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Phenomenology of the Medical Act: Reflections from Gadamerian Hermeneutics

Arturo G. Rillo[1], Beatriz Elina Martínez-Carrillo[1]
[1] *Faculty of Medicine / Autonomous University of the State of Mexico, Mexico*
Corresponding Author: dr_rillo@hotmail.com

ABSTRACT: *In the doctor-patient relationship, medical practice is characterized by the development of the medical act which will be assessed traditionally from the area of medical sciences. But compared to the advances of medical humanities, how knowledge of the action allows the doctor? How is the medical act in the world of life? What is your sense of understanding in the world of life? The starting point for exploring these questions is to understand the medical act as a phenomenon. In the world of life experience of the medical act is expressed as an intentional experience. We conclude that the structure of the medical act is the arena in which convergence components of different dimensions, including the technical dimension and the dimension bioethics.*

KEYWORDS: *Medical act; Medical Bioethics; Experience; Phenomenology; Gadamerian hermeneutics.*

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I. INTRODUCTION

In the daily actions of medical practice, the medical act begins, develops and ends, and with it the commitment of current medicine. In this sense, the medical act is the intervention with which the doctor approaches to treat the disease state so that the patient returns to his state of health, in a way that makes it possible to alleviate pain and suffering in this transit (Manuell Lee, 2007). Thus, the medical act is presented through the concretion of different actions: clinical communication, physical examination, diagnosis, therapeutic indications and prognosis (Aguinaga Recuenco, 1999). These elements acquire different meanings in the development of the doctor-patient relationship. This relationship is the setting for the practice of medicine (Laín Entralgo, 1983; Goold and Lipkin, 1999) and is based on a trust agreement. The agreement that is established by mutual agreement between the patient and the doctor is threatened daily by the utilitarianism that underlies the institutions that have health and disease as merchandise objects (Crawshaw et al, 1995; Chin, 2001). In this context, the following questions are shown as lines of reflection: what is the meaning of the medical act in the doctor-patient relationship? What is the purpose of the medical act that takes place during the clinical meeting between doctor and patient?

In the field of health sciences, the medical act is presented as a fact that arises from the biological sciences in the context of the paradigm of the biomedical model through which it tries to reestablish lost health (Cautin y Lilienfeld, 2015), establish means of prevention for the disease not yet acquired, granting possibilities to preserve health and alternatives for coexistence despite the consequences of the pathology (Wade y Halligan, 2004).

In the biomedical model, the medical act is specified in the results of the intervention on the health-disease process without having to show the act itself, so it is exercised, according to clinical researchers, with a hypothetical-deductive character through which establishes a critical path of diagnostic probability to discover the disease and is assisted by pharmacological research and the exact sciences for the application of scientific knowledge in medical technology (Croskerry, 2009; Gruppetta and Mallia, 2020).

The foregoing leads the doctor to consider that it is essential to master the biomedical sciences and know the technological advances to carry out a professional practice that responds to the patient's health needs. In this becoming, he has forgotten the medical humanities, the spiritual dimension of the human being is not of his interest and presents limitations to support his clinical actions in a bioethical culture that makes it possible to carry out congruent diagnosis and treatment, not only with the problems health of the patient, but with his vision of the world, perspective of life and personal fulfillment (Cole et al, 2015; Isaac et al, 2016; LaFleuer et al, 2007).

The human being is historically located in the world of life in which he establishes relationships with his natural, social, psychological and spiritual environment. Being-in-the-world, he establishes a distance between his consciousness and reality that is determined by the sense in which he understands the relationship with himself and with others (Gadamer 2001). In this line of reflection, the doctor, in his different historical

periods, seeks to shorten the distance between the reality of the patient and the consciousness of his clinical work by investigating a truth that allows him to solve the disease and pain, making this search, a virtue of their daily performance. This implies that the medical act is not limited to an instrumental and utilitarian rationality; but then what is the medical act? How to understand the medical act?

