

Body Consciousness in the Healthcare Environment: The Body for Oneself and Other

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Abstract

Like the human mind, the human body is the medium by which we represent ourselves, whether we are patients or healthcare providers. This paper concerns the significance of understanding the existential phenomenological side of a patient's body within healthcare. To care for a patient's body, one needs to be aware of how the body appears to itself, to others, and in a larger environmental reality. We think and feel and observe the world with our body, especially with the brain and nervous system, but also with other dimensions of the body manifesting itself as a somatic tonus. The healthcare providers' body does not only represent a profession, but also who they are as a person and what kind of environment by which they are affected. The same applies to patients' bodies. As a medium for experiencing, a medium inseparable from our very being, our physical body functions as a surface open to and in contact with the healthcare environment that surrounds it. In the modern healthcare regime, the human body is nearly always visible and under constant surveillance. In the environment of control and visibility, bodies become medicalized, psychologized, and normalized to fit into sociocultural demands of economic and structural adaptations, social participation and communication, which in certain situations seem hostile to the ideology of care, freedom, and humanity. We should realize that our ethical concepts and norms, even the very notion of humanity, depend on social forms of life involving the ways we experience our bodies in different medical and sociocultural situations.

Keywords: Body consciousnesses, alienation, perception, subjectivity, objectivity, medicalizing

The Living Body in a Healthcare Environment

In a healthcare environment the patient becomes a patient by being seen and accepted as a patient. A patient is defined by the relationship to the healthcare environment and by the relationship to the healthcare provider. Every look directed toward the patient is manifested in connection with the appearance of a sensible form in the perceptive field. The look that the healthcare provider manifests, no matter what kind of healthcare provider it is, is a pure reference to the patient's knowledge of self. What the patient apprehends immediately when hearing the provider's footstep is not that there is someone there; it is being vulnerable, in a body that can be hurt, that one occupies a place and that one cannot in any case escape from, the space in which

one is without defense, in short, that one *is seen*. This means that all of a sudden, the patient is conscious of self, sees self because somebody else sees him/her. In this situation, the patient's consciousness goes from an unreflective consciousness to a reflective consciousness for self. To be aware that one is an object for others relates to different feelings, such as shame and pride. Shame, is shame of self; it is the recognition of the fact that the patient is indeed that object which the healthcare provider is looking at and judging. The patient can be ashamed only by losing freedom in order to become a given object for others. Beyond every knowledge that the patient can have, the patient is this self, which the healthcare provider knows. The alienation of self, which is the fact of being-looked-at, involves at once the alienation of the world which the patient's occupies. The patient is seen laying in the hospital bed, with the result that the patient does not see self properly, nor the healthcare provider. The patient cannot escape or organize the situation differently.

Because the patient's body is 'being-in-the healthcare environment' and because the patient's body is the patient's being-there in the healthcare environment, any description of the patient's body has as its correlate a disruption of the healthcare environment it belongs to. So is the case for the healthcare provider's body.

To get a broader understanding of the body being-in-the-healthcare environment and the body's ability to manifest the stigma of past experience that also gives rise to desires, failings, and errors, we can follow the French philosopher and existentialist Jean-Paul Sartre ([1943]2003), who relates the body to a three-dimensional body as such – that is, the body *for others*, that is, in relation to a social context, the body in relation *to itself*, and, lastly, the body in relation to an *ontological* notion. In this example, the body as being-for-others is a body in a healthcare situation. In this case, the other's body should be seen as meaningful and not perceived as a thing among things, as if it were an isolated object, a healthcare provider, or a patient with purely external relations with other objects in the healthcare institution, such as furniture and medical equipment. In a medical context where one exchanges information and experiences, there is a radical difference between objects and human beings.

