Chapter 16

Phenomenology of Nursing as a Cultural Discipline

Florence Romijn Tocantins  
Universidade do Rio de Janeiro – UNIRIO  
<florence@nitnet.com.br>

and

Lester Embree  
Florida Atlantic University  
<embree@fau.edu>

Abstract: A professor of nursing in Brazil leads a group of colleagues in an effort reflectively to understand what nursing is fundamentally and they use the social phenomenology of Alfred Schutz in their reflections. She agreed to answer questions about their work via e-mail from a phenomenological philosopher interested in understanding such a discipline. He is convinced by her answers that nursing is indeed a cultural discipline of the practical sort. She teaches him much about her discipline; focuses on how her group investigates nurses as they relate to patients/clients, and correlatively, on patients/clients as they relate to nurses; and ultimately shows that nursing involves a personal as well as a professional attitude and is as such not so much about curing as about caring. The joint effort expressed...

1. The origin of this chapter deserves explanation. Early in 1999, a temporary department devoted to the centennial of the philosopher Alfred Schutz (1899–1959) was added to the website of the Center for Advanced Research in Phenomenology, Inc. (www.phenomenologycenter.org). One day that summer I received an e-mail from Dr. Florence Romijn Tocantins, a professor of nursing, who told me of a group of nurses she led in Rio de Janeiro who used Schutz’s thought in research and nursing practice and asked if we would be interested in a bibliography.

When the list came, one title seemed to epitomize the work: “The Meaning of the Anti-HIV Test for the Client—An Attempt to Understand.” Schutz’s fundamental category is “subjective meaning,” which is the meaning for the person, i.e., how the person interprets something from within her situation, and the attempt to understand such meanings is called “subjective interpretation” as well as “understanding” and is the fundamental method in the cultural sciences for him. To me it was obvious that the subjective meaning or insider interpretation is what would guide the patient’s behavior, and that understanding it would be crucial in caring for her. That fall I was able to go to visit Rio on a trip in South America, to meet the members of the Grupo de Estudos de Alfred Schutz, to participate in their conference on Schutz and nursing, and to talk at length with Florence as she showed me around Rio.

I had previously written on the phenomenology of the cultural disciplines, wanted to try out my ideas on a practical discipline, knew something about Schutz’s philosophy, and was curious about nursing, having often heard that there was something called “phenomenological nursing,” which was usually based on Heidegger or Merleau-Ponty. How I intended to proceed to investigate such a discipline needed an insider with expertise and so I proposed collaboration; my new friend was willing, and eventually we got going and produced this profoundly coauthored text, the best literary form for which is the dialogue.

Dr. Tocantins could not come to the research symposium in January 2001, but Dr. Susanne Wiegand, who had training and experience as a nurse as well as now as a medical doctor, performed Florence’s part when we read the first part of the dialogue aloud. Florence and I are grateful to Susanne for this help as well as to the colleagues there—Susanne included—who joined vigorously in the discussion, a video of which was sent to Florence and her group.—Lester Embree

in a dialogue also shows how a philosopher can learn about nursing. Presumably other disciplines of the same sort, e.g., psychiatry, could be reflected upon in analogous fashion.

Safeguarding the subjective point of view is the only, but a sufficient, guarantee that social reality will not be replaced by a fictional non-existing world constructed by some scientific observer.

Alfred Schutz (The Theory of Social Action, 50)

Introduction

Dear Florence,

It is now a bit over a year since I met you and your colleagues at the I. Seminário de ALFRED SCHUTZ: O Agir Humano no Mundo da Vida at the Escola de Enfermagem Alfredo Pinto, Universidade do Rio de Janeiro – UNIRIO. The happy memory is as vivid now as it was while I was there! Please say hello to all my friends there—especially Fabiana de Souza—for me.

I am writing now in hopes that we can finally begin the project we talked about during my last day there, i.e., a dialogue by e-mail, an e-dialog, about nursing. Are you are ready to go?

Florence: I’m ready.

Lester: Okay. Let me ask you a first question just to give us a concrete focus to start from. If I recall correctly, you yourself are in public health nursing and teach that at the university. But that is just one type of nursing. What other types are there?

Florence: As areas of activity, you have hospital and public health institutions; as areas of knowledge, you have public health nursing, collective/social health nursing, community health nursing, child health nursing, women’s health nursing, adult health nursing, and elderly health nursing; as practical areas you have clinical nursing, surgical nursing, obstetrics nursing, infectious disease nursing, pediatric nursing, ambulatory nursing, public health nursing, intensive care nursing, and emergency nursing

Lester: That raises for me the question of what all these types of nursing have in common, but let’s let that question hang in the air and try to come back to it later. Let me say how I have my own small acquaintance with nursing, which is of course from the patient’s point of view and in the past, but I am currently also interested as a philosopher and thus doubly an outsider of your discipline. I have undergone nursing myself as a surgery patient in the hospital as well as having been dealt with by the nurses of my internist and various specialists over the years.

Florence: Do you mean that your internist/specialist had some health problems and was in need of professional nursing care? A nurse is a nurse of/for (sick or healthy) person(s) in need of nursing care in order to get healthy and/or stay healthy. As a professional health care provider s/he is a member of a professional health team, each approaching the person(s) with his/her own professional knowledge, attitudes, and practices.

Lester: No, I’m referring to when I was myself a patient and had the health problems. But now that you mention it, my nurses in the hospital and even in the doctor’s office when
I go for a checkup indeed function as members of teams. To put this in fancier terms as well as to go on to something else, let me say that my basically commonsense “outsider interpretation” (which expression I prefer to Schutz’s and Max Weber’s objektiver Sinn) as a patient needs to be corrected or maybe “controlled” by your professional “insider interpretation” (subjektiver Sinn) as a nurse.

Florence: But if the “outsider interpretation” also reflects commonsense experience, which is real for the “outsider,” why should or could the “insider interpretation” correct or control a different reality?

Lester: Well, I would say it depends on what the topic is. If it is nursing, then I as a patient was an outsider to nursing when I was in the hospital and I interpreted things on the commonsense level. But now I am also or instead an outsider to nursing from my philosophical standpoint, while you are a nurse and can, from the standpoint of your professional experience, decide when my philosophical interpretations do or do not fit the nurse’s reality. Another way to put this is to say that the way you as a nurse seek to understand a client’s insider interpretation is like I as a would-be philosopher of nursing seek to understand a nurse’s insider interpretation.

Florence: I think I continue to assume a phenomenological attitude in trying to understand your way of thinking and acting toward nursing, the same way we are trying to understand what nursing should be in the client’s perspective. That’s one of the reasons we adopted Schutz’s thought. What made you assume Schutz in your work?

Lester: My interest comes from Schutz’s theory of the cultural sciences, which I am extending phenomenologically from his very few remarks about “applied science” to questions about nursing in relation to something even broader than Schutz that I call phenomenology of the cultural disciplines. Your interest is different, isn’t it?

Florence: Our Grupo de Estudos de Alfred Schutz shares with you the interest in Schutz, but we began with a research project about health needs as experienced in the nursing practice of a public health unit. As a researcher I recognized that health needs emerge in the concrete client-nurse relationship, which I, as an academic nurse—insider as a nurse and outsider as related to daily practice—couldn’t grasp in its entirety without interpreting the typical social act between two typical subjectivities—the client and the nurse.

Lester: Okay, that makes sense to me. And then the client has insider interpretations that the nurse seeks to understand from her/his professional standpoint, which is from outside of the client.

This somehow reminds me of something else we decided last year. You will not only consult with your nursing colleagues who have also been using Schutz in research as well as practice, but also with the philosopher Creusa Capalbo, Universidade Federal do Rio de Janeiro – UFRJ and Universidade Estadual do Rio de Janeiro – UERJ, who has been working with your group. In this way we will have the benefit of the wisdom of your whole group. On my side I will have help from the philosopher Maria-Luz Pintos Peñaranda of Universidade de Santiago de Compostela. You have not met her, but I am sending you her curriculum vitae. With her I have been discussing via e-mail the topics of embodiment and gender, which seem relevant to our issues.
Florence: Do you think it will be a dialogue about gender? I don’t think so.
Lester: Nor do I, but I have learned to be careful. For example, I tend to think of people acting alone, but have learned that it is easier for women to think of people acting as members of groups. Also, Maria Luz has already asked why it is that the vast majority of nurses are women, i.e., does nursing come more from a feminine rather than a masculine perspective? Maybe this could be something that we also return to eventually.

Florence: Does considering gender mean that nursing involves personal and professional attitudes at the same time?
Lester: Well, I do think there is always a danger that personal attitudes might adversely affect a professional attitude. But at the same time, I think that there are always personal motives for becoming a professional and that personal attitudes, e.g., sensitivity and insensitivity, also have a positive or negative influence.

Florence: I’m asking because if the personal attitude prevails you aren’t or don’t practice as a nurse but simply as a person who is caring for somebody. Maybe you would like to know what a group of first-year graduate students referred to as their “in-order-to” motive for studying nursing at the University of Rio de Janeiro – UNIRIO. As still “outsiders” to nursing they wanted to learn to take care of (sick) persons, to get a job, and to learn to help people to get or stay healthy.

