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Scientific Contribution

Gadamerian dialogue in the patient-professional interaction

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

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

Introduction

In the bioethical literature, several models of the patient-professional relationship have been presented.[1] These models can be roughly divided into three familiar categories. The first category emphasizes the authoritative expertise of the professionals, placing the patients completely into their skillful and benevolent hands. This traditional conception of the patient-professional relation is usually referred to as *paternalism*. This has now been widely rejected, at least in theory though it may still prevail in practice. The second model emphasizes the fact that the vital interests of the patients are at stake in this relationship. The patients should have the right to determine what is done to their bodies and physicians should respect their decisions. This category is usually characterized in terms of *patient autonomy*.

These two models suffer from the same serious flaw. I will put it succinctly: The patient-professional relationship is not regarded as inter-personal and dialogical. Neither model is conducive to conversations between patients and professionals with the aim of enhancing understanding. Instead, both contribute to the estrangement of professionals from their patients. The popular alternative of constructing the relationship of a patient and a professional in terms of a contract fares no better. Not only does it feed upon an element of mutual distrust but it also presupposes a more equal relation between the partners than is possible in most health care situations. That relation is unequal because the patient is inevitably the weaker partner in at least two senses. He is weaker in the sense that he doesn't have the necessary knowledge to evaluate his own condition and, of course, because he is in need. This weak standing of the patient makes him unusually dependent upon health care professionals, because he is often full with "personal anxieties and fears that illness and its treatment engenders".[2] Because of this, communication in health care has two main objectives, to inform the patient and to provide him with emotional support.

In light of this it is important to look for ways to enhance the *dialogical relation* between patients and professionals. The third category refers to such attempts. Here the focus is on the relationship between the two partners engaging in a shared deliberation resulting in a joint decision which is based upon mutual trust. Only by meeting in such a dialogue will they respect each other as persons which I take to be the fundamental moral requirement of health care.[3] This is a nice vision or a guiding idea. However, it is not sufficient to criticize the practice of paternalism and patient autonomy and require responsible co-operation between patients and professionals. The process of co-deliberation and joint decision-making needs more attention than it has been given in the literature on this subject. We must be clear about what it implies, whether it is realistic and what advantages it may have over other modes of patient-professional relation. Since the vehicle of this mode of relation is the dia-

logue, one important way to do this is to inquire into the nature of conversation. In this paper I have chosen to consult with the German philosopher Hans-Georg Gadamer, because I believe that his philosophical hermeneutics contains helpful insights for this task. This belief is based on the presumption that in the professional-patient relation it is of major importance that the partners reach *mutual understanding*, which is a prominent notion in Gadamer's philosophy. This requirement has no place either in the paternalistic or the patient autonomy modes of interaction. But it has to be basic where the aim of the interaction is to reach a common decision which respects both partners.

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

The objectification of the other

In explicating what he calls "the hermeneutic experience" (in his major work, *Truth and Method*), Gadamer distinguishes between three modes of "experience of the 'Thou' ". The first is characterized by a claim for what he calls 'objective knowledge' of the other, objective in the sense that it neglects her subjectivity: "We understand the other person in the same way that we can understand any other typical event in our experiential field, i.e. he is predictable" (TM,[4] 322). Gadamer puts forth two types of criticism of this claim to objective knowledge of the other. The first is a general hermeneutic critique which rejects this approach because it is based upon "the naive faith in method and the objectivity that can be gained by it" (322). This faith is naive in the sense that it does not realize that scientific methods are no neutral devices which can be used to discover objective truths about any subject matter. A method, no matter how sophisticated, brings the subject to light from a particular, limited perspective. These limitations are certainly not peculiar to scientific method. It is a general characteristic of human understanding that it is radically bound to the presuppositions that we bring with us into the particular situation of the matter we are trying to understand. These presuppositions can roughly be divided into three kinds. *Cultural* presuppositions, shared by those who are nurtured by the same cultural heritage; *personal* presuppositions, shaped by our individual history and life experience; and *theoretical* presuppositions, fostered by the scientific community to which one belongs and shared by the colleagues of a discipline. These various presuppositions constitute an horizon within which our understanding moves and without which we would not be able to understand anything. In this way, our limited perspectives are the conditions for our understanding. "They are simply conditions whereby we experience something – whereby what we encounter says something to us."[5]