Exploring these questions requires stating two coordinates that delimit the horizon of understanding of the structure of the medical act. The first is the distinction between natural sciences and humanities, to which Bioethics belongs, even though Potter thought of it as the bridge between the sciences and the humanities (Potter, 1971). The second is phenomenology, which describes the structures of experience as they are presented in science without resorting to theory, deduction or assumptions from other disciplines such as the natural sciences (Husserl, 1999; Svenaeus, 2000).

From this horizon, it is understood that the medical act is not only practiced by the doctor, but is also incorporated into his experiential experience, his life story, it is part of his being-doctor, and when he recovers at the level of the Consciousness is concretized as a life experience, therefore, how is knowledge of the medical act possible? How is the medical act presented in the world of life? What is your sense of understanding in the world of life?

With the purpose of exploring these questions, the analysis of the medical act was carried out from the scope of Gadamerian hermeneutics. To expose the philosophical analysis carried out, it begins with the delimitation of the horizon of understanding of the medical act to continue with the experience, experience, characteristics of the medical act so that the understanding of the dimensions of the medical act is founded.

II. ON THE WAY TO UNDERSTANDING THE MEDICAL ACT

The term act is linked to the concept of action, which implies that it is understood as the possibility of doing and the result of that doing. The human act is made up of idea, will, purpose and freedom; so it is the object of ethics (Gárate, 1995). From bioethics it is said that human action depends on a variety of events to be chosen according to the individual intellectual properties depending on the time in which the action is carried out, as well as the prevailing morality, which is why puts intention first (Beauchamp, 2003; Reich, 2003).

According to ideal utilitarianism, it is argued that one should always act in such a way that the action has the best possible consequence and is not merely that of increasing pleasure (Moore, 1993; O'Mathúna, 2016); so medical action results, as traditional ethics indicates, in an act of supreme goodness where the best consequences are always sought, to increase their virtue.

The medical act, as a human act and phenomenon, exists as an intentional experience that involves the awareness of the relationship with the other, with the patient. Experience from which feelings of frustration, pain, love and suffering derive; all aspects that provide a specific value to the doctor-patient relationship.

Understanding the medical act phenomenologically, guides reflection to the analysis of an event where the medical-clinical activities that have differences in the daily life of medical work are structured and linked. Also, the medical act is circumscribed to the experience that is being built in the process of being-in-the-world of life, in such a way that it is transcendent individually and depends on the commitment that the doctor and the patient establish, to achieve efficient communication and offer expectations that are, for both, congruent to their perception and experiences.

III. MEDICAL ACT EXPERIENCE

Experience is a form of knowledge that implies the ability to act because it derives from the observation and experience of an event, or it can come from the things that happen in life in such a way that the experience implies a practical knowledge that it accumulates depending on the experiences to which the subject is subjected (Husserl, 1999).

For Roger Bacon, experience is a way of knowing and identifies two types: one corresponds to the experience that is acquired through the senses, it is acquired by interacting with the object of knowledge; the other is to know those things that are not in what we observe, so that knowledge is acquired by what is indicated by those who have had the experience of things directly, reference is made to the authority of the expert (Bacon, 1980; De Michelle-Serra, 2003).

Thinking, from the phenomenology of Husserl, the medical act as experience, implies attributing to it an intuitive knowledge that is specified in the perception of the doctor's actions in the doctor-patient relationship. Thus, the first moment in the phenomenology of experience is the primary perception of which a description is made according to what the senses project towards consciousness (Husser, 1983), so that the doctor looks at himself in relationship with his world that surrounds him and experiences the perception of the patient's reality, from the historicity of his consciousness.

This first perception is superimposed on the experience provided by the patient, and results in the awareness of the medical task aimed at providing the care that the patient requires. This makes the medical act an act of conscience in which the patient's act to preserve and experience the disease is reflected in the act of the

doctor itself. Living the medical act after the fusion of the horizon of understanding of the patient makes it possible to carry out the analysis of her problem by applying reason. From the biomedical model of health care, this implies an instrumental rationality.