Lester: Is this different from the “in-order-to” motive (or purpose) of a typical nurse? I hope we can get to what they would say after being trained. But let me now add that I want to try to bring out something about willing and objects-as-willed that I believe implicit in Schutz’s account of the type of action he calls Wirken, which I prefer to call “influencing.” By “willing” I mean making choices and pursuing purposes, i.e., having “in-order-to” motives. In addition, I want to attempt at least to show the place for and nature of valuing and objects-as-valued in a discipline like nursing, where I believe what might be called compassion plays an essential role. Schutz only alludes to values and valuing to in his very last paper, “Some Structures of the Life-World.” I believe he did so under the influence of Dorion Cairns, who is also a huge influence on my own position.

Florence: What is the meaning of “compassion”? I am thinking about my “in-order-to” motive when I practice nursing as a caring professional in a public health unit. I would call it a kind of solidarity, an aiming to be close to and to understand somebody that gives me an opportunity to help and give information about what s/he can do about her/his health situation. I wouldn’t call it compassion. It’s more an attitude toward another person who requires help in order to feel well or to stay healthy.

Lester: I am not sure about compassion, but from my outsider standpoint I suspect that there is a basic kind of mood or feeling or passion in professional nurses, that it is toward clients, that it is positive but probably not the same as love and I hope it is usually not pity, which I am not sure is really positive; maybe “compassion” is not the right name for it. I expect to look into Buddhism on the topic of compassion before very long.

But maybe this is another problem for nursing that we can set aside for now, although I would be curious about whether you recognize something like this from your insider standpoint. In my profession, there is a passion concerning wisdom and reason and my
contacts with nurses both as a patient and as a philosopher lead me to suspect, from outside, that your passion is different.

**Florence:** Some nurses affirm that their practice is a helping practice, where somebody needs help to care for him/herself, and, if s/he can’t do it on his/her own, then somebody else, i.e., a nurse, will to do it for him/her. This means that the nurse knows and can do more than the person, the patient or client him/herself, or the parents of a sick or hurt child, as the situation is defined by the health professionals. So it is a case of power over somebody else. Although there are nurses who, without the knowledge of why and what for, do things for others because they are as fellow human beings in need of something they can’t do for themselves.

**Lester:** Is’t helping people learn to care for themselves and also for each other, e.g., children to care for their elderly parents, also part of it?

**Florence:** Of course. With this comment I have to look back and think about my biographical situation for what made me study nursing. That is a long time back and the only thing that comes to mind now is doing something for those who were close to me and could not do it for themselves, especially when they did not feel well.

**Lester:** But what you refer to in what you just said, i.e., “doing” and “helping,” seems more a matter of willing than the feeling behind it. I remain curious about the affectivity, the emotions or passions, as “because”-motives behind nursing practice. Probably I’ll bring it up again later. Too bad we can’t talk about everything at once!

Maybe you have come to believe something else is more important or you have become more interested in something else, but when we talked more than a year ago, your thought was that the relationship of the nurse with the patient was the most important thing.

**Florence:** It still is. Nursing as a social relationship between two or more persons—nurse(s) and client(s).

**Lester:** I thought you might say something like that! There must also be such a relationship among the members of the nursing team as well as between the patient or client and her/his family, but we want to focus on the nurse/client relationship, right?

**Florence:** Right. Let me begin by saying that it is a relationship where the nurse (a person) is not only someone dealing with a physical body with health problems or disease, which can be called a “cure relationship,” but recognizes the client as a person who thinks, feels, and acts, who needs and looks for help to get or feel well, i.e., the nurse is in a “care relationship.” In this perspective, health care needs can be investigated by approaching the typical action with its “in-order-to” motive that the client has for seeking health care.

**Lester:** Of course! But since I have been focusing on the nurse’s insider interpretation and did not seek the client’s insider interpretation, I did not think of that.

So I guess we have now gotten started. Probably because I am a philosopher, I feel the need now to say how I fit nursing into a larger framework, but more important by far is how much sense, if any, what I say makes to a nurse, i.e., you. And please interrupt me as we go along—or wait until I run out of breath!
I. What Kind of a Discipline is Nursing?

**Lester:** Many think that a phenomenologist can only observe and describe her own individual conscious life, but actually one can describe the collective lives of the group(s) one is a member of, i.e., one’s own group, as well as other individuals and other groups, although the quality of the evidencing progressively declines in those cases. One can even advance claims that are open to interpretation so as to refer to individuals and groups, whether of the phenomenologist’s own or of others. Although false, “All nurses are women” would be such a claim, and one can then specify it for own vs. other and individual vs. group.

Anyhow, one can ask what nurses do and a person of common sense might answer that nurses help doctors take care of people with respect to health. “With respect to health” seems a good formulation because it includes preventative as well as crisis or, maybe better, curative medicine as well as the opposite of health that comes from injury as well as disease. But I wonder if all nursing is assistance of doctors. What is your view? I do not think that it is a matter of equipment because I think that nurses and doctors use the same tools and facilities.

**Florence:** In my perspective the main difference lies in the physician’s and nurse’s professional attitude toward the patient and the kind of intervention they engage in. In general, if somebody doesn’t feel well or feels sick s/he will seek (professional) help. A doctor will diagnose a disease and prescribe a treatment or medication for that person/patient, so s/he won’t feel symptoms and/or present symptoms of the diagnosed disease. If the person can’t do it for him/herself, the nurse (and/or other health professionals) will contribute to implement the medical (doctor) prescription.

These are non-doctor activities. In this situation and as common sense, the nurse is the assistant of the doctor, aiming at the patient’s recovering to normal status. But who will perform each activity, and the way it will be performed, will be established and guided by the knowledge belonging to the different health professionals involved. In this sense, each health professional acts autonomously, aiming at the recovery of the person/patient.

**Lester:** Thank you. I can see that now. Another topic to mention and hope to come back to: how is “normal status” defined? I seem to recall that there are pretty good definitions from the World Health Organization, but let me proceed to what I have in mind here.

Since I try to be philosophical, which signifies among other things that I try not to take anything for granted, I wonder whether what I have just offered as a piece of common sense is actually shared among many people. But regardless of whether this is relevant or is not, the far more important thing is how nurses experience their calling from within. And from within, what do they experience, i.e., encounter and interpret?

**Florence:** The nurse encounters persons with lived experiences in a social world who expect to be informed and/or helped—not only as a problem/disease, but as a human being experiencing a situation, mostly related to what s/he understands as health, which s/he does not know and/or cannot handle/solve by him/herself, and that is why s/he is looking for help.

**Lester:** That was actually a “rhetorical question,” but your answer nevertheless teaches me more about your discipline!
If I want to approach nursing from a different and philosophically outside way, I ask myself what sort of an effort or practice it is. In answer, I say that nursing is a discipline of the cultural kind and of the practical sort. This is my thesis and what I am saying derives from the introduction I wrote some years ago to *Phenomenology of the Cultural Disciplines*. Let me begin, however, with the notion of "discipline" and get to how a discipline can be scientific.

When I was a child, I had several of the usual childhood diseases, e.g., chickenpox, and was kept home from school and was cared for by my mother. It seems legitimate to say that she nursed me. Certainly my mother was not without skill, but I think she had a low level of skill. If we call what she had “amateur skill,” we can go on to recognize at least three higher degrees. In many societies, rural areas as well as richer areas within them included, there are what ethnologists call “curers,” e.g., midwives, who help women deliver babies and who have learned their somewhat specialized skills through apprenticeship to older midwives, usually their own mothers. This skillfulness can be called a craft, especially if we allow for degrees of sophistication among the various crafts. Carpentry could be learned and practiced as a craft in the same way. Besides delivering babies, curers know a great deal about medicinal plants and treating disease and injuries such as broken bones.

Florence: Interesting. In Portuguese those lay midwives are called lay-carers (*comadre, “curiosa,” cuidador leigos, parteira leiga*). They are carers because they know how to help the pregnant woman in what she can’t do for herself or what no close relative knows how to do. Their action includes monitoring the progression of the process of childbearing, explaining to the woman what to do, staying with her, and welcoming the newborn into this world. She doesn’t intervene directly in the physical process of childbearing, she supports the so-called physiological process and the woman as a human being. All her actions are learned through her own deliveries and progressive practice with a more experienced midwife. The only way to be accepted as a midwife is by other woman in her own community. In this context I agree with your thesis that the lay-caring of lay midwives is an effort of a cultural kind and of a practical sort.

Lester: Beyond amateur and “crafty” nursing, I think there are nurses who have had formal training and are somehow formally certified. In the article mentioned, I wrote of “specialized teachers and courses, concentrated programs, classroom instruction, textbooks, journals, disciplinary jargon, and finished students who are certifiable whether or not certificates are officially granted” (p. 5). In the United States there are Licensed Practical Nurses and Registered Nurses, LPNs and RNs. These I would say are of the third level and belong to a discipline in my technical signification of the word.

I am less sure about whether there is a fourth degree, but I am thinking of nurses having additional degrees of high-level specialized preparation and thus expertise that the typical nurse does not have. Is my hunch in this respect correct?