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

It is not surprising, therefore, that Gadamer's second critique of this methodological approach to the 'Thou' is from a moral point of view. Its objectification of the subject leads easily to a manipulation of the human being. There is no regard for the subjectivity of the other; it has been methodologically excluded in order to ensure objective results. As a consequence, "His behaviour is as much a means to our end as any other means" (TM, 322). In fact, this claim to objective knowledge of the other is a mode of *observation* rather than of interaction and *communication*. Though it may be medically effective, it cannot be conducive to a good professional-patient relationship. To the contrary, this approach is probably a major explanation of the fact that many patients are frustrated by their interaction with health care professionals, especially medical doctors. I wonder whether the remarkably common claim "the doctor did not listen to me" is not a consequence of a methodologically oriented doctor-patient relationship. The doctor is so preoccupied with making "predictions concerning [the other] person on the basis of experience" (TM, 321), that the other is never taken seriously. Enclosed within this horizon of theoretical prejudgements, the professional cannot relate to the person who is seeking his help or advice. In Gadamer's words, he is not an understanding person: "The person with understanding does not know

and judge as one who stands apart and unaffected; but rather, as one united with a specific bond with the other, he thinks with the other and undergoes the situation with him" (TM, 288).

Premature understanding of the other

Let us now turn to the second mode of the "experience of the 'Thou' ", which Gadamer discusses in *Truth and Method*. His initial description of this relationship goes like this: "the 'Thou' is acknowledged as a person, but that despite the involvement of the person in the experience of the 'Thou', the understanding of the latter is still a form of self-relatedness" (TM, 322). There are two crucial things in this passage. The first concerns the difference between these first two modes of experience of the 'Thou' and the second has to do with what they have in common. The advance of the second view compared to the first is that now the other is acknowledged as a person. This seems to imply that I recognize the otherness of the 'Thou' and the importance of understanding him as a subject with needs and preferences which may have to be taken into account or respected. The subjectivity of the other is thus to this extent brought to the fore. However, this recognition of the 'Thou' is radically limited by the "self-relatedness" of the person claiming to understand the other.

It is the self-relatedness which this mode of understanding shares with the methodological approach, although it makes itself manifest in a quite different way. While the methodological approach made no claim to understand the other, this second approach "claims to express the other's claims and even to understand the other better than the other understands himself" (TM, 322). The other is, as it were, already understood in advance. Instead of exercising theoretical distance for the sake of objectivity, I now attempt to swallow the other completely in my own apparently emphatic understanding. His horizon is thus fully subsumed into my own. But this overbearing presence and involvement in the alleged interests of the other is not a fruitful ground for mutual understanding. As Gadamer writes: "The claim to understand the other person in advance performs the function of keeping the claim of the other person at a distance" (TM, 323). In effect, it turns out to be a means of domination and not of a deliberation for a shared decision.

It is worth noting that the examples Gadamer provides for this mode of interaction are drawn from a professional-client relationship: "By understanding the other, by claiming to know him, one takes from him all justification of his own claims. The dialectic of charitable or welfare work in particular operates in this way . . . " (TM, 323). This is a well known form of benevolent paternalism. And it can even be more dangerous than the indifferent, distant paternalism of the methodological approach, precisely because of its initial apparent recognition of the other as a person. The manipulation of the scientific observer can be easier to avoid because he has absolutely no interest in the subjectivity of the other. He appeals only to the objectivity of his procedures. The professional who seductively and prematurely claims to understand seeks to establish a different authority which may make the other more dependent upon the relationship. It implies an interpretation of needs and interests which are to be "for the best" according to the understanding professional. This interpretation will not be worked out in a dialogue between the two partners because the professional already understands the other person. In effect, it is just as monological as the methodological approach because it does not allow the other person to enter into the relation except on its own terms. A health professional practicing in the spirit of this mode of interaction would not, therefore, hear her patients any better than the distant believer in method, although she might diplomatically employ dialogical techniques.

