

BEYOND BIOMEDICINE: DEVELOPING NEW MODELS OF MEDICAL  
PRACTICE FROM THE PRAGMATIST AND EXISTENTIALIST TRADITIONS

A Thesis

by

CODY WAYNE MOORE

Submitted to the Office of Graduate Studies of  
Texas A&M University  
in partial fulfillment of the requirements for the degree of

MASTER OF ARTS

May 2012

Major Subject: Philosophy

Beyond Biomedicine: Developing New Models of Medical Practice from the Pragmatist  
and Existentialist Traditions

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## ABSTRACT

Beyond Biomedicine: Developing New Models of Medical Practice from the Pragmatist  
and Existentialist Traditions. (May 2012)

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Chair of Advisory Committee: Dr. John J. McDermott

This thesis seeks to address two distinct sets of criticisms that have been offered at medical practice. The first criticism suggests that medicine today is too exclusive in its application of the term ‘disease.’ As a consequence, important biological phenomena are marginalized by physicians and scientists. The second criticism suggests that medicine has been too inclusive in its understanding of disease. As a result, many biological phenomena that were once considered ‘natural’ or ‘normal’ aspects of human life are now given a medical dimension that they previously did not have.

The goal of this thesis is to understand why two seemingly contradictory criticisms have been applied to the same practice. To answer this question, I invoke Edmund Husserl’s important analysis of modern science to argue that medicine suffers from a problem of ‘naïve objectivism.’ This problem is present under the dominant paradigm of medical diagnosis, the biomedical model.

Having identified the source of these two criticisms, my goal is to then develop new models of medical practice that can address these criticisms. First, I turn to John Dewey’s philosophical naturalism to develop a medical model that can address the

problem of exclusion in biomedicine. Then, I turn to Martin Heidegger's existential analytic to develop a medical model that can address the problem of inclusion in biomedicine. I supplement both of these analyses with research generated in the medical humanities fields, attempting to show how the biomedical model of medicine fails to meet the goals of medical care.

The end result of such analysis is the development of two new medical models that can serve to replace the biomedical model. I offer no attempt to adjudicate between these two models, instead leaving such issues to be handled by the patient and the physician throughout the course of his or her treatment.

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## CHAPTER I

### INTRODUCTION

Medicine today stands at the forefront of our national consciousness. At the political level debate rages over questions of if and to what extent the government should have a hand in medical care. At the economic level, the quality of the medical benefits offered by our prospective employer is an important criterion in deciding if we should take a new job. At the level of popular culture individual or groups of physicians have daily television shows on which they discuss issues of health. We live in a society that is obsessed with health, and as such, is obsessed with the institution that stands guard over our health. This thesis deals with the profession that places the promotion of human health as its highest priority; this thesis is about medicine.

Of course, medicine is too broad of a topic to be handled by any single project. Thus, it will be helpful to delimit what this thesis is *not* about. This thesis does not attempt to engage the long-standing ‘medicine as science’ versus ‘medicine as art’ debate.<sup>1</sup> This debate has garnered much attention in the medical humanities field and it undoubtedly has its merits. Perhaps the most positive outcome of these debates is that the fundamental assumptions about the essence of medicine are always under careful examination. Be that as it may, I will set this question aside for the length of this project.

Additionally, this thesis is not centered on medical ethics. There are an innumerable number of important medical ethics cases that have turned up in the

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This thesis follows the style of the *Chicago Manual of Style*.

medical humanities literature. All across the United States, degree programs in bioethics are emerging, often times as dual-degree programs with medical schools. Thus, this topic is an extremely important and fruitful one for considering the normative grounds for medical care.<sup>2</sup> However, I am not placing ethical concerns as the foundation for my analysis. This is not to suggest that ethical considerations will not emerge throughout my project. But before these issues can even be considered, I must first do a significant amount of preparatory work.

Ultimately, this thesis is about what it means to be human and how the practice of medicine relates to us in our humanity. The most basic of relationships that guides medical care is that of the metaphor. Medicine is guided and shaped by a certain metaphor that sets the limits of what it can and cannot say or do. The goal of this project is to show that the current metaphor guiding medical practice can no longer remain in place if the goals of medicine are to be realized. Having shown this, I want to offer two metaphors that could serve to replace the current metaphor in medicine.

But before we analyze the specific metaphor guiding medicine I want to ask: what are metaphors? They are powerful combinations of words and images through which we are able to share meanings and values with others. Metaphors are somehow able to reach beyond the semantic meanings of the individual words of which they are comprised; they say more than can be said. They color our perception of the world in ways we can never begin to fathom. Whether we like it not all of our individual thoughts are organized and granted meaning by the metaphors under which we operate. As such, it is oftentimes difficult for a metaphor to vanish. Even after one has long run its course

we often find that so many of our deepest values have attached themselves and refuse to release their hold.<sup>3</sup> Metaphors are not easily changed.

I have suggested that there is one metaphor that is so deeply ingrained within the ethos of medicine that we struggle to view ourselves in any other way. We are conditioned to see our body as a machine. This metaphor shapes our understanding of ourselves. It influences our approach to the sciences. It governs how we relate to one another. And, most importantly for our purposes here, it undergirds the practice of medicine. Medicine views the body as a machine. Health, then, is the state in which the body is operating as it should. Disease is a state of disrepair, in which the machine seems to be fraying or malfunctioning. Under this metaphor the task of medicine is that of occasionally offering repairs to the machine in order to keep it operating.

It seems so strange that an inorganic image should serve as the guiding metaphor for a practice so deeply rooted within the biological sciences. Yet there are historical reasons for the predominance of such a metaphor. Consider this strange moment in Rene Descartes' *Meditations* that I believe to be one of the first instances of this notion:

But then if I look out of the window and see men crossing the square, as I just happen to have done, I normally say that I see the men themselves [...] Yet do I see any more than hats and coats which could conceal automatons?<sup>4,5</sup>

In the midst of his famous skeptical analysis, Descartes glances out his window. He sees men walking down the street, but he wonders if they are even really men and not machines. It is such a peculiar line, almost a throwaway comment in the midst of some of his more famous claims. Even though Descartes moves beyond his skepticism through his famous *cogito*, the upshot of his stray comment remains: the body could just as easily

be substituted for a machine. This is the metaphor that shapes our understanding of what it is to be a human.

If anything this notion of the body as a machine has only increased since the time of Descartes. The industrialization of the west in the nineteenth century greatly reinforced this image into our cultural consciousness. How else should we describe the famous time-motion studies of Frederick Winslow Taylor than as an all out attempt to reduce the human laborer to a mere machine? In this regard, Marx was wholly justified in his asserting that capitalism had reduced the laborer “a mere appendage of flesh on a machine of iron.”<sup>6</sup> We live in a society that has taken the Cartesian notion of the body as a machine and turned it into an extremely profitable venture. Yet, I cannot help but ask: is it conceivable to imagine new metaphors to describe human beings? An important task of this thesis will be to bring to light thinkers who have sought to challenge the hegemony of the Cartesian worldview. It is only when we have reimagined the nature of human beings that we can reimagine the nature of the practice that seeks to care for those beings.

Yet this project is about more than just the metaphors that guide medical practice. It is also about the measure of medical practice. What is the measure for medical care, the standard by which we judge an act adequate or not? Rather, where do we look to find the measure of medical practice? The measure for medicine can only be found in one of two places; within the patient-physician relationship itself or external to it. In medicine as it is practiced today, I will show that the measure is found outside of the patient-physician relationship. In addition to developing a new metaphor, one of my goals here

is to bring the measure of medicine into the midst of the clinical encounter; to have the aim of medical care defined through the combined efforts of the patient and the physician.

But this project is about more than just the measure. Ultimately, it is about finitude. Medicine struggles with finitude. Just look at the metaphor guiding it; there is no necessary reason why the machine should ever have to fully break down. If we are able to keep the repairs in full order then the machine should be able to keep operating in smooth fashion. But this is not the case. Medicine struggles with finitude because it misunderstands what it is to be human. To be human is to be finite. What does it mean to practice medicine in the face of human finitude? This question is largely sidestepped in modern medicine because the ‘problem’ of finitude is itself sidestepped.

If we reimagine each of these features: metaphors, measure, and finitude, then medicine must change. Ultimately, change is the goal of this thesis. It is not that medicine has served us poorly; it has served us quite well. To deny this would be an affront to those who died of diseases that are today easily treated. But, the thrust of this project is that medicine can no longer serve us in the same capacity. It must change. Change must come at many levels. It must be as diverse as how we train the next generation of physicians to how we are able to relate to death. In these and many other respects, medicine must change.

The ultimate goal of this project is to make good on the promise of medicine. To do so will require a new conception of what it is to heal, to take care, and to practice medicine in our age.

## CHAPTER II

### THE CRISIS OF THE MEDICAL SCIENCES: UNDERSTANDING CRITIQUES OF THE BIOMEDICAL MODEL

For more than a century the practice of medicine has operated under a methodological model known as the biomedical model<sup>7</sup>. Under this model medicine has employed the techniques and assumptions of sciences such as molecular biology, genetics and biochemistry in its unceasing attempt to eradicate disease. Biomedicine<sup>8</sup> has radically altered our relationship to and understanding of the phenomena of disease and health over the course of its brief existence. It goes without saying that throughout the twentieth century biomedicine greatly improved both the quality and the quantity of life for an incalculably large number of people. For instance, in western nations the average life expectancy rose from 47 years to 74 years in the twentieth century alone.<sup>9</sup> Despite the vast improvements in health, biomedicine has been the target of numerous critiques, especially since the 1970's. George Engel's 1977 article *The Need for a New Medical Model: A Challenge for Biomedicine* has served as a modern-day touchstone for those who wish to propose a new model for medicine. In the piece Engel develops several criticisms of biomedicine and then offers a brief sketch of an alternative model, the biopsychosocial model.<sup>10</sup> Engel's concerns have been taken seriously, but have yielded little change in medical practice.<sup>11</sup> More recently David Morris has attempted to reinvigorate Engel's concerns through his elucidation of what he calls the biocultural model of medicine.<sup>12</sup> Despite the efforts of Engel and Morris, among numerous others,

the fact remains that the biomedical model seems today nearly invulnerable. The awe inspiring capabilities of biomedicine render nearly any attempt to call it into question paltry at best, nefarious at worst.

I contend that the reason these multiple critiques of biomedicine have failed to affect change is because different authors have mistakenly seen themselves offering mutually exclusive critiques of the biomedical model. That is, various opponents of the biomedical model have failed to recognize that the multiple criticisms offered all emanate from singular concerns. This is due to the fact that the emphasis within the medical humanities is often placed on medical *practice* at the expense of the philosophical underpinnings of these practices. Thus, the ultimate aim of this chapter is to uncover the philosophical question that motivates these criticisms of biomedicine. What is it, ultimately, that has led numerous thinkers to contend that in spite of the enormous success of biomedicine, something is ultimately *wrong* about our contemporary practice of medicine? The answer, I contend, is the problem Edmund Husserl named “naïve objectivism” in his 1935 *Vienna Lecture*. Biomedicine has run into a crisis because of its fidelity to positivism and its repudiation of the life-world in which it now finds itself.

The justification of such a claim, however, will require a thorough examination of both the biomedical model itself as well as two of the most prominent critiques that have been leveled against it. The first critique, what I am calling the crisis of success in biomedicine, claims that the very successes of biomedicine have largely rendered it functionally inert with respect to disease as it is understood today. This is because the

biomedical model has so profoundly altered our relationship to disease that the conception of disease employed by the model is no longer adequate to the task of medicine. The second critique, the crisis of medicalization, draws upon fears concerning the medicalization of what were once considered ‘normal’ aspects of human life. Simply put, this critique asserts that biomedicine (and science more generally) sees itself as the only legitimate way in which to view the world. All meaning must be validated by science before it can actually mean anything. I will show that while the two critiques appear to contradict one another at the level of medical practice, they are in fact two attempts to address a single flaw in the biomedical model—naïve objectivism. It is only once biomedicine and its major criticisms have been covered that I will turn to Husserl’s *Vienna Lecture* in order to demonstrate the problem of naïve objectivism in biomedicine. In doing so I hope to strengthen the philosophical underpinnings of these two critiques that have been leveled at the biomedical model of medicine which will in turn open the path to developing new, philosophically rigorous models of medical practice.

### **Positivist Biomedicine: Repairing the Machine of the Body**

In referring to medicine as positivistic I am referring to 19<sup>th</sup> century notion of science as a value-neutral, objective and universally true method of understanding and controlling natural phenomena. It is perhaps not too bold of a claim to state that with respect to the sciences contemporary biomedicine stands as a last gasp of this positivistic worldview. Physics, for instance, has undergone a crisis of foundations thanks to the work of Heisenberg and Einstein. Astronomers have discovered a universe that exceeds

our ability to grasp it. Even mathematical logic, thanks to the work of Gödel, has found itself incomplete. However, since its development in the late 19<sup>th</sup> Century, all of the scientific and practical developments within biomedicine have served to further the notion that we are consistently making progress in our incessant war against disease.<sup>13</sup>

Historically, we can pinpoint the scientific origins of biomedicine to Robert Koch's elaboration of the germ theory of disease in 1882.<sup>14</sup> The ensuing decades brought about miracle drugs such as sulfanilamide, penicillin and streptomycin, new vaccinations against polio, mumps and measles, and new discoveries such as the structure of DNA and its role in coding for proteins in the body. Simply consider the list of names that became world famous in this time period—Lister, Fleming, Salk, Watson and Crick. The later half of the twentieth century yielded a total revolution in medical and surgical techniques: CPR, open heart surgery, dialysis and prosthetic limbs to name only a very few. So powerfully and rapidly had biomedicine transformed our relationship to health and disease that one could easily defend the claim that a physician practicing in the 18<sup>th</sup> century had more in common with Greco-Roman physicians than with a 21<sup>st</sup> century physician.

Yet what grants such power to biomedicine? Specifically, what are the methodological and metaphysical commitments of biomedicine that have rendered diseases such as tuberculosis and the bubonic plague frights of the past to be heard of only in history or literature classes? It would be foolish to assume that one could pinpoint a list of necessary and sufficient features comprising such a complex phenomenon as a diagnostic model. Biomedicine is multi-faceted and contains contrasts

and contradictions in both its philosophical and practical dimensions. Nevertheless, there are five features of the biomedical model that are emblematic of a consistent theme that has consistently plagued biomedicine since its inception—the notion of biomedicine as a human practice that will ultimately emerge victorious over disease.<sup>15</sup> First, biomedicine is positivistic in its comportment. Never having had its foundations called into question, biomedicine has had no legitimate reason to jettison positivism, the predominant scientific ideology of the late nineteenth century. Positivism sought, through a strict adherence to empiricism and the employment of reason, to construct the sciences into a unified, value-neutral entity. Of particular importance to the positivist is the belief that the laws of science are universally ‘true,’ and can be used in all places at all times. Thus, the biomedical model itself is universally true, and is *the* appropriate way by which to view medical phenomena such as disease, death or disability.

A second feature of biomedicine is that it is strictly reductive in its employment of scientific laws. Reductionists group natural phenomena into hierarchical levels based upon their complexity. For instance, Oppenheim and Putnam, in their essay *The Unity of Science as a Working Hypothesis*, divide nature into six levels—from human societies at the top, down through individual human psychology, biological entities, molecules, atoms and finally elementary particles at the bottom.<sup>16</sup> One object is considered “higher-order” than another if it is a member of a higher level than is another object. For example, the economy is a higher-order phenomenon than a bacterial cell, which is itself a higher-order phenomenon than an electron. The converse is true for the term “lower-order.”

A reductive understanding of science necessitates two beliefs concerning the various laws governing these hierarchical phenomena. First, a reductive approach to the sciences entails a belief that all of the sciences can be unified into a single, hierarchical whole. Social laws describing the development of human civilization are, under a reductive approach, nothing more than numerous iterations of and combinations of the psychological laws of each of the individuals within a society. These psychological laws themselves emerge from the interplay of numerous biological laws, which are in turn merely laws of chemistry and so on. Thus, the laws governing a set of higher-order objects can be effectively reduced to a combination of laws governing the phenomena at the next lower level.

