214–26). Menses, for instance, is strongly associated with uncleanness, weakness, and irrationality, and is frequently a source of shame and disgust according to Simone de Beauvoir (1989, 315). As a (*the?*) main marker of sexual difference, the meaning of menstrual blood is overdetermined (Young 2005, 109). The semiotics of menstrual flow are captured in Grosz’s strong statement: “women’s corporeality is inscribed as a mode of seepage” (Grosz 1994, 203). This excess and “indeterminacy of body boundaries challenges that most fundamental dichotomy between self and other, unsettling ontological certainty and threatening to undermine the basis on which the knowing self establishes control” (Shildrick 1997, 34). Women’s bodies regularly transgress Leder’s conceptualization of the largely contained and unrevealed visceral interior: in menstruation and lactation, a woman’s visceral depths come to the surface of her corporeality (Richardson and Harper 2006, 5). The experience of illness and chronic disease also frequently brings the bodily fluids to the surface. And what of the caregiver’s experience, which brings the typically female caregiver into close contact with the visceral excretions of her wards in the acts of changing dressings and diapers, emptying bedpans, feeding, cleaning, and drawing blood? To be clear, this is not merely a flawed physiological distinction being challenged, but a phenomenological one too. Leder’s model describes a specifically masculine embodiment that rests on the physiological tendency among men to be able to compartmentalize and overlook the viscera more easily. Leder illustrates a phenomenological world shaped by this bodily tendency.

In sum, the androcentrism of the phenomenological absent body problematically remains undertheorized in medical phenomenology. While Iris Young effectively demonstrated the gendered problematic of Merleau-Ponty’s “flesh,” the critique must be extended to Leder’s “flesh and blood.” To fail to address the implications of feminine corporeality is to somehow suggest that gender only signifies the outer body (flesh) and not the corporeal interior—what Vicki Kirby called “all the oozings and pulsings that literally and figuratively make up the differential stuff of the body’s extra-ordinary circuitry” (Kirby

1997, 76). Further, the gender-neutral reading of corporeality is disconfirmed by developments in internal medicine, where research is increasingly being sex-differentiated. Even our bodily systems seem to have gendered dimensions.

Conceptualizing modern medicine: This is the age of evidence-based medicine

Phenomenological efforts to create an intertwined evidence-based patient-centered care will likely encounter problems because phenomenological approaches criticize an outdated picture of biomedicine that does not reflect the evidence-based movement's dramatic impact on medicine. Picking up from my earlier comment that clinical epidemiology is now held by some to be a *basic* medical science, I want to highlight the corporeal significance of this insofar as until the ascendancy of "clin epi," the only branches of scientific research held to be basic to medicine were those that directly studied the structures and functions of the inner corpus—physiology, anatomy, biochemistry, and so on. Thus medical research and practice are working from a very different conceptual framework than the biomedical focus on bench science.

The body-as-machine is still implicitly operating in evidence-based medicine insofar as this theory of body represents the reductionism of scientific medicine. But this framework does not capture the changes that EBM has enacted in scientific medicine—away from the pathophysiology and bench science of biomedicine in favor of a more data-driven and statistical approach. *This* feature of the evidence-based program suggests the erasure of the individual body (mechanistic or not) as a consequence of this epistemic effort to create more universalizable biomedical knowledge. As practicing physicians find themselves "straight jacketed" by the clinical guidelines and protocols that they are expected to follow (Loewy 2007), the patient's voice has little resonance. Even informed patient decision making may be reduced to "take it or leave it" with respect to the pre-established treatment protocol that follows from the patient's clinical indicators (Bluhm 2009). While biomedicine advanced the generic mechanization of the patient's body, now the once allegedly interpretive "art" of clinical practice is being systematized via protocols, algorithms, and guidelines. Further investigation into the implications of this epidemiological influence on the medical body is needed. While a feminist bioethical focus on concretely situated living bodies is part of the necessary critical response to current discursive elements of medical epistemology, so is an account of the body within a data-driven framework. Feminist technoscience studies provide an avenue

into the latter issue. Katherine Hayles (1999) investigates the doomed fate of “post-human” embodiment in an information age. In *Data Made Flesh* (2003), Robert Mitchell and Philip Thurtle similarly examine the status of the organic body in this era of biotechnology. These ominous commentaries regarding the loss of the fleshy, mortal body due to cybernetics and informatics highlight the risk, described by Donna Haraway, of being “raptured out of the bodies that matter in the lust for information.” These comments, while admittedly only cursory, are meant to inspire necessary questioning among feminist and non-feminist health researchers alike regarding the status of the body in the data-driven health-care context.