From the hermeneutical point of view, the methodological and the prematurely understanding professional suffer from the same major limitations. They both imagine that they are free of prejudices. As a consequence, they are unconsciously dominated by their prejudices which hinder them in being able to open up to the other person. They do not reflect on the fact that they belong to a tradition which shapes and nourishes their perceptions and understanding of the other in such a way that his subjectivity is concealed. The 'solution', Gadamer suggests, is to become conscious of the role these factors play in our judgements and perceptions. He calls this awareness "effective-historical consciousness". In the third mode we will see how this is brought to bear on human interaction.

Openness to the other

Gadamer writes about the third mode of the experience of the 'Thou':

> In human relations the important thing is . . . to experience the 'Thou', truly as a 'Thou', i.e. not to overlook his claim and to listen to what he has to say to us. To this end openness is necessary . . . . Without this kind of openness to one another there is no genuine human relationship. Belonging together always also means being able to listen to one another. (TM, 324)

As is clear from this passage, Gadamer regards "openness" as the key to good human relationship. What

does this openness imply? I can discern four aspects of this openness which Gadamer mentions either directly or indirectly: openness to oneself, openness to the other, openness to the subject matter, and openness to tradition. I shall comment briefly on each of these four aspects.

The first of these, *openness to oneself*, means primarily that the individual recognizes his radical finitude and the fact that he is dominated by prejudices. By means of this recognition he is able to slacken the bonds of his prejudgements and acquire new experience. Therefore, Gadamer refers to this frequently as "openness to experience". The experienced man, in this sense, is not someone who "already knows everything and knows better than anyone else. Rather, the experienced person proves to be . . . someone who is radically undogmatic; who because of the many experiences he has had and the knowledge he has drawn from them is particularly well equipped to have new experiences and to learn from them" (TM, 319). This openness to oneself and to experience is a prerequisite for all other aspects of openness, because it alone can make room for the claim of the other, the subject matter and the tradition. If this fundamental openness is not there, the individual will only perceive what confirms his own expectations and preconceptions. Because he lacks self-knowledge, or ignorance in the Socratic sense, he is blind to experience.

As Hegel saw, experience is essentially a negative process. It is the dialectic of building up and breaking down of expectations. We acquire experience when something does not fit our previous expectations and as a consequence we have a broadened horizon and a new perspective. Rather than confirming our prior knowledge, experience reminds us of our limitations. "The dialectic of experience has its own fulfillment not in definite knowledge, but in that openness to experience that is encouraged by experience itself" (TM, 319). Self-assertive knowledge, on the other hand, precludes the possibility of reexamining one's positions. Such arrogance can also be a mechanism of defence and self-protection. It takes courage to risk one's preconceptions because they form the familiar world where we find our everyday refuge and security. The willingness to risk our prejudices in this manner is thus a requisite for authentic understanding. Only in a dialogical encounter with the subject matter or with the other can we confront our prejudices and thus escape their dogmatic claim.

The importance of professional openness to oneself, in this sense, has been neglected in the literature about the professional-patient relation. An important example of a writer who has dealt with this issue is the American psychiatrist Jay Katz. Katz argues that physicians' attitudes and value orientations, both crucial elements in Gadamer's horizon of preconceptions, deserve separate consideration "since they crucially affect the decision-making process":

> Doctors must become more sensitive to the impact on their conduct of personal, professional and institutional value orientations, be they their attitudes towards death, their constant quest to defeat the grim reaper, the importance they ascribe to age, their attitudes towards acute and chronic, reversible and irreversible illness, their views about the patient as a worthy or unworthy partner in the decision-making process, the deference they give to colleagues, house staff and the institution itself and much more. Unless physicians consider and sort out these matters prior to their first encounter with a patient, the decision-making process is fatally flawed *ab initio*.[6]