Furthermore, reductive approaches to science necessitate a one-way chain of causality within the structure of scientific laws. Simply put, reductionism forbids higher-order phenomena from playing a causal role in the activity of lower-order phenomena. That is, parts can only cause the whole to act. The whole can never cause individual parts to act. In the context of biomedicine, this places a huge emphasis on an understanding of biochemical mechanisms and pathways. Biochemists explain the most basic phenomena within the scope of biomedicine, thus they hold the key to understanding the delicate balance between health and disease. Furthermore, laws of psychology and sociological are considered less important under biomedicine.

Robert Aronowitz details this in his discussion of various historical treatments of ulcerative colitis. Prior to the 1980's physicians explained the disease through psychosomatic factors. Then, explanations suddenly shifted to autoimmune effects.

What is interesting, he notes, is that our understanding of what actually *caused* the disease did not improve as a result. Nevertheless, the autoimmune explanation is today considered *the* explanation for ulcerative colitis. The reason, Aronowitz contends, is that in biomedicine reductive explanations are treated as *de facto* more scientifically rigorous than are non-reductive explanations.<sup>17</sup>

In brief we see that a reductive approach to the sciences, as employed by biomedicine, drives the physician's focus downward to simpler and more basic phenomena. As Engel writes, "[f]rom the reductionist viewpoint, the only conceptual tools available to characterize and experimental tools to study biological systems are physical in nature."<sup>18</sup> For instance, consider the rise of psychopharmacology at the expense of psychoanalysis and other forms of "talk therapy."<sup>19</sup> While the causes for such events are numerous and complex, it is in no doubt due to the fact that when available, biomedicine will favor explanations involving lower-order phenomena.

A third pertinent feature of biomedicine is that it is structured upon a series of dualisms. First, there is a strong subjective/objective dualism at play in medicine involving the elevation of objective measures of disease and a suppression of subjective accounts of disease. The physician is expected to play the part of an impartial observer of the manifestation of disease in patients. What the patient reports about the disease is only important insofar as it can help the physician narrow down which objective tests to perform. Furthermore, the physician must suppress her own subjective tendencies while examining the patient. The climax of such thinking is to be found in what is today known as evidence-based medicine (EBM). In EBM, a committee of researchers issues

guidelines describing what a physician should do in a given situation based on the current and best available scientific data.<sup>20</sup> The goal of EBM is to eliminate the performance of unnecessary medical procedures and tests based off of either the patient's or the physician's so-called subjective whims. Objective science should instead guide the practice of medicine.

There is, interestingly, another dualism at work in biomedicine—the Cartesian dualism of minds and bodies. Such a dualism emerged strongly in medicine in the 17<sup>th</sup> century as a result of the Catholic Church granting doctors permission to dissect and study the body. However with such permission came “a tacit interdiction against studying man's mind or behavior.”<sup>21</sup> The reasoning for such was that the body was not where the true substance of the person could be found, thus it could be examined without generating theological problems. The external world was explainable by causal mechanistic laws, but the mind was not something that could interfere with such laws. The mind was subject to the experiences of the body, but an inseparable gulf kept the mind from causally affecting the body. David Morris argues that biomedicine's approach to pain management highlights such mind-body dualism.<sup>22</sup> Biomedicine focuses on pain as the message that some harm has been done to the body. The mind plays the role of a passive spectator of this pain. Thus, pain management centers on drug prescription and even potentially surgery as cures. Furthermore, it tends to avoid cognitive therapies that see the mind playing an active role in the construction of pain. Like scientific reductionism, mind-body dualism also pushes biomedicine towards specific practices and explanations and away from others.

A fourth pertinent feature of biomedicine is that it excludes any explanations of disease or methods of treatment that do not comply with any of the aforementioned features. Thus disease is defined so as to exclude the possibility of a non-reductive explanation. This disallows psychological, social and environmental factors from playing a causal role in the diagnosis disease. Etiology can only flow in one direction for biomedicine. Additionally, disease is defined so as to exclude the patient's subjective experience of the disease, or as Engels states it "[biomedicine] encourages bypassing the patient's verbal account by placing greater reliance on technical procedures and laboratory equipment."<sup>23</sup> In essence, the existence of a positive test result is deemed both a necessary and a sufficient condition for the presence of disease. The implication of this is that the *absence* of a somatic etiology indicates the *absence* of a true disease, no matter the patient's experience of feeling ill or not.

Aronowitz details this clearly in his discussion of lay-physician debates concerning Chronic Fatigue Syndrome (CFS) in the 1980's. Patients would present to their physicians complaining of unceasing lethargy. Scientist and physicians were unable to locate a somatic cause for this phenomenon, and CFS was largely ignored by physicians, given mock labels such as "yuppie flu." However, interest in CFS grew immensely when a possible link was suggested between the virus-like symptoms of CFS and the Epstein-Barr Virus (EBV). Even though the link was later seriously called into question, Aronowitz argues that the surge in interest is quite telling of the biomedical model:

The importance of pathobiological mechanisms in defining and legitimating diseases is illustrated by the fact that chronic fatigue syndrome gained notice as a

new disease only as a result of attention given to the apparent correlation between abnormal DBV serologies and a vague viral-like illness.<sup>24</sup>

The very legitimacy of CFS as a disease was in question because it did not fall within the strict parameters of disease in biomedicine. Despite patient experience to the contrary, biomedicine will continue to attempt exclude conditions such as CFS from the category of disease because they do not fit nicely within the objective, reductive scientific approach employed by biomedicine.

All told, the previous four features all culminate into a fifth, the metaphor that undergirds biomedicine's self-awareness. Simply put, biomedicine sees the body as a machine and sees the practice of medicine as the means by which this machine can be repaired. We can see how this follows from the previous aspects of biomedicine. Mind-body dualism creates a split between different aspects of the person, so as to focus the practice of medicine onto the body of the person and away from the mind. The body can be given an inorganic metaphor because the true life of the patient is in the mind. Scientific reductionism reinforces this view by excluding from disease features that are larger than the unit of the individual. Disease is always caused by the defect of a part of the machine. Finally, the tone of this metaphor is shaped by the mechanistic attitude of late-nineteenth century positivism.

I highlight this feature of biomedicine because the metaphor is quite telling of the metaphysical and methodological assumptions of the biomedical model. New models will require new metaphors, and elucidating these metaphors will orient our thinking as we attempt to enrich new models with philosophical rigor. It is with this thought in mind

that I will now turn to two critiques of the biomedical model, along with their recommendations on how to change the model so as to improve the practice of medicine.

### **The Crisis of Success: Changing Models for Changing Times**

The first serious critique of the biomedical model hinges upon the belief that the biomedical model has essentially run aground as a result of its own successes. A dialectic is at play within biomedicine: the very conditions that first granted the biomedical model its success have effectively been eradicated by the biomedical model itself. Ostensibly the goal of medicine is to help promote health through the regulation of disease, and the biomedical model has excelled in this for over a century. But, critics contend, the biomedical model has succeeded to such a degree that the nature of disease as a whole has radically changed. Specifically, simple infectious diseases are no longer the dominant plague of mankind. They have been replaced by a host of new kinds of diseases and syndromes: seemingly unconquerable infectious diseases such as HIV, chronic diseases such as diabetes, terminal diseases like many forms of cancer, and even psychological disorders such as schizophrenia. These new, dominant diseases raise the question of whether or not a strictly reductive etiology is sufficient to meet the goals of the practice of medicine. These critics contend that the answer to this question is no, and that we must extend our thinking beyond the mere confines of the individual patient and reimagine disease within the context of the societies in which they flourish.

This critique is predicated upon the belief that a medical model must always be tempered by pragmatic considerations of what is acceptable in light of the goals of medicine. Any medical model, including the biomedical model is not true *as such* but is

true only insofar as it is appropriate to the task at hand. As Engels writes, “a model is nothing more than a belief system utilized to explain natural phenomena, to make sense out of what is puzzling or disturbing.”<sup>25</sup> As van Fraassen has made clear, a model is true only in the context of its ability to answer a specific “why” question.<sup>26</sup> For biomedicine, the relevant why questions involved the causes of human diseases. Thus, the biomedical model gained its truth only on the condition that it was able to adequately address the pertinent why questions of its day.

As previously detailed, biomedicine has been able to provide a seemingly incalculable number of answers to our questions about medical phenomena. This arose from the fact that throughout much of the course of its history biomedicine has been more than adequate to the task at hand. But is this still the case? An historical examination of the transformation of disease in our era can help explain what this is not so. Medical historian Thomas McKeown has argued that the predominant diseases of any era are to be understood by “the prevailing conditions of life.”<sup>27</sup> In the late 19<sup>th</sup> century, with the rapid urbanization of the west, infectious disease served as the predominant disease. But the biomedical model has been so successful that it has revolutionized the prevailing conditions of life in the west. Infectious disease has been effectively vanquished, and the material conditions of human life have sufficiently changed so as to result in new forms of disease. We no longer live in fear of cholera or polio. Instead, we wait with dread for a physician to diagnosis us with cancer. We anticipate that we will live to an age in which our bodies will begin to fail long before the hour of our death. In some cases we even live in fear of diseases that have emerged

because of the biomedical model. For instance, we are now confronted with the possibility of Multi-Drug Resistant bacteria, resulting in diseases that would have been impossible but for the very successes of biomedicine. Although it may be difficult to pin down a specific disease that could be seen as particularly emblematic of our era, there is no doubt that the nature of disease today is markedly different than in previous eras.<sup>28</sup>

Yet medicine today still rigorously applies the same 19<sup>th</sup> century principles to a world of 21<sup>st</sup> century diseases. It has, as Engels writes, attained the status of scientific dogma:

The biomedical model has thus become a cultural imperative, its limitations easily overlooked. In brief, it has now acquired the status of *dogma*. In science, a model is revised or abandoned when it fails to account adequately for all the data. A dogma, on the other hand, requires that discrepant data be forced to fit the model or be excluded.<sup>29</sup>

Thus, we must consider specific, modern diseases and how the biomedical model fails to adequately treat these. My analysis will commence with an examination of George Engel's biopsychosocial model and his question concerning the possibility for grief to be a disease. Next I will consider Mary Tinetti and Terri Fried's argument that the practice of medicine must include the modification of both biological and nonbiological factors. Finally I will address Paul Farmer's concept of structural violence in medicine, specifically in the context of tuberculosis (TB) and multidrug-resistant tuberculosis (MDRTB). My goal in this analysis is to uncover the basic concern at play in these writers and the course of action they recommend for the practice of medicine.

As mentioned before, George Engel offered one of the earliest iterations of this critique against biomedicine. Engel describes an alternative to the biomedical model that

will seek to incorporate sociological features without forsaking the remarkable power of the biological sciences. He describes the practice of medicine under his model as follows:

[The physician] must weight the relative contributions of social and psychological as well as of biological factors factors implicated in the patient's dysphoria and dysfunction as well as in the decision to accept or not accept patienthood and with it the responsibility to cooperate in his own care.<sup>30</sup>

Thus, we see that Engel attempts to undermine the reductive tendencies of biomedicine by allowing higher-order phenomena such as psychological and sociological states to play a causal role in disease. Furthermore, Engel attempts to undermine the subjective-objective dualism at play in biomedicine but incorporating considerations of *why* the patient presented in the first place. That is, Engel recognizes that patients have specific goals in mind; they do not necessarily perceive themselves as machines in need of repair. Addressing these goals is not outside the scope of a physician's work, he contends.<sup>31</sup>

By undermining reductionism and subjective-objective dualism, Engels hopes to call into question the exclusionary principles at work in biomedicine. Experiences that may not have once been thought of as diseases (and hence were excluded from the concern of physicians) could now fall within the scope of a physician's duties. Engel considers grief as a potential candidate for attaining status as a disease.<sup>32</sup> Like many infectious diseases, grief runs its course in response to a specific etiology. Furthermore, grief involves many of the same social factors as do classical diseases—we do not deem the grieved person to be responsible for their situation and we forgive them for neglecting their “normal” duties of life. However, biomedicine insistently confines itself to diseases of the body. Engel wishes to call this into question and seeks to challenge the

traditional training that a physician receives. “The physician’s basic professional knowledge and skills,” he writes, “must span the social, psychological, and biological.”<sup>33</sup> Although Engel offers little further elaboration of what this might look like, his argument was one of the first to suggest that an alternative medical model may be necessary.

Tinetti and Fried’s 2004 article “The End of the Disease Era,” continues along the same vein as did Engel. They offer the somewhat provocative notion that biomedicine’s explicit focus on disease is harmful to patient well-being, because it ignores “the changed spectrum of health conditions, the complex interplay of biological and nonbiological factors, the aging population, and the interindividual variability in health priorities.”<sup>34</sup> Whereas Engel wanted to extend the definition of disease to include members formerly excluded, Tinetti and Fried wish to drop the disease designation altogether in order to bring about a cultural shift within medicine. This effectively results in a similar conclusion--medicine, they contend, ought to expand its focus to include nonbiological factors such as patient experience or pertinent social factors.

They offer a detailed picture of what patient care may look like under such a practice, which they refer to as the individually tailored model of medicine. They emphasize its use especially in the case of chronic disease. Under this model a patient presenting to a physician generates a series of three questions by the physician.<sup>35</sup> First, the physician asks *how* the chief complaint bothers the patient. This purpose behind this is to develop a differential diagnosis, as the biomedical model would do, but also to determine the pertinent psychological and sociological factors that are at play in the

encounter. Second, the physician asks what the patient's specific goals are for treatment. For instance, does the patient desire to increase mobility or life-span? How important is independence to the patient? The goal of this stage is to incorporate the patient's subjective life-goals into a specifically tailored treatment plan. It sets limits on which treatments the physician considers viable and which are deemed off limits. The third set of questions incorporates the information gathered in the first two sets and asks the patient what psychological and sociological factors could be altered in their lives. The purpose of the three sets of questions is to develop an individually tailored approach for each patient in each case.

Tinetti and Fried conclude that "health care must become more interdisciplinary."<sup>36</sup> Biomedicine sees itself as the crown jewel among disciplines such as social work or counseling. What these authors suggest is that medicine must seek to incorporate some the key insights of these fields into its own framework. They cannot be seen as a mere supplementation to medicine, but instead must come to form an integral part of what it is to practice medicine. A patient's health can no longer be thought of only in terms of biological perturbations. Instead, medicine must broaden its scope for the sake of patient health.

The final figure I will analyze in this section is Paul Farmer. While Farmer does not ally himself with critics of the biomedical model, I will seek to demonstrate that his account of structural violence in medicine falls within the same family of critiques. Farmer, both a physician and an anthropologist by training, has spent much of the last two decades living in rural Haiti to practice medicine and conduct research concerning

the interplay of social structures and human health. He contends that there exists systemic violence in the structure of healthcare, especially aimed at particularly vulnerable social groups. Farmer contends that in Haiti, “political and economic forces have structured risk for AIDS, tuberculosis, and, indeed, most other infectious and parasitic diseases.”<sup>37</sup> Farmer’s approach to medicine seeks to balance the individual treatment of patients with the desire to effect changes in the political and economic structures that serves to keep the world’s impoverished groups systematically ill.

In his work *Pathologies of Power*, Paul Farmer details his visit to several Russian “TB colonies;” prisons in which most if not all of the prisoners had some form of tuberculosis. The overcrowded and undernourished prisoners serve as a breeding ground for the disease, ensuring that nearly all of the prisoners will suffer multiple infections.<sup>38</sup> Furthermore, the medical staff was not guaranteed access to the necessary antibiotics. This situation raises the following question of scientific reductionism: can we adequately think of disease without reference to the social conditions from which it emerges? What *caused* this outbreak of disease? Ultimately, yes, biomedicine is strictly correct in asserting that the tuberculosis outbreak is caused by the bacteria. But Farmer contends that the social organization of the prison system itself *is as* responsible for the outbreak of tuberculosis *as is* the bacillus. Thus, medicine is most assuredly *not* justified in seeking to exclude societal structures from its purview.