Knowing oneself in the world is the first phenomenal experience where the knowledge that allows the human being to live in the world that surrounds him arises, it is also the evidence that the first impression overcomes the previous judgment that the doctor has regarding suffering from the sick. This first impression has been called "clinical eye", and in it there is an abstention from judgment to make direct contact with the disease and thus obtain new information that guides and makes sense to rational analysis through clinical judgment (Upshur and Chin-Yee, 2016).

The type of clinical data (be they signs or symptoms, laboratory or cabinet studies) are closely related to the specific and objective state of the patient, becoming an intentional act causing reality to develop in the intentional life of consciousness, with all its possibilities of truth; which represents the intentional aspect of the medical act.

In this context, the experience of the medical act, or rather, the medical act as experience, refers to a procedural knowledge (knowing how to do, how to do something), rather than a declarative knowledge (theoretical and factual knowledge, in terms of know what things are). The knowledge that experience provides is not a theoretical or technical knowledge and it is possible because it is not reduced to a knowledge only of the object; on the contrary, the knowledge that derives from the experience shows a better knowledge of the object with respect to the previous knowledge, which does not imply that it is a definitive knowledge. As Rodríguez-Granjean (2002) points out, the knowledge that the experience transmits is not a 'already knowing something', but a discovering new facets each time in a process that is never and can never be considered definitive and in which the other is always present.

Medical knowledge is then an experiential knowledge in which the awareness is acquired that the other exists through immediate bodily self-experience (Coreth, 1989), that is, at the moment the doctor experiences the medical act, he does it object of conscience and recognizes the patient as another human being who experiences his illness in terms of a *pathos*, of a feeling that induces the humanization of the medical act.

In the medical act, not only is the patient known, but rather a human being who lives, suffers, cries, in short, who suffers (Lain Entralgo, 1983); but also, that it is the object of the joy and hope of living, since the existence of the patient who manifests himself to the doctor in his clinical work is not an existence that is required as necessary to give himself, but is always contingent, relative, to the context of life of doctor and patient.

Experience about something is gained when the subject realizes that it is not as it had been thought and that after interacting with the object, it is better known as the knowledge about the object has been transformed. In this sense, the medical act is recognition, because if the subsequent development of the experience were to abandon what was acquired from the empirical field, a mere illusion would be fostered, or rather, a hallucination, a mere coherent dream.

This implies, according to Gadamer (2002, 2006), that experiences are only possible if expectations are had, for that reason a person of experience is not the one who has accumulated more experiences, but the one who is able to allow them; that is, it overcomes prejudices, since they express moments in the historical life of the experience (Cía Lamana, 2002). A clear example is the investigation of prejudices carried out by Francis Bacon (1994) where an anthropological approach to experience can be observed.

The contribution that prejudice makes to the research process consists of understanding the essence of the medical act, since it is not about eliminating the preconception that the doctor has of his clinical work; on the contrary, the doctor must become conscious and clarify the meaning of the experience from the first approximation that he makes through the sensation of what he can observe. The sense of experience is a path always under construction from which the concept of the observed reality will be formed and that later will allow the analysis of new experiences, which will lead to new concepts, so that the experience incorporates in its sense, the circle hermeneutical understanding-interpretation-application as a virtuous circle that will lead to the experience of the world of life.

In the historicity of the world of life, the experience of the medical act is shown with an experiential sense of a painful type for the patient, so it is difficult for the doctor to depart from the medical care model where the knowledge and authority of the doctor are they syncretize in shared responsibility with the patient, enabling both to become active, communicative and dialogue agents during the disease process. In the experience that becomes a dialogue between the suffering patient and the doctor who has knowledge to mitigate pain, the introspection of the medical act is gestated to search for its essence, managing to have uncovered the human character of the medical act. To continue on this path, it is necessary to analyze the experience of the medical act and understand the characteristics with which it is shown in the world of life.