Certainly, this radical demand that Katz places upon physicians is unrealistic. From Gadamer's point of view, it would be impossible for physicians to "consider and sort out these matters prior to their first encounter with a patient". We cannot become completely transparent to ourselves or get rid of our prejudices with a sweep of reflection. However, Katz is in agreement with Gadamer that the limited rationality and competence of *both* patients and professionals requires that they engage in conversations. It is not sufficient to talk to or interview the patient. Here Katz makes a crucial point:

> The . . . assumption that doctor's contributions to any conversations, in contrast to patient's contributions, are influenced largely by rational . . . considerations, has made both self-reflection by physicians and searching conversations between them and their patients from which both can learn seemingly irrelevant.[7]

It follows from both Katz's and Gadamer's analysis, that only those who are open to themselves will genuinely listen to *other* people. "Openness to the other", Gadamer writes, "includes the acknowledgement that I must accept some things that are against myself, even though there is no one else who asks this of me" (TM, 324). This is implied in the negativity of experience. I can only hear the other if I can recognize him in his difference, in his otherness. It would be false, however, to think that I can fully understand the other regardless of my own 'web of beliefs'. Then we are likely to fall into the trap of premature understanding. The best we can accomplish in this matter is what Gadamer calls a "fusion of horizons". I can neither transcend my own horizon nor project myself fully into the other's horizon; the new experience I gain in an open dialogue with another can at

best incite a re-examination of my own beliefs and thus broaden my horizon. Such is the movement of human understanding. Because it is an ongoing process which involves self-formation no less than the understanding of the other, one never *fully* understands. In fact to talk about understanding the other can be misleading. To understand another person as a 'Thou' means to recognize the other's irreducible individuality. This is a *moral* requirement rather than a *cognitive* accomplishment, yet, as Gadamer says: "to distinguish between a normative function and a cognitive one is to separate what clearly belongs together" (TM, 277).

In light of this, it may be more appropriate to talk about understanding *with* the other than of the other. What is being understood with the other is the *matter* at hand, for example an important decision concerning medical treatment. This is how I interpret Gadamer's description of the understanding person who "thinks with the other and undergoes the situation with him" (TM, 288). The 'I-Thou' relationship takes place within a situation as a field of concern(s) to be shared or dealt with in some way. This relationship is always mediated by an object of concern which enables the fusion of horizons to take place. What counts, therefore, is not that I attempt to project myself, as it were, into the other's mind but that we focus together on the *subject matter*. This is the task of conversations: "To conduct a conversation means to allow oneself to be conducted by the object to which the partners in the conversation are directed" (TM, 330). "To be conducted by the object" is the key to what I called *openness to the subject matter*. This phenomenon is of major significance because it combines and gives concrete direction both to the openness to self and to the other. If they are truly conducted by the subject matter, the partners will surrender to the dialectical movement of questions and answers intended to bring it to light. "A person who reflects himself out of the mutuality of such a relation", Gadamer writes, "changes this relationship and destroys its moral bond" (TM, 324).

To let oneself be conducted by the subject matter is to preclude that the relationship is being strategically mastered by the professional or dominated by theoretical prejudices. This implies that the subject matter can be delineated – that there is a nature of the case – apart from the preconceptions of the partners in the dialogue and which facilitates the fusion of their horizons. Thus the partners meet, so to speak, in the subject matter and the criterion of a successful dialogue is that they achieve a common judgement or a consensus concerning it: "Dialectic as the art of conducting a conversation is . . . the art of seeing things in the unity of an aspect . . . i.e. it is the art of the formation of concepts as the working out of a common meaning" (TM, 331). This leads us to what Gadamer calls *openness to tradition.* Because the subject matter has been shaped by tradition, this is an important demand. Since tradition is the objective substance of cultural meanings, "as the basis of all subjective meaning and attitude" (TM, 269), every human activity and interpretation implies a communication with it in some sense. But Gadamer tends to slide too easily from claiming that we are in fact radically dependent upon tradition to the normative stance of imputing *authority* to tradition. Given the limitation of our individual perspectives, we can only come to a sound judgement by listening to the voice of tradition which preserves the wisdom of the generations. In our openness to tradition, we are thus not only to decipher our roots in it, we must accept the *validity* of its claims. If we are going to raise a principled claim against this tradition we are likely to distort and manipulate the situation, advocate a sort of "tyranny of principles" which entangles us in our own prejudices.