Thus, we can see that Farmer clearly belongs in the tradition of those who offer this critique. Each of these examples has served to highlight the consistent theme of this critique—biomedicine is no longer up to the task of adequately dealing with disease. We

can no longer pretend that social, psychological, environmental or even political factors do not play a role in shaping our understanding of and response to disease. What is needed is a new medical model that will be able to incorporate each of these factors without mitigating the positive effects that the biomedical model has had on human health.

### **The Crisis of Medicalization: Turning Death into a Disease**

The second series of criticisms that have been leveled at biomedicine appear to be completely contradictory to the first set of critiques. Whereas the crisis of success focused on how biomedicine excluded relevant aspects of disease and even certain disorders from the category of disease, the crisis of medicalization contends that biomedicine has been too *inclusive* in its understanding and treatment of disease. Simply put, those who point to the crisis of medicalization believe the biomedicine has turned “normal” aspects of human life and development into diseases, making “problems” out of phenomena that were once considered natural. The most obvious example of this and the one which I will dedicate my attention to is the manner in which biomedicine has turned aging into a problem. The biomedical model operates under a metaphor of repairing a broken machine. If the body is viewed in this manner, then aging is seen as a first order problem for medicine, since it represents visible manifestations of the machine beginning to fray. In this section I will briefly sketch criticisms of biomedicine raised in Carroll Estes and Elizabeth Binney’s article “The Biomedicalization of Aging: Dangers and Dilemmas,” as well as is Kaufman *et al.*’s article “Revisiting the Biomedicalization of Aging: Clinical Trends and Ethical Challenges,” in order to

properly understand this critique and the recommendations it offers for medical practice. I will then link their critiques to biomedicine's treatment of the phenomenon of death.

Estes and Binney offered one of the earliest iterations of the problem of medicalization, specifically with respect to the reinterpretation of the experience of aging by the biomedical model. They contend that since biomedicine is specifically equipped to deal with diseases with a specific etiology, it cannot help but come to view all medical phenomena in this manner, regardless of whether or not such a view is appropriate.<sup>39</sup> Strictly speaking, aging is not a disease. However, since biomedicine does such a good job treating disease, why can we not treat aging in terms of disease? Thus the biomedicalization of aging is engaged in a cycle of self-perpetuation. We *must* see aging in terms of disease in order for the biomedical model to be employed. And as biomedicine develops better and newer techniques and drugs to combat disease, aspects of aging that are not inherently disease-like are pushed to the side. This culminates in our coming to view aging as we would a disease. The implication of this is that biomedicine will not yield any ground—our experience of aging must change since biomedicine most assuredly will not.

Kaufman *et al* continue along this line of thought in their 2004 article “Revisiting the Biomedicalization of Aging.” They contend that the enormous technological changes of the past decades have culminated in a shift in attitudes towards aging and even death. We now have capabilities to sustain an individual's life far beyond its “natural” course. A consequence of this, Kaufman contends, is that these capabilities have been culturally translated into a moral imperative to extend life beyond its natural course.<sup>40</sup> Because we

*can* extend a life, we *must* extend a life. As the technological imperative gains more and more social force, it becomes harder for patients to refuse medical treatment.

The biomedicalization of aging is intimately linked to the biomedical model's anxiety concerning the medical phenomenon of death. Aging and death are a breaking down of the machine of the body, a specter that mocks the positivist attitude of biomedicine. Biomedicine counters this by engaging in an all-out war against death and its herald, aging. As David Morris contends, the locus of this war is found in a full-blown cultural denial of the reality of death which is perpetuated by biomedicine. "Death is a scandal," he argues, "partly because it unmasks the illusions that we can live forever."<sup>41</sup> Thus, the ultimate anxiety of biomedicine is not about aging per se, but only about aging insofar as it is indicative of the reality of death.

Thus, the ultimate worry for those who suggest a crisis of medicalization is that biomedicine contains its own implicit values—an anxiety about death, the preservation of life for its own sake, and the disavowal of all values that are not inherently biomedical in nature. The concern is that these values undermine our traditional values with respect to aging and death. We may have once favored a patient's right to refuse a life-saving treatment, but biomedicine attempts to undermine this autonomy through its technological imperative. We may have once understood death to be a natural part of life, but today we hide behind the illusion of medical advancement. The suggestion offered by Kaufman, Estes and Binney is that medicine should attempt to offer an alternative to the biomedicalization of aging, even though they do not explicitly indicate what this kind of resistance may look like.<sup>42</sup> What is needed, then, is a medical model

that will not attempt to impose its own values onto aging and death, but will instead grapple with the meaning these phenomena inherently have.

What I wish to conclude with is that while the proponents of the two critiques appear to be completely different, they in fact stem from a similar philosophical concern. The opposition occurs *only* at the level of medical practice. Whereas the crisis of success offers solutions that require the expansion of biomedicine's purview, the crisis of medicalization contends that biomedicine has already expanded its purview too far. It seems as though these two critiques are irreconcilable at the level of practice. Furthermore, I have no intention of attempting to reconcile them. Instead, what I will seek to do in my final section is to show that at least philosophically, these critiques are both modern-day iterations of Husserl's charge of naïve objectivism in the sciences.

### ***The Vienna Lecture and Naïve Objectivism***

Edmund Husserl, a key figure in the phenomenological movement, dedicated the latter part of his career to elaborating what he saw as an impending crisis within the sciences. Specifically, Husserl contended that the sciences, as a result of their numerous successes, had covered over a key component of their methodology. The result was what Husserl referred to as naïve objectivism in science. Husserl explains naïve objectivism as follows:

Someone who is raised on natural science takes it for granted that everything merely subjective must be excluded and that the natural-scientific method, exhibiting itself in subjective manners of representation, determines objectively.<sup>43</sup>

That is, researchers in the sciences have mistaken their observations as objective, and have covered over the fact that they are subjective beings whose attitude about the world

cannot be separated from what they observe in the world. Science is conducted by subjects, and these subjects are unable to wholly separate their work from their subjectivity, despite the positivist's claims to the contrary. Consider, for example, two different researchers who come across the same set of data. One researcher is nearing the age of retirement and lacks the mental alacrity of her earlier years. The other is young and enthusiastic about his research. Can we honestly maintain that their observations are not intimately linked to what they feel about their subject matter? It is quite conceivable that results that appear as inconclusive evidence to the first researcher could very well lead to puzzlement and further research by the second.

While Husserl maintains that specific observations are entirely subjective, he argues that these do not emanate wholly from the researcher herself. Instead, the subjective observations are grounded in what he refers to as the life-world:

But the researcher of nature does not make clear to himself that the constant fundament of his—after all subjective—work of thought is the surrounding life-world; it is always presupposed as the ground, as the field of work upon which alone his questions, his methods of thought, make sense.<sup>44</sup>

The life-world is the totality of significance, meaning, or even meaningfulness possible within a given society at a given time. Thus, any thought, even subjective, by a researcher is itself undergirded by the life-world. Only in the context of a specific life-world can a claim posited by the sciences make sense. The implications of this view are profound. Science cannot claim to be universally true for all times and all places according to Husserl. Instead, science and society are inextricably linked. Science can only be made sense of if it is viewed in the context of the society that produced it. We can thus examine Husserl's worry about naïve objectivism in the context of the life-

world. Naïve objectivism occurs, Husserl believes, when science ignores the fact that each of its claims emerges out of a specific life-world and instead takes itself to be offering universally true, objective statements.

Husserl contends that one of the causes of this naïve objectivism is a series of dualisms that has been established within the sciences. We have already seen Husserl oppose a first kind of dualism—that between the researcher and what is researched, between subject and object. However, Husserl also attacks a second kind of dualism within the sciences:

But the situation can never improve [...] so long as the recognition has not emerged that the dualistic view of the world, in which nature and spirit are to count as realities in a similar sense, though one is built on the other causally, is a mistake.<sup>45</sup>

Husserl argues that naïve objectivism in science arises out of a strict mind-body dualism in which the body acts as a causal agent upon the mind. Under this view the mind is subject to the same laws of nature as are any other phenomenon. Supporters of this dualism would argue that in order to understand the mind, one must first understand basic sciences, and progressively learn more and more complicated science until the complex phenomenon known as mind can be adequately explained by a scientific law. Such a view is precisely backwards, Husserl thinks. To hold such a view is to believe that science laws are universally valid independent of the mind that employs the law. Husserl asserts that scientific laws most assuredly *do* grant us great insights into understanding the world. However, he contends that science runs aground when it focuses only on the laws and forgets to understand the laws in the context of the life-world from which they emerged. Scientific laws ought not to be viewed as a one-way

causal street. Instead, an adequate understanding of science involves interplay between the life-world, the minds it shapes, and the scientific laws explaining the physical world.

It is fairly simple to show how both crises offer different takes of the naïve objectivism of biomedicine. Critics such as Farmer and Engel contend that biomedicine excludes sociological, psychological, and political factors of disease at its own peril. The reason that biomedicine must do so is that biomedicine is built upon universal scientific laws that are considered trans-historical in their truth and reach. Yet such a view ignores the fact that scientific laws can be meaningful only in the context of a particular life-world. To make biomedicine *true* in itself is to ignore the life-world that allowed it to come into being. Furthermore, it ignores the fact that life-worlds can come out of being; scientific laws can fall out of truth and become essentially meaningless. By incorporating factors such as politics, sociology and psychology medicine can acknowledge the role that the surrounding life-world plays in its own capacity for meaningfulness.

Contained within the totality of meaningfulness are the values that are held within a certain life-world. In particular, the life-world will have certain values with respect to the phenomena of aging and death. By imposing its own values onto these phenomena, biomedicine undermines and ignores the importance of the life-world in which it operates. In the same manner it exhibits naïve objectivism. Thus, we have analyzed both critiques with respect to a proper philosophical foundation—the naïve objectivism that Husserl believes to be an integral part of the sciences.

In summary, Husserl suggests that the modern sciences face a crisis; that is, a time to choose. We can continue down the path of naïve objectivism, feigning objectivity at the expense of the life-world in which we live. Or we can, and should, reject our naïve approach to the sciences and discover the intimate interactions between the scientist and the objects of study. We should see our sciences as an expression of the life-world in which we flourish and not as the guardians of universal truth.

Ultimately the strength of this argument rests upon the assertion that something about the practice of medicine is wrong. Husserl's discussion of naïve objectivism is useful insofar as it allows us to hint as what exactly is wrong about medicine. Furthermore, it sets us on the course for developing new models of medicine that will pay homage to their own dependence upon the life-world in which they flourish.

### **Conclusion**

Having identified the philosophical foundation for a critique of biomedicine, the task at hand is to develop new models of medicine that can meet the demands of these critiques. In the next chapter I will offer a medical model that specifically meets the demands of the crisis of success—a metaphor of the patient as live creature based in John Dewey's philosophical naturalism. Then, I will develop a model of medicine as care to answer the crisis of medicalization, grounded in the existential analytic of Martin Heidegger. Regardless of whether or not these two critiques are entirely compatible with one another, I will attempt to establish that they meet the demands of challenging the naïve objectivism of the biomedical model.

CHAPTER III  
THE PATIENT AS LIVE CREATURE: USING JOHN DEWEY'S PHILOSOPHICAL  
NATURALISM TO CRITIQUE MEDICAL PRACTICE

The yield of the previous chapter was that we were able to highlight two fundamental flaws that are exhibited in biomedicine—the insistence that biomedicine must be universally true and the fundamental disconnection between the practice of medicine and the lifeworld in which it flourishes.<sup>46</sup> The task at hand in this and the following chapter is to consider new philosophical visions that can undergird the practice of medicine. The ultimate goal is to develop new models of medicine that are able to maintain the strength of biomedicine while simultaneously meeting the criticisms made evident through Husserl's analysis of modern science. It must be made explicit; I do not advocate a wholesale jettisoning of science in favor of chicanery or pseudo-science. What I seek is not to reject the goals of medicine but to realize them more fully. Yet, I believe this is possible only at a cost. Medicine can no longer operate with the absolute certainty that was a hallmark of positivism. In its place, medicine must make room for ambiguity and subtlety in diagnosis and care. Furthermore, medicine as it is practiced today must forgo any claim to universality. Each patient is wholly distinct and unique, and no single set of diagnostic criteria can be expected to address each of their individual health concerns.

What is needed, then, is to look to different philosophical traditions in which to ground medicine. It is from these new foundations that a new model can be developed.

Biomedicine, as I have argued, was best captured by the philosophical vision of Descartes. The dualistic and mechanistic metaphysics of Descartes ultimately culminated in a picture of the human as a soul residing inside the machine of the body. While educators and clergy were responsible for taking care of the soul, the less important aspect of human life, the body, was to be handled by physicians. New models will require new understandings of what it is to be human, however. Given these and the above considerations, I propose the following criteria for choosing philosophical traditions to undergird medicine: it must reject a dualistic view of humanity, it must reject a purely mechanistic understanding of the sciences, it must have criterion for truth that are relative to the situation at hand, and it must involve some element of fallibilism or finitude. It is with these criteria in mind that I now turn my attention to the philosophical naturalism of John Dewey. I will seek to show that Dewey's philosophical vision accords with Husserl's desire to reimagine the sciences and that we will be able to use Dewey as a starting point for developing a new model of medical practice.

In the following sections I will offer a survey of several fundamental aspects of Dewey's philosophical naturalism: his Darwinian roots, his understanding of human and social existence as natural, his emphasis on the precarious aspects of existence, and his description of the transaction between humans and their environment. All of these aspects together culminate in a new metaphor for human existence, the human as a live creature, which can serve to replace the metaphor of the body as a machine. The principle guiding this overview is how Dewey's understanding of human existence can be used to criticize particular failings of the biomedical model of medicine. This will be

illustrated through a reexamination of the crisis of success to show that it cannot account for the patient as live creature. I will show that physicians operating under the biomedical model are unable to adequately address this crisis; that Dewey's philosophical project can reveal *why* this is so and how to develop a new model to avoid these pitfalls.

### **The Darwinian Heritage: Mind and Society as Natural**

It is not an exaggeration to claim that John Dewey was the first philosopher to take seriously Darwin's theories and their implications for our understanding of human nature.<sup>47</sup> Dewey believes that because of the insight revealed by Darwin we are no longer able to conceive of humans as beings distinct from nature. It is not as if the world were an empty box that we were simply dropped into at some point in our past. Instead, our nature and the order of nature itself are one and the same. We emerge from out of nature itself, but this emergence in no way implies a difference in *kind* from nature. Instead, our emergence is one of increasing degrees of organizational complexity that have developed through millennia of evolutionary development:

While man is other than bird and beast, he shares basic vital functions with them and has to make the same basal adjustments if he is to continue the process of living. Having the same vital needs, man derives the means by which he breathes, moves, looks and listens, the very brain with which he coordinates his senses and his movements, from his animal forbears. The organs with which he maintains himself in being are not of himself alone, but by the grace of struggles and achievements of a long line of animal ancestry.<sup>48</sup>

Thus the Cartesian notion that man exists through the union of two wholly distinct kinds of substances, mind and body, is false. Our minds may be much more complexly organized than our bodies, but they are not of a fundamentally different nature.

Furthermore, the Darwinian insistence upon adaptation again reinforces the notion that our existence is wholly natural. Dewey's repeated emphasis of the importance of the organs in the above passage highlights two key implications of our adaptive existence. First, our organs offer us the coordination necessary to thrive in a given set of environmental circumstances. We have eyes and ears so that we are better able to avoid dangers and can more easily find shelter or sustenance. In the same way we have the mental capacities we do in order to develop long-term goals of how to better our overall station in life. Thus our cognitive organs, like our sense organs, point towards nature and allow us to interact with it in a way that is more conducive to our existence. Secondly, Dewey here emphasizes the historical or emergent nature of both our sense and mental organs. The upshot of this is that the particular faculties we do have are intimately tied to the kind of environment in which our ancestors lived. Thus, Dewey's acceptance of Darwinian evolution entails a wholesale rejection of any kind of dualism between mind and body. Our *entire* existence is natural, including our minds.