Florence: In Brazil the formation of nurses occurs differently than in the United States and consequently the typical nurse may also differ. Well, at least I think so, but let me

---

explain. The nurse (enfermeira(o)) is somebody graduated in nursing (four years) from the university; the nursing technician (técnico de enfermagem) is somebody with eleven years of formal education, a two years professional/practical study, and officially granted certification in nursing; and a nursing aid (auxiliar de enfermagem) is somebody with eight years of formal education, one year of professional training, and officially granted certification in nursing. Nurses belong to the multi-professional health teams and are responsible for the nursing assistance and care developed by the nursing team.

**Lester:** Not doctors?

**Florence:** No. The enfermeira(o) organizes the health assistance situation, the resources, and the nursing care, while the nursing technicians and aides perform the care procedures. Although the nurse also performs some care procedures with or for the client (mostly the more complex procedures that involve knowledge about why, what, and how), it is mostly the nursing technician’s and aide’s procedures that are more visible to the client.

In this way and for common sense, the nursing technician and nursing aid are the typical nurses who perform practical efforts of bathing, medication, vaccination, (health) information, etc. Is it a cultural kind of effort? I wouldn’t say so, because the procedures they perform are based on evidence from the natural sciences.

**Lester:** This depends on what “cultural” signifies. For me, if the thing related to is more than a naturalistic object as it would be in a biological theory, for example, then it has some value and use for whoever is relating to it, and if it has a mental life, then it has them, i.e., use and value, for her- or himself as well.

**Florence:** I can’t deny that when people or clients talk about a good nurse they aren’t talking only about procedures, but also about a certain manner of performing those procedures, a manner that comprises much more a human/personal attitude toward the other than the pure professional procedure. But it is the process of caring that is important and not the good nurse as the product, the result. So when the typical nurse cares, s/he establishes a social relationship, and not only performs a (technical) procedure, but develops an effort of a cultural kind and of a practical sort.

We can’t forget that the typical nurse learns to perform procedures comprised in an attitude toward a human being, but the focus is the procedure and not the other person. So, and coming back to your question: how typical nurses experience their calling from within? And from within, what do they experience, i.e., encounter and interpret? I will answer: that’s a nice and almost easy investigation to do!

But you are also thinking of nurses having additional degrees of high-level preparation and thus expertise that the typical nurse does not have. Here in Brazil we call it post-graduation. Those with a practical focus get a specialization degree and those with a theoretical/pedagogical focus get Master’s degrees, while those with an academic focus get the Doctor of Nursing degree. And on these levels I can understand you when you call nursing a discipline.

**Lester:** Well, actually, on my view, the técnico de enfermagem seems already in the discipline because there is some formal training and certification, which the craft and amateur levels do not have. There can be levels within a discipline. Some of this may be just
slight differences in the significations of words between languages and professions (someday we should ask an American nursing professor to comment on this).

Now I want to change the question again: if this sketch clarifies how nursing is a discipline, what sort of a discipline is it? I want to go on to say that in all human practices, the conscious or mental lives involved are composed of basically four components: experiencing, believing, valuing, and willing, with the last three playing different roles in different kinds of disciplines. Thus we can recognize “cognitive disciplines” or sciences because the goal in them is justified belief expressed in words or, technically speaking, knowledge. In contrast, there are practices, such as landscape architecture, where the goal is enjoyment of the product. Let us call these “evaluational or axiotic disciplines” because in them it is not believing, but liking that predominates, e.g., the liking or enjoying of a park by the people who visit it.

Finally, while believing and valuing are also involved in the background, when willing predominates and the end, and not just the means, is a change in physical reality, we can speak of “practical disciplines.” In a practical discipline, willing predominates and is willing-for or willing-against some actuality, seeking to prevent or destroy it as well as to foster or create it. For nursing, the actuality can be called health. (Calling it that raises the question for me of what differentiates nursing from other health care professions, e.g., what doctors do. Is there a standard answer here?)

Florence: In the nurse’s world it is usual to say that doctors aim at a cure and nurses aim at the person’s well-being/health through care.

Lester: Could we add this to the list of things to come back to? I think there is a great deal in this simple-seeming contrast, which seems a slogan.

Florence: Okay.

Lester: In any case, if health is the purpose or end, then other things, e.g., medicines and inoculations, are means to the cure or prevention of illness. Yet there is also valuing and disvaluing (liking and disliking) in the background when willing predominates and makes a discipline practical. Except for situations where the patient/client values something more highly, e.g., the attention that being sick can bring to the client, health is preferred to illness, and preferring can be part of justification as well as simply a motive for willing.

Now nursing is often called an “applied science.” To me this formulation misleadingly suggests that there was first a science, temporally speaking, and then a practice is derived from it, while in fact there has been nursing like my mother did and even craft-level nursing for many thousands of years, and thus long before the rise of anything we would recognize as science, although science can actually be considered dramatically improved “lore” and of course science has improved and is still improving nursing wonderfully. I think we can say that “lore” amounts to relevant beliefs derived from experiencing and passed along in words as well as by example.

Florence: I agree. It is almost common sense for nurses that in a historical perspective, our practice was “scientifically theorized” to attend to the institutionalization of health assistance, which requires care for those who must be interned to be cured.

Lester: Instead of “applied science,” I would prefer to speak of nursing as “scientific” or “science-based” (provided, clearly, no implication is taken to the effect that there must
be a sophisticated cognitive foundation before there is a specialized practice at all, but only that scientific foundations are as necessary for nursing as a discipline as well as for professional schools where men and women are formally taught to be nurses).

Is this enough on how nursing is a scientific practical discipline? (By the way, I imagine that law is a discipline, and indeed a practical one, but not one that is not science-based.) If this is enough, let me remark that the nursing I have experienced, witnessed, or heard about is based on natural or, as I prefer challengingly to say, naturalistic science. It seems to me, however, that it ought also to be based on some cultural science. Does one not need to know some history, sociology, and even ethnology in order to relate well to one’s clients as a public health nurse?

Florence: Here in Brazil nurses are taught embryology, histology, anatomy, pathology, and physiology as disciplines for understanding disease, as well as epidemiology as one of basic disciplines to understand the occurrence and distribution of chronic and infectious/contagious diseases. But we are also taught psychology, sociology, and anthropology as disciplines that contribute to understanding the client’s being or acting in the lifeworld. Nevertheless, in a hospital where persons are interned for cure, the nurse’s caring practice is still conducted, with very few exceptions like psychiatric nursing, in terms of diseases, medical problems, or even medical procedures. Even in public health units, where the nurses have their actions directed by epidemiological (health) problems of groups of children, adolescents, mothers, adults, elders, etc., aiming at health promotion and disease prevention, it is still a disease such as tuberculosis or arterial hypertension, and its prevention through vaccination/immunization, that mainly directs the nurse’s practice. In both types of (health) institutions nurses develop their care actions through a relationship with persons, but it isn’t the person him/herself that is the focus of their action.

Lester: I hope I am wrong, but my impression is that nurses in the United States are not prepared formally in any of the cultural sciences, but rather only in the naturalistic sciences.

Florence: I am not certain about the American nursing curriculum either, although I have read many articles about nursing and cultural/ethnic groups. Another question we must have in mind is related to the discourse of nurses about nursing. In this respect we must be very careful when talking about nursing as a practice from a theoretical point of view, as the practice itself often doesn’t fit the theoretical discourse. That is, academic nurses write about and discuss nursing as they imagine it is or should be; typical nurses (as known by the clients) don’t write about but practice their profession in a health institution, so what is written about nursing isn’t always real. That’s why we in our Grupo and as (academic) nurses opted to study nursing with a phenomenological approach. And because nursing involves a relationship between persons, it must involve a social phenomenological approach, i.e., what Alfred Schutz describes.

Lester: This makes perfect sense to me. And so I guess that knowledge of psychology, sociology, and anthropology helps the nurse understand the patient as a person.

Excuse me, I have just remembered that another reason why “applied science” can mislead is the fact that a scientific discipline like nursing is not based on one science, but
draws on a multiplicity of them in its educational, practical, and research aspects, i.e., at least chemical and biological sciences you list.

Finally, I am trying to extend some reasoning by which the naturalistic and cultural sciences are differentiated, applying the distinction not only in the cognitive disciplines/sciences, but also in practical disciplines with scientific foundations. The key word in Schutz’s writings is of course “meaning.” On his view, when a group takes the meaning of something for granted, that something is a cultural object and the group is a cultural group. There are also cultural situations and even cultural worlds, so I sometimes use “cultural object” in a broad signification to cover them too.

Upon a little reflection, one can easily see that the “meaning” of this or that is learned. E.g., I was not born thinking that there were nurses and that they concerned themselves with health and caring, but I have come to believe it. But what is meaning? Most speak as if it was obvious, but I am not so sure. Schutz focuses on how it is the product, first of all, of the commonsense thinking of everyday life and is expressed in vernacular language. I want to go beyond his letter and say that things are fundamentally cultural when they have values and uses for us due to habits in individuals, and traditions in groups, of valuing and willing things. For example, it seems traditional in hospitals for nurses (among others) to strive to establish and preserve places that are as clean as possible, something I myself can hardly be said to do in everyday life. My office is always a mess and has never been disinfected!

