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RESEARCH PAPER

The phenomenon of vulnerability in clinical encounters

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Abstract After a brief, personal reflection on Aron Gurwitsch's life and his many influences on my career, I devote this lecture to some of the central themes of a phenomenology of medicine. Its core is the clinical encounter, which displays a certain structure I term the asymmetry of power (physician) and vulnerability (patient, family)—a complex contextual imbalance characterized by multiple points of view, hence points for reflective entrance. These are then interpreted phenomenologically in terms of *epoché* and reduction (practical distantiation), evidence, reflection, and other related themes. I conclude with a suggestion about ''the fundamental method'' of phenomenology, free fantasy variation.

Keywords Clinical encounter · Asymmetry · Power · Vulnerability · Method · Evidence

Prelude

While reading the Schutz–Gurwitsch correspondence, I suddenly realized several uncanny circumstances. What haunted in my reading can be readily laid out. But that I seem compelled to do that, I make no effort to explain. For one, I was reminded of my grandfather on my father's side, and his various wanderings across Europe,

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ending up in the United States, and of several of my last conversations with Aron Gurwitsch.

You may understand, then, when I tell you that I have become haunted of late by uncanny connections, anomalous happenings. Perhaps this is because I have myself become an odd circumstance, one that attracts such oddities. I am in any case not merely somewhat elderly, retired and increasingly irascible, but chock full of memories of earlier and, obviously better days—''back when things were good,'' I can almost hear lyrics rendered into wistful song. And, of course, I am still trying earnestly to make good sense of things, though in the manner of the maverick I tended to be for so many years.

Gurwitsch's history, it is well known, is marked with wandering. Born in Vilna, Lithuania, his father moved the family to Danzig to escape the 1905–06 pogroms. Later, Gurwitsch, the Nazis hot on his heels, continued to escape and wander, from Danzig to Berlin, Frankfurt, Göttingen, Paris, and thence to the United States where his wandering continued for many years as he sought a permanent position, until he eventually secured appointment at The New School Graduate Faculty, where I was already studying—with Schutz, Marx and Cairns, among others—as the replacement for his dear friend, Schutz, who had only recently died—before, sad to say, he could actually direct the MA thesis he insisted I write (on Gabriel Marcel, after I mentioned in passing how I found his writing seriously opaque; ''ach, gut, Herr Zaner, then you will write on Marcel. Gut!''

My own history bears curious similarity to that course of life, although I knew little of this while Gurwitsch was alive. Reading his remarkable exchange of letters with Schutz, edited by Richard Grathoff (1989), however, brought on an eerie sense: my grandfather, Morris Zirulnik, as a young man left his home in Belarus with his new and very pregnant wife, escaping pogroms at about the same time as the Gurwitschs, and landed in Brooklyn where my father was born right off the boat. Name then changed to ''Zaner,'' to match the one his brother had acquired at Ellis Island four years earlier, he then moved the family to Toledo, Ohio, where my father grew up.

Affected with some wanderlust, too, my father not only left Ohio right after high school in the 1920's for a scholarship at a tiny, rural teachers' college in Flagstaff, Arizona, where he met my Protestant mother, left his Jewish faith and practices, moved about the West, and played his clarinet when he could. Unlike Gurwitsch, though, I was raised a Protestant—thanks to my mother, the daughter of an old-time rancher, a cowboy from Southeastern Arizona—although I confess that the Protestant tradition rarely felt *heimlich* to me, something I on the other hand felt quite deeply with what I gradually came to grasp of the traditions of Natanson, Schutz, Marx and Gurwitsch.

There are other peculiar things I might mention: that, for instance, I'm now the age at which my father died; and, oddly, Gurwitsch as well, at age 72, on June 25, 1973. At about the time of Gurwitsch's death, I entered upon what became, ultimately, a new career in the world of clinical and research medicine. I had the chance to discuss this change with him more than once and, although he had some serious doubts and disputed it with me, he eventually came to appreciate my interest in this new direction.

Our dispute centered on this: he could understand that the field of medicine stood to learn much from phenomenology, but disputed that the latter had much to learn from medicine. I thought he was wrong, and reminded him of his own earlier study

and work with Gelb and Goldstein, Wertheimer and others in Gestalt psychology: didn't he learn as much from those encounters as I hoped to learn from medicine? Then, thrusting a *coup de grace*, so I thought, at our last meeting—when he asked me to take over the direction of two dissertations as if he were anticipating the death which happened only a few months after this conversation.