Dewey furthermore contends that human society and the cultural meanings developed within society are also natural:

Ability to respond to meanings and to employ them, instead of reacting merely to physical contacts, makes the difference between man and other animals; it is the agency for elevating man into the realm of what is usually called the ideal and spiritual. In other words, the social participation affected by communication, through language and other tools, is the naturalistic link which does away with the often alleged necessity of dividing the objects of experience into two worlds, one physical and one ideal.<sup>49</sup>

Dewey sees our ability to communicate as a functional tool allowing us to anticipate problems and collectively plan for future events. The upshot of this for Dewey's thought

is that social institutions and practices such as education, religion, politics or medicine are to be viewed as highly organized *natural* phenomena. There is no difference in kind between the institutions humans create and the order of nature itself. If we consider this fact from a Darwinian perspective, as Dewey does, then it means that institutions themselves ought to be adapted to the environment in which they flourish. Thus, no institution can be thought of as being universally, trans-historically adequate to the task of furthering human life. Instead, the prevailing conditions of life must at all times be brought into consideration in the development of institutions and practices.

I will conclude this section by highlighting Dewey's concerns that science may forget this truth about its own origins and practices:

The history of the development of the physical sciences is the story of the enlarging possession by mankind of more efficacious instrumentalities for dealing with the conditions of life and action. But when one neglects the connection of these scientific objects with the affairs of primary experience, the result is a picture of a world of things indifferent to human interests because it is wholly apart from experience. It is more than merely isolated, for it is set in opposition. Hence when it is viewed as fixed and final in itself it is a source of oppression to the heart and paralysis to imagination.<sup>50</sup>

The similarity between Dewey's concern for the sciences and Husserl's account of naïve objectivism is quite striking here. It signifies that Dewey believes that even the practice of science must fall within the bounds of the social settings in which its practitioners live. Thus, we see that Dewey's overall philosophical vision meets the criteria necessitated by Husserl's critique of the modern sciences. Having offered a brief sketch of Dewey's understanding of human and social existence, I must now examine two key aspects of his thought. First, I will elaborate on Dewey's insistence that existence involves the interplay between the precarious and the stable. Following this I will further

elucidate the transactions that Dewey believes occur between humans and their environment. With these two insights developed, I will be able to turn to develop Dewey's analysis of "the live creature" as a new metaphor to guide medical thought.

### **The Precarious and the Stable**

Dewey's most famous work, *Experience and Nature*, sets about the task of making clear the structural features of human experience. Staying true to his Darwinian roots, Dewey forcefully argues that since the human capacity to experience is itself natural, then it follows that the structure of our experience accords with the structure of nature itself. Thus, if we want to understand any facet of our existence, we need to look no further than to the structure of our own experiences. The first structure that Dewey examines is what he refers to as the interplay between the precarious and the stable. He seeks to challenge the long-standing philosophical assumption that "the stable," that is, what is universal, necessary, and permanent is in some sense more real than "the precarious," what is random, contingent and in flux. We see the suppression of the precarious in Plato's philosophy, in which the permanent, unchanging forms warrant the title of Being, but the changing world of our senses does not. The things we see are merely shadows on the wall of a cave according to Plato. Dewey, however, seeks to usurp the traditional prioritization of permanence over the precarious:

If we follow classical terminology, philosophy is love of wisdom, while metaphysics is cognizance of the generic traits of existence. In this sense of metaphysics, incompleteness and precariousness is a trait that must be given footing of the same rank as the finished and the fixed.<sup>51</sup>

We experience the world as both precarious and stable. We can consider something as basic as a building. We experience buildings as inherently stable; they have a sense of

permanence and order that grants them the usefulness to us. Nevertheless, anyone who has encountered a building following a natural disaster is cognizant of the fact that the building is also precarious, subject to whims outside anyone's control, and is truly impermanent.

The precarious and the stable are inseparable from one another, and our existence depends upon the unceasing interplay between the two. Yet, we have historically done our best to dismiss the precarious aspect of experience. We see the destroyed building and feel dismay, stating something like "I never thought that could happen." The precarious seems to us so *foreign*, as though it were an intrusion. Nevertheless, Dewey insists that we are wrong in responding to the precarious in this way. For Dewey, no existence, whether an inanimate object, an organism's life, or a human institution, is ultimately permanent. Everything that is built will one day be undone, whether by human decision or the corroding forces of nature. Any philosophical vision that covers over this fact, that is, that suppresses the precarious aspect of existence, suffers from a form of self-deception.

We experience the precarious and the stable not only in objects like buildings, but in human existence itself, Dewey contends. This follows straight from a Darwinian sensibility; we experience the world as precarious and stable because doing so confers on us an adaptive advantage in a world that is, in fact, precarious and stable:

Man finds himself living in an aleatory world; his existence involves, to put it baldly, a gamble. The world is a scene of risk; it is uncertain, unstable, uncannily unstable. Its dangers are irregular, inconstant, not to be counted upon as to their times and seasons. Although persistent, they are sporadic, episodic.<sup>52</sup>

Here we see Dewey at the height of his anthropological prowess. He uses his discussion of our experience of the precarious to show that this is how we actually exist in the world. What is most important here is that, for Dewey, nothing can change this fundamental truth about the precarious nature of human existence. Scientific advancement can help us to better adapt to our world; it can give us the means to more rapidly and forcefully respond to the manifestation of the precarious, but it cannot get rid of the precarious completely. The precarious is not equivalent to Heraclitus' *logos*, which orders the cosmos through measured and structured change. Rather, Dewey is insistent that the precarious signifies the occurrence of truly *random* events that escape any governing law that would seek to truly order them.<sup>53</sup> The precarious nature of human life cannot be banished through advances in knowledge or even social organization. Instead, we must always be wary, looking for signs of the precarious seeking to emerge from out of the stability we cherish.

Yet we need not hold a completely negative view of the precarious. Instead, Dewey insists that the precarious aspect of human existence makes possible all that we value or cherish:

The union of the hazardous and the stable, of the incomplete and the recurrent, is the condition of all experienced satisfaction as truly as of our predicaments and problems. While it is the source of ignorance, error and failure of expectation, it is the source of the delight which fulfillments bring.<sup>54</sup>

It is only because we are capable of having our aims thwarted that we are able to celebrate their realization. It is only because we have experienced the swift and violent force of the elements that we are able to value having a building that will protect us. The stable without the existence of the precarious is ultimately meaningless to us. It offers a

finished and final world in which the possibilities of change, chance or novelty are removed. Although some might crave such an existence, it does not reflect in world in which we actually live. Instead, we live our lives trying to anticipate and adjust to the varying forms of precariousness that loom over the stability we cherish so greatly.

### **The Transaction between Organism and Environment**

I will now further develop a notion that was implicit within Dewey's Darwinian heritage—the fact that we undergo transactions with the environment. Again, the world is not just some open container that we are dropped into. It is the means through which we are able to exist at all.<sup>55</sup> As we saw in the previous section, the environment is precarious and presents us with a multitude of dangers. Yet we need not believe that our relationship to the environment is entirely antagonistic. Instead, we are intimately bound to and depend upon the very thing that offers us our greatest dangers:

At every moment, the living creature is exposed to dangers from its surroundings, and at every moment, it must draw upon something in its surroundings to satisfy its needs. The career and destiny of a living being are bound up with its interchanges with its environment, not externally but in the most intimate way.<sup>56</sup>

We are always involved in a relationship of ebb and flow with our surrounding environment. Nature presents the source of our danger as well as the means by which we can temporarily overcome such a danger. Furthermore, even the goals towards which we work are themselves natural. Thus, in all of our strivings and struggles, the environment provides to us the source of our troubles, the means by which we can reorganize our situation, and the ends towards which we work.

Yet what is the environment? More specifically, is the environment limited to what we would traditionally call “natural,” to the exclusion of the social or cultural? As has been shown, for Dewey, every facet of our existence is natural. Thus, we cannot exclude the social aspects of human existence from the totality of our environment. Furthermore, humans are always undergoing a constant transaction between themselves and their social aspects of their environment. Whereas our transactions with the material aspects of our environment yield hunger and its satiety, our social transactions yield alienation and its temporary resolution through novel meanings. Politically, our transactions yield discontent followed by reformation or revolution. This is not to say that our strivings are always satisfied by our attempts to rework our environment. Dewey is well aware that there exist some situations in which the organism will not be able to adapt to its environment. Ultimately, every organism will encounter some situation from which it cannot recover. Thus, even the ebb and flow between the organism and its environment will at some point draw to a close.

### **The Live Creature**

It is with the preceding discussion in mind that I now want to introduce the dominant metaphor that Dewey uses to describe a flourishing human.<sup>57</sup> Ultimately, I wish to utilize Dewey’s discussion of the live creature to undermine the metaphor of the body as a machine. Dewey discusses the live creature in his work *Art as Experience*:

Life itself consists of phases in which the organism falls out of step with the march of surrounding things and then recovers unison with it—either through effort or by some happy chance. And, in a growing life, the recovery is never mere return to a prior state, for it is enriched by the state of disparity and resistance through which it has successfully passed. If the gap between organism and environment is too wide, the creature dies. If its activity is not enhanced by

the temporary alienation, it merely subsists. Life grows when a temporary falling out is a transition to a more extensive balance of the energies of the organism with those of the conditions under which it lives.<sup>58</sup>

Here we see all of the previously discussed elements synthesized into an organic image of how it is we both do and undergo the process of living. Dewey outlines three different ways in which the live creature can exist. First, he is capable of growing. Growth, for Dewey, is our capacity to reconstruct our experiences in a way that can be fruitfully applied to new situations. Growth can only occur through the occasional alienation of the organism from the flow of his environment. Consider, for instance, a student working her way through a series of math problems. The student works through the first few problems with ease, but eventually comes across one that is difficult. After some effort, consulting a tutor, or just through sheer luck, the student is able to solve the problem. The student's flow was interrupted by the challenging problem, but it is only problems like these that will allow the student to improve at math.

Dewey believes the same is true of all aspects of life, not merely education. It is only when we are first puzzled, interrupted, or struggle with something and then overcome this that we are able to be better adapted to our environment. The process of falling out of step with our environment makes it possible for us to improve our overall lot in life. We see again reverberations of the interplay between the precarious and the stable in this metaphor. We cannot grow if we live in a totally stable world. Instead, the precarious balance we oftentimes have with our environment is the source of much of the good in our lives.

But Dewey does not insist that we always grow as a result of falling out of step with our environment. It is possible, he contends, to merely subsist. If we are unchanged by our experience of alienation then we cannot grow. Consider the alcoholic who returns back to his drink only having just recovered from the last binge. He is unable to adapt himself, to learn from his previous mistakes. He is unable to grow. The contrast between this and the live creature is telling:

But the live creature adopts its past; it can make friends with even its stupidities, using them as warnings that increase present wariness. Instead of trying to live upon whatever may have been achieved in the past, it uses past success to inform the present.<sup>59</sup>

One who subsists attempts to hold onto the past for its own sake. But the live creature, one who is growing, uses the past as an indicator so as to mark all of its current experiences. Whereas those who subsist despise their pasts as shameful, the live creature knows that his failures are those exact things that make growth possible. The contrast between growth and subsistence serves as a warning to us: falling in and out of step with the flow of the environment is not enough to warrant growth. Instead, it is incumbent upon us to learn from this process itself, to adapt to the ebb and flow of our existence.

But Dewey makes note of a third mode of existence, one in which the live creature falls too far out of step with the flow of its environment. If this occurs then death can be the only result. The creature can at this point no longer transact with its environment, and without this transaction, it has lost the very medium through which it was able to live at all.

### **Health as a Process, Illness, and the Task of Medicine**

Having given a brief account of Dewey's metaphor of the live creature, I wish to now turn the focus more directly to issues related to medicine. I will commence, then, with a simple question—what is health? The phenomenon is so glaringly obvious to us yet we struggle to put it into simple words. It is no wonder then that Hans-Georg Gadamer titled his book on the subject *The Enigma of Health*, for health is a difficult puzzle to piece together. A common definition is that developed by the World Health Organization in 1948, stating that health is “a complete state of physical, mental and social well-being, and not merely the absence of disease or infirmity.”<sup>60</sup> What is most important in this conception of health is the insistence that health is a *state*. Doubtless it is a complex state involving an incalculably large number of factors, but it is viewed as a state of being nevertheless. Using Dewey's notion of the live creature, I want to propose the notion that health is a process.<sup>61</sup> We are not in a *state* of good health, we are *health-ing*, so to speak.

We already have insight into what this process of health will look like because the hallmark of the process of health, I contend, is growth. Growth is indicative of a live creature, one who is able to seize hold of its experiences in order to continually transform its way of living in the world. Thus, to undergo the process of health is to experience all of the ebb and flow of the live creature's existence in a manner conducive to growth. It will be helpful, then, to offer a brief analysis of the process of health with respect to both the precarious and stable aspects of existence as well as through the transaction between the live creature and its environment.

First, health exists as both precarious and stable. Like with almost every other thing we encounter, we tend to value the stability of health and cover over the fact that it has its precarious movements as well. We seem to think of health as the state in which we normally function, and this is in many respects very true. But health oftentimes requires a state of what we might otherwise be tempted to call illness. When the body is in a stressful situation it responds with mechanisms that, in order to return to the stable, are themselves quite precarious. The epidermal cells, for instance, will undergo cell death if they are exposed to too high a concentration of UV rays. The reason is that exposure to excessive UV rays drastically increases the chance of DNA mutations, ultimately increasing chances of cancer.<sup>62</sup> The body has evolved mechanisms so as to avoid this greater harm by causing a lesser. We experience this occurrence, the sunburn, and would be more prone to categorize it among bodily afflictions than we would as part of the process of health. But, if we are to take Dewey seriously, we must come to see this as an example, along with numerous others, of the fact that even health itself has its precarious moments, and that these precarious moments are what allows us to enjoy the stable.

Furthermore, health cannot be understood except as in the context of the organism transacting with its environment. There are two important consequences that follow from this fact. First, we must always keep in mind that, for Dewey, the environment has the richest of meanings. Thus I am not referring only to the physical environment, but to the social environment as well. *I contend that we cannot understand what it means for any individual organism to have health except insofar as we are able*

*to grasp him in the totality of his relationships with his environment, whether social or physical.*

The second factor to consider for the organism interacting with its environment is this—we must stand watch for drastic changes in the environment. If changes occur, then the way in which the organisms transact must change as well. Consequently, certain factors that we may have considered the hallmark of health may no longer be. Furthermore, factors that were once ignored could become indicators of an organism who is falling too far out of step with the environment. We must resist the urge to force old conceptions of health onto a moving target. Instead, we must seek to encourage novel notions of health that emerge in response to changes in the environment. This is a counterpoint to dogmatism; just because certain practices have yielded powerful results in the past does not signify that they are universally legitimized. Instead, we must greet changing circumstances with an openness to reconsider our assumptions about what practices are proper or adequate to our stated goals.

In addition to a conception of health, we can also see a definition of illness that follows from this metaphor. Illness occurs when the creature is unable to successfully complete the process of health without aid. That is, illness occurs when the creature falls out of step with the flow of the surrounding environment, and it unable to regain step with it without the assistance of the physician. It is interesting to note that with these definitions, the distinction between illness and health is one of degree and not one of kind. The process of health has as an integral component the precarious. Illness, then, occurs when the precarious aspects of health become too dominant and threatens to

disrupt the creature's ability to attain stability. Finally, it is important to note that this definition of illness includes all of the phenomena that biomedicine calls 'illness,' and, as will be shown, is also more inclusive.