Florence: Okay. But in my perspective your example of keeping places clean (and disinfected?) is more a professional than a personal attitude, inserted in a institutional (hospital or public health unit) cure/care situation.

Lester: Sure, I just offered that as an example of something deeply routine or traditional. Also, I don’t really think my office needs to be disinfected!

To continue, in the naturalistic sciences (and hence in disciplines that are naturalistic due to being chiefly founded on such sciences), Schutz holds that the scientist abstracts from the commonsense meanings things have for us to begin with. My favorite example for this is how a diamond becomes a case of crystalline carbon in a geology laboratory and is then, for a while, no longer a symbol of engagement to marry or “a girl’s best friend.” But here again I go beyond the letter of Schutz to say that the value and use as well as the commonsense interpretation that makes cultural objects cultural are abstracted from and that this is something that becomes habitual in a naturalistic scientist’s research attitude.

Next, I want to ask whether the objects that the nurse centrally and chiefly deals with or experiences in activities of nursing are cultural objects, which would mean that nursing is a cultural rather than a naturalistic discipline. If you reply that nursing deals with persons, I completely agree, but then I would point out that people make up a species of cultural object because they have values and uses as well as interpretations for themselves and each other already in everyday life and also for nurses (and even philosophers!) and

that they are thus more than merely biological objects. Differently put, nursing deals with people in situations of the sociocultural world.

**Florence:** That’s what we as the Grupo de Estudos de Alfred Schutz defend, but we enlarge the situation, stating that nursing is a social relationship between two or more persons, which can only be described and understood through the meaning(s) the persons—nurse and client—attribute to their action going into the professional relationship—nursing. In this sense, its not nursing that deals with people, but the person-nurse and at the same time, the person-client deals with nurses. So then here is a relationship between a professional subjectivity and a client subjectivity, which makes nursing a sociocultural world in itself.

We have been discussing what makes us—as nurses and sometimes as typical nurses—have a different attitude toward the client, and we came to the conclusion that it is much more a personal than a professional attitude. We believe that nursing must involve a relationship with a reciprocity of perspectives where the client brings what s/he needs in order to stay or become healthy or well and the nurse associates her/his professional knowledge with a personal attitude toward another person to help to satisfy that need.

Most of our studies have been focusing on the client trying to find out what must be the attitude of the nurse, with nursing understood as a social relationship. In this context the client looks for interpersonal communication, for a person who clears up his/her doubts about the (health) situation as it is lived by the client him/herself and not only from a professional (medical) perspective.

Some other studies focus on the “in-order-to” motives of the nurse to care, trying to work out the structure of nursing in different settings. And what has been emerging is the development of health programs in a public health unit and the aim of caring for a person as if s/he was a relative, performing technical procedures.

**II. Social Phenomenological Nursing**

**Lester:** As I recall, when I first heard of your group, you said that your colleagues use the thought of Schutz in research and practice. I have been curious about that ever since. It seems to imply that nurses engage in two fairly different types of activities, research and practical actions. Of course we have touched on these already in passing, but could you now tell me about the concrete and specific research activities first? We can come back to the action (and also the relation of action and research) afterward.

**Florence:** In relation to your request I have thought about the research our group has accomplished, looked over the titles, and re-read the abstracts. It all seems to fit into two categories: (1) the nursing perspective/action as it relates to an “other”; and (2) the “other’s” perspective and the lived experiences within it relating to nursing/health care.

**Lester:** I see. Both are social attitudes, i.e., directed toward a specific other; one attitude is in the typical nurse or the nursing team and toward the patient/client, and the other is in the patient/client (and his/her family) and is an attitude toward nursing.

**Florence:** Yes. Now the nursing category focuses on nursing actions in different settings, which is to say, different health care situations, but the project directed to the “other” is always there. The meaning of the professional action, its “in-order-to motive,”
is to give (direct or indirect) care. Let me now give you some titles in English (the formal list with people’s names and the other bibliographical details can go at the end of our dialogue): “The Nurse Acting in a Basic Health Unit”; “The Nurse and the Assistance of Non-Physical Needs of the Client: The Meaning of Action”; “The Nurse and the Promotion of the Student’s Health”; “The Nurse as Instrument of Action in Taking Care of the Aged—A Social Relation in the Perspective of Alfred Schutz”; and “The Care Giver in the Action of Taking Care within Oncological Nursing.”

And let me give you an example by quoting from one of the abstracts: “The study sought the meaning of the action of caring attributed to nurses who care for persons with cancer and undergoing medical treatment. We began with the question, ‘what does it mean for you to provide care in oncology?’ and asked for a description. Once analyzed, the responses made an understanding of the nurse’s typical action possible. Nursing care in such cases includes a great deal of complexity and professional competence well beyond the technical-scientific sphere and has implications for several facets of the nurse’s life. She needs strategies in order to be able to face her tasks. Schutz’s thought helped us unveil the existential motives of such persons and what lead him/her to have such a motive.”

**Lester:** This could be extended to include all of the types of nursing you listed at the very beginning, couldn’t it? These titles and the abstract seem to be about what nurses do as interpreted in terms of Schutz’s theory of action.

**Florence:** Of course. But you seem to focus on nursing and not on the client, and if so, it looks different to me. In our perspective, when we talk about the subjects of the academic/scientific writings that emerge from professional practice, we are talking about the nurse’s caring project, and essential to that project is the other who must be cared for.

**Lester:** Okay. That makes them social actions.

**Florence:** That’s right. And if we take the second perspective, the one that focuses on the patient/client, what we find as common to all of them is, on an everyday level, a request or search for (health/nursing) care. That is the “in-order-to” motive of the patient/client. Maybe you can see this in the titles of some of the other writings from our group: “The Meaning of the HIV Test for the Client—An Attempt to Understand”; “The Needs of the Client Interned in a Psychiatric Hospital and the Help of the Nurse”; “Phytotherapy as the Client’s Need”; “The Needs of Clients with Hansen’s Disease Seeking Health Orientation”; “The Needs of a Person’s Family in an Intensive Therapy Unit: A Comprehensive Perspective for the Humanization of Care”; and “Health Care Needs of the Female Client Seeking to Consult a Nurse.”

**Lester:** Yes, I can see that the focus is different but there is still the social relationship between nurse and client, only now are you focusing on the client side. Actually, you and your group focus on two different focuses, perspectives, or standpoints, that of the client and that of the nurse, don’t you?

**Florence:** That is again right. Topics of these two sorts come up in our twice-monthly meetings or “encounters,” as we call them because they are intense and intellectually exciting. But most of our interest is in methodology: how can we, in a systematic way, construct a structure or model of nursing knowledge and practice?
I must emphasize that the consensus in our discussions is that the nurse, as a professional health care giver, aims to give care to a person or group of persons who are “living” a situation that is associated with his/her/their health and for which they need help. The lived situation creates needs—health care needs that the client expects to have met. We ask ourselves what these health care needs are in the nursing perspective and what they are in the client’s perspective.

Lester: Thank you. Let me offer now three comments, and then let’s go to the other type of nursing activity. First, I can see that Schutz’s thought really does serve as a foundation for your research. Second, I think you have not only answered the question we left hanging near the beginning of our dialogue—the question of what all the types of nursing have in common—but we have also confirmed that nursing is, in my terms, a cultural discipline of the practical type, which is to say that the emphasis is on practical purposes or “in-order-to” motives, which appear to be in the effort of the client to become/stay well and in the nurse to preserve or restore health as best as possible. That makes it practical. Naturalistic science does not seek to understand what happens in terms of purposes. But again, I guess “health,” just like “needs,” may have different meanings for the client and for the nurse or team of nurses.

Florence: You are right when you say that “health” and “needs” may have different meanings for the client and for the nurse. And they really have. When we analyze the reciprocity of perspectives—the typical action of the client searching for care versus the typical action of the nurse when offering care—we find differences. For example, knowledge of “life” versus biomedical/epidemiological knowledge. That’s why our group is certain that to supply somebody’s health needs, the care giver must ask the client/patient what those needs are as he/she understands them and listen closely.

Lester: For the other type of nursing activity, I have a set of questions. Your research is phenomenological, but what about your practice? I assume you will say that Schutz’s thought as your group has specified and concretized it for nursing does influence practice, but how does that happen? Can you give me some examples of actions that are different from the actions of non-phenomenological nursing? And implied in this are ultimately the questions, I suppose, of whether your clients have better care due to this different practice, and how that might be judged?

Florence: It is interesting that you are asking about our “different practice,” because it isn’t that different at all. What we are trying to do, especially those who accomplished the studies based on Schutz’s thought focusing on the client/patient, is that instead of asking questions about matters that we as practicing nurses want to know, we ask what brought the person to look for care/help and what s/he is expecting. At the same time, those questions involve a certain attitude, a phenomenological one of listening to, and not only hearing, what the client as a person is bringing to us in the way of situations and/or problems, and not going on immediately to insert what is said into a knowledge-structure of the disease/health program. It is only after caring for the person him/herself, with his/her felt needs, that we bring in the biomedical and/or epidemiological approach. In this sense, the (health) situation lived by the client is the fundamental focus of our professional action.
Lester: I am asking for examples because I imagine that many of the differences are subtle and thus probably difficult to describe.