The Patient's Body Being-for-Others

Suppose that we see a patient's body in the hospital bed. If we were to think of that body only as a puppet, we should apply to the patient's body the categories which we ordinarily use to group temporal-spatial things, such as furniture, hospital beds etc. Perceiving the patient's body as a living body with a unique history with feelings and fears, on the other hand, is not to apprehend an additive relation between the bed and the patient; they cannot be counted or summed up or stored away as if they were of the same kind. Unlike the hospital bed, the patient has a mind that expands the temporal-spatial character of furniture. Although, in this example, the *other* is a patient by virtue of the fact that we are looking at a person in a hospital bed, and not vice versa, the patient is perceived as a medical object around which the healthcare environment is organized. The patient's body is also a center of its own field of perceptions and actions, and the space the patient inhabits is the space in which it stays. This interpretation indicates two dimensions of the patient's body: the patient body as being-for-itself (the patient's body as it is normally appearing for the individual) and the patient body as being-for-others (the patient body as it normally appears to the health care providers). A third ontological dimension is then

generated, so to speak, by the interaction between these first two dimensions: The patient's awareness of being an object for others means that the patient's body also exist for itself as body known by others (e.g., Sartre, [1943]2003, p. 375). Being-with-others follows, then, from being-for-others. Being for other is also related to what Sartre describes as "being-seen-by-others" (p. 281).

Plurality of Consciousnesses

The plurality of consciousnesses in the healthcare environment makes everyone aware of its own singularity, and the dependence of others in the healthcare situation. The different consciousnesses in the healthcare environment are directly supported by one another in a reciprocal interaction. This position allows us to define the way in which the patient and the healthcare provider appear to one another. The fact that a healthcare provider's duty is to care for a patient's body depends on the fact that the patient is another person than the healthcare provider. The patient is of interest to the healthcare provider only to the extent that the patient is *the other*, that is, an object for the healthcare provider's interest and profession, and conversely to the extent that the patient reflects the healthcare provider, that is, in so far as the healthcare provider is an object for the patient's interest. A patient and a healthcare provider create each other. The development of their self-consciousness depends on the value and art of the other's recognition. As a healthcare provider it is your duty to recognize a patient. To meet the patient and to make yourself recognized by the patient you must risk 'your life' in an existential way. To risk one's own life in this sense, is to reveal oneself as not bound to any objective form or to any determined rules. In this relationship the healthcare provider can also pursue the 'death' of the patient as an independent consciousness if one makes the patient a slave of one's own need for recognition, control, and approval.

To Lévinas (1985), the root of caring is to be found in the immediate face-to-face encounter with those to whom we find ourselves responsible, prior to any reflection on or consideration of our interests or duties. Giving priority to ethics over both epistemology, on the one hand, and ontology, on the other, Levinas developed a phenomenology of intersubjective responsibility and a theory of justice based our ethical consciousness when meeting 'the face of the Other' (Lévinas, 1985). If a healthcare provider meets the patient's face only with a medical gaze, the patient is reduced to a medical object without being recognized for his/her unique will and his/her unique feelings, hence the term "death of the patient". "To risk one's life" means in this case to take the risk of stepping out of medical terms and opening your eyes for the patient's unique experience and worries which cannot be reduced to medical concepts. To 'meet' the patient is to recognize the patient's emotions and experiences.

The challenges of the human body and its relation to consciousness is often obscured by the fact that while the body is from the start posited as a certain thing having its own laws and capable of being defined from outside, consciousness is then reached by the type of inner intuition which is peculiar to it. To Wittgenstein, human consciousness emerges on the interface between three components of stimuli and animal behavior: communication, play, and the use of tools (in Kotchoubey, 2018). Wittgenstein explains this further through the question: Why do people think?