Finally, we can develop a brief overview of the task of medicine given our understanding of the patient as live creature. The goal of medicine is very simple; medicine must help the creature reconstruct its relationship to the environment when it has fallen out of step with the flow of its surrounds. Furthermore, medicine must encourage the patient to grow and not merely subsist. While this seems quite trivial, if we consider the conclusions of the precarious and the stable and the transactions between the organism and the environment, we see that the goal of medicine entails a deep relationship between patient and physician. Furthermore, as I will seek to demonstrate throughout the rest of this chapter, it requires an institutional transformation of medical practice.

### **Diagnosing Biomedicine**

Having established a conception of health grounded in Dewey's philosophy, I want to now reexamine the crisis of success that was discussed in the previous chapter. My purpose is as follows—I want to show that biomedicine itself has fallen out of step with the flow of human disease. It has done so because it has been based on an improper understanding of the way in which we exist. In essence, biomedicine has interpreted its positive results as proof that it has learned the *truth* of human health and disease. I contend that biomedicine was successful because its methods were functionally ideal for the kinds of diseases it was employed against. But, it has become dogmatic in its

application of this methodology. As such, it has been unable to discern a massive shift in the nature of human health and illness. The only responses biomedicine has to this shift in human health is to either keep applying the same methodology as before or to exclude the disease in question from medicine's purview. The crisis of success emerges out of biomedicine's favoring of the stable over the precarious and its emphasis on the *ends* at the expense of the process by which we achieve these ends. In ignoring the process it covers over the importance of the transaction between the patient and her environment. This all culminates in health being viewed as a state by biomedicine, and I contend that this is no longer an innocent assumption.

Recall that biomedicine operates through a series of exclusions. The exclusions manifest themselves in numerous ways—by limiting what possible treatments are considered acceptable, by forbidding certain explanations from disease, and sometimes, by excluding certain biological phenomena from the category of disease itself. These exclusions emanate from the fact that biomedicine came of age in the era of infectious diseases. It is in every way designed to target and eliminate infectious diseases as serious health issues for humankind. And, biomedicine has been largely successful at this task. But this is where biomedicine runs into problems. Infectious diseases lend themselves to a conception of health as a state. These diseases involve foreign agents whose presence or absence marks our relative stages of illness or health, respectively. The infection occurs, the machine breaks down, the doctor “fixes it,” and the machine is repaired. Thus, we say the patient goes from a state of health to illness and back to health.

Yet what are we to say about other categories of disease? We no longer live in an age dominated by infectious disease; we live in an age of chronic or terminal diseases, or ‘diseases’ that struggle to attain that label at all. Primary care physicians find themselves dealing more and more with issues of blood pressure, arthritis, obesity, cholesterol, depression or ADHD than they do with tuberculosis or cholera. These diseases do not lend themselves as easily to the metaphor of a machine breaking down. There is no easy ‘fix’ for these issues. For instance, it is oftentimes the case that when a patient starts taking medication for one of these diseases he will continue to take this medicine for the rest of his life. There are ebbs and flows throughout the patient’s life, times in which he seems to have control of his disease and times in which it seems as though his existence is quite precarious. Thus, we live in an era in which the health and illness are more obviously a process than they are states of being.

Yet biomedicine has remained fixed on a notion of health as a state. It has sought to ignore the fact that health is a process involving both the precarious and the stable and is itself subject to changes in the patient’s environment. Biomedicine accomplishes this through the process of exclusion mentioned in the previous chapter. Why are psychological and social issues excluded from etiological considerations? Why are objective tests valued above the patient’s account of their health? Why is it that some diseases such as chronic fatigue syndrome (CFS) themselves struggle to attain the status of disease at all? The answer, I contend, is a repression of the precarious and a de-emphasis of the organism’s transaction with its environment. In each of these types of exclusions there is an important precarious element of health at work. Human

psychology and sociology are deemed ‘soft’ sciences compared to the rigors of biochemistry. Patients are unreliable, so we cannot trust their reports as we can test results. CFS cannot truly be a disease or else it would showcase itself at the cellular level. With each of these claims we see that biomedicine wants to exclude factors that are harder to control, that exceed to the immediate abilities of their methods to predict and explain. Biomedicine wants disease and health to be stable, predictable, and easily verifiable. But they are not. This desire stems from an improper view of human existence, a Cartesian world of mechanistic and deterministic laws governing matter. This view has no sense of novelty and no possibility for higher order phenomena like the mind or society to affect matter. But this simply will not do in a new era of human health. We must move on past these exclusions and embrace a medical model that seeks to grasp human health in the totality of its environment.

### **The Physician as an Agent of Social Transformation**

If medicine is to embrace Dewey’s understanding of human existence then I can see no other conclusion than that the physician must become an agent of social transformation. Disease and health are not fixed; they are dependent upon changes in the environment and the way in which humans interact with this environment. They also are not states; they are processes with both their precarious and their stable moments. Thus, medicine must become an institution that seeks to constantly transform itself so as to adapt to the needs of patients in any era. I refer to the transformation as social so as to emphasize that in every capacity medicine must be concerned with social dimensions of health.

If the task of medicine is to help the organism navigate the ebb and flow of his environment, then there is no more overall effective way to do this than for the physician to become a strong advocate for social transformation. What does this precisely mean? It means two main things. First, in terms of individual patient care, the physician must come to see patients as an integrated whole, an individual whose social setting is as important of a health factor as are biological factors. In many respects, this is the position the holistic medicine movement advocates; however, I hope to avoid the pseudo-scientific tendencies of holistic medicine. Furthermore, this model asks doctors to go beyond treating individual patients; it asks physicians to seek to transform social institutions and practices that adversely affect patient health. No longer can medicine be seen as only care for individuals. Instead, medicine must seek to transform the relationship that patients have with their environment by helping to change the environment itself.

First, how would individual patient care be different under this model? Again, this model is in many respects inspired by holistic medicine's sensibilities, but retains allopathic medicine's practices.<sup>63</sup> Recall Tinetti and Fried's article "The End of the Disease Era" in which they advocate a transition to 'personalized medicine,' which requires dialogue between patient and physician as to the patient's health goals, her social environment, and what considerations are most important for her happiness.<sup>64</sup> Through this conversation the patient and physician together come up with a treatment plan that places the patient's goals as the highest priority and seeks to change both the environment and use any necessary medications to achieve this goal. Notice how this

practice is much more akin to Dewey's account of the live creature than it is to the Cartesian body as a machine. The focus here is not on fixing something broken in the patient, but helping them to transact better with their environment. The physician can do so by addressing the patient and the environment as an inseparable unit.

In addition to individual patient care, this medical model asks physicians to become advocates for social changes that will positively benefit patient health. In that regard, perhaps the first institution to be targeted should be medicine itself. Such a change can occur only when medicine first comes to recognize itself primarily as a social practice. Physicians must come to see themselves first and foremost as social agents, as individuals who ought to always seek to understand the social implications of what it is they do. Medicine cannot fall into mere routine or else it runs the risk of dogmatism. It must stay abreast with patient goals, societal values and cutting edge technology. Naturally, physicians already have a tremendous workload, so it might seem too much to ask doctors to become experts in these fields. Nevertheless, it seems as though the impetus for such change can occur during medical school or before. Medical schools can seek to broaden the scope of the humanities training that patients receive, adding courses in medical anthropology, medical sociology, or more general medical humanities.<sup>65</sup> If the medical school curriculum itself could not be altered then medical schools could require applicants to have taken such courses throughout their undergraduate education.<sup>66</sup>

But it is not only the institution of medicine itself that must be transformed. There are numerous institutions that are associated around the practice of medicine

itself—insurance, pharmaceuticals, counseling, nursing homes, and countless more. These institutions are not innocent bystanders; they comprise an integral part of the patient’s social environment. Thus, if medicine is to include social factors into its health considerations then it physicians must take a second look at the way in which these institutions positively or negatively affect public health.<sup>67</sup> Physicians must consult with policy experts and public health officials in order to determine how and in what ways these institutions can best serve patient health. And, if a certain policy change is believed to be beneficial then it must be part of the physician’s task to lobby government officials to effect changes in the name of patient health. Certain policy decisions can no longer be seen as external to patient health; they are part of parcel of the social environment and can have drastic effects on health.

I believe that the delicate balance between showing care for individual patients and agitating for social reform can be found in Paul Farmer’s work in the Russian prison system. Due to extreme overcrowding and criminals having no right to a speedy trial, most of the prisons in Russia have become infested with multidrug-resistant tuberculosis (MDRTB). Farmer’s first action when he arrived at the prisons was to develop a new treatment plan that was ideally suited for this specific context. The World Health Organization had advocated a treatment program for MDRTB, known as “directly-observed therapy, short course” (DOTS).<sup>68</sup> However, given the extreme circumstances of the prisoners, DOTS was considered cost-ineffective. This claim led Farmer to question the set of assumptions that guide the institutions of medicine, public health and pharmaceuticals:

[I] had shown that MDRTB can be treated successfully in settings of overwhelming poverty. All that was left, then, was the recurrent mantra that the drugs were too expensive to be cost-effective. But this mantra was repeated without honest investigation of *why* the drugs, long off patent, were so expensive. Thus has the notion of cost-effectiveness become one of the chief means by which we manage (and perpetuate) modern inequality.<sup>69</sup>

Farmer's immediate reaction is to employ the appropriate methods to treat MDRTB.

However, certain social factors beyond his ability to immediately change prevent him from doing this adequately. His response is to question these factors, to move beyond only treating the patients (which he still does) to asking questions about the social institutions and practices that directly affect public health. He is unable to separate these factors from the actual biological questions associated with MDRTB. In this regard, I see Farmer's actions as being in accord with the notion of the patient as a live creature. He is not attempting to fix something broken about the patient; he is attempting to use everything within his power to change the dynamic of biological and sociological factors so that these individuals will be able to live in their environment. This is the goal that medicine ought to strive towards.

### **Conclusion**

There is one last aspect that must be brought into consideration here. Ultimately, the precarious nature of our existence wins out. Everything that is built is undone. The goal of this model is to help medicine embrace the fact that health and disease are themselves not stable. They change, they adapt to changing environments. As such, the task of medicine must involve transformations of patient care and even transformations of entire institutions. Nevertheless, there is no institutional change that will change the fact that ultimately, each of us will step so far out of the flow of our environment that we

will not be able to recover. Thus, even though I here strive to improve human health in every capacity, I hold no illusions of immortality. Medicine, I fear, does hold such illusions. Thus, I want to specifically address issues related to aging and death in the following chapter. To do so, I will reexamine the crisis of medicalization in the context of Martin Heidegger's philosophical vision.

## CHAPTER IV

## MEDICINE AS CARE: AUTHENTIC BEING-TOWARD-DEATH IN MEDICINE

In the face of the tremendous advances of medical technology in the twentieth century, the cultural image of physicians has undergone a radical shift. For instance, we no longer think of a country doctor tending to a patient all night, but instead picture an internist taking notes on a laptop, seeing as many patients in a day as is possible. Although such a transformation is telling in many respects, the focus here is on continuity between both images; the earlier country doctor and the modern internist both, in their own way, exhibit the practice of medicine as care. Medicine was, is, and always will be about care. As Michel Foucault informs us, Western medicine originated in the Greek world as one tradition, among many, of practicing *epimeleia heautou*, the care of the self.<sup>70</sup> One could practice care through other means as well, and the Greek world was inundated with manuals about proper diet, athletic training, and sexual advice helping citizens show care for themselves. One need only take a cursory glance at contemporary society and its obsession with health to see that we not so different from the ancient world. We can join gyms, go on diets, buy lotions to protect our skin, and, in the midst of these and countless other practices, we can turn to medicine. Modern medicine, like its ancient counterpart, exhibits care.

Yet what is care? After all, to claim that medicine exhibits care seems quite obvious and unhelpful for the development of a new model of medicine. If biomedicine already showcases care, then what need is there for an alternative model of medicine as

care? To answer these questions I will employ Martin Heidegger's existential analysis employed in his work *Being and Time*. Whereas Dewey's philosophical vision grounded a response to the crisis of success, Heidegger's project will allow us to confront the value problems implicit within the crisis of medicalization. Heidegger contends that ontic practices such as medicine can exhibit care only because we first and foremost *are* care ontologically. That is, it is only because we are the kinds of beings who care about our being, about the fact that we exist, that we are able to develop practices such as medicine in the first place. Thus the notion of the physician caring for the patient is already a derivative concept of care, fundamentally grounded in our being as care. Heidegger believes that we mostly relate to our being as care in an existentially inauthentic manner. In this chapter I am seeing if it is possible for medicine to exhibit care in an authentic, ontological way. The determination of this question is fundamental to the development of a new model of medicine, one grounded in an existential conception of care.

The path to developing a notion of medicine as care requires a deeper understanding of several aspects of Heidegger's analysis. I will commence with a brief sketch of what Heidegger means by an existential-ontological notion of care. Next, since medicine, like all work, involves others for whom and with whom we labor, I will then examine his account of authentic and inauthentic modes of being-with others. I will show that to authentically relate to a patient, a physician must see her role as helping her patient open up possibilities for his life. This, in turn, will turn us toward the phenomenon that Heidegger believes opens up and allows all possibilities to be at all—

our relationship towards our own death, which he refers to as being-toward-death. Next, I offer a sketch of an existential picture of illness, something hinted at yet left undone by Heidegger in *Being and Time*. Following the existential analysis of death and sickness, I will show how biomedicine relates to these phenomena in an existentially inauthentic manner through tranquilization of the anxiety about our death. As an antidote to this inauthentic relation to death, I will analyze Anatole Broyard's work *Intoxicated with My Illness* to show the potential for medicine to foster authentic being-toward-death. All told, the model of medicine as care must come to see sickness and death not as failures of medicine but as phenomena that open up and grant patients their very possibilities to be.

### **The Being of Dasein as Care**

The concept of care has a venerable heritage within the history of philosophy. Heidegger offers a powerful account of the phenomenon of care throughout his existential analysis of human beings, or Dasein.<sup>71</sup> In §41 of *Being and Time*, Heidegger defines care as “being-ahead-of-oneself-already-in (the world) as being-together-with (innerworldly beings encountered). This being fills in the significance of the term *care* [...]”<sup>72</sup> There are three facets of care, then, that must be elaborated in turn. First, care involves *being-ahead-of-oneself*. What Heidegger means by this is that Dasein is never merely in the present moment. Instead, the present moment is itself shaped by the fact that Dasein is oriented by the future. We live ahead of ourselves--planning, projecting, setting goals and acting upon them. Heidegger believes that in doing so we are utterly free, and thus utterly responsible, to choose what we make of our lives. There are

infinitely many ways that Dasein can choose to enact its possibilities to be. In so choosing Dasein is making manifest its being as care—it is only because I care about my existence that I am able to enact possibilities to be.

Care also involves the element of *already-in*. We are thrown into existence without the power to choose the time and place in which we are born and live. Existentially Heidegger believes this manifests itself in the fact that we are *affective* beings; that is, we are able to be affected by forces that are outside of our control.<sup>73</sup> We can see this in the fact that we find ourselves in various moods that differently shape and contour how we encounter the world. These moods should not be confused with those we may traditionally associate with psychological research. Instead, moods are existential structures showcasing the fact that we answer to conditions outside of our control. Heidegger believes that certain moods, anxiety in particular, best demonstrate the being of Dasein as care.<sup>74</sup> When we are anxious we encounter the world as inherently meaningless. The system of meaning between Dasein and things in the world breaks down. All that remains, Heidegger believes, is the experience of our being as pure possibility. We are anxious about the fact that we exist in the first place and about the fact that one day we will not exist. That is, we experience anxiety only because we are the kind of beings who care about our being.

Finally, care involves the element of *being-together-with*. Here Heidegger is referring to the fact that we are not the kind of beings who are indifferent to the world we find ourselves in. We take care of things in the world. The classic Heideggerian example is the hammer in the workshop. We take care of the hammer by properly using

it—by embracing it in the totality of relationships that it exists in. In doing so, we reveal the hammer in all of its possibilities to be. Heidegger believes that what grants the hammer its possibilities to be is the being of Dasein itself, and Dasein's own possibilities to be. That is, a hammer is what it is only insofar as it can be encountered by us and taken care of in our performing of tasks.