IV. EXPERIENCE OF THE MEDICAL ACT

By linking phenomenology with the medical act, the intentional experience appears as "consciousness of". Human acts are intentional experiences, however, not all experiences are intentional like sensations and feelings (Hernández, 2002; Paulín et al, 2009). The experience of the medical act is specified in a know-how that is acquired with empirical knowledge and opens up the experience of the medical act in search of an intentional explanation of it. This implies starting from the existing theoretical formations in the history of medicine to return to the living intention of the acts or experiences in which the concepts were built (Villanueva Barreto, 2006).

In contemporary medicine, the medical act is delimited by the biomedical paradigm, making it controllable, predictable, routine, daily and probabilistic, however, it has been shown that suffering and the circumstances surrounding medical care require incorporating the sociocultural paradigm into understanding (Bolton and Gillett, 2019; Mendoza González, 2001). The sociocultural implies a movement of scientific thought towards the world of life giving meaning to the understanding of the cognitive, practical and evaluative experience of the medical task, it is a return to life, where the social structure in which the doctor operates is implicit as well as the historical moment by which its transit through the world develops.

The social in the medical act configures a horizon of multiple ways of perceiving, of appearance and of synthesis of different scenarios, always changing, that articulate the understanding of the lived experiences of the doctor and the patient. The social transcends the age, society and culture of the doctor; in short, it goes beyond his immediate life history to configure a matrix that gives meaning to the medical act as an intentional experience of a phenomenological nature, making the medical act an everyday act through which the health professional seeks the good of the sick person (Bolton, 2020).

The good that the doctor seeks is everything that inspires and allows the total and full development and growth of the patient in all its dimensions: organic or corporal, spiritual, mental, social (Córdoba Palacio, 2003). However, when the doctor looks in the space of his office or in a hospital room, he sees himself in front of a body that presents physiological, biochemical or anatomical alterations, which must be analyzed to integrate a diagnosis and derive a treatment; so that the medical act shifts between ritual and the power of diagnosis and therapy (Córdoba Palacio, 2007).

In this situation, the doctor shows his level of competence and professional experience, in which the updating of medical knowledge has been synthesized with the abilities and skills to question and explore the patient, as a sick body. In this ritual, he looks for a criterion of truth based on scientific evidence that guides him to provide a guarantee to the patient. However, this criterion of truth represents more than a diagnostic or therapeutic analogy, a personal experience through which he assumes the possibility of an accurate diagnosis and effective therapy.

On the other hand, the patient is in search of a human being who can help him solve his health problem and provide him with satisfactory medical care. Satisfaction with the medical act represents 35% of satisfaction with the care the patient receives; However, it is the organizational aspects of the health service provider institution that currently have the greatest influence on patient satisfaction (Serrano del Rosal and Loriente-Arin, 2008).

For the medical act to exist in everyday life as an experience, experience is essential. The experience within the medical act observed from phenomenology, is the meeting that the doctor has with his patient. Even when Bioethics indicates that they are two people on equal terms to decide (Bedoya Hernández y Builes Correa, 2009), phenomenology shows two different people with a common goal who can walk along parallel paths and cause tension in the medical encounter and lead to conflicts of a bioethical nature.

V. CHARACTERISTICS OF THE MEDICAL ACT

The experiential experience of the medical act is specified in two fundamental moments: the clinical method and the clinical interview. It is through the clinical method that experience is acquired during the medical act, while medical communication makes it possible to experience this experience. Both elements give certainty for the practice of medicine in a regime of freedom, even when it has been regulated by law (Galván-Méndez et al, 2015; Rillo eta al, 2013).