Why do they calculate the thickness of walls of a boiler and do not let the chance determine it? Can a calculated boiler never explode? Of course, it can. We think about actions before we perform them. We make representations of them, but why? We expect and act according to the expectancy; ...Expectancy [is] a preparatory action. It outstretches its arms like a ball player, directs its hands to catch the ball. And the expectancy of a ball player is just that he prepares arms and hands and looks at the ball. (Wittgenstein, 1996, pp. 109, 139)

What Wittgenstein calls “expectancy” is comparable to what Kant and Merleau-Ponty call “intentionality.” The consciousness, like the body (hands and arms), is directed toward comprehending different kinds of environments. The body-consciousness relation is by nature difficult or even impossible to grasp empirically. If the body is sick or does not function normally, the body-consciousness relationship presents major problems for the patient, because the consciousness does not exactly know what to worry about. If the patient tries to grasp his/her consciousness in its absolute authenticity and by a series of reflective acts, and then seeks to unite it with a certain living object composed of a nervous system, a brain, respiratory, and circulatory organs, whose very matter is capable of being analyzed chemically into atoms of hydrogen, carbon, nitrogen, etc. then the patient is going to encounter overwhelming difficulties, because the consciousness is at the same time connected to the body and separate from it.

Because the patients cannot have direct contact with sick organs, viruses, cells, etc. they become objects living their own live in a patients’ body. The difficulty stems from the fact that as the patients try to unite consciousness to their body, they connect it with something foreign, something they cannot regulate, talk to, or heal by themselves. Because the patients’ body consciousness is related to something that they cannot fully understand or even control, the consciousness often relates to what the healthcare provider tells them, to tests, pictures, and what they read and see. Of course, the healthcare providers who have taken care of them, the surgeons who have operated on them, have been able to have direct experience with the patients’ physical body which they themselves do not know. The patients seldom disagree with what the healthcare provider tells them, or claims what they saw, or knows to be wrong. So far as the healthcare providers have had any experience with a patient’s body, it is the body as it is for them, and not for the patient. The patient body as it appears for the patient does not appear to the patient as it does for the healthcare provider. To the patients, the body represents experience, history, lived life and identity, that is, who they are. All throughout radiology procedures, patients can see the pictures of their vertebrae on a screen, and a pregnant woman can see her baby through ultrasound; it appears as something outside the body, that is, more like a property than the patients’ being.

Body Consciousness – To Touch and To Be Touched

When it comes to body consciousness, human beings, such as patients and healthcare providers, can see and touch their limbs, be it a leg or a hand. Nothing prevents us from imagining an arrangement of the sense organs. As human beings we can see our eyes direct their glance upon the world or upon another human being. However, in this case, as in other cases, we look at our eyes as if they belong to a foreigner, as *the other* in relation to our own eyes. We experience our eyes as a sense organ constituted in a particular way, but we cannot ‘see the seeing’. That is, we

cannot observe our eyes in the process of revealing an aspect of the healthcare situation. Either our eyes are things among other things, or else they are that by which things in the healthcare situation are revealed to us. They cannot be both at the same time. Similarly, we see our hands touching objects, but do not fully know them in their act for touching them. Our hands reveal to us the resistance of objects, be it a bed, a book, medical instruments, furniture and artifacts, or other bodies, their hardness or softness, but not themselves. We can see our hands only in the way that we can see any object/instrument outside ourselves, something similar as a prosthesis. We unfold a distance between them and us, and this distance comes to integrate itself in the distances which we establish among all the objects in a healthcare environment.

A healthcare provider touches a wounded leg. The patient half raised up on the bed watches anxiously as the healthcare provider does so. There is no essential difference between the healthcare provider's perception of the patient's leg and the patient's own perception of it, except that they may look, and look for, different things. What the healthcare provider sees can cause the patient a lot of anxiety. How bad is it? Does it look better or worse than yesterday. The same insecurity applies for touch. When the patient touches the leg with the finger, the patient realizes that the leg is touched and has some control of what and how the leg is touched. When the healthcare provider touches the leg, the patient has no control of what and how the leg is touched. This shows that we are dealing with two essentially different orders of reality. To touch and to be touched, to feel that one is touching and to feel that one is touched.