The *grace* of the *coup* was that it brought his attention to one of the texts he much loved, Husserl's *Ideen*, volume I, in which (§ 60, to be precise), Husserl urged anyone who would aspire to philosophy to "fertilize" his or her fantasy "by observations in originary intuitions that are as abundant as possible" (1982, p. 131). To do this, Husserl emphasized, it is imperative to turn to history, art and especially poetry, learning to practice and, indeed, to enhance thereby the method of free-fantasy variation. Doing so will soon make it clear that "'*fiction' is the vital element of phenomenology, as it is of every other eidetic science*... fiction is the source from which the knowledge of 'eternal truths' draws its nourishment" (1982, p. 132 and footnote).

I don't actually recall Gurwitsch's specific response,[1] but I can say that he seemed to change his mind about what I was then beginning to engage: to explore the sphere of medicine, broadly understood, as my own way of reaching, by deliberately and systematically "fertilizing" my fantasy, serious understanding of phenomena central to my own thematic pursuits: self, embodiment, alterity, sociality. What better way to test one's ideas about these than to pose them in the context of, say, the new genetics: at precisely which point in human development does "self" happen?—or of difficult pregnancies: how damaged must a fetus be for it never to become a self?—or, something now dear to me, old age: is there a time when an old man or woman ceases to be a "self"; clearly, I would learn, death, but equally, birth constitute major challenges to our understanding. What better way to enable interesting discoveries about ourselves than in the concrete circumstances of clinical life, illness, hope, loss, grief, birth, and death?

Now, after spending most of my career in this pursuit, I note that I was able to stick with that decision—and that I am now the very age Gurwitsch was when we last talked just before his death in Zurich: 72. Now, at the same age when he died, I find myself invited to give the lecture named for him.

Nor is this all. Perhaps more literally than necessary, I must note at least in passing that the reference to that peculiar text from Husserl's *Ideas I*, on fertilizing and impregnating one's fantasy, fiction, and such, is, I have discovered, not merely squarely on target and true in the strictest sense, but as well that there is far more in his seemingly odd choice of terms, "fertilizing," "fiction," and the like, than perhaps even Husserl realized. In any event, unlike Gurwitsch—who, in a conversation I once had with him when I invited him to lecture at the University of Texas-Austin, denied any real understanding of art—I have often tried my hand there, variously, even to the point where much of my recent writing has been devoted to a kind of fiction. And, with that, proving at least to myself the fuller truth of Husserl's remarkable insight: therein lies indeed greater clarity and much keener understanding of the things themselves than I at least had been able to grasp otherwise.

[1] I do, however, vividly recall the first time I met this charming man; Maurice Natanson, my undergraduate studies mentor at the University of Houston, invited Gurwitsch there for a lecture. This was at a time when this college was surely in the hinterlands. In any event, at the conclusion of his lecture, I asked him a question—something to the effect of why he had himself "gone into" philosophy. His response was stunning: he pounded the table at which he had lectured, sending papers flying, and proclaimed loudly: "To be *clear*, Herr Zaner, to be *clear*!"

Passing on a tradition takes many forms and paths. My own, clear enough I suppose to those who know my work over the past two or three decades, has been governed by my encounter with clinical medicine and biomedical research—more specifically, in the course of my efforts to explore the possibilities, dimensions and discoveries as a philosopher working in depth within clinical and research situations among the incredible variety of people and encounters that constitute the world of illness and clinical life and death.

Here, then, is one effort to carry out, faithfully, at least some of his legacy; I trust the path that I have taken, within the deep and wide shadows cast by this great man, will indeed honor him.

An aspect of a phenomenology of medicine: the clinical encounter

Medical historian Harrison Coulter once noted that ''medical thought thus grows out of, and is governed by, therapeutic experience. Therapeutic theories in all their variety are attempts to make sense out of the healer's experience with the patient'' (1975, p. vii). I have long thought this correct, even though it is also true that things are considerably more complex. The physician's experience is not just with the patient's body, but with what the patient tells the doctor, in response both to what the patient believes he or she hears the doctor say and to his or her own experience of the pain, discomfort, etc. The physician's experience is similarly complex. Moreover, both interpret: each other's own experiences, illness, etc.; what the other says about various affairs (illness, the weather, whatever); what each believes is 'said' by the other's overt and tacit gestures, and so on.