The context of this regulation indicates that the technical and auxiliary professionals of the health disciplines shall provide their services to the best of their knowledge and belief, for the benefit of the user, taking into account the circumstances of the manner, time and place, in which they present their services (Comisión de Arbitraje Médico del Estado de Jalisco, 2002; Momblanc and Mombranc, 2018). The foregoing implies that health personnel can choose from among the different alternatives accepted by *Lex Artis ad hoc*. It is important to remember that the medical act, although typically performed by the doctor, it is recognized that it can be performed by other types of health personnel who have the documentation that accredits them to carry out this activity in any of the settings in which medicine is practiced (Casa Madrid Mata, 2005; Guerrero-Sotelo et al, 2019).

The settings in which medicine is practiced include, from the national institutes of health to the private practice, without forgetting the rural health centers. However, when you think about the characteristics of the medical act, to what extent do you refer to large hospitals? The hospitals of the 3rd level of care in Mexico, concentrate cutting-edge technology, allowing highly specialized medicine to be practiced. At the beginning of the 21st century, it is evident that this type of medicine is necessary, but at no time is it the ideal of medicine that will solve the health problems of the population.

The doctors who work in these health institutions have extensive experience in diagnostic techniques and treatment of complex diseases, the product of training 5 to 10 years after graduation and have become the ideal of the Western doctor who aspires to practice highly specialized medicine.

The most frequent illnesses are cared for in 2nd level hospitals. It also has highly specialized doctors and is important for the practice of medicine. But the scenario in which 80% of health problems are solved is in the office. It is in this scenario where the postmodern doctor develops, who cannot move away from the human sciences, but neither from the exact sciences, from biology, from anthropology, and even from law. Multidisciplinary participation in patient care provides an important experience that allows the doctor to carry out their activities in accordance with current bioethical values.

With what has been stated so far, it can be understood that the medical act has the following characteristics: professionalism, standardized execution, purpose, legality, and no formality (Manuell Lee, 2007).

In relation to the professionalism of the medical act, it is indicated that it can be carried out by duly trained and empowered health personnel, which implies the certification of professional competences by both universities and medical colleges.

In terms of the *Lex Artis ad hoc* of health personnel, you can only perform actions that are expressly supported as valid in light of the generally accepted medical literature (Manuell Lee, 2007). The *Lex Artis ad hoc* can be understood as that evaluative criterion of the correctness of the medical act performed by the doctor that takes into account the characteristics of the medical professional, the profession, the complexity and vital importance of the doctor, and the influence on other endogenous factors, the state or intervention of the patient, their family members, or the health organization itself, to qualify said act according to the normal required technique (Aguinaga Recuenco, 1999).

The main purpose of the medical act is to protect health; which justifies various actions carried out in medical practice, among which clinical research stands out. The legality of the medical act is limited, on the one hand, to the legitimacy of the medical practice in adherence to the applicable regulations and, on the other, when the validly informed consent of the. The non-formality of the medical act is based on the fact that for the performance of the medical act there is no written contract to provide the health service, however, the documentation of the medical act is mandatory in the clinical record (Secretaría de Salud, 2012).

Understanding the medical act as an intentional human act circumscribed by the context of the doctor-patient relationship and the instrumentation of theoretical knowledge, practical knowledge and the doctor's experience, now allows us to indicate the dimensions that make up its structure.

VI. DIMENSIONS OF THE MEDICAL ACT

The significance of the characteristics and activities that make up the medical act encourages the articulation of the following dimensions: technical dimension, moral, ethical and bioethical dimension, economic dimension and social dimension.

The technical dimension of the medical act involves assisting and curing the patient, and it is in the interest of medical science to determine whether the actions have been correct, indicated or contraindicated, appropriate and necessary. It is specified in the diagnosis and treatment, so it can be understood as a therapeutic act that aims at the quality of medical practice (Hellou et al, 2020; López Barreda, 2015; McCulloug, 2013; Taboada Rodríguez, 1998). When looking at this dimension from the field of the history of medicine, it stands out that for a long time medicine has been empirical, dominated by the medical clinic, which aspires to diagnose through signs and symptoms; as well as restoring the state of health through medical or surgical treatment (Laín Entralgo, 1998).