In conclusion

This paper has called for a contemporized medical phenomenology that features the embodied subject situated in evidence-based medicine. The recent appeals for an integrated system of evidence-based patient-centered care were interpreted to justify renewed attention into medical phenomenology, as its intertwined conception of medicine still resonates as the most honest and most desirable characterization of medicine—what Pellegrino called in the 1970 Sanger Lecture “the most humane of the sciences; the most scientific of the humanities” (published in Pellegrino 1979). A review of the previously established themes of medical phenomenology was undertaken in order to highlight the perceived successes and failures of the philosophical effort. It was acknowledged that the phenomenological account of illness powerfully offered an experientially intuitive illness narrative as a totalizing experience of “things not being right in the world” (Baron 1985, 608), and the rupture “of the previous unity of self” (Toombs 1988, 223). Despite its persuasive appeal, further investigation uncovered one of two shortcomings in medical phenomenology: the absent body that operates in health and other instances of supposed bodily ease. Feminist research has challenged this allegedly generalizable experience of the body receding from perception. The charge of androcentrism was demonstrated to pertain not only to the exosomatic existential-phenomenological body, but to the visceral body too, as the female body regularly transgresses the assumed sequestering of bodily fluids to the receded endosoma. Medical phenomenology’s second theoretical deficiency lies in its maligning of 1970s biomedicine. A twenty-first-century medical phenomenology must reflect the advances in medical research that have initiated the evidence-based medicine movement. Intertwined medicine’s previous nemesis, biomedicine, has evolved into evi-

dence-based medicine, and the “biomedical body” has similarly evolved into a data-driven body, or a body of formal probabilistic reasoning.

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Notes

1. Clinical epidemiology is described as an “apparent oxymoron” by Mykhailovskiy and Weir (2004) for these reasons.

2. Others are thought to be able to know better by having access to selective summary data about the patient and the ability to compare such summary data for an individual to that of a population as a way of determining the proper action for a given individual. This is proper course in epidemiology.

3. The Evidence-Based Medicine Working Group object to the charges of “cookbook medicine” in Sackett et al. (1996).

4. The radical reflection of phenomenological research does not deny the existence of the physical, social, and cultural forces that organize the meaning structures of phenomena. Instead, this attitude (or “bracketing” in Husserl’s language) reveals the prejudices that are taken for granted in our everyday experience.

5. The Society for Health and Human Values was established in 1969 as a membership organization committed to human values in medicine. In 1998, it merged with the Society for Bioethics Consultation and the American Society for Bioethics to form the American Society for Bioethics and Humanities.

6. Michel Foucault used the term *Man-the-machine* in *Discipline and Punish* to capture the materialist leanings in seventeenth-century thought (Foucault 1994, 136).

7. In other writings, the body in modern medicine is likened to a *corpse* (Foucault 1994; Shildrick, 1997; Leder 1990, 1992a). The epistemological primacy given to the disease lesions and other anatomical revelations exposed via dissection explains why the corpse came to be valued over the living body in medicine. The automaton and the corpse similarly serve as opponents to the phenomenological lived body. Leder (1990; 1992a) develops the concept of the “Cartesian corpse” that signaled the material reduction of the soul and the docility of the manipulable body.

For unlike the changing and unpredictable lived body, “the dead body is at last self-contained. Because the corpse is a sheerly material and predictable thing, it lends itself to reductive and quantifiable forms of explanation that are compatible with the conceptualization of ‘Life as abstract quanta of force’ (Leder 1990, 147).

8. Indeed, the ideal patient becomes the silent one. In Richard Baron’s (1985) ironically titled article “I Can’t Hear You While I’m Listening,” the author recounts:

It happened the other morning on rounds, as it often does, that while I was carefully auscultating a patient’s chest, he began to ask me a question. “Quiet,” I said, “I can’t hear you while I’m listening.” (606)

9. While not phenomenologists, Holmes et al. (2006) wrote one such critique of the hegemony of evidence-based practice, “Deconstructing the Evidence-based Discourse in Health Sciences: Truth, Power and Fascism,” and managed to inflame sectors of the health research community by describing evidence-based health care as a “microfascist” program. The paper inspired a wave of blog rants against “postmodern medicine” that were reminiscent of the science wars of the 1990s.

10. This very liminality has been noted by Shilling as being precisely what has made Merleau-Ponty’s work on the bodily basis of experience so influential (2005, 56). Indeed, it offers exactly the sort of theory of body that feminists have been hoping for!

11. Nor should we ignore the many feminist theorists who find valuable feminist insight from Merleau-Ponty’s work. Sullivan (2000) has listed those insights to include “the primacy given to bodily existence. The attention paid to pre-reflective aspects of human life, including the indeterminacy and ambiguity; the importance of situation and situatedness for understanding our engagement with/ in the world; and the crucial role that habit plays in corporeal existence” (184).

12. For an interesting negotiation of and effort to overcome some feminist reservations regarding Merleau-Ponty, see Kruks (2006).

13. Merleau-Ponty introduced the concept of “flesh” to signify the anonymous and pre-personal body—those bodily commonalities that make intersubjectivity and shared meaning possible. Commentators have interpreted “flesh” to mean both flesh of body and flesh of the world. Leder’s (1999) focus on flesh of body is an important contribution to medical phenomenology.

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