Hence, the experience of illness—one principal focus of medicine's attention and actions—is what I termed, following Gurwitsch's insight, an intrinsically complex contexture (1981, p. 198). This contexture has to be the main focus of attention if we would understand the fundamental sense of medicine, which Edmund Pellegrino termed the ''clinical event,''[2] or what I have called the ''clinical encounter'' (1988/2002). It is from within this complex of experiences (of self, of other) and overlapping interpretations (of self, of other), that a phenomenology of the illness experience must be worked out—a study which is one of the fundamental themes, as I see it, of a phenomenology of medicine more broadly (Zaner, 1995a, 1999, 2003, 2005), clearly of a piece with the theories of perception worked out by Gurwitsch, and of sociality worked out by Schutz—all of which constitute parts of the fundamental phenomenology conceived by Husserl.

Experience is the point both of departure and return for theory: its ground and ultimate test, the evidence for what must be at once illuminated and elucidated. Consider merely some aspects of a patient's experiences: a pregnant woman, for instance, experiences her body; her past, hopes, plans, and fears; her developing fetus; what her husband or friends did and said, as well as what her physicians did and said (and all the others involved, including myself should I be asked to consult, as happened many times during my time at Vanderbilt). Everyone's experiences are similarly complex.

Nor is this all. Every situational participant not only experiences but interprets the encounter from within his or her own biography: history, typifications, life-plans,

[2] This clinical event is the centerpiece of medicine, Pellegrino rightly insists (1983, pp. 153–172).

undergirding moral and religious views, etc. (Schutz & Luckmann, 1973). These encounters are also framed by prevailing social values, written and unwritten professional codes, governmental regulations, hospital policies, unit or departmental protocols, etc.—any or all variously contributing to ''what's going on'' in any specific case (Zaner, 1988/2002, pp. 129–152).

To simplify matters, consider only the patient and her or his physician. Each is a *self*[3] and thus is essentially reflexively interrelated with the other. Briefly, the patient experiences and interprets her or his own condition, but also experiences and interprets the physician's experiences and interpretations. The latter include the experiences and interpretations of the patient (and how she or he is thought to experience and interpret the doctor)—and both patient and physician are to some degree aware of this complexity. In a word, the relationship is complex, intersubjective, and reflexive. Each experiences and interprets the other, their respective interpretations of one another, and at the same time within their relationship, experiences and interprets the relationship itself (1981, pp. 217–239).

To focus on a clinical encounter, then, is to focus on a complex context characterized by presenting multiple points of view, hence, points for reflective entrance—which at one point I termed ''complexure'' (1981, pp. 92–110)—and is thus to come into the responsibility for respecting the integrity of that context: its constituents, their mutually constituted and multiple interrelationships, and the always changing, temporally and socially variable situation—that living context within which each participant meets and encounters the others and that is organized around certain determinable constitutive features. For instance, a pregnant woman's doctor is there to take care of her, to understand what is presented by ultrasound images, for example, and to do whatever is necessary to ensure healthy fetal development—and to have plans in place should something unexpected occur, or in the event of errors, etc.

For example, this pregnant woman experiences her pregnancy and her developing fetus (in ways specific to this phenomenon), and this experience is complexly textured by the ways in which she experiences and interprets what her physicians (and others) tell her, what she's read, and what she knows from other sources too. Similarly, in a situation in which I was asked to consult, a woman's physicians experienced and interpreted her words (tone, intensity, word-choice, etc.) and physiognomy (lips, head, eyes, etc.) as ''anger'' they felt was directed at them and as about ''abortion.'' Both experienced and interpreted the relationship itself. Regarding diagnostic data, for instance, she said ''I know they're only trying to do their best'' (interpreting the relation as ''trying to help''); her physician said, ''She seems to think we're being deliberately unclear'' (the relation was ''not going well'').

To probe clinical situations phenomenologically is to work somewhat like a detective: deliberately alert to the multiple ways in which participants interrelate, variously experience, and interpret one another and, within that complex and ongoing relationship, to figure out what's going on in the clinical relationship itself. Even a brief moment reveals a complex of reflexively interrelated voices, each with its own complex emotional, volitional, valuational, and cognitive tonality, and each demanding to be heard and understood so that decisions can be made and

[3] Gurwitsch would have preferred not to use ''self'' but *consciousness* only, consistent with his ''non-egological theory of consciousness.

aftermaths borne. In this sense, phenomenological reflection and explication is a species, it seems to me, of contextual or circumstantial understanding.