In the twentieth century, biotechnologies burst into the medical field that apply new techniques to the progress of science and experimental practices, deepening the study of the etiology of the disease, specifying the diagnoses and advising the most appropriate treatments. various diseases, especially pharmacological and surgical ones. It is the technology applied to medicine, which has made it possible to promote life and act on death, through molecular biology, genetic engineering, assisted fertilization and organ transplantation (Altamirano Bustamante et al, 2006). Furthermore, a significant impact is expected on the technical dimension of the medical act through the technological explosion that will derive from the results of the study of the human genome (Ureta, 2001).

Ethics deals with the becoming of the person through their free acts, only a free act has an ethical dimension, for this reason, since the medical act is a free act, it is, on the one hand, an object of ethics and, on the other, it has a dimension ethics (Bedoya Hernández, 2009). The ethical dimension of the human act is, first of all, its sociocultural context in which it unfolds, together with the scientific criteria of truth according to its ideological structure. In this sense, medicine has its own deontology in accordance with the activities carried out during medical work; But the issues that medical care encompasses today through the use of advanced technology show that medical ethics exceed the standards of deontology contained in the codes of professional ethics (Alterio Ariola et al, 2005; World Medical Association, 2015). Therefore, in the bioethical dimension of the medical act, medical ethics and medical deontology should not be displaced; nor does it isolate it from the legal, political, psychological and social dimensions.

Having stated the above, the bioethical dimension of the medical act is oriented towards the analysis of the actions themselves in relation to the doctor's duties towards the patient or their consequences, it must respect confidentiality. This implies that it derives from the experience and the intentional experience of the doctor, so it can be understood as an ethical act that attends to the quality of the person who works (Taboada Rodríguez, 1998).

Bedoya Hernández (2009) considers that the bioethical dimension of the medical act can be experienced as an expression of instrumental ethics and intersubjective ethics. In instrumental ethics, the word displayed in the act performed by the professional has an instrumental value. In intersubjective ethics, the word occupies a privileged place as a possibility of restitution of the subjectivity of the patient and the construction of a doctor-patient relational fabric in which the curative action takes place.

In the bioethical dimension, the medical vocation and the aims of the medical act are articulated to promote a good life in patients, oriented towards the full good as a fundamental ethical criterion; since the practice of medicine, as a science and art of curing the sick and preserving their health, means for the professional, the duty to display a technically perfect activity and submit to the ethical discipline proper to their profession.

VII. CONCLUSION

The medical act is a structured event, differentiated in its daily life and experience in the world of life determined by the communication that is established in the medical encounter, which is why it has a phenomenological structure that derives from the following elements: intentionality of consciousness and phenomenological experience.

The intentionality of consciousness makes it possible to understand the world of life. In this sense, the medical act as an intentional object of the doctor, represents an attitude where knowledge must be linked to the use of technology in such a way that it allows to carry out a work as dictated by conscience. Thus, the medical act is a human act that implies an intentional experience through which the means, ends and consequences of what is being done are known. In this case, freedom refers to the moments when medical decisions of an irreplaceable and non-transferable nature are made.

Understanding the medical act as a phenomenon makes it possible to understand that its existence is determined by its historical evolution, surrounded by multiple circumstances that configure it in a context of responsibility, trust, orientation in matters of decisions; However, none of them, in particular, determines the development of the medical act, on the contrary, the medical act is the scene in which all these elements converge.

Finally, it is clear that the medical act has a technical dimension and a bioethical dimension inextricably linked. The technical dimension refers mainly to the fact that the work carried out is good in terms of its effectiveness and for this there are multiple technological tools. The ethical dimension refers to the good of the person who works, that is, the subject who performs an action becomes good or is perfected as a person.

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