Florence: I agree with you. It isn’t very easy to describe all the processes. I’ll try to do it with the development of a nursing consultation to pregnant women in a basic health unit. First, you have to know that prenatal nursing is a programmatic health action, developed in primary (public health) care units, and aims to assist pregnant women, with a basis in the epidemiological characteristics of that group. That means that the unit has a kind of protocol for nursing consultations every trimester, including interview and technical procedures, laboratory examinations, specific information for the woman about what to do and not to do, vaccination, etc. In general, at every visit, the nurse reads the register of what has already been done, asks how the woman is feeling, evaluates the child’s heartbeat, and gives new information. If some situation or measurement that does not fit the norm for pregnant women is identified, the woman is directed to the physician of the health unit.

Under the influence of Schutz’s thought, the nurse consultation occurs slightly differently. Instead of having the consultation protocol as basic direction, we begin by asking how the person is feeling—and not only as a pregnant woman, but especially as a person, how things have been going since our last encounter, and what is “new.” If some information relating to the protocol emerges during such a dialogue, it is discussed and procedures followed.

For example, Woman 1: “I am feeling that I am getting too big!” Nurse: “Let’s take a look. Would you mind laying down for a moment? What have you been eating? Do you think it is good for you or the baby?” Or Woman 2: “What can I do so my baby will be healthy? What must I feed him?” Nurse: “During the first six months the best you can do is to breast-feed him, and take care of both of you. Have you already had training in breast-feeding? Don’t forget that as soon as you are discharged from the hospital after the delivery we are expecting both of you here at the unit. Are you still working at that factory?”

What I am trying to say is that during the consultation by the “social phenomenological” nurse, the dialogue is conducted by the client and the nurse applies her knowledge to the client’s lived situation. When some procedures or information are not directly or indirectly brought up by the client, the nurse asks specific questions about aspects of the woman’s lived situation so that they can be subject to communication and/or intervention.

Lester: And implied in this ultimately are the questions, I suppose, of whether your clients have better care due to this different practice and how that might be judged?

Florence: Are you kidding me? If this kind of care is better or not, it is only the client/patient who can tell you! But there is one thing that attracts our attention and in some way can be understood as a positive result of this type of care. In both situations—be it a person looking for health care in a basic health unit or a person asking for help or care in a hospital ward—the preference is for the nurse who uses a social phenomenological approach.
We sometimes discuss the topic of quality of care in our Grupo and our consensus is that the clients do keep coming back to the same nurse, which is the one who has a phenomenological attitude. Since a dimension of the quality of care is the fulfillment of the health care needs of clients, a social phenomenological attitude on the part of the health care professional contributes to that quality.

**Lester:** I’m impressed! I also like it that you say “social phenomenology” rather than “phenomenological sociology” when referring to Schutz’s thought, because he was first and foremost a phenomenological philosopher focusing on the social and not really a sociologist, even though he taught it. And actually, most of his examples come from the so-called “Austrian economics” school of marginal utility, and there would have been some very interesting results if he had been asked to teach political science at the New School during the war! But now let me ask you my last question.

**Florence:** Did you notice that my “presence” in our dialogue is much more related to the applications of Schutz’s thoughts than his thought in itself? But I agree with you, Schutz focuses on the phenomenology of a social human being, and in this sense on the phenomenology of his/her relationship with other human being(s).

**Lester:** Actually, I was counting on your focus on that connection because it is precisely what I do not know about!

Now I have come to see how you gather data through professional experience, participant observation, and conducting interviews, and how you have developed what Schutz came to prefer to call “constructs” that are of the nurse in general and the client in general. And I also see that you can then go on to develop specific constructs of the various forms of nursing and also of clients. The latter would vary, I guess, with age, sex, and illness, and also the setting of the home, clinic, hospital, etc. Furthermore, there can be a group of clients, e.g., a family, that is cared for, and often the caring is done by a group of nurses. So clearly there is much more to nursing than we have discussed.

**Florence:** That’s a very interesting observation about nurses and clients. Although they do in fact vary, as professionals and persons within “their” objective situation, their typical actions in health care situations do not vary.

**Lester:** Excellent. And many aspects are covered in this bibliography you have sent me, but I suppose there is much more that your “Rio group,” as I call it, will be researching. I’ve also mentioned that I see how you draw on Schutz, but let me add that in just looking over his essay, “Common-Sense and Scientific Interpretation of Human Action,” which is the first paper in the first volume of his *Collected Papers*, I see much of what you use.

**Florence:** You are right, in some way we have as a central theme of our discussions the integration of commonsense (client) and scientific (nurse) human action.

**Lester:** Now my last question is about standpoints, levels, etc. Schutz has a taxonomy of actors, partners, observers, social scientists, and philosophers that seems to fit what we have been doing. To put the persons involved in our effort into his taxonomy, there is first of all the standpoint of the client with the health problem, then there is that of the nurse, and that is usually all that is involved, although sometimes there may be a student looking on in order to learn. The client is interested in getting or staying well. The nurse is
interested in caring for the client. One can think of their two standpoints as on the same level.

But you and your group go a step further and seek to understand nursing as a social relationship and interaction between the nurse and the client. Just as the health problem is most vivid to the client, the doing of nursing is most vivid to the nurse whom you reflect upon. I think it is this reflecting upon nursing that earns you and your group the adjective “phenomenological.” The standpoint of you and your group is the third standpoint and makes for a second level. It is different from the first level of straightforward nursing and its clients. In my Schutzian-style terms, you and your group are outsiders attempting to develop an interpretation about the interpretation coming from inside that first level relationship.

Florence: I can’t say anything more! You said/wrote everything! I agree entirely.

Lester: Thank you. But what about you and I? Your standpoint is that of the phenomenological nurse and mine is that of the phenomenological philosopher. We both reflect on nursing, but my reflections are based on yours. You have kindly turned in a new direction, so to speak, in order to have this dialogue with me. I do not ask questions of the nursing of clients directly but rather through asking question of a nurse who reflects on nursing. My standpoint is philosophical, and besides my general curiosity about nursing, my interest focuses on whether nursing can fit my model of a practical cultural discipline, which we have seen that it does.

Florence: I have been very careful in agreeing with you about this expression, “nursing as a practical cultural discipline,” especially about the idea of “cultural,” which is used in different ways, many negative—in the “science”/professional world, culture isn’t science. How could I, in this context, accept nursing as non-science, even if this doesn’t mean that it isn’t “scientific”? Another term brought me some difficulties: “practical.” But I agree with you if we understand “cultural” as value expressions related to activities of human subjects. The investigations developed by the Grupo de Estudos de Alfred Schutz are finding that nursing involves personal (client and nurse!) and professional (nurse) values expressed through a social relationship/caring for (activity) aiming at care/health. In this sense, nursing can be understood as a practical cultural discipline.

Lester: Your interest is different from mine (and I am not even sure why you have invested time in helping me!), but we have proven that we can communicate quite well enough.

Florence: (At first sight, this may appear an egoistic answer, but it isn’t.) I haven’t invested time helping you; I was, or better, I am helping myself! You, through our dialogue, gave me the opportunity to reflect on my own reflections and those of our Grupo, including the Grupo itself, because what was being written from my side was the subject of our discussions. So it wasn’t an investment of time, it was a personal/academic investment, which involves myself as a person and as a professional.

But if you want to know what is—to stay in Schutz’s style—my “in-order-to” motive—I want (and still want to continue) to stay in contact, and discuss further, the application of Schutz’s thoughts to “nursing” with somebody who knows and understands those thoughts more than I do.
Lester: I am not at all sure that I understand them more than you do, but perhaps I understand them more abstractly, in which case your concrete applications make my understanding deeper.

Another way to put all this is to say that there are three levels involved. On the bottom is the straightforward interactions between nurse and client. On the second is the nurse phenomenologically reflecting on the straightforward nursing interactions and of course interacting with the persons on the second level, i.e., your group. And on the third level there is the phenomenological philosopher reflecting on nursing via your reflection on nursing, i.e., through asking questions of the phenomenologically reflecting nurse. My final question, at least for now, is: does this talk of standpoints and levels and interests in our effort make sense to you?