To enter such a scene with the idea of trying to help is to be faced with the prominent need to sort things out: what's going on and what might be done for it? This cannot be done beforehand: one never knows in advance which issues must be dealt with, nor just how the gradually uncovered issues are to be managed. The problems are strictly those facing the people whose situation it is—that couple and their physicians. Similarly, alternatives, decisions, and outcomes are strictly theirs. Any encounter presents its own set of issues, moral and other—they are context-specific in the sense that working with and on behalf of such persons, helping them appreciate and advising them, and the like, requires a strict focus on the respective situational definitions (Zaner, 1988/2002, pp. 251–282). To understand these, there is nothing for it but to try one's best, so far as possible without interpretive predispositions, to get at the concrete ways in which the participants themselves experience and understand their situation, and endow its various components with meaning.

This suggests that in clinical situations, moral issues are presented for deliberation, decision, and resolution solely within the contexts of their actual occurrence (1988/2002, pp. 242–248). Determining what's troubling the people, what's on their minds, and thus figuring out what has to be addressed and how, requires cautious, attentive probing of their ongoing discourse, conduct, the setting, and other matters presented as constituting this specific context—making every effort to take nothing for granted.

Such situations present an already ongoing clinical encounter among the people involved. Thus, every situational constituent, including any moral issue, is presented solely within an ongoing relationship between patient and physician (1988/2002, pp. 29–91)—at least, in its minimal form. That relationship is not itself, however, the focal theme for either patient or physician. The physician is instead concerned to help the patient (or at least to do no harm). The patient's concern is to have distress relieved, injuries healed, disease resolved, or at least to be comforted and cared for. Clinical ethics—or what I may here chance to term phenomenological-contextual understanding—addresses that relationship itself, including each component intrinsic to it, attending to each of these integral constituents within that temporally ongoing contexture, to use Gurwitsch's term.

These points can be expressed in formal phenomenological terms. (1) The ''method'' involves *epoché and reduction*. Gaining genuine knowledge or science requires, Husserl insists, that one ''put out of action all the convictions we have been accepting up to now, including all our sciences,'' so as to ''immerse oneself in the scientific striving and doing'' specific to the pursuit of science (1960, p. 7). This idea, at first perhaps only a ''vague generality,'' can be taken as *ein Leitfaden* (a clue) for reflective consideration, making its inner ''intention'' or claim progressively clearer (1960, p. 9). This focus is a sort of ''precursory presumption'' guiding reflection: what is it that one claims or aims at when one strives to be ''scientific''—or, in my case, strives to be ''clinical—or when a patient ''seeks help'' for some ''problem''?

Crucial to the undertaking is adopting a rigorous reflective ''attitude'' or ''orientation'' (*Einstellung*) that enables one ''to immerse oneself in'' (*sich einleben in*), thereby becoming reflectively cognizant of, the practices specific to medicine, with its inherent claims and end. This methodical shifting to a reflective orientation is the ''epoché''; rigorously maintaining it throughout the course of inquiry is the ''reduction.''

(2) Every endeavor includes the possibility of just this sort of reflective-attentive shift—whether or not it is actually undertaken. Precisely because the practitioner experiences the field, s/he can recognize what MacIntyre terms the ''goods'' internal to it (its ''standards of excellence'' or ''virtues''),[4] and indeed may even periodically reflect on it. On the basis of such experiences and reflections, one can (and sometimes must) stop and think about the field and one's involvement.

Reflection in a strict sense requires a specific shift of focal attention (epoché)—away from active involvement in clinical cases for their own sake, to considering them *as examples* of the practice—an attentional shift that needs to be *sustained* throughout the reflective project (reduction). To stop and think about the efforts and actions specific to any field is, on the basis of one's own pertinent experiences, to become reflectively attentive to its inherent ''intention'' (1982, pp. 125–141). This complex reflective act might be termed a sort of practical distantiation, contextual-circumstantial understanding, or more simply, phenomenological reflection.

