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Radu BANDOL¹

Abstract

The study aims to argue that the humanist model of medicine approaches the practice of self-care, the latter being an actualization of the former concerning all those ideas and issues in which they overlap. The humanistic model covers patient-centred medicine and offers a holistic approach to the patient which involves treating him/her as a patient, not as a body (as in biomedicine), emphasizes the doctor-patient partnership atmosphere, a relational, communicational and informational environment. The concept of spatialization in philosophy came out as an empirical mechanicist model in sciences and influenced the appearance of the biomedical model. In the humanistic model, the patient can be, to a certain extent, the factor making decisions with regard to the chronic disease. Self-care matches especially the human medicine with regard to the outlook on the patient as a person (holism), the long-term partnership in the communication, information and correct decision-making for the disease, the empathic environment, the responsibility shared between two people, the assistance provided when making decisions for the patient's "friendship" with the chronic disease.

Keywords: *Biomedical Model of Medicine, Humanistic Model of Medicine, Spatialization, Self-care.*

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1. The ascendant of the biomedical model and the humanization of medicine

The biomedical model has emerged as the standard of the approach to medicine and, implicitly, of its subject – the individual, at least in the United States and Europe. The philosophy of medicine aims to found a metaphysics and an ontology of medical sciences, in the light of *telos* and of their original