To conclude this section, I will highlight the fact that each element of care is integrally bound up in Dasein's possibilities to be. Thus, in saying that the being of Dasein is care, Heidegger means that in every respect, Dasein finds itself encountered with possibility and not actuality. To care for ourselves in an authentic manner means to recognize and knowingly enact certain possibilities for our lives. We are free, of course, to deny ourselves these possibilities. When confronted with the fact that we can enact new possibilities to be we can reject this with inauthentic remarks such as "That's just the way I am." Yet, this inauthenticity is possible only because our being is first and foremost to be possible. Having elucidated Heidegger's concept of care as Dasein's coming to recognize and enact possibilities to be, I will now turn to a question concerning the interaction of two Dasein, what Heidegger calls being-with. Specifically, I wish to have questions concerning the practice of medicine to more directly orient the discussion that follows. In what ways can physicians authentically show their being as care? Is it possible to have an existentially authentic relationship to another Dasein, between a patient and a physician?

### **Being-With: Authentically Relating to Patients**

Having been educated in a positivistic tradition, physicians who practice under the biomedical model are encouraged to interact with patients in the manner deemed most appropriate by biomedicine—through objectification, what Michel Foucault describes in *The Birth of the Clinic* as the dispassionate, normalizing ‘clinical gaze’ of the physician.<sup>75</sup> Biomedicine emphasizes the physician as a scientist, and the scientist is one who stands back and observes objects. Thus for biomedicine the only proper manner of involvement between physician and patient is one observation of the latter by the former.

We can already see how this stands in opposition to Heidegger’s notion of care. We are not the kind of beings who engage the world as dispassionate observers. Rather, we are intimately involved in taking care of things. Yet other people are not mere things; they are Dasein just as I am. Heidegger develops an important account of the way in which we relate to other Dasein, which he refers to as *being-with*. In opposition to much of post-Cartesian Western thought, Heidegger does not view the existence of others as a ‘problem’ for his philosophical vision. Instead, he believes the very structure of being-in-the-world always already presupposes the existence of others for whom and with whom I engage in work. Dasein, in its very being, shows concern for other Dasein. The objectification of others is possible only because we already find ourselves involved with others through this concern.

In a famous passage from §26, Heidegger details inauthentic and authentic modes of showing concern for others, respectively named *leaping in* and *leaping ahead*:

[Concern] can, so to speak, take the other's "care" away from him and put itself in his place in taking care, it can *leap in* for him. Concern takes over what is to be taken care of for the other. The other is thus displaced, he steps back so that afterwards, when the matter has been attended to, he can take it over as something finished and available or disburden himself of it completely.<sup>76</sup>

There is the possibility of a concern which does not so much leap in for the other as *leap ahead* of him in his existentiell potentiality-of-being not in order to take "care" away from him, but rather to authentically give it back as such. This concern [...] helps the other to be come transparent to himself *in* his care and *free for* it.<sup>77</sup>

To leap in is to take a decision away from another Dasein, to decide a matter for them.

To leap ahead, however, is to help the other Dasein confront the decision with an understanding of its own possibilities to be. That is, to leap ahead is to authentically show concern for another Dasein, to make it transparent to them their being as care.

This can be made clearer through an example from education. Consider a student asking a professor for aid in writing a term paper for a course. If the professor were to leap in, she would simply tell the student what topic to write the paper on. In so doing, the professor is closing off the student's authentic possibilities to choose. The student is not authentically choosing his project; he is simply doing as he is told. However, if the professor were to leap ahead, she would instead use her knowledge of the material to guide the student towards developing a project of his own choosing. In so doing she is granting the student the possibility of properly expressing care for his own being.

We can now consider the phenomena of leaping in and leaping ahead in the context of medicine. How can a physician leap in ahead in her interactions with a patient? In what way can a physician help her patients authentically relate to their being as care? How should a physician help a patient authentically embrace his possibilities to

be? All three of these questions are oriented by the possibility of authentic being-with in the practice of medicine. The answer, I contend, may seem antithetical to our traditional notions of medicine. Medicine, we are told, is often a matter of life and death. If medicine is to express an existential sense of care, we may be tempted to think that the emphasis should be on the former, life. Yet this is not the case. As an ontic practice, medicine may concern itself with the preservation of life; however, when considered as an ontological practice of care, medicine, like Dasein, must take its orientation from death. Thus, for a physician to leap ahead she must help her patients as Dasein authentically relate to the possibility that grants them their being as possibility; their own deaths.

### **Being-Toward-Death**

Heidegger's analysis of death has played a major role in shaping the phenomenological and existentialist movements in the twentieth century. While I will dedicate a significant effort to elucidating the key points of his analysis, I wish to retain my orientation with respect to the practice of medicine. In what ways can Heidegger's analysis of death yield insights for physicians, patients, and the relationship between the two? We are not without precedent in considering his discussion of death in the context of medicine. Heidegger himself raises the following question in §49 of *Being and Time*:

Or must sickness and death in general—even from a medical point of view—be conceived primarily as existential phenomena?<sup>78</sup>

The remainder of this chapter will take orientation from this curious line offered by Heidegger. What Heidegger suggests is that medicine must come to see death and sickness as existential phenomena, and not merely in an ontic, derivative manner. With

respect to death, Heidegger dedicates much effort to elucidating the existential character of death, which will be the focus of this section. The following section will provide a brief sketch of what an existential account of sickness might look like, something here suggested by Heidegger but not actually carried out. Finally, I will consider the various ways in which the biomedical model attempts to relate to death in either a derivative way, or at best, in an inauthentic manner. I will offer recommendations based on Heidegger's analysis of what an authentic relationship towards death will look like.

Here, however, we must address Heidegger's account of being-toward-death. It is this relationship to our own death that allows Dasein to authentically understand its possibilities to be, and, as such, to understand its being as care. It is perhaps easiest to begin by delimiting what Heidegger's conception of death is *not*. He draws a distinction between death as an existential phenomenon and 'demise' as a biological event. Demise, according to Heidegger, is the future event in which a Dasein as biological creature will draw its last breath and pass from a state of living to no longer living. He believes that this conception of death as a future event is derivative of the fundamental, existential conception of death that he is hoping to elaborate.

The problem with such a notion of death as a future event is that it conceives of the phenomena in terms of actuality. Heidegger, in contrast, sees death not as an actuality but as a possibility, specifically, death is our "*ownmost, nonrelational, certain, and, as such, indefinite and insuperable possibility.*"<sup>79</sup> I will elaborate each of these elements in turn. However, it would be helpful to first elaborate what Heidegger means by death as a possibility. By death, Heidegger is referring to the fact that we are the kind

of beings who can die. Moreover, we are the kind of beings that *know* that we will die. Thus, it may be helpful to think of Heidegger's notion of authentic death as similar to the concept of mortality. We live in the light of our own death. Thus, death is not an event far away in the distant future; our death is something that shapes our very being as care. We carry around with us the fact that it is possible for us not to be, and this gives contour to the various possibilities that we choose to enact.

We must now address three fundamental aspects of death that highlight the manner in which death grants Dasein its very possibilities to be.<sup>80</sup> First, death is our ownmost. What Heidegger means by this is that nobody can die my death for me. Even if someone offers his life to save mine, he has not altered the fact that one day I will die. The realization that our death is our own helps us to see our being as possible. That is, since our death is our own, we must come to see that our life and all of our possibilities to be are ours as well. We are responsible for taking ownership of our lives, for expressing care for our being through the enactment of our possibilities to be. It is because death is our ownmost that we are capable of care.

Next, our death is nonrelational. According to Heidegger, every task we perform and every possibility we enact is deeply embedded within a powerful matrix of relationships. We perform work on behalf of others. We choose what possibilities to enact from out of the circumstances we find ourselves in relation to. Most of the time, we allow others to choose our possibilities for us, but even in authentically choosing we still stand in relation to those around us. Consider, for instance, someone who inauthentically dresses fashionably because 'that's simply what one does' and someone

who purposefully defies fashion trends. Despite the contrary positions held by the two, both, in one way or another, stand in relation to the predominant fashion trends of the time. But death is the negation of all relations. When confronted with death, Dasein is torn from all of the relations it finds itself in, authentic or not. The result of this is that it is only through death that Dasein is individuated. In every other facet of its life, Dasein is shaped by being-with other Dasein. But Dasein confronts its own death only as itself and not through mediation or relation to any other.

Finally, Heidegger contends that death is insuperable. This means that death is a phenomenon that cannot be bypassed or overlooked. No matter what, Dasein must confront its own death. Thus, our death is something that is certain. But it is a certainty that is indefinite. For Dasein carries its death with it at all times, never knowing when it will die. Again, we must not lapse into an ontic notion of death as a future event. Dasein carries its death with it as an insuperable, certain yet indefinite, *possibility*. Since death is insuperable, Dasein is always comporting itself to its death in some way; that is, Dasein cannot be indifferent to its death. Even if it willfully ignores its death Dasein will still die. The possibility of my death is not like the possibility of my becoming a professor. I can ignore the possibility of becoming a professor, and this possibility will remain closed off from me. But death, as insuperable, is a possibility that I cannot bypass. I stand in relation to my death at all times, and I cannot remain indifferent to this.

Thus death is our ownmost, nonrelational and insuperable possibility to be. It is what grants to us the possibility of our being as care. It is what grants to us our individuality. We cannot remain indifferent to our own death. How, then, are we to

relate to our death? As with all existential structures of Dasein, the relationship to death, Dasein's being-toward-death, can occur in either an authentic or an inauthentic mode.

Authentic being-toward-death is known as anticipation. To be authentic Dasein must relate to itself own death through anticipation:

But anticipation does not evade the impossibility of bypassing death, as does inauthentic being-toward-death, but *frees* itself *for* it. Becoming free *for* one's own death in anticipation liberates one from one's lostness in chance possibilities urging themselves upon us, so that the factual possibilities lying before the insuperable possibility can first be authentically understood and chosen. Anticipation discloses to existence that its extreme possibility lies in giving itself up, and thus it shatters all one's clinging to whatever existence one has reached.<sup>81</sup>

When we confront our death through anticipation we come to see the folly of any sense of completion and actuality in our being. Anticipatory being-toward-death has as its hallmark Dasein's self-understanding as possible and not actual. We are not the kind of beings who can ever be complete in life; to be complete would signify a closing off from all new possibilities to be. To be authentic means that Dasein must always see itself as incomplete, as always able to be open to new possibilities, that is, to enact its being as care.

But Dasein can relate to its death in an inauthentic mode as well. Heidegger believes that inauthentic being-toward-death can manifest itself in a variety of ways. First, we can relate to death through the *temptation* to treat it as if it will happen to anyone but us. We often speak about death in an impersonal manner. We use phrases such as "one dies" to depersonalize death as our ownmost possibility. We do this, Heidegger thinks, as a retreat from death, for "in this way everyone can convince him/herself that in no case is it I myself, for this one is *no one*. "Dying" can be leveled

down to an event which does concern Dasein, but which belongs to no one in particular.”<sup>82</sup> Thus, when we speak of death in abstraction, we are covering over the phenomenon and retreating from our being as possibility.

Another manner of inauthentically being-toward-death occurs through *tranquilization* of Dasein from the possibility of death. This occurs, Heidegger thinks, when we attempt to comfort the dying, trying to reassure them that everything will be alright. In effect, we are not merely trying to reassure them, but are tranquilizing our anxiety about our own deaths. Heidegger believes the phenomenon of tranquilization most readily shows itself when somebody does die; “the dying of others is seen as a social inconvenience, if not a downright tactlessness, from which the public ought to be spared.”<sup>83</sup> We do not want to confront our own death, so we hide from the deaths of others. This allows us to try to maintain a state of indifference towards our own death, keeping our anxiety at bay.

Finally Heidegger believes that we can inauthentically relate to our death through what he calls *estrangement* from our death. We are estranged from our deaths when we turn from anxiety about the possibility of our death to fear of death as a future event. We are then condemned by others for expressing this fear, again leading us towards a sort of stoic indifference to our own death.<sup>84</sup>

### **Being-Toward-Sickness?**

Having recounted Heidegger’s account of death as an existential phenomenon, I will here offer a brief sketch of an existential account of sickness<sup>85</sup>; something suggested by Heidegger but not actually carried out. I propose that whereas death is the limit case

of our being, and hence, the ultimate source of our being as care, sickness can be seen as a qualitatively milder source of Dasein's possibilities to be. Our comportment towards sickness does not have the full force of Being-Towards-Death, yet it nevertheless manifests a parallel structure. Thus, for any given sickness, Dasein will find itself confronted with new possibilities to be that are opened up by that sickness. I will follow the spirit of Heidegger's analysis of death as closely as I can. Thus, examinations of sickness which consider it terms of biological perturbations must be seen as ontic and, thus, derivative accounts of sickness. Instead, Dasein must come to understand that it is the kind of being that is capable of being sick at all. Sickness, like death, is an ontological phenomenon that grants patients possibilities to be.

Of the three features of death detailed by Heidegger, sickness best shows its self in the context of being our ownmost. Like death, nobody can take my sickness from me; nobody can suffer my disease or disability in my place. Despite our best intentions to feel the pain of another, we are simply unable to do so. This is because, like death, sickness exhibits the character of being our ownmost possibility. Furthermore, sickness is an insuperable possibility for us. There is no getting around the fact that we are the kind of beings who are capable of being sick. Like death, the insuperability of sickness is both certain and indefinite. We do not know how or when we will become sick, yet we carry with us at all times the certain that at some point we will be sick. It seems as though we cannot make the case for sickness being nonrelational. It is death, and death alone that tears Dasein out of the context of meaningful relationships it finds itself in. If anything, sickness may reveal to Dasein the totality of reference it finds itself in.<sup>86</sup>

As an existential possibility to be, Dasein can either authentically or inauthentically enact its being-toward-sickness. As with death, to authentically relate to sickness would be to see it as an opening through which Dasein could enact new possibilities to be. For brevity's sake I will consider only the tranquilization of sickness as an inauthentic being-toward-sickness. As with death, we treat sickness as a something to be ashamed of, something to hide away from society. We are scandalized by sickness, and we recoil from the suggestion that sickness is a possibility that we all face. In so doing, we tranquilize ourselves from the insuperable nature of sickness as an existential possibility.

Thus, although sickness differs greatly from death with respect to its nonrelational nature, we see that the existential structure of sickness can generally be mapped onto that of death. The importance of this for my account is that when I consider biomedicine and how it fosters inauthentic being-toward-death, I need not focus solely on examples of death proper.<sup>87</sup> Instead, I can consider examples that include inauthentic being-toward-sickness as examples of the flaws of biomedicine. Having sketched an existential account of sickness, we must now raise again the question that motivated the entire investigation. How can physicians help their patients authentically relate to their sickness and death? How does medicine, as practiced under the biomedical model, fare with respect to this existential account of death? How might we imagine the practice of medicine anew given the insights that Heidegger's account of death has granted us? Equipped with a richer understanding of Heidegger's analysis of death, we can now

attempt to address these questions. I must now examine the biomedical model in order to show how it inauthentically relates to sickness and death as existential phenomena.

### **Biomedicine and the Tranquilization of Death**

It seems fairly obvious from the previous account that the practice of biomedicine centers on an inauthentic being-toward-death. Recall that biomedicine takes its methodological foundation from the biological sciences. Hence, it is unsurprising to find that biomedicine necessarily views death as a future event. In this section I will attempt to show how my claim that biomedicine employs an inauthentic understanding of death helps make sense of a variety of phenomena in the medical practice. Namely, I want to reexamine many aspects of the biomedicalization of aging as addressed in the second chapter. However, equipped with Heidegger's existential analysis of death we will be able to more adequately understand this phenomenon.