There is nothing mysterious here; it is something each of us does many times in our daily preoccupations with more or less skill and attention. The method, Husserl once observed, is the very same as that which ''a cautiously shrewd person follows in practical life wherever it is seriously important for him to 'find out how matters actually are''' (1969, pp. 278–279). Just such seriousness was evident in the situation I mentioned of the pregnant woman; it was vital that she and her husband understand what they faced so that they could decide and act. They engaged in at least a form, perhaps only the first stages, of reflection—''stages,'' for they did not proceed too much further with it. Their reflections were (Husserl might have noted) only the ''beginning'' of wisdom, but, he emphasized, it is ''a wisdom we can never do without, no matter how deep we go with our theorizings'' (1969, p. 279).

(3) The ''seriously shrewd'' person must judge on the basis of soundest available evidence—which at times means acting on the basis of uncertain and/or ambiguous findings. She must judge, in Husserl's terms, ''on the basis of a giving of something itself, while continually asking what can be actually 'seen' and given faithful expression'' (1969, pp. 278–279). Whether one has practical (for example, trying to have a baby) or theoretical concerns (for example, interpreting diagnostic tests), to seek sound judgment requires a concerted effort to know, ''really and truly,'' just how matters actually stand. The matters at hand, if you will, *mattered* to this woman and her physician; both had a vital interest in knowing so that they could then decide on which action was best for them and their baby.

In different terms, every knowing always involves an appeal to evidence which is, ''in an *extremely broad sense*, an '*experiencing*' of something that is, and is thus...'' (Husserl, 1960, p. 12). Evidence is not a sort of rare and special ''datum,'' nor is it a magical wand or a conferral from on high having special privilege or guarantee (Husserl, 1969, pp. 161, 177, 180, 289). Evidence is, rather, a matter of relevant experience and is essentially contextual—relative to whatever it may be that best serves as the grounds for what is claimed and to the specific types of experience

[4] Alasdair MacIntyre's definition of ''practice'' (1981, p. 175) is apropos: ''By a 'practice' I...mean any coherent and complex form of socially established cooperative human activity through which goods internal to that form of activity are realised in the course of trying to achieve those standards of excellence which are appropriate to, and partially definitive of, that form of activity, with the result that human powers to achieve excellence, and human conceptions of the ends and goods involved, are systematically extended.'' Science, among other activities, is specifically included.

through which the affairs in question are at all encountered. Thus, evidence about fetal hydrocephaly cannot be the same as evidence for alleging that a couple is ''angry.''

Even if there seems to be good evidence for believing that something is this or that, the possibility of error or deception cannot be precluded—and in the context of clinical medicine, that possibility forms the principal rationale for the necessity of alternative planning, sometimes hierarchically organized. The possibility of deception is inherent in the evidence of experience (in Husserl's broad sense) and ''does not annul either its fundamental character or its effect...'' (1969, p. 156). Not even genuine evidence provides ''an absolute security against deceptions'' (1969, pp. 157, 284–289). In ethics, especially clinical ethics, there is a clear demand for addressing uncertainty, error, deception, and ambiguity.

As experience in the generic sense (*Erfahrung*), evidence refers to the particular ways in which some affair (''anger,'' ''hydrocephaly,'' etc.) is experienced (is given or otherwise presented), or through which one is able to become aware of or to encounter that affair—and on that basis, come to know it, make claims about it, etc.: for the physician to attribute ''anger'' to that woman strictly meant that certain matters (words, facial expressions, etc.) had been correctly interpreted and could be verified by someone else. *Evidenz* is strictly correlated to the modes of givenness (*Gegenbenheitsweise*), the ways in and by means of which the things allegedly known are encountered as ''they themselves,'' as Husserl says, ''in person''[5] (*leiblich*)—in the ways specific to the ''things'' in question.

In the case of the pregnant woman, this need for good evidence was prominent. The family obstetrician first referred the couple to the medical center physician who later asked me for help, on the basis on the ultrasound and clinical examination. The center's obstetricians saw that first ultrasound and obtained another, as well as an alpha-feta protein test and, together with radiologists and others qualified to read such images and laboratory findings, came to the judgment that the fetus had severe problems. The couple, on the other hand, barred by lack of experience and knowledge of such things, could base their beliefs and concerns only on what they were told by the physicians (''hear-say'' evidence, even if from ''experts''). But the physicians' notion that the couple ''seemed angry at us for mentioning 'abortion''' turned out to be not well grounded; the belief was quite wrong even while the claim that they were ''upset'' was correct. Clinically assessing this situation led immediately to the various claims, the evidence provided (or that could be provided) for their respective beliefs and claims, and working from that point to locate other, more appropriate beliefs and claims and their respective reasons or evidences.