Florence: The easiest thing for me to do at this point is simply to write “yes” to this “final” question, but I hope we can we can discuss this more on a future occasion. ’Til then—

Best,

Florence

References
Araújo, Penha Regina V. L; Tocantins, Florence Romijn. “Necessidades Assistenciais da Cliente Mulher ao Procurar a Consulta de Enfermagem uma abordagem fenomenológica na perspectiva de Alfred Schutz.” [Health Care Needs of the Female Client Seeking to Consult a Nurse: a phenomenological approach with the perspective of Alfred Schutz] <regnurse@openlink.com.br / cauperj@openlink.com.br / florence@nitnet.com.br>

Brum, Ana Karine Ramos; Tocantins, Florence Romijn. “O Enfermeiro como instrumentode ação no cuidar do idoso—uma relação social Na perspectiva de Alfred Schutz. [The Nurse as Instrument of Action in Taking Care of the Aged—A Social Relation in the Perspective of Alfred Schutz] <karine.brum@bol.com.br / florence@nitnet.com.br>

Carvalho e Silva, Ana Lúcia Alves de; Rodrigues, Benedita Maria Rego Deusdará. “O Exame Físico em Enfermagem: uma análise compreensiva na ótica do graduando.” [Physical Examination for Nurses: A Comprehensive Analysis from the Point of View of the Graduating Student.] <bdolfo@ieg.com.br>

Castelo Branco, Alba Lúcia; Tocantins, Florence Romijn. Necessidades de Cliente Internada em Enfermaria Psiquiátrica e a Assistência de Enfermagem (Rio de Janeiro: Gráfica Minister, 1996). [The Needs of the Client Interned in a Psychiatric Hospital and Nursing Assistance] <albacbranco@uol.com.br / florence@unirio.br>

Castelo Branco, Alba Lúcia; Tocantins, Florence Romijn; Elsas, Berenice Xavier. “Encontro Interativo uma perspectiva para a Enfermagem Psiquiátrica.” [Interactive Encounter: A Perspective for Psychiatric Nursing] <albacbranco@uol.com.br / florence@nitnet.com.br>

Cylindro, Antônia da Conceição; Tocantins, Florence Romijn. “A Fitoterapia como uma Necessidade do Cliente: uma perspectiva de Assistência de Enfermagem.” [Phytotherapy as the Client’s Need: A Perspective for Nursing Assistance] <florence@nitnet.com.br / florence@unirio.br>
Jesus, Maria Cristina Pinto de. *Educação Sexual: o cotidiano de pais e adolescentes* (Juiz de Fora) (Minas Gerais: FEME, Set. 1999). [Sexual Education: Everyday Life of Parents and Adolescents] <petronib@enfermagem.ufjf.br>

Lima, Eurinilce Xavier de; Rodrigues, Benedita Maria Rego Deusdará. “O Enfermeiro Assistencial Preceptor e o ensino ao Residente de Enfermagem uma aneles compreensiva.” [The assistant nurse as a preceptor and the action of teaching nursing residents a comprehensive analysis] <eurinilceX@aol.com / bdolfo@ieg.com.br>

Peres, Patrícia Lima Pereira; Rodrigues, Benedita Maria Rego Deusdará; Tocantins, Florence Romijn. “A enfermeira face as necessidades da criança em creche publica: uma perspectiva de compreensão apoiada na abordagem fenomenológica de Alfred Schutz” [The nurse and the needs of the child in a public day-care center: an understanding perspective based on the phenomenological approach of Alfred Schutz] <bdolfo@ieg.com.br / florence@unirio.br>

Popim, Regina Célia; Boemer, Magali. “O cuidador na ação de cuidar na enfermagem oncológica: uma perspectiva orientada sob o enfoque de Alfred Schutz.” [The Care Giver in the Action of Taking Care within Oncological Nursing: A Perspective Guided by Alfred Schutz’s Approach.] <rpopim@aol.com.br>


Silva, Helena Baltar da; Tocantins, Florence Romijn. “Vida ... Vida ... Vida ... Reflexões sobre o brincar de criança que tem seu cotidiano na rua na perspectiva de assistir em Enfermagem.” [Life... Life... Life... Reflections about the playing of the child who has his/hers daily life in the street in a perspective of nursing attendance] <florence@nitnet.com.br / florence@unirio.br>

Silva, Maria Andrade e; Tocantins, Florence Romijn; Rodrigues, Benedita Maria R. D. “O Enfermeiro e a Promoção da saúde do escolar: possibilidade de um projeto comum na escola.” [The Nurse and the Promotion of the Student’s Health: The Possibility of a Common Project in the Primary School] <mariaibrincando@ig.com.br / florence@nitnet.com.br / bdolfo@ieg.com.br>

Silva, Teresinha de Jesus Espírito Santo da; Tocantins, Florence Romijn; Souza, Ívis Emília de Oliveira. “O Enfermeiro e a Assistência a Necessidade Não Física do Cliente: o significado do fazer” [The Nurse and the Assistance of Non-Physical Needs of the Client: The Meaning of Action] <teresinh@pcshop.com.br / florence@nitnet.com.br>

Steigleder, Heliane Lopardi e; Tocantins, Florence Romijn. “As necessidades do cliente com hanseníase ao buscar a educação em saúde: uma abordagem compreensiva para a atuação do
enfermeiro.” [The Needs of Clients with Hansen’s Disease Seeking Health Orientation: A comprehensive approach for the nurse action] <florence@nitnet.com.br / florence@unirio.br> Tocantins, Florence Romijn; Souza, Elvira De Felice. “O agir do enfermeiro em uma unidade básica de saúde: análise compreensiva das necessidades e demandas.” *Escola Anna Nery Revista de Enfermagem* 1, n. especial (julho 1997), 143–59. [The Nurse Acting in a Basic Health Unit: Comprehensive Analysis of Needs and Demands] <florence@nitnet.com.br / florence@unirio.br>
Table of Contents

Preface

Volume One

Chapter 1: John Brough, Art and Non-Art: A Millennial Puzzle

Phenomenology enjoys abundant resources with which to investigate such perennially vexing issues in aesthetics as the ontological status of the work of art, its ideality, its relation to beauty, and the nature of artistic experience. Phenomenology is especially well equipped to contribute to the recent discussion, prominent in the analytic tradition, of the proper definition of art, or, in phenomenological terms, of the essential features that distinguish the artwork from things that are not art. This essay will attempt to shed light on this issue by examining both the external cultural horizon in which certain objects appear as art and the internal structure of the appearing artwork itself.

Chapter 2: Shaun Gallagher and Francisco Varela, Redrawing the Map and Resetting the Time: Phenomenology and the Cognitive Sciences

We argue that phenomenology can be of central and positive importance to the cognitive sciences, and that it can also learn from the empirical research conducted in those sciences. We discuss the project of naturalizing phenomenology and how this can be best accomplished. We provide several examples of how phenomenology and the cognitive sciences can integrate their research. Specifically, we consider issues related to embodied cognition and intersubjectivity. We provide a detailed analysis of issues related to time-consciousness, with reference to understanding schizophrenia and the loss of the sense of agency. We offer a positive proposal to address these issues based on a neurobiological dynamic-systems model.

Chapter 3: Ronald Bruzina, Construction in Phenomenology...

“Construction” in phenomenology is best understood in the context in which it was first introduced into phenomenology (in Eugen Fink’s Sixth Cartesian Meditation of 1932), namely, as serving in the methodology of the disclosure of transcendental origins. Since these origins are in principle non-presentable, non-givable—being themselves that which gives rise to the horizons for presentation and giving—the originative can only be conceptualized as in excess of intuitional demonstration. The originative is thus methodologically “speculative,” in a specifically phenomenological sense, and representable only via “construction,” that is, in terms of what passes within the intuitionally givable. The character of this problematic, and the radical insights its pursuit can yield, is shown in Maurice Merleau-Ponty’s phenomenology of living being, especially in his late work on “the visible and the invisible” in the context of his lectures on nature from 1956 to 1960.

Chapter 4: Ted Toadvine, Ecophenomenology in the New Millennium.

Ecophenomenology is a new program of research operating at the intersection of ecology and phenomenology and recommending a mutually enriching dialogue between the two. The first half of this chapter explains the need for both a phenomenology of ecology and an ecological phenomenology, and sketches the basic lines of ecophenomenological investigation in the areas of axiology, ontology, and methodology. The second half of the chapter makes the case for an ecophenomenological examination of agricultural experience and explores agriculture’s role as mediator between nature and culture. The roots of culture, I suggest, lie in the primordial experience of risk and faith characteristic of subsistence cultivation.

Chapter 5: Elizabeth A. Behnke, Phenomenology of Embodiment/Embodied Phenomenology: Emerging Work

Part I raises issues of method and identifies areas needing further descriptive phenomenological research. For example, we should consider a broader spectrum of bodies, modes of embodiment, and styles of bodily awareness; we should describe cultural shaping of bodily life without falling into cultural determinism; we should explore bodily experience...
in its dynamic ongoingness; and we should continue to develop a truly embodied ethics. Part II uses the method of “unbuild-ing” (Abbau) to locate a somaesthetic “dimension”; traces the passive constitution first of a somaesthetic “field,” then of the “Innenleib” as a transtemporal identity/unity; and inquires back from somaesthetic sensings to their kinaesthetic correlates.

Chapter 6: John Drummond, Ethics......
This chapter considers two trends in phenomenological approaches to moral philosophy, namely, the axiological approach and the deontological, in relation to the contemporary discussion between neo-Aristotelians and neo-Kantians about how best to address the problem of an apparent separation between moral motivation and the ground of moral obligation. The chapter suggests that a careful consideration of the phenomenological approaches leads to a distinction between “manifest” and “non-manifest” or “transcendental” goods that unites the basis of our moral motivation with the ground of our moral obligations.

Chapter 7: Michael Barber, Ethnicity and Phenomenology: Primordial vs. Social Constructionist Approaches......
This chapter discusses the relevance of phenomenology for six major issues regarding ethnicity. It examines the sociological debate about whether ethnic identity is a primordial given of social existence or a social construction. It argues that both social formations beyond kinship, of which ethnicity one, and kinship itself make possible a social world whose typification and relevance structures, eidetically considered, are in a sense primordial for establishing personal identity. This minimalist account of ethnicity makes possible a playing field on which various in-groups socially construct their identity in the light of ever revisable relevances and depending on ever changeable circumstances.