The first aspect of this phenomenon to be discussed is the unceasing drive to keep patients alive at all costs long after the hope of recovery has long gone. Recall Kaufmann *et al*'s 2004 article "Revisiting the Biomedicalization of Aging," in which they discuss what they call the technological imperative of biomedicine with respect to care of the elderly.<sup>88</sup> Essentially they argue that the default status of physicians is that technical ability implies ethical necessity. That is, if we *can* extend the length of an individual's life then we *must* do so, despite the wishes and desires of patients and their families. What drives physicians to suggest radical, life-prolonging medical procedures that will do little other than add a few weeks to a patient's life? Why do children of elderly parents often require that expensive procedures such as dialysis or intubation be

performed on their parents long after the hope of a recovery has passed? The answer, I contend, is tranquilization of our being-toward-death.

Tranquilization, recall, expresses itself as concern for the being of another Dasein; however, it is really an attempt to numb ourselves to death as our own possibility. That is, Heidegger believes that as we attempt to reassure a dying person that they will be healed, we are really attempting to pacify our anxiety about our own deaths. It is important to note the plural nature of this tranquilization. It is not specifically the physician's fault any more than it is the patient's or their family's fault. There is a sort of collective, yet depersonalized sense of responsibility for this tranquilization. This insight allows us to bypass the temptation to 'blame the doctors,' as is common in criticisms of biomedicine. We can blame no one and yet everyone, allowing us to bypass questions of blame and turn instead to understanding the problem of the tranquilization of death in order to attempt to develop a solution for it.

Tranquilization again manifests itself through the problematization of aging that occurs within biomedicine. One of the hallmarks of biomedicine is that it sees the slow but gradual degradation of the body as a medical problem as if it were an infection or a disability.<sup>89</sup> Heidegger's analysis can help us better understand why this is. Would it not be appropriate to view aging as a physiological manifestation of the fact that death is an immanent possibility that we all carry with us at all times? No matter our attempt to tranquilize death or view it as a far off future event, aging serves as a constant reminder of the fact that we are the kind of beings who are able to not be. But biomedicine can offer us recourse to aging such as no other human practice ever could. If a patient has

wrinkles, a plastic surgeon can remove them. If the patient has trouble walking, a surgeon can replace his knee. If one has burdensome, elderly parents, an offshoot of biomedicine, nursing homes, will house them and take care of them. There is nothing inherently wrong with these practices in and of themselves, but they highlight the way in which we treat death's herald, aging, as socially unacceptable in an attempt to tranquilize the anxiety we face concerning death as our insuperable possibility to be.

Naturally biomedicine feels shame not only in conjunction with aging, but with death itself. Death mocks the technological progress that we have achieved through biomedicine. In this end, the game is still the same; people still die from disease. The response by those who employ biomedicine is to express shock or shame associate with this. As Davis Morris informs us, biomedicine operates under the illusion that we can fully conquer disease. Thus "death is a scandal," he argues, "partly because it unmask the illusions that we can live forever."<sup>90</sup> Death scandalizes us because it disrupts the constant tranquilization with which we confront the anxiety about our own deaths.

In his work *How We Die*, Sherwin B. Nuland offers a telling description of the way in which physicians respond to aging and death. It is worth citing the passage at length:

The diagnosis of disease and the quest for overcoming it with his intellect are the challenges that motivate every specialist who is any good at what he does. He is fascinated with pathology. When faced by the certainty of his own impotence to treat it, the would-be healer too often turns away. If a riddle is by its nature insoluble, it cannot long hold the interest of any but a tiny fraction of the doctors who treat specific organ systems and disease categories. Old age is as insoluble as it is inevitable. By giving scientific names of treatable diseases to its manifestations, too many of the specialists from whom the elderly seek care retain their riddle and their fascination. They also believe they give patients some kind of hope, though in the end the hope must always prove to be unjustified.<sup>91</sup>

Here we see a repetition of the earlier analysis that biomedicine offers a tranquilization of death as our insuperable possibility to be. He in particular believes this description is true of specialists and their relation to death and aging, though I see no reason why the analysis could not hold for primary care providers as well. Death and aging are an unsolvable puzzle to the physician. When the physician can no longer sustain the illusion that he will solve this puzzle, he resorts to feeling powerless and covers over this by offering false hope to the patient. This occurs because biomedicine has fully ensconced itself in a derivative notion of death, yielding an inauthentic relationship to death, our insuperable possibility to be.

### **Authentic Being-Toward-Death in Medicine as Care**

How then can we begin to think of a new model of medicine as care? The distinction between medicine as care and biomedicine must hinge on their respective relationships to the phenomenon of death. As we just saw, biomedicine clearly holds what Heidegger believes is an existentially inauthentic notion of being-toward-death that ultimately stems from its understanding of death as a future actuality. In contrast, medicine as care must seek to develop an authentic being-toward-death through an understanding of death as possibility. To aid in this attempt I will turn to Anatole Broyard's collection of essays, *Intoxicated by My Illness*, written following his diagnosis to prostate cancer. What I will show is that, for Broyard, the discovery of his death yielded an opening of new possibilities for his life. This occurred through the development of what he calls 'illness narratives,' which are constructed through the

collective efforts of both the patient and physician. Through examining his thoughts I hope to briefly sketch what medicine as care might look like.

Broyard recounts his initial reaction upon discovering that he had prostate cancer:

It wasn't that I believed the cancer was going to kill me, even though it had spread beyond the prostate—it could probably be controlled, either by radiation or hormonal manipulation. No. What struck me was the startled awareness that one day something, whatever it might be, was going to interrupt my leisurely progress. It sounds trite, yet I can only say that I realized for the first time that I don't have forever.<sup>92</sup>

We can clearly see that Broyard does not employ a derivative understanding of death. That is, he does not consider his death in the context of the specific, ontic disease that plagues his body. Instead, upon the discovery of this disease he comes to relate to his own death as a possibility to not be. We see here the possibility for patients to conceive of death as an existential phenomenon, and not merely as a derivative, ontic future event.

However, simply regarding death as an existential phenomenon does not necessarily entail having an authentic relationship to it. What is needed is for the patient, Dasein, to relate to his death as which opens up new possibilities to be. I contend that Broyard does precisely this through his relationship to death and disease through narrative:

My initial experience of illness was as a series of disconnected shocks, and my first instinct was to try to bring it under control by turning it into a narrative. Always in emergencies we invent narratives [...] When people heard that I was ill, they inundated me with stories of their own illnesses [...] Storytelling seems to be a natural reaction to illness.<sup>93</sup>

Relating to illness and death through narrative is truly a function of embracing new possibilities to be. As such, the structure of narrative emulates the being of Dasein as

care. Recall that care contains facets of Dasein project itself ahead from out of its thrownness in order to enact possibilities immediately at hand. Narrative provides this same structure to the patient's experience of his own death and illness. First, as in care, narratives are oriented by the future and our concern for what possibilities await our characters of interest. Next, narratives emerge from out of past events that shape and give contour to which possibilities the characters can enact. Finally, narratives provide meaning and coherence to the relationships and actions that the characters are involved with through their daily encounters. If viewed in this manner, the development of illness narratives could become the foundation for a patient's existentially authentic being-toward-death.

In what manner could the practice of medicine aid in this project? How ought physicians to cultivate such illness narratives? First, we must reimagine what it means to be ill. Biomedicine cannot help but see illness, or even disability, as a defect, a deviation from what a 'normal' human should be like. As such, biomedicine always offers a narrative of compensation; that is, it relates to disease in a *compensatory* manner. The patient must be compensated for the fact that they have a terminal disease, or that they have lost a limb. Medicine must do everything it can to make sure the patient is not troubled by this deviation for normalcy. But must this always be the case? Medicine must recognize and in turn must help patients recognize that phenomena such as illness, disability, or pain can grant to patients new possibilities to be, possibilities that they otherwise would not have had.

In making this claim I run the risk of sounding as though I am positing a theodicy that will attempt to justify suffering and pain. In my attempt to show that this is not the case it will be helpful to consider an example from the life of St. Paul. In the Christian Scriptures St. Paul writes of “a thorn in his flesh” which causes him deep pain.<sup>94</sup> He repeatedly asks God to remove this pain, only to be told that he has been given this pain in order to prevent him from becoming prideful. Thus, St. Paul comes to accept this pain as an important and meaningful aspect of his faith and life. This example is telling through both its similarities and differences from the account of medicine I am seeking to develop. Like my claim about medicine, St. Paul ceases to desire compensation for his pain. He integrates the pain into his being and allows it to shape all of the future possibilities he enacts. In so doing, I believe that medicine could learn from the example of St. Paul.

However, the impetus for this relationship to the pain came not from St. Paul himself, but from God. In this, my account is markedly different. What gives meaning to and decides how one ought to relate to illness, pain, and suffering? Nothing other than Dasein itself can do this. No external source can demand the patient respond in a certain way; to do so would be to leap in, to inauthentically close off the patient’s possibilities to be. The measure for how a patient ought to comport himself to his afflictions is internal to each individual patient. The problem with biomedicine is that it has already leapt in, deciding that the patient only ought to view his affliction as an unwelcome disturbance from which he ought to be compensated. Thus I am not offering a theodicy that diminishes pain and suffering; I am offering a critique of an institution that robs patients

of the possibility of writing their own illness of narrative; that is, of relating to their pain and suffering in a manner of their own choosing.

Returning to the concept of developing illness narratives, the question must be raised as to what role physicians could play in these. Broyard believes that the physician must come to see himself as an integral character involved in the patient's narrative:

Whether he wants to be or not, the doctor is a storyteller, and he can turn our lives into good or bad stories, regardless of the diagnosis. If my doctor would allow me, I would be glad to help him here, to take him on as *my* patient.<sup>95</sup>

The task of the physician is that of a storyteller, helping the patient see possibilities that are opened up by disease. Notice that Broyard deemphasizes the actual diagnosis at hand. In this he is rejecting a compensatory attitude towards illness and is instead focusing on the narrative aspect of disease. This, in turn, strengthens the concept of a model of medicine that focuses on opening up possibilities to be, medicine as care.

In the above passage Broyard speaks of the relationship between the patient and physician is one of reciprocity. Even as the physician strives to help the patient craft his narrative, the patient in turn must help the physician. What help could the patient give to the physician? Simply put, the patient can leap ahead of the physician in helping him cultivate his being as care. As Broyard points out, this repudiates traditional conceptions of professionalism that have developed over centuries of medical practice:

Physicians have been taught in medical school that they must keep the patient at a distance because there isn't time to accommodate his personality, or because if the doctor becomes too *involved* in the patient's predicament, the emotional burden will be too great [...] A doctor's job would be so much more interesting and satisfying if he simply let himself plunge into the patient, if he could lose his own fear of falling.<sup>96</sup>

The emotional distance from a patient demanded of a professional is precisely the kind of indifference that Heidegger believes is most anathema to Dasein's being as care.

Broyard's prior analysis had suggested that by becoming more deeply invested in his patients the physician is more fully able to help the patient enact their many possibilities to be. Here, however Broyard is suggesting that in doing so the physician is actually showing care for his own being; he is opening up new possibilities of his own. Thus, in authentically relating to others, the physician is authentically relating to his own being as care.

This brief sketch is merely an attempt to offer an alternative to the view of illness, pain and suffering demanded by the biomedical model. Under such an account, these phenomena can have no inherent meaning other than to be biological aberrations for which the patient must be compensated. Medicine as care will not require the physician and patient to see these phenomena in this manner, however. Instead, it is up to the combined efforts of the two to develop a detailed narrative through which the experience of disease and suffering can be incorporated into the patient's life in order to help him encounter new possibilities to be. In doing this the physician is expressing his own being as care, both by authentically being-with other Dasein, as well as through developing new possibilities opened by the patient.

### **Conclusion**

Having examined Heidegger's existential analysis of Dasein, I have suggested how the practice of medicine might benefit from his unique understanding of the concept of care. Biomedicine clearly showcases inauthentic, derivative notions of death and

sickness through the biomedicalization of aging, or through its need to treat all biological difference as though it were a problem in need of compensation. But death and sickness are not first and foremost actualities; they are ontological possibilities. By recognizing these as possibilities that open up the patient's own possibilities, Dasein is expressing its being as care. In medicine I have suggested that this might occur through the patient and physician jointly developing an illness narrative which highlights the being of both parties as care. Through the use of such narratives, I believe that the physician/patient relationship could be marked by authenticity.

The difficulty, however, lies in the fact that no institutional change can bring about medicine as care. If medicine is to be existentially authentic, it will be so only because physicians and patients are authentic. Although we can dissuade the worst practices with respect to end of life care, this in no way guarantees an authentic relationship to death. Fortunately, as Broyard points out, the patient can serve as the teacher in the relationship just as easily as the physician. Thus, patients can challenge their physicians to embrace a more existentially authentic mode of practice. In doing so, patient and physician together can bring about medicine as care.

## CHAPTER V

### CONCLUSION

What are we to do with two separate medical models? It is tempting to conclude this project by showing that the two models are in total congruence with one another, that they are ‘consistent.’ If Kant is right, then human reason cannot help but seek a unifying or organizing principle that lies beneath disparate phenomena.<sup>97</sup> In that regard, I would be wholly justified in undergoing such an endeavor. It may also be tempting to try to offer principles by which to adjudicate which model may be better for which types of diseases. In some sense, I have more strongly allied Deweyan model with chronic diseases and the Heideggerian model with terminal diseases. But I believe that both accounts are fully capable of addressing any category of disease.

It is true that these two models are similar. For instance, I did not address the notion of medicine’s compensatory attitude when I developed a model out of Dewey’s philosophy. Yet, if the notion of health involves both precarious and stable aspects, then it seems as though if medicine were to compensate for every defect the patient would never be able to grow. Growth, health, requires falling out of step, and the patient does not need to be compensated for this. Her own way of transacting with the environment will compensate her through the reconstruction of her experience. Medicine should only keep this process within certain bounds. Thus, the two models are more similar than I have made explicit prior to this.

Such similarities aside, to focus solely on these similarities, to make them the *summum bonum* of my project, would be to limit the very real differences between them. Heidegger, for instance, truly worries about the impacts that technology will have on our understanding of human nature.<sup>98</sup> If we too openly embrace the technological frame we run the risk of covering over our being as care. Dewey is not troubled by technology in the same way. While it is true strong technological critiques can be made from out of the pragmatist tradition, Dewey would counter that even the most dependable of all technology can never cover over the precarious aspects of our existence. Furthermore, technology allows us to more easily transform the relationship between the organism and its environment. Thus, there is not complete congruity between the two either. I will not try to cover over these real differences. To do so would be to limit the individual strengths of these thinkers.

Furthermore, it would violate one of the very principles by which I introduced this project—measure. If I were to impose a new *model* onto medical practice I would in effect be leaving the measure outside of the patient-physician relationship. I have developed multiple *models* and they exist to serve the goals of medical care. The decision of which model is more appropriate is to be decided by the individuals directly involved. In this respect, it is not even necessary to fully jettison biomedicine. If the patient suffers only from a common infectious disease that is easily treatable, then why not employ a medical model that, in this case, might be best suited to deal with this disease? The danger of this is that biomedicine wants to view itself as *the only*

appropriate model. The two new models, I believe, will tend to avoid this urge to assert themselves in such a hegemonic way.

In this regard, my thesis is thoroughly postmodern. As Lyotard writes, the development of postmodernism entails the end of large meta-narratives that attempt to synthesize all of human experience into a totalized whole.<sup>99</sup> Biomedicine is such a meta-narrative. But, as Lyotard points out, what is needed is a turn towards little narratives, stories that are localized and pluralistic.<sup>100</sup> The two models developed here are little narratives. They do not attempt to capture the totality of human health and disease. They do not offer universal accounts of how the physician must act. They only seek to give voice to a certain respect of what it is to be human and how medicine can relate to this humanity.

Thus, I offer no adjudication between these two models. They are based on two distinct but powerful conceptions of human existence. They entail different attitudes towards patient care. They offer distinct recommendations for medical practice. There is nothing wrong with these differences. One is not by nature more 'correct' than the other. They will both relate to us in our finite existence, offering us ways to affirm life in the face of our own mortality. There is little else we could ask medicine to do.