The Patient's Body-for-Itself Makes Different Perceptions and Perspectives

To understand what it means to be wholly conscious or *for-itself*, we must understand that the world exists in front of the body as an indefinite multiplicity of reciprocal relationships with its objects, which make it difficult or impossible to experience the world in the same way. For example, for the patient, the glass is to the left of the decanter and a little behind it. For the healthcare provider however, it is to the right and a little in front. No one's consciousness can fly over the world, in this case the room, in such a way that the glass should be simultaneously at the right and at the left of the decanter, in front of it and behind it. Similarly, if the respirator machine hides the table with the book that the patient is reading, this is not the result of some imperfection of the patient's visual organs, but because the book, such as it is placed, does not exist as a visual object for the patient, although the healthcare provider can see it while entering the room. This is how the world exists in front of consciousness. The patient's body-for-itself, that is, the patient's pure consciousness, decides what is real or not, so it is for the healthcare provider as well, the body-for-itself is consciousness, always in relation to the world.

Another example illustrating the patient's body-for-itself: When the patient is sitting in an armchair, still in the hospital room, reading to be distracted from the pain in the leg, the patient does not cease to be a sick person. The patient's injury is still there, and the leg is still broken although the patient experiences the pain in such a way that it disappears in the corporal totality which includes reading an exciting book. The patient could have been anywhere in the world, the only thing that occupies the patient's consciousness, in this case, is an exciting story in a book. During the reading the pain is neither absent nor unconscious, it simply forms a part of that distance-less existence for itself. If a little later the patient turns the page of the book, the pain in

the leg, without thereby becoming an object to knowledge, will pass to another distraction of consciousness. These statements agree with the empirical observation that this is because it is easier when reading to 'be distracted' from a pain in the leg or in the lower back than from, in this case, pain in the eyes. For pain in the eyes is precisely the *patient reading*, and the words which the patient reads refer the patient to the pain every instant, whereas the pain in the patient's leg or back is the apprehension of the world.

Suppose that the patient suddenly stops reading and starts focusing on the pain in the leg. This means that the patient directs a reflective consciousness on the pain in the leg. Thus, the patient's consciousness reflected-on, in the patient's pain, is apprehended as posited by the patient's reflective consciousness. It is a reflective consciousness without any assessment, it is a reflective consciousness which transcends itself and which tends to look at the pain at a distance to be able to contemplate it and to think it. The reflective consciousness is therefore to exceed the pure consciousness of pain to make the pain external and observable, that is, pain-as-object. In this case, the reflection tends to make of pain something *psychic*.

The psychic object captured through pain is, according to Sartre, *illness* ([1943]2003, p. 359). This object has all the characteristics of pain, but it is unlimited and passive, at the same time. It is a reality which has its own time, not the time of the external universe nor that of consciousness, but psychic time, that is, the time that the French philosopher Henri Bergson describes as *durée réelle* (Bergson, [1889]2012). Bergson outlined his theories about time in his doctoral thesis: *Time and Free Will: An Essay on the Immediate Data of Consciousness* (1889). Here Bergson distinguished between time as we experience it, lived time – which he called 'real duration' (*durée réelle*), and the mechanistic time of science, the time we use to measure time, that is, the time healthcare providers use in their daily praxis at the hospital. Time, as the patient experiences it through illness and pain, however, is based on a misperception: it consists of superimposing spatial concepts onto time, which then becomes a distorted version of the real thing. Time is perceived via a succession of separate, discrete, spatial constructs, just like seeing a film. We think we're seeing a continuous flow of movement, but in reality, what we're seeing is a succession of fixed frames or stills. For Bergson, to claim that one can measure real duration or real pain by counting separate spatial measurable constructs, is an illusion. According to Bergson ([1889]2012, p. 35) we give a mechanical and medically measurable explanation of a fact and then substitute the explanation for the fact itself. We should for example not compare a pain of increasing intensity to a measurable tone which grows louder and louder, but rather to a symphony, in which an increasing number of instruments make themselves heard.

Within the characteristic sensation, which gives the tone to all the others, consciousness distinguishes a larger or smaller number of sensations arising at different points of the periphery, muscular contractions, organic movements of every kind: the choir of these elementary psychic states voices the new demands of the organism, when confronted by a new situation. (Bergson, [1889]2012, p. 35)

“It is at once the whole melody and a ‘moment’ in the melody,” Sartre says ([1943]2003, p. 360).