Chapter 8: Mary Jeanne Larrabee, Phenomenology and Gender...
This chapter takes two approaches to the topic of gender and phenomenology. First, it discusses the ways phenomenological methods can be applied to the study of gender. Second, it considers whether these methods are gendered. I summarize contributions of early phenomenologists on the topic of gender, followed by critiques of these, and then survey work from the end of the 20th century applying phenomenological analyses to women’s and men’s experiences of gender. Through a cross-cultural review the essay discusses the presupposition that the number of sexes/genders is limited to two, plus the implications arising from the gendered experiences of persons who are intersexed, transexed, and transgendered.

Volume Two
Chapter 9: Thomas Seebohm, The Methodology of Hermeneutics as a Challenge for Phenomenological Research.....
The first section is a survey of a phenomenologically guided general theory of understanding and its levels, namely, animalic understanding, elementary understanding, higher understanding, and the process of understanding in cultural traditions. Such a phenomenological theory is the presupposition for a phenomen-o logical critique of methodologically guided hermeneutics. The second section is a survey of phenomenological viewpoints that can be applied in a critique of the principles and canons of general text hermeneutics and addresses the question whether they can be considered as warrants of objective validity in interpretations. A last section offers a sketch of the specific problems of archaeological hermeneutics.

Chapter 10: David Carr, On the Phenomenology of History
In this chapter I try to outline a phenomenological approach to history, and to distinguish it from standard or traditional philosophies of history. Philosophy of history has traditionally taken the form either of a metaphysics of history or of an epistemology of
history. The former has tried to discern the grand design of the historical process, while the latter has asked how our knowledge of history is possible. Instead of an epistemology, I propose a phenomenology of history, which traces our concepts of history back to our experience of the historical. And instead of a metaphysics I propose an ontology of history, an account of the historical character of human existence. I conclude by describing several topics that issue from this phenomenological approach and that need to be further explored.

Chapter 11: Roberto J. Walton, The Phenomenology of Horizons

An analysis of horizontality implies an elucidation of its structure, function, and motivations. An essential structure can be disclosed in the light of a series of oppositions. On this basis a twofold function can be pointed out, for horizontality both enables the process of legitimation and provides a ground for intentional acts. Also to be dwelt upon are the motivations for the further forming of new horizons and the uncovering of pregiven horizons. A still further step is to develop this theme into a consideration of the motivating force of horizontality, i.e., its significance for trans-cendental philosophy and post-Husserlian phenomenology.

Chapter 12: Dan Zahavi, Phenomenology and the Problem(s) of Intersubjectivity

One of the classical objections to phenomenology has been its alleged failure to solve the problem of intersubjectivity—be it by way of omission, i.e., by simply failing to recognize the philosophical significance of intersubjectivity, or by way of an inborn shortcoming, i.e., by being in principle incapable of addressing this issue in a satisfactory manner. Drawing on the work of Scheler, Heidegger, Merleau-Ponty, Husserl, Sartre, and Levinas, the aim of this chapter is to demonstrate the erroneous nature of this criticism and to present an overview of four different and distinct phenomenological approaches to intersubjectivity.

Chapter 13: Olav Wiegand, Phenomenology of Logic and Mathematics

In each of the problem areas mentioned in Part I, this chapter attempts to formulate several questions of interest to present-day phenomenology of the formal sciences. The problems addressed are in general formulated with reference to Husserl’s work and the phenomenological research program of a theory of science (Wissenschaftstheorie). Part II begins with the Lucas-Penrose thesis, which is the interpretation of the Gödel theorems according to which there are mathematical truths that cannot be found by merely employing algorithms; human mathematicians find truths by an “insight” that is essentially non-algorithmic. Genetic phenomenology can offer a thoroughgoing descriptive account of mathematical insight as emerging out of pre-linguistic experience. Our discussion will focus on the concept of “categorial intuition,” which is an important part of the phenomenological explication of “mathematical insight” (better: “mathematical intuition”). In the last section two points will be argued: (1) mathematics is consistent since its primitives (“categories”) are regimented concepts that stem from the pre-linguistic experience of the world, and (2) phenomenology does not allow for a causal or stochastic explanation of categorial intuition. At least non-reflective mathematical intuition is essentially non-algorithmic in nature.

Chapter 14: Richard M. Zaner, Envisioning Power, Revisioning Life: Prominent Issues for a Phenomenology of Medicine

Since the 1960s, philosophers in medicine have been interested in the doctor-patient relation: the interpretation of symptoms, the nature and requirements of clinical judgment, the social structure of clinical encounters, and the multiple forms of uncertainty and responsibility in decision-making. Such matters undergird many questions captivating public attention, including those before birth (abortion, alternative means to attain pregnancy, prenatal diagnosis, along with genetics and embryos) and those at the end of life (euthanasia, brain death, withholding and withdrawing life-supports, and others). Recently, medicine is undergoing radical changes, from concern to cure disease to the ancient dream of eugenics, from restoration of health to the deliberately engineered transformation of living beings. I explicate the implications of these developments, in particular the ironies and
questions buried within the genetic utopias that inspire the new visions and revisions of human life.

Chapter 15: Javier San Martín and María Luz Pintos Peñaranda, Animal Life and Phenomenology

Following the preferences of Western culture in which nonhuman animals are treated as non-subjects, most phenomenological analyses deal primarily with human life. But in his actual research, Husserl shows that we are entwined with nonhuman animals because the primary stratum of our life is the experience of our own animate body. In the first part of this chapter, a variety of texts in which Husserl speaks about animality are interpreted to prove that animals of all species are transcendental subjectivities. In the second part, Husserl’s indications are followed to outline an ontology of what is common to both human and nonhuman animate life.

Chapter 16: Florence Romijn Tocantins and Lester Embree, Phenomenology of Nursing as a Cultural Discipline

A professor of nursing in Brazil leads a group of colleagues in an effort reflectively to understand what nursing is fundamentally, and they use the social phenomenology of Alfred Schutz in their reflections. She agrees to answer questions about their work via e-mail from a phenomenological philosopher interested in understanding such a discipline. He is convinced by her answers that nursing is indeed a cultural discipline of the practical sort. She teaches him much about her discipline; focuses on how her group investigates nurses as they relate to patients/clients, and correlatively, on patients/clients as they relate to nurses; and ultimately shows that nursing involves a personal as well as a professional attitude and is as such not so much about curing as about caring. The joint effort expressed in a dialogue also shows how a philosopher can learn about nursing. Presumably other disciplines of the same sort, e.g., psychiatry, could be reflected upon in analogous fashion.

Volume Three

Chapter 17: David Woodruff Smith, Ontology

Phenomenology (appraising our lived conscious experience) would seem to bracket ontology (appraising what ultimately exists). Yet from its inception, phenomenology has both presupposed and led into fundamental ontology. Here we consider specific ontological categories, starting with Aristotle’s list and moving to Husserl’s complex system of formal and material essences. Husserl’s categories are systematized and reorganized. We consider then the ontology of intentionality, as well as nonexistent objects and modes of being as opposed to types of beings. Finally, we consider how we might frame an up-to-date system of ontological categories consonant with phenomenology.

Chapter 18: Dermot Moran, Analytic Philosophy and Phenomenology

In this chapter I argue that the two modernist traditions of phenomenology and analytic philosophy stem from common roots. Both began with the same conception of philosophy as an \textit{a priori} descriptive discipline and both rejected absolute idealism and psychologism. Analytic philosophy, however, in the main, especially under the influence of Quine, has been drawn toward \textit{naturalism}, whereas Husserl’s critique of naturalism has meant that phenomenology has moved in an anti-naturalistic and in fact explicitly \textit{transcendental} direction. Husserl’s wide-ranging critique of naturalism has particular relevance for analytic philosophy seeking to overcome a reductive scientism, and conversely, recent developments in the philosophy of mind and in the cognitive sciences could provide much material for phenomenologists who want to follow Husserl’s program of identifying the ABCs of consciousness. In the 21st century, the two main streams of contemporary thought could again merge into a single tradition.

Chapter 19: Robert Bernasconi, Reviving Political Phenomenology: The Quest for Community and Its Drawbacks
This chapter addresses political phenomenology in terms of three questions: what is the political? what are the basic units of politics? are there political communities? The tendency of phenomenologists to approach the political in terms of the concept of community is challenged. In an attempt to prepare for a reinvigoration of political phenomenology and to establish some of the terms it may employ, certain tasks are proposed, including phenomenological investigations of political activities, such as voting and opinion formation, and of the different kinds of collectivities that form and provide the context for political groups. The capacity of phenomenology to embrace a multiplicity of perspectives is presented as one of its great advantages.

Chapter 20: Burt Hopkins, Phenomenological Psychology: Tasks and Problems for the New Millennium

I situate basic issues pertaining to phenomenological psychology within the context of a general reflection on the status of psychology as a science at the end of the millennium. I then discuss Husserl’s formulation of phenomenological psychology, and take up his project of establishing it as an autonomous science. I investigate the phenomenon of “projection” as a guiding example in this regard, and draw pro-visional conclusions about its constitution as well as about the proper method and content of phenomenological psychology.