(4) To consult as an ''ethicist'' on such a case is to be focused on the situation (people, setting, circumstances, issues, etc.) itself, for its own sake. My concerns in that event are strictly therapeutic: to help the couple understand what they face, what they have been told, and especially to help them become more aware of their own moral views so that they can more likely reach decisions commensurate with those views. On the other hand, this and other encounters may also be submitted to philosophical reflection, such as what has concerned me here. For that, the clinical encounter must be considered strictly as an *example* which, taken along with other

[5] Thus, Husserl can say that evidence ''*consists in the giving of something-itself*,'' along with the discipline of giving them faithful linguistic expression (which he includes in his ''normative principle'' of evidence) (1960, p. 14).

examples, helps make certain common themes prominent. These can in turn be systematically considered in further reflective work, leading ultimately to a more embracing philosophical understanding.

More technically, as I suggested much earlier (1973, pp. 29–43), to consider any clinical case as an example is to practice a version of ''free-fantasy variation,'' to which Husserl gave extraordinary significance. It is ''... *the fundamental form of all particular transcendental methods*,'' and provides ''the legitimate sense of a transcendental phenomenology (Husserl, 1960, p. 72).''[6] Whatever one may think of that, it is significant that Husserl regarded this method as the centerpiece of phenomenological inquiry, the key way to apprehend ''essences.'' While he sought to establish phenomenology as a transcendental discipline, it has seemed to me that certain versions of it are at work in a variety of areas (Polkinghorne, 1983). It might even be more accurate to say that there are a whole battery of variational methods (Zaner, 1975, pp. 125–141).

One specific type became clear, for instance, in the course of my reflections on certain clinical encounters which I hoped would help elucidate the phenomenon of ''self.'' It soon became evident that this sense is curiously prominent where ''self'' seems at times *absent*. Reflecting on cases involving brain-injury, for example, a crucial and distinctive ability of the phenomenon of self stands out through its very absence: ''possibilizing'' or ''thinking for the possibly otherwise''—i.e. the ability to transcend the immediate present. Just this striking absence of an otherwise normal human capacity is forcefully presented in those cases—while, at the same time, its absence presents a patient as needing therapeutic attention (1981, pp. 173–180).

Kurt Goldstein, I believe (1981, pp. 173–175), followed precisely this type of method in his work with brain-injured patients (1942, 1948), as did the psychiatrist Gerhard Bosch (1970) in his study of infantile autism (Zaner, 1981, pp. 182–198), Erwin Straus when he treated a delusional patient (1966), and Gurwitsch when he did those classic studies of Hans and others with Gelb and Goldstein. This variational or exemplicative method can as well be found, with interesting variations, within clinical medicine. For instance, clinical diagnosis, specifically its ''detective-work'' (methodical differential diagnoses) and eventual selecting (with the patient) what is ''best,'' no less than the ongoing conversations patients and families—all turn out to exhibit strikingly similar features.

I have mentioned only several phenomenological notions. Much has been left out: the intentionality of experience, the differences among the relatively inexplicit awarenesses and active ones, the meaning of ''feeling,'' encounters with others, and inner-time consciousness, to mention but a few. A full phenomenology of clinical life has thus been only suggested. It nevertheless seems clear that this approach is remarkably fruitful, eminently practical, and above all faithful to the subtlety and complexity of these encounters (Zaner, 2001, pp. 127–144).

[6] Husserl carefully distinguished his method as ''a variation carried on with the freedom of pure phantasy and with the consciousness of its purely optional character—the consciousness of the 'pure' Anything Whatever,'' and thus as focused on each actual or possible example as exemplifying the purely possible. In this, he distinguished it from ''*empirical variation*''; the method is thus a strictly philosophical one, although there are, as I argue in the text, a number of interesting versions of the method even in empirical science and medicine (1969, pp. 247–248).

In the aftermath

Only some aspects of the experience of doctoring have been delineated. All I have tried to do is provide some insight into the fuller phenomenon of clinical medicine, with nothing said about the increasingly significant theme of research. Without anticipating what might come out of that more complete study, then, the following summary of my approach to it as centered in the clinical encounter can be given.