Across each pain the patient apprehends the entire illness and yet it exceeds them all, for it is the synthetic totality of all the pains, the theme which is developed by them and through them. The

matter of the illness does not resemble that of a melody, In the first place it is something purely lived; there is no distance between the consciousness reflected-on and the pain nor between the reflective consciousness and the consciousness reflected-on. The result is that the illness seems unnatural but without distance. It is outside the patient's consciousness as a synthetic totality and already close to being elsewhere. On the other hand, it is in the patient's consciousness, it fastens onto consciousness with all its teeth, penetrates consciousness with all its notes; and these teeth, these notes are the patient's consciousness. The illness is the patient in the sense that the patient gives to it its matter. It is the patient's sick body-for-itself.

The Body as an Object among Other Objects

To the French historian and philosopher, Michel Foucault (1954), for a sick person, the body often ceases to be a point of reference against the opportunities in the world of other human beings. The body becomes unrecognizable to consciousness because its impulses stem from a fixed image of the world. In this state, the body can be experienced as hard as wood, or hard as brick. Occasionally, the full body awareness (that is, the awareness of a physical body in time and space) disappears to the extent that one ultimately has only an awareness of a disembodied life and an unrealistic idea of an immortal existence.

In cases where the patient's body becomes alienated and unrecognizable for self, the body appears to the patient as the body-for-other and as an object among other objects. In this situation, the body finds itself on a new plane of existence (a psychic body) (e.g., Sartre, [1943]2003, p. 361), and in situations similar to what the German philosopher and psychiatrist Karl Jaspers (1971), calls *boundary situations* (*Grenzsituationen*). Jasper's boundary situations constantly affect our psychic and physical lives. If we attempt to escape boundary situations by managing them with rationality and objective knowledge, we must necessarily flounder. Instead, boundary situations require a radical change in the being-for-oneself and being-for-other relationship. The proper way to react within boundary situations, according to Jaspers, is not by planning and calculating to overcome them but by the very different activity of becoming the person we potentially are. This happens when we enter the boundary situation with open eyes, that is, externally. To experience boundary situations is connected to growing and development. Through boundary situations we enter our own experience as a self or as an individual, not directly or immediately, not by becoming a subject to ourselves, but only insofar as we first become a reflective object to ourselves just as other individuals become a reflective object to us or in our experience.

To explain what actually happens when our body becomes sick and alienated, that is, a body for other, and a body alienated to itself and the environment where it is placed, Foucault (1954), in his earliest texts, turns away from the phenomenological inward analysis to a naturalistic neurologic and sociocultural approach. To Foucault there are anatomical reasons for how we experience ourselves in relation to other. The precise makeup of an individual's nervous system is partly a product of individual experience and sociocultural conditioning. Foucault points out that the objectified and alienated body tends to transform environmental and institutional conflicts and present historical conditions into inner personal life histories, which can lead to paradoxical defense reactions in the body's nerve cells, such as anxiety, blushing, and sweating. Sartre ([1943]2003), describes these bodily physical sign reactions as a constant consciousness

not of the body as being-for-itself but of the body as being-for-others. He suggests that the explanation here is that we attribute to the body-for-other as much reality as we do to the body-for-us, or more accurately, the body-for-other *is* the body-for-us, but it is inapprehensible and alienated.

When we become an object for others, and we experience sickness, social alienation, and isolation, we can find in the disintegrated self an illustration of the body-consciousness-experience parallelism in which conscious states run parallel to isolated bodily occurrences. In such a state, the isolated body may causally affect our perception so that what one perceives may serve as a subjective veil between ourselves and the real things around us in society or in the healthcare environment where we work or stay. However, the body consciousness of the integrated person is not allowed to disintegrate in this way. An integrated person's body does not act as a separate cause to introduce distortions into the patient's perceptions. A disintegrated self may be parallel to an isolated cycle of physical events, but true consciousness is parallel to environment and can hardly be explained logically or by scientific concepts (Sartre, [1943]2003, p. 224).