Obedience to authority

In the description of the third experience of the 'Thou', one detects a tension which makes it unclear what implications it has when applied to the patient-professional relationship. Clearly, there is an inconsistency between Gadamer's description of the openness to the other and the openness to experience on the one hand, and the openness to tradition on the other hand. The historical heritage of the medical profession, the Hippocratic tradition, has certainly not been very conducive to the mutual dialogue that Gadamer endorses. This traditional attitude regards the helping relationship as necessarily one-sided.[8] The main argument behind this paternalistic attitude is quite simple. Health professionals have expertise knowledge of the patient's condition which the latter has not. It is the professional obligation to make use of this knowledge in a way which secures the best interests of the patient. The best interests of the patient are to be evaluated in terms of his medical condition which can only be properly done in light of professional expertise. Patients should not be worried with information about their condition because, in addition to lacking knowledge to understand it, they are sick people who need comfort. Therefore, the professional will not involve the patient in a complicated decision-making process, but makes the decisions himself based on his professional knowledge and experience.

This may sound convincing but it is not unproblematic. It is true that the professional has the knowledge of a patient's medical condition, but that premise is not

sufficient to draw all the conclusions just described. First, it is not correct to say that professional knowledge of the patient's medical condition is identical to knowledge of the patient's best interests. These interests cannot be fully identified without knowledge of the patient's own understanding of them. He is an individual with a unique history and particular projects, and is not treated as a person unless his own point of view is taken into account. Usually there are treatment options and no single decision should be deemed justified without consulting the patient. As R.S. Downie argues, "When a patient refuses to accept treatment . . . his concern is with the total good [rather than the medical good], which he is likely to know better than the doctor."[9] Or as Katz puts it: "The doctor knows more about the illness. The patient knows more about his needs."[10] Hence the importance of conversation for both partners.

Katz admits that there is a paternalistic element in his prescription, namely the obligation to *converse*. But this obligation enhances self-determination because one of its aims is that the professional will understand the reasons for the patient's refusal or consent: "The obligations that I advocate", Katz writes, "are imposed on *both* parties; they do not ask for one party to submit to the other; they are grounded in mutuality."[11] The openness to the other in Gadamer's authentic dialogue is also based on mutuality. There is a reason to suspect, however, that this mutuality is endangered by his emphasis on the validity of tradition which is antagonistic to the idea of individual autonomy. This becomes problematic when the dialogue is brought to bear on the patient-professional relationship.

The strongest reason for practicing the patient-professional dialogue is to respect and accept the patient as a person. This cannot be done without respecting the patient's self-determination. That Gadamer does not place much emphasis on this notion is well demonstrated in his analysis of the phenomenon of play which for him is a paradigm of the hermeneutical situation. The proper subject of play is not the playing individual, but the game itself. In this lies the fascination of play, according to Gadamer, that it tends to master the player in such a way that it calls for a total engagement and spontaneous self-representation. We lose ourselves in the game and are dominated by its structure. In order to lose ourselves in the game, we must give in to the "to-and-fro movement" of the play itself. The more authentically we participate, the more we are possessed by the game. In thus conforming to the rules of the game and subjecting himself to it, the player "relinquishes the autonomy of his own will".[12] This analysis lends it very well to the dialogue. If we authentically participate in the dialogue, we relinquish our autonomy in order to elucidate the subject matter. This is a marvellous description of a dialogue between a patient and a professional when there is no major disagreement. But if such disagreement arises, it seems that the pressure would be on the patient to relinquish his autonomy.