An accidental disruption in the routine flow of life, illness or distress of the sort invoked in the encounter mentioned renders the person uniquely vulnerable, placed within a complex network of unavoidable trust relationships (of doctors, substances, techniques, procedures, etc.). It disrupts, to a greater or lesser extent, the person's usual ways of relating with other people, making the ill person unusually reliant on others who, in the nature of the case, work within situations that are invariably charged with uncertainty and ambiguity, yet that have something vital at stake, and with people who are fallible. These others, usually strangers working within settings mostly unfamiliar to the sick person, possess or profess the power to know ''what's wrong,'' ''how to deal with it,'' and ''what to expect.'' At the same time, to become ill is to want and seek to understand vitally, precisely to the extent that we do not (or perhaps cannot) understand ''what's happening,'' ''what's wrong,'' and ''what should be done about it.'' At times we desperately need to know that these strangers really do know what they profess to know, can do what they profess to be able to do, and care for us while taking care of us.

The illness experience thus displays complex and compelling moral dimensions. The uniqueness of each relationship and the conversations and actions by which it is carried out, constitute this dyad as characteristic of and even fundamental to moral life. On the one side, the vulnerability and appeal of the ill person; on the other, the response from the professed healer/helper (Marcel, 1940, 1951). Their relationship, deeply textured in our times by complex forms of personal, professional, and social expectations, social norms and institutions, and complicated by strangers engaging in multiple forms of intimacy, is essentially asymmetrical, the very fact of which constitutes a complex and altogether special set of occasions for awakening our moral sense in a basic way. That relationship itself places the helper in a position in which he/she is able to take advantage of the multiply disadvantaged sick person, but precisely that is what ought not be done—an ''ought'' understood in the very beginnings of medicine's history, seen as needing an oath and covenant, and secured in most ''codes'' since that time.[7]

While clearly ''disabling,'' illness or distress is at the same time among the most powerful and morally ''enabling'' (Zaner, 1981, pp. 181–237) of our experiences—keen and rigorous sensitivity to which is a critical requirement of a fully humane and scientific medicine. As the couple in the situation to which I've alluded manifestly demonstrated during our several conversations, even significant loss is not always and only negative. For, although they did eventually opt for abortion and thus lost the child they hoped to have, and even though they continued to suffer from

[7] Specifically in its strong emphasis on what for Edelstein is a ''fusion'' of two principal virtues: justice (dike) and disciplined restraint (sophrosyne)—which leads to the seminal ideas of confidentiality (vow of silence), protecting of patients (keeping them from ''mischief''), and beneficence (Edelstein, 1967, pp. 6–40, 326–347; Zaner, 1988/2002, Ch. 8). I think that the virtue of courage must also be added to this mix.

the losses, uncertainties, and ambiguities of their experience, they nonetheless demonstrated gratitude, a sense of recovery, and an orientation toward the future marked by a thematic sense of promise. More subtly, they seemed grateful, in a way, even for having been through the experiences of pregnancy, diagnosis, deep reflection and discussion, decision and aftermath. Indeed, although they expressed their belief that abortion was not a desirable outcome, they were grateful even for that, as seemed evident in their words after the abortion was over and it was learned that their infant not only had a large myelomeningocele and hydrocephalus, but also an omphalocele (open abdomen with organs lying outside)—and, in all likelihood, still other anomalies that would have made it all but impossible for the infant to live for very long after delivery. Texturing their words was a keen sense that it would not be right to ''make such a child live'' with no hope of correction.

I don't really know whether what I have had to say in this brief way would have made Gurwitsch smile or grimace, but I think he would have recognized how his work has deeply infused my efforts, guided, and inspired me—as have those of his close friend and fellow in exile, Alfred Schutz; and of his friends and colleagues in later years at The New School, Dorion Cairns, Werner Marx, and Hans Jonas.

I do know, too, that their writings and their presence as teachers have figured profoundly in my own life, teaching, and writing, so much so that it is by now probably not possible to parse out who or what or which figured in this or that of mine. In any event, I wanted to share here merely some of what I think might bear repetition, in the hope that it will indeed rightly honor and enrich the memory of my mentor and uncanny friend of my later years, Aron Gurwitsch.

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