Because the human attention, the human body, and the human environment is integrated in the human self, we cannot understand the development and change of the self by seeing the consciousness, the body, and the environment as separate unities. The self will not be experienced as a self if one divides it into separate parts because we are our consciousness, our body and our environment; our consciousness and body (behavior) are the center of the environment in which the self exists and cooperates with other selves.

Taking the patient as an example of a disintegrated self who experiences the body as object among other objects, it appears to the patient that the others accomplish functions which are unreachable. Still the patient engages in resistance, that is, the patient fights a social battle to be part of the functions of everyday life, to be recognized and appreciated as a fellow human being among other fellows. In this case, we are talking about a confrontation between forces, that is, the domination and subordination of bodies and attention, and the confrontations, conflicts, and struggles that produce individual and historical changes and events. To Valsiner (2014, p. 153):

Human relations are filled with turning another person – an autonomously functioning human being – into an object (...). Young adolescents become objects for governments and warlords to recruit to fight for one or another more or less desirable social objective. Persons of all ages are made into consuming objects who actively as autonomous and intentional subjects – buy and consume consumer products. Wives consider their husbands their property and the husbands may believe the opposite. Slave-owners and soccer club owners treat their slaves and players as objects that can be re-sold and whose lives should be insured. Pet owners have their pets as objects of adoration. Grooming, and walking. And so on.

The Existential Phenomenological Body

The essential characteristic of the bodily self is that the body is, or has, a pre-objective relationship with its surroundings. This relationship has intentionality, in Kant's and Merleau-

Ponty's sense of the word, in that the body is directed toward comprehending different kinds of environments. To Merleau-Ponty ([1945]2002), our feelings and experiences rely on the body and its existential phenomenological and somatic experience. We think and feel with the body, especially with the brain and nervous system. Our bodies are likewise affected by mental life and cultural ideas of what is thinkable and behaviorally relevant, as when certain thoughts and behaviors bring a blush to the cheek and change our heart rate and breathing rhythms, possibly because we are ashamed of what we think and how we behave according to something and someone.

The healthcare environment gives us the languages, values, behaviors, and technology through which we think and act and express ourselves aesthetically, professionally, and personally. The same environment affects the types of diet, exercise, and somatic styling that shape not only the patients' bodily appearance but the way the patients experience their body, whether as a holy vessel or a burden of sick flesh, a pampered personal possession for private pleasure, or a tool to serve the medical or social good. Conversely, the healthcare environment, its institutions and medical achievements, cannot thrive or even survive without the animating power of embodied thought and action of different patients and healthcare providers. The healthcare environment quality of healing, trust and humanity depends on the level of the body-conscious harmony that the healthcare providers and the patients promote and display.

The term 'existential phenomenology,' refers to different theories belonging to a group of European philosophers, historians, and psychologists/psychiatrists, whose works bridge culture, history, existentialism, phenomenology and psychoanalysis. The term as it was developed generally spans the decades between the 1920s and 1960s. In this environment we find Sartre, Merleau-Ponty, Bergson, Jaspers, Binswanger, and a lot of other thinkers (Joranger, 2015). By linking subjectivity to a unique and reflexive actor, as well as to the sociocultural and historical environment and vice versa, the existential phenomenologists focused on topics related to experience and meaning making. Under the subject of meaning, the existential phenomenologists discussed the relationship between objectivity and subjectivity, body and mind, culture, event, environment, history, language and imagination, as well as the meaning of conflicting social relations and sociocultural contexts.

Seeing the human body through the lens of existential phenomenology, the human body does not signify only the flesh, it signifies a much larger existence in the temporal sense as well as in the spatial sense. In terms of time, the body has an existence that runs through it and even extends further to its 'ancestors.' In terms of space, the body has an existence that runs through its flesh and extends further to the environment that sustains that flesh, that is, everything that touches the body: be it the healthcare provider, climate, food, medical equipment, architecture, furniture, medical records, etc. (Foucault, 1984). This means that the extension of the human body is identical to the extension of material existence. Our body is the natural symbol as well as the existential basis of the environment it is in or represents. What separates the human body from being a pure material existence is self-consciousness, the awareness of being a patient in a hospital bed or a healthcare provider in a hospital, vulnerable, responsible, and meaningful for yourself and others.

Final Remarks

Normally, we do not see ourselves reading, laying, seeing, or walking or dressing, we are the lived act of seeing. All things seen are gathered and organized by the center of global reference, our body. Our eye is our possibility of reading the medical record, or of observing the healthcare provider. Our teeth are our possibility of chewing our food. Our body is our possibility of forever going out toward something out there, in our acts. 'You are your body' means, then, 'you are you' in perceiving, experiencing, and acting out. You perceive, therefore you are; or rather, for you to perceive is to exist as yourself as something meaningful, that is, a healthcare provider, a parent, a grandma, a friend, etc. You are your perception. 'You are' is 'you act.' This is your active ontological inter-involvement with the environment, and what is really meant by 'intentionality' is your consciousness that, in turn, is your body. Somatic consciousness, that is, body experience and body attention, is always shaped by institutions and environments, and thus admits of different forms in different environments, or in different subject positions within the same institution and healthcare environment.

As human actors, the patient and the healthcare provider move beyond the natural world and rediscover the social and institutional world, not as an object or sum of objects but as a permanent field or dimension of feelings, existence and experience (Joranger, 2019). Our relationship to the environment that we find ourselves in every day, like our relationship to the world, is deeper than any expressed perception or judgment. It is as false to place ourselves in a sociocultural environment as an object among other objects, as it is to place the sociocultural environment within ourselves as an object of thought. In both cases, the mistake lies in treating culture as an object that can be exactly scientifically measured. Our identity and our behavior are presented in such a fundamental and profound way that we only explicitly become aware of them when our usual interaction with the surroundings is disturbed by something that is forced upon us. This can happen when your psychiatrist treats you with drugs against your will, or when you are under scientific investigation, that is, when your doctor looks and measures your body against standardized medical measures, as if your body was a physical object, or the psychologist measures your cognitive skills through standardized measurements.

These are the alienated feelings many patients and healthcare providers experience every day. They feel trapped inside a restricted and controlling healthcare system where they are measured and objectified. When this happens, their body is designated as alienated (Sartre, [1943]2003). The experience of social and cultural alienation is then achieved in and through affective bodily structures, such as high blood pressure, shyness, blushing, and sweating. These are all signs that together with other signs, such as words and clothing, etc. make the body part of a larger semiotic meaning system, which all human beings are involved in and constructed by. "Signs do not occur in isolation" (Valsiner, 2014, p. 100). They are made to present their object in sign complexes that may include a combination of signs and bodily expressions. As human beings, situated in a healthcare environment, we experience ourselves, more or less indirectly from the particular standpoints of other individuals in the environment to which we belong.

Intersubjective social relations and prejudice involve a historical, physical, and bodily connection that is crucial for understanding the power structures that involve the relationship between patients, healthcare providers, and their environment. Through our bodily self we experience the world around us. Consciously or unconsciously, it drags our actions and consciousness toward what we understand as essential and important. The existential body is affected by environmental

power structures, historical and sociocultural ideas of what is thinkable, observable, and behaviorally possible in a certain environment. In the modern healthcare environment, the human body is nearly always visible and under constant surveillance (Foucault, 2003). In the healthcare environment of control and visibility bodies become medicalized, psychologized, and normalized to fit into demands of economic adaptation, clinical participation, and communication, which in certain situations seems hostile to the ideology of care, freedom, and humanity. The body consciousness experience exemplifies our multiform ambivalent human condition between power and frailty, worthiness and shame, dignity and brutishness, knowledge, and ignorance. We should realize that all our ethical concepts and norms, even the very notion of humanity that underwrites them, depend on social forms of life involving the ways we experience our bodies in different activities and sociocultural situations, in the healthcare environment.

Statements and declarations: There are no financial or other conflicting interests directly or indirectly related to this manuscript.

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