Chapter 21: Natalie Depraz, Holy Body and Rainbow Body: The Lived Body as an Exemplary Access to the Absolute

After having provided some indications about the way the articulation between phenomenology and theology has been settled by some of the most prominent phenomenologists (Husserl, Heidegger, Stein, Levinas, Henry, and Marion), I use the practical and mystical path in theology as the only view proving adequate to an experiential and descriptive phenomenological approach as opposed to the hermeneutical one. I then proceed to a description of the experienced praxis of a spiritual life, according to three steps that correspond to the three preconditions of a religious spiritual attitude toward life: (1) I show how necessary it is to be in possession of a steady religious “hearth,” whatever it be, and correlative, how necessary it is to be able to go through a de-localization of such a traditional anchorage thanks to the adoption of another one; then (2) I make an explicit phenomenological claim about the primacy of the level of practical and mystical experience over the theoretical level of a rationalized doctrinal set of theological principles; finally (3) I account for the experience of the lived body as being the only relevant starting point and the only legitimate end goal of any genuine spiritual life, which involves, of course, a renewed phenomenological understanding of what we currently call the “lived body.” I indicate how such a more complex understanding of the body can be usefully worked out thanks to two main religious traditions that focus on the body as a clue to spiritual life, i.e., Eastern Orthodox Christianity and Tibetan Buddhism.

Chapter 22: Don Ihde, Phenomenology and Technoscience

Technoscience studies, sometimes also science studies, is an interdisciplinary field that combines work in the philosophy of science, philosophy of technology, and the social studies of the sciences. This essay briefly explores some of the developments and key figures in the field, taking note of connections with phenomenology and hermeneutically oriented philosophy. These studies, usually humanities and social science perspectives upon science, have become a forefront field only in the last two decades, but hold promise for considerable development. And while there are only a few phenomenological-hermeneutical philosophers currently working in this area, the problems and approaches offer serious opportunities for new entrants. The essay concludes with a concrete experiment in technoscience studies at the State University of New York – Stony Brook and describes current research projects.

Chapter 23: LEE, Nam-In, Active and Passive Genesis: Genetic Phenomenology and Transcendental Phenomenology

In this chapter I will first deal with three important issues of passive and active genesis
that need further discussion: (1) the methods of genetic phenomenology, (2) the relation between static and genetic phenomenology, and (3) genetic phenomenology and the problems of foundation. Thereafter, I will discuss one important topic of passive and active genesis in detail, namely, the concept of transcendental subjectivity in genetic phenomenology. In comparison to the traditional concept of transcendental subjectivity, the concept that I will sketch out will turn out to be revolutionary. It is so revolutionary that some may not accept it as legitimate. However, this concept is not only legitimate, but also better than the traditional one in many respects. For example, it can serve as a good starting point for philosophical dialogues, on the one hand, between transcendental phenomenology and other forms of phenomenology, and on the other hand, between phenomenology and other streams of contemporary philosophy and science. Moreover, it can provide us with a useful tool to deal with various philosophical issues that we are now confronted by in an age of pluralism and environmental crisis.

Notes on Contributors

Index of Names
Preface

This work has been organized under the auspices of the Center for Advanced Research in Phenomenology, Inc. (www.phenomenologycenter.org) to mark the transition from the second to the third millennium, which is also the transition from the first to the second century of the phenomenological tradition. To serve this purpose, over two dozen colleagues were brought together in Delray Beach, Florida, in January 2001, to discuss many of the drafts of what have become chapters of the present work. Others who were unable to participate in that research symposium have nevertheless contributed chapters.

We began by inviting participants with expertise in certain “areas”—that is, fields where phenomenological investigation has proven fruitful. There are other areas than those we have addressed—for instance, cyberspace, interculturality, psychiatry, generational difference—but either no phenomenological expert for those areas was known to us, or those who were known were unable to contribute. No doubt other areas exist, but an overview of the phenomenological field as a whole is already beyond the grasp of even a consortium of editors. While the contributors are from a variety of countries, we especially regret the absence of contributions from Eastern Europe, but otherwise we have tried to draw on as much of the planet’s resources for phenomenology as we could within the limits of the space and time available. The result at least hints at the global vitality of phenomenology.

Each participant was invited to write a substantial essay of about 9,000 words on her or his area. In addition, each was encouraged to engage the area on two levels: first, to identify five to fifteen pressing problems for phenomenology in that area; and second, to advance the account of one such problem through original phenomenological analysis. It has not always been possible to impose uniformity of structure on the result—the areas lend themselves differently to the project’s aims—but in every case the reader will find insights into the “state of the art” as well as the kind of independent reflection that phenomenologists are known for. In addition, this work is remarkable for how very little it contains in the way of interpretations of texts. We feel that this concern for the “matters themselves” is the most appropriate beginning of phenomenology’s second century that could be asked for.

The expression, “The Reach of Reflection,” refers, of course, to the fundamental method of phenomenology. But if the way of attaining phenomenological results is not particularly new, our way of disseminating them is. So far as we know, this is the first large publication of original work in phenomenology to be published over the Internet. Inevitable glitches aside, we believe that web publishing will have an important role to play in the future. Because production and distribution costs are low, only a very modest price per copy is needed to recover those costs. And because the cost to purchase a copy (with no limit on how many printouts can be made once the copy is purchased) is low, dissemination in less affluent countries—where phenomenology is no less vital than in more affluent ones—becomes far easier. Communication is possible as never before. The e-mail address for the author of each chapter is not only symbolic; it is a serious invitation to communicate. Again, this is the future.

As phenomenology enters its second century another change comes into view, one that
bodes well, we think, for our tradition. About half the chapters take up more or less
traditional philosophical themes or phenomenological problem-areas. These include
aesthetics, embodiment, ethics, hermeneutics, history, intersubjectivity, logic and
mathematics, ontology, politics, psychology, and religion, as well as “technoscience” and
the “cultural disciplines,” which extend the scopes of the traditional philosophies of the
natural and the social or cultural sciences. Yet an almost equal number of chapters are
devoted to relatively new areas, including constructive phenomenology, cognitive science,
ecology, ethnicity, gender, genetic phenomenology, horizonality, medicine, and nonhuman
animal life. In addition, one chapter confronts an issue that could not have appeared at the
beginning of phenomenology’s first century, but will play an increasing role in its second:
the relation of phenomenology to analytic philosophy.

Phenomenology came to the world’s attention with Husserl’s *Logische Untersuchungen*
of 1900–1901. It was adapted from philosophy into psychiatry by Binswanger and Jaspers
on the eve of World War I, and then into a score of other non-philosophical disciplines in
the decades that followed. During those same decades of the last century, it spread to over
a score of nations, beginning with France, Japan, Russia, and Spain also before World War
I.

The first creative phase of phenomenology occurred when young people at Göttingen
before World War I extended the reach of realistic phenomenology into many new areas.
The second phase is constitutive phenomenology, which began to appear in print in 1913
and was led by Husserl himself—powerful insights are being found in his *Nachlass* still—and
has been continued by his closest followers. The third phase is existential
phenomenology, which includes the early Heidegger and then Arendt, Beauvoir, Merleau-
Ponty, Sartre, and others. These thinkers expanded phenomenological reflection beyond
those areas recognized by its earlier practitioners. A fourth phase is hermeneutical
phenomenology, which began about 1960. Though its emphasis on textual interpretation
can at times conflict with phenomenological method, hermeneutical phenomenology (and
even deconstruction in some of its forms) has opened original areas of phenomenological
research that have been cultivated productively.

Today, a renewed interest in original phenomenologizing in the area of religion
seems to have begun in France, and other new ventures in such areas as ecology, ethnicity,
gender, nonhuman animal life, and so on, can be discerned. It appears that something like
a fifth period in the phenomenological tradition has begun, and we hope that the present
work will contribute to fostering it.

Finally, a few technical remarks. First, we have arranged the chapters alphabetically
by topic, except for one that may function as a sort of conclusion. Second, we have divided
this text into three volumes so that if the whole is printed out, each can be bound separately
and handled more easily. Third, we are including the abstracts of the chapters in the table
of contents, as well as in advertisements, so that a useful overview of the work’s contents
can be easily had on the screen of one’s computer. This facilitates selecting and printing
specific chapters one may be especially interested in. Fourth, let us repeat that once this
work has been purchased with a credit card from www.electronpress.com there is nothing
to prevent printing out more than one copy. Finally, since a new and unconventional mode
of publication is being ventured here, we encourage all who appreciate both the mode and the contents of this work to get the word out among their colleagues. In the spirit of experimental *Symphänomenologisierung*, we hope to extend the reach of reflection even further in the new millennium.

Steven Crowell
Rice University
<crowell@rice.edu>

Lester Embree
Florida Atlantic University
<embree@fau.edu>

Samuel J. Julian
University of Memphis
<sjjulian@memphis.edu>

*The Reach of Reflection* is available electronically only, at www.electronpress.com. The price is $12.00 for all three volumes