This point must not be overstated. I am convinced that a Gadamerian dialogue properly conducted would in most cases be conducive to not only mutual understanding but to patient autonomy as well. It is a major obstacle for patient autonomy in the general practice that he or she is not listened to. I am not advocating what Downie calls "consumer conception of autonomy" (although I think it may apply in certain situations, such as in maternal care and terminal care) where the professional role is to respond to the patient's wishes. In that regard, Gadamer is correct to emphasize professional authority because it is irresponsible to respect the patient's will when it is irreconcilable with the aims of the profession and role-specific obligations of the professionals which are shaped by the nature of the subject matter. What I find missing in Gadamer's theory is the importance of respecting the other's *negative* self-determination which in the patient-professional relation makes itself manifest in the patient's right to refuse treatment. Take the example of a Jehova's witness refusing blood-transfusion while undergoing a risky operation. This is an interesting example because the witness presumably is observing her tradition which conflicts with the medical tradition (unless it has now become a tradition to respect such wishes!). Moreover, the witness's decision should gain support from the liberal tradition of religious tolerance and respect for the individual pursuit of happiness, strange as that may sound in this particular case.

So, there is a variety of traditions in the situation which make it unclear what significance the appeal to tradition has. However, in light of Gadamer's account of the authority of the expert, it seems that the medical tradition should prevail. In addition to the openness to tradition and the quest for common meaning already mentioned, these arguments concern the status of authority in Gadamer's theory. While he accepts the enlightenment distinction between faith in authority and the use of one's own reason, he wants to show that tradition is often a source of 'true' authority that can be rationally accepted. Tradition is not a true authority when it is accepted blindly and without rational arguments, as romanticism would have it, but only when it is critically taken over:

> it rests on recognition and hence on an act of reason itself, which aware of its own limitations, accepts that others have better understanding . . . the recog-

> nition of authority is always connected with the idea that what authority states is not irrational and arbitrary, but can be seen, in principle, to be true. (TM, 249)

While I believe that this viewpoint provides an important corrective to naive ideas of the sovereign rational power of critical thinking, I also think that Gadamer's position is in need of some revisions. As it stands, it basically says: Given the limitations of our individual perspectives, our prejudices and ignorance, we have good reasons "to concede the possibility of superior knowledge and insight to someone else".[13] Although this may be a realistic and even responsible attitude for a patient to take in most cases, it fails in the hard cases where there is a disagreement between a patient and a professional. In his essay "Behandlung und Gespräch", Gadamer talks about the doctor carefully guiding the patient in the treatment process and does not even raise the possibility of a disagreement between the two. But supposing that it were to take place, the doctor backed by professional authority and long standing tradition could hardly be blamed for overriding the patient.[14] On this interpretation, it is the patient who "must acknowledge some things that are against" his preconceptions, i.e. if he is wise enough to admit his own ignorance and believe in the authority of the doctor.

My conclusion is that there are arguments for paternalism built into Gadamer's dialogical theory. Perhaps it is precisely his reluctance, explained by his Aristotelian and Hegelian heritage, to let principles trump accepted practice which is at the root of this lack of respect for the other's self-determination. If this is a correct interpretation of Gadamer's theory, it is too inconsistent to serve as a guiding idea for fleshing out the model of co-deliberation. The undifferentiated implications of the openness to tradition and the uncritical acceptance of authority implied therein, betray the fruitful insights of his analysis of the authentic dialogue. I am afraid that the dialectic of reciprocity that Gadamer discerns at work in the 'I-Thou' relationship encourages uncritical submission of one partner to the other, the ignorant patient to the wise professional. In any event, we have to face the danger of dialogical domination in the patient-professional interaction, even though the conversation is carried out with the intent of respectful understanding.

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Notes

1. See, for example, Szasz and Hollander (1956), Veatch (1972) and Smith (1981).
2. Katz (1984), p. 226.
3. Cf. Árnason (1994).
4. Abbreviation for Gadamer (1975), *Truth and Method.* Page numbers referring to this book are included in the text in parenthesis.
5. Gadamer (1977), p. 9.
6. Katz (1985), pp. 49–50.
7. *Ibid*, p. 57.
8. This is also the view of Martin Buber, who coined the vocubulary of the 'I-Thou' relationship. Buber (1965), p. 31.
9. Downie (1998), s. 18.
10. Katz (1984), p. 102.
11. Katz (1985), p. 60.
12. Gadamer (1977), p. 53.
13. Warnke (1987), p. 135.
14. Gadamer (1993), pp. 159–175.

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