## NOTES

<sup>1</sup> Otto Guttentag informs us that this distinction goes at least as far back as Jacob Henle's 1847 book *Handbuch der Rationellen Pathologie*. Otto Guttentag, "The Phrase, 'Art and Science of Medicine'," *California and Western Medicine* 50, no. 2 (1939): 86.

<sup>2</sup> For an excellent article detailing the historical and ideological development of bioethics see Ronald Bayer and Amy L. Fairchild, "The Genesis of Public Health Ethics," *Bioethics* 18, no. 6 (2004): 473-492. They argue that bioethics emerged from out of the ideology of the New-Left in the 1960's and 1970's. Thus, bioethics is undergirded by an ethos of autonomy.

<sup>3</sup> The most obvious example of this fact can be found in the insistence upon rugged individualism that is rampant in American political life. How far behind must we leave the frontier before American citizens will stop speaking as though they are self-made? How long until the social is no longer seen as the enemy of the individual, but that which makes it possible? For a more extensive analysis of such questions, see Josiah Royce, "The Philosophy of Loyalty", in *The Basic Writings of Josiah Royce, Volume 2*, ed. John J. McDermott (New York: Fordham University Press, 2005), 891-892.

<sup>4</sup> Rene Descartes, *The Philosophical Writings of Descartes, Volume II*, trans. John Cottingham, Robert Stoothoff, Dugald Murdoch (Cambridge: Cambridge University Press, 1984), 21.

<sup>5</sup> For a more in-depth discussion of this passage from Descartes and its implications for medicine see Patricia Benner, "The Phenomenon of Care," from *Handbook of Phenomenology and Medicine*, ed. S. Kay Toombs (Dordrecht: Kluwer Academic Publishers, 2001), 351.

<sup>6</sup> Rius, *Marx for Beginners* (New York: Pantheon Books, 1976), 79.

<sup>7</sup> It must be stated here and throughout that the word model must be used cautiously. "Model" is suggestive of a set structure, whereas these models are like processes of understanding of explaining.

<sup>8</sup> Taking my cue from the vast literature in the medical humanities, I will use the term 'biomedicine' to signify the practice of medicine as it is practiced under the biomedical model.

<sup>9</sup> Mary E. Tinetti and Terri Fried, "The End of the Disease Era," *The Journal of American Medicine* 116, no. 3 (2004): 179.

<sup>10</sup> George L. Engel, "The Need for a New Medical Model: A Challenge for Biomedicine," *Science* 196 (1977): 129-136.

<sup>11</sup> "The biopsychosocial model, which was introduced by Engel more than 30 years ago, is widely accepted and taught, but is employed clinically in a rather limited spectrum of entities." Tinetti and Fried, "The End of the Disease Era," 180.

<sup>12</sup> David B. Morris, *Illness and Culture in the Postmodern Age* (Los Angeles: University of California Press, 1998), 12.

<sup>13</sup> I do wonder about the philosophical implications of epigenetics as a possible counterexample. Although at this point little work has been done concerning the philosophy of epigenetics, the upshot seems to be that our confidence in the Central Dogma of molecular biology may be too naïve an understanding of the world.

<sup>14</sup> Morris, *Illness and Culture*, 55.

<sup>15</sup> All of these features, though not explicitly enumerated as such, can be found in Engel, "The Challenge for Biomedicine," 130-131.

<sup>16</sup> Paul Oppenheim and Hilary Putnam, "The Unity of Science as a Working Hypothesis," in *The Philosophy of Science*, eds. Richard Boyd, Philip Gasper, and J.D. Trout (Cambridge: MIT University Press, 1991), 405-428.

<sup>17</sup> Robert A. Aronowitz, *Making Sense of Illness: Science, Society, and Disease* (New York: Cambridge University Press, 1998), 48.

<sup>18</sup> Engel, "The Challenge for Biomedicine," 130.

<sup>19</sup> Gardiner Harris, "Talk Doesn't Pay, So Psychiatry Turns to Drug Therapy," *New York Times*, March 5, 2011, accessed January 24, 2012, [http://www.nytimes.com/2011/03/06/health/policy/06doctors.html?\\_r=1&ref=health](http://www.nytimes.com/2011/03/06/health/policy/06doctors.html?_r=1&ref=health).

- <sup>20</sup> Stefan Timmermans and Aaron Mauck, "The Promises and Pitfalls of Evidence-Based Medicine," *Health Affairs* 24, no. 1 (2005): 18.
- <sup>21</sup> Engel, "The Challenge for Biomedicine," 131.
- <sup>22</sup> Morris, *Illness and Culture*, 116-117.
- <sup>23</sup> Engel, "The Challenge for Biomedicine," 132.
- <sup>24</sup> Aronowitz, *Making Sense of Illness*, 26.
- <sup>25</sup> Engel, "The Challenge of Biomedicine," 130.
- <sup>26</sup> Bas van Fraassen, "The Pragmatics of Explanation," in *The Philosophy of Science*, eds. Richard Boyd, Philip Gasper, and J.D. Trout (Cambridge: MIT University Press, 1991), 326.
- <sup>27</sup> Thomas McKeown, *The Origins of Human Disease* (Oxford: Basil Blackwell, 1988), 91.
- <sup>28</sup> Morris, *Illness and Culture*, 72-76.
- <sup>29</sup> Engel, "The Challenge for Biomedicine," 130.
- <sup>30</sup> *Ibid*, 133.
- <sup>31</sup> I recognize that to a large degree a physician's work is regulated by HMO's that limit the physician's ability to dive deeper into psychological and sociological factors of health. However, must this fact be seen as the end of discussion, or can we allow it to open up questions and concerns about the practice of medicine anew?
- <sup>32</sup> Ultimately, I do not think Engel believes that there is an imperative to include grief as a disease. What he ultimately wants is for "mere" psychological phenomena such as grief to be treated with the same dignity as biological perturbations.
- <sup>33</sup> *Ibid*.
- <sup>34</sup> Tinetti and Fried, "The End of the Disease Era," 179.
- <sup>35</sup> *Ibid*, 181.
- <sup>36</sup> *Ibid*.
- <sup>37</sup> Paul Farmer, *Pathologies of Power: Health, Human Rights, and the New War on the Poor* (Los Angeles: University of California Press, 2005), 30.
- <sup>38</sup> *Ibid*., 120.
- <sup>39</sup> Carroll L. Estes and Elizabeth A. Binney, "The Biomedicalization of Aging: Dangers and Dilemmas," *The Gerontologist* 29, no. 5 (1989): 589.
- <sup>40</sup> Sharon R. Kaufman, Janet K. Shim, and Ann J. Russ, "Revisiting the Biomedicalization of Aging: Clinical Trends and Ethical Challenges," *The Gerontologist* 44, no. 6 (2004): 735.
- <sup>41</sup> Morris, *Illness and Culture*, 14.
- <sup>42</sup> Estes and Binney, "The Biomedicalization of Aging," 596; Kaufman, Shim and Russ, "Revisiting the Biomedicalization of Aging," 737.
- <sup>43</sup> Edmund Husserl, "The Vienna Lecture," in *The Continental Philosophy Reader*, eds. Richard Kearney and Mara Rainwater (New York: Routledge, 1996), 10.
- <sup>44</sup> *Ibid*, 10-11.
- <sup>45</sup> *Ibid*, 12.
- <sup>46</sup> Of course, these two flaws are intimately linked. If biomedicine depends upon the transcendent lifeworld in which it exists then it cannot be universally true outside of it.
- <sup>47</sup> John Dewey, "The Influence of Darwinism on Philosophy," in *The Essential John Dewey Volume 1: Pragmatism, Education, Democracy*, eds. Larry A. Hickman and Thomas M. Alexander (Bloomington: Indiana University Press, 1998), 39-45. Dewey is not, of course, the first philosopher to write on Darwin; however, he *is* one of the first to write on Darwin in a way that does not advocate Social Darwinism.
- <sup>48</sup> John Dewey, *The Later Works of John Dewey, Volume 10, 1925-1953: 1934, Art as Experience*, ed. Jo Ann Boydson (Carbondale: Southern Illinois University Press, 1987), 19.
- <sup>49</sup> John Dewey, *The Later Works of John Dewey, Volume 1, 1925-1953: 1925, Experience and Nature*, ed. Jo Ann Boydson (Carbondale: Southern Illinois University Press, 1981), 7.
- <sup>50</sup> Dewey, *Experience and Nature*, 20.
- <sup>51</sup> Dewey, *Experience and Nature*, 50.

<sup>52</sup> Dewey, *Experience and Nature*, 43.

<sup>53</sup> Again, the Darwinian theme shines through. Although Darwin was unaware of molecular genetics, he was insistent that the changes that occur to species overtime occur at random, with no hidden purpose or telos. Modern developments in molecular genetics seem to concur, that there is no discernible *reason* for genetic mutations to occur. Instead, they appear to be truly random.

<sup>54</sup> Dewey, *Experience and Nature*, 57.

<sup>55</sup> Consider, for instance, Descartes' *Meditations* in which he questions whether or not we can know if the external world exists. Dewey finds this question to be ridiculous and distracting from fruitful philosophical discourse.

<sup>56</sup> Dewey, *Art as Experience*, 19.

<sup>57</sup> Naturally, the live creature is not limited to humans alone, but since the focus here is on the practice of medicine, I will table any discussion of this metaphor applying to other animals.

<sup>58</sup> *Ibid.*, 19-20.

<sup>59</sup> *Ibid.*, 23.

<sup>60</sup> WHO. Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June 1946, and entered into force on 7 April 1948. "Frequently Asked Questions," World Health Organization, accessed February 23, 2012, <http://www.who.int/suggestions/faq/en/>

<sup>61</sup> Although Dewey did not cover health with the same rigor as he did education or politics, he still offered enough remarks to justify such a view. Consider the following assertion from *Experience and Nature*: "Health in this case is not in itself an end of any natural process; much less an end-in-itself. It is an enjoyed good when it happens just as disease is a suffered ill," Dewey, *Experience and Nature*, 93. The emphasis is temporal, indicating that Dewey conceives of health and illness as events and not in static terms.

<sup>62</sup> D. Kulms and T. Schwarz, "Molecular Mechanisms of UV-Induced Apoptosis," *Photodermatology, Photoimmunology & Photomedicine* 16, no. 5 (2000): 195.

<sup>63</sup> I worry that allopathic medicine rejects too much in order to avoid any association with naturopathic or holistic medicine. Allopathic medicine must come to see sociological and psychological factors as integral to human health. This is not necessarily lead to physicians concerned with "spiritual energies" or practicing quackery.

<sup>64</sup> Mary E. Tinetti and Terri Fried, "The End of the Disease Era," *The Journal of American Medicine* 116 (2004): 179.

<sup>65</sup> Fortunately it seems as though many medical schools have begun moving in this direction. See Arno K. Kumagal "The Conceptual Framework for the Use of Illness Narratives in Medical Education," *Academic Medicine* 83, no. 7 (2008): 653-658 or Rachel R. Hammer, "An Education that Pierces What the Knife Cannot: A Student Perspective," *Anatomical Sciences Education* 3 (2010): 151-153 as excellent examples of ways medical schools are incorporating a more thorough approach to the humanities.

<sup>66</sup> Interestingly enough, the Medical College Admission Exam (MCAT) is changing in 2015 and will have a test section dedicated to sociological and psychological aspects of human health. Thus, it seems that at both the undergraduate and medical school levels, medicine is opening itself up to the importance of these factors. See "MCAT 2015", American Association of Medical Colleges Website, accessed February 16, 2012, <https://www.aamc.org/students/applying/mcat/mcat2015/testsections/>.

<sup>67</sup> Given the explosive nature of public policy debates on socialized medicine, I will only make a brief comment about it here. It seems that if we adopt Dewey's philosophical project as the foundation for medical practice then the physician could reach no other conclusion than to advocate *for* socialized medicine. However, I do not want this issue to sidetrack my own project here.

<sup>68</sup> Farmer, *Pathologies of Power*, 124.

<sup>69</sup> *Ibid.*, 124-125.

<sup>70</sup> Michel Foucault, *The History of Sexuality Volume 3: The Care of the Self* (New York: Vintage Books, 1988), 99-104.

<sup>71</sup> I will mostly use ‘Dasein’ throughout the remainder of the chapter to refer to human beings, especially in the context of discussing Heidegger’s project.

<sup>72</sup> Martin Heidegger, *Being and Time*, trans. Joan Stambaugh, revised by Dennis J. Schmidt (Albany: SUNY Press, 2010), 186.

<sup>73</sup> The notion has a long heritage in the German tradition. It is akin to Kant’s notion of ‘intuition,’ the faculty by which we are able to relate to objects outside ourselves. Immanuel Kant, *Critique of Pure Reason*, trans. Paul Guyer and Alan Wood (Cambridge: Cambridge University Press, 1998), 172.

<sup>74</sup> §40 of *Being and Time* focuses solely on anxiety as a mood that reveals the being of Dasein as care. However, in his essay “What is Metaphysics?” Heidegger suggests that other moods, including boredom, yield the same insight. See Martin Heidegger, “What is Metaphysics?” in *Martin Heidegger: Basic Writings, Revised and Expanded*, ed. David Farrell Krell (San Francisco: Harper Collins, 1993), 93-110.

<sup>75</sup> Michel Foucault, *The Birth of the Clinic* (New York: Vintage Books, 1994), 4.

<sup>76</sup> Heidegger, *Being and Time*, 118-119.

<sup>77</sup> *Ibid.*, 119.

<sup>78</sup> *Ibid.*, 238, emphasis added.

<sup>79</sup> *Ibid.*, 248.

<sup>80</sup> The following features are described in §53 of *Being and Time*, 252.

<sup>81</sup> *Ibid.*, 253.

<sup>82</sup> *Ibid.*, 243.

<sup>83</sup> *Ibid.*, 244.

<sup>84</sup> *Ibid.*

<sup>85</sup> By ‘sickness’ I am referring to infectious, genetic, chronic, and terminal diseases; disabilities such as being mentally or physically handicapped; and even biological phenomena such as pain. Thus I am trying to capture as many biological phenomena with the term as is possible.

<sup>86</sup> This is the position advocated in Fredrik Svenaeus, “Illness as Unhomlike Being-in-the-world: Heidegger and the Phenomenology of Medicine,” *Medical Healthcare and Philosophy* 14, no. 3 (2011):333-343.

<sup>87</sup> However, I will still tend to speak mainly in terms of death for brevity’s sake.

<sup>88</sup> Kaufman *et al.*, “Revisiting the Biomedicalization of Aging: Clinical Trends and Ethical Challenges,” 735.

<sup>89</sup> Estes and Binney, “The Biomedicalization of Aging: Dangers and Dilemmas,” 589.

<sup>90</sup> Morris, *Illness and Culture in the Postmodern Age*, 14.

<sup>91</sup> Sherwin B. Nuland, *How We Die* (New York: Alfred K. Knopf, 1994), 72.

<sup>92</sup> Anatole Broyard, *Intoxicated By My Illness: And Other Writings on Life and Death* (New York: Clarkson N. Potter, Inc., 1992), 3-4.

<sup>93</sup> *Ibid.*, 19-20.

<sup>94</sup> The passage can be found in 2 Corinthians 12:7-10

<sup>95</sup> *Ibid.*, 53.

<sup>96</sup> *Ibid.*, 49

<sup>97</sup> Kant, *Critique of Pure Reason*, 99.

<sup>98</sup> Martin Heidegger, “The Question Concerning Technology,” in *Martin Heidegger: Basic Writings, Revised and Expanded*, ed. David Farrell Krell (San Francisco: Harpers, 1993), 332.

<sup>99</sup> Jean-Francois Lyotard, “Answering the Question: What is Post-Modernism?,” in *The Continental Philosophy Reader*, eds. Richard Kearney and Mara Rainwater (New York: Routledge, 1996), 429.

<sup>100</sup> *Ibid.*, 436.

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