Scientific Contribution

Gadamerian dialogue in the patient-professional interaction

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Abstract. In his seminal work, *Truth and Method*, the German philosopher Hans-Georg Gadamer distinguishes between three types of what he calls the experience of the ‘Thou’. In this paper, Gadamer’s analysis of this experience is explained in terms of his philosophical hermeneutics and brought to bear upon the patient-professional relationship. It is argued that while Gadamer’s analysis implies fruitful insights for a dialogical account of the patient-professional interaction, it harbours elements which are conducive to paternalistic practice of medicine. The strong attribution of value to tradition and the respect for authority emphasized in his theory result in a lack of sensitivity for individual self-determination which is needed for a successful account of the patient-professional relationship.

Key words: dialogue, Gadamer’s hermeneutics, paternalism, patient autonomy, prejudices, professional-patient interaction

Introduction

In the bioethical literature, several models of the patient-professional relationship have been presented. These models can be roughly divided into three familiar categories. The first category emphasizes the authoritative expertise of the professionals, placing the patients completely into their skillful and benevolent hands. This traditional conception of the patient-professional relation is usually referred to as paternalism. This has now been widely rejected, at least in theory though it may still prevail in practice. The second model emphasizes the fact that the vital interests of the patients are at stake in this relationship. The patients should have the right to determine what is done to their bodies and physicians should respect their decisions. This category is usually characterized in terms of patient autonomy. These two models suffer from the same serious flaw. I will put it succinctly: The patient-professional relationship is not regarded as inter-personal and dialogical. Neither model is conducive to conversations between patients and professionals with the aim of enhancing understanding. Instead, both contribute to the estrangement of professionals from their patients. The popular alternative of constructing the relationship of a patient and a professional in terms of a contract fares no better. Not only does it feed upon an element of mutual distrust but it also presupposes a more equal relation between the partners than is possible in most health care situations. That relation is unequal because the patient is inevitably the weaker partner in at least two senses. He is weaker in the sense that he doesn’t have the necessary knowledge to evaluate his own condition and, of course, because he is in need. This weak standing of the patient makes him unusually dependent upon health care professionals, because he is often full with “personal anxieties and fears that illness and its treatment engenders”. Because of this, communication in health care has two main objectives, to inform the patient and to provide him with emotional support. In light of this it is important to look for ways to enhance the dialogical relation between patients and professionals. The third category refers to such attempts. Here the focus is on the relationship between the two partners engaging in a shared deliberation resulting in a joint decision which is based upon mutual trust. Only by meeting in such a dialogue will they respect each other as persons which I take to be the fundamental moral requirement of health care. This is a nice vision or a guiding idea. However, it is not sufficient to criticize the practice of paternalism and patient autonomy and require responsible co-operation between patients and professionals. The process of co-deliberation and joint decision-making needs more attention than it has been given in the literature on this subject. We must be clear about what it implies, whether it is realistic and what advantages it may have over other modes of patient-professional relation. Since the vehicle of this mode of relation is the dia-
logue, one important way to do this is to inquire into the nature of conversation. In this paper I have chosen to consult with the German philosopher Hans-Georg Gadamer, because I believe that his philosophical hermeneutics contains helpful insights for this task. This belief is based on the presumption that in the professional-patient relation it is of major importance that the partners reach mutual understanding, which is a prominent notion in Gadamer’s philosophy. This requirement has no place either in the paternalistic or the patient autonomy modes of interaction. But it has to be basic where the aim of the interaction is to reach a common decision which respects both partners.

My contention is that Gadamer’s theory of understanding the other implies important criticism of familiar modes of patient-professional relation and offers fruitful insights for developing a dialogical model of shared deliberation and decision-making. Nevertheless there are features in his theory which underpin medical paternalism of a sort which can hardly be defended. Thus when Gadamer’s dialogue is put to a real test its internal inconsistencies come to light.

The objectification of the other

In explicating what he calls “the hermeneutic experience” (in his major work, Truth and Method), Gadamer distinguishes between three modes of “experience of the ‘Thou’”. The first is characterized by a claim for what he calls ‘objective knowledge’ of the other, objective in the sense that it neglects her subjectivity: “We understand the other person in the same way that we can understand any other typical event for what he calls ‘objective knowledge’ of the other, the ‘Thou’”. The first is characterized by a claim to objective knowledge of the other. The first claim to objective knowledge of the other is a mode of ‘objectification of the other’ implies important criticism of familiar modes of patient-professional relation and offers fruitful insights for developing a dialogical model of shared deliberation and decision-making. Nevertheless there are features in his theory which underpin medical paternalism of a sort which can hardly be defended. Thus when Gadamer’s dialogue is put to a real test its internal inconsistencies come to light.

These presuppositions that we carry with us into every situation make themselves manifest in the fact that we have certain anticipations and prejudices about the matter. If we are not aware of this and act unreflectively upon these judgements we are prejudiced in the ordinary sense of the word. The danger of theoretical or methodological presuppositions, as compared to the cultural and the personal is, I believe, that they are much less readily recognized as being ‘biased’ or limiting. To the contrary, the belief is common that a truly scientific method is unaffected by all prejudice and therefore it alone can reveal objective knowledge. Gadamer does not explicitly deny that this may be true in the case of the natural sciences, but he thinks that it distorts the hermeneutic experience when the subject matter belongs to the human sciences. In those cases, the exclusion of “subjective elements” precludes dialogical understanding. There is no “fusion of horizons”.

It is not surprising, therefore, that Gadamer’s second critique of this methodological approach to the “Thou” is from a moral point of view. Its objectification of the subject leads easily to a manipulation of the human being. There is no regard for the subjectivity of the other; it has been methodologically excluded in order to ensure objective results. As a consequence, “His behaviour is as much a means to our end as any other means” (TM, 322). In fact, this claim to objective knowledge of the other is a mode of observation rather than of interaction and communication. Though it may be medically effective, it cannot be conducive to a good professional-patient relationship.

Though it may be medically effective, it cannot be conducive to a good professional-patient relationship. To the contrary, this approach is probably a major explanation of the fact that many patients are frustrated by their interaction with health care professionals, especially medical doctors. I wonder whether the remarkably common claim “the doctor did not listen to me” is not a consequence of a methodologically oriented doctor-patient relationship. The doctor is so preoccupied with making “predictions concerning [the other] person on the basis of experience” (TM, 321), that the other is never taken seriously. Enclosed within this horizon of theoretical judgements, the professional cannot relate to the person who is seeking his help or advice. In Gadamer’s words, he is not an understanding person: “The person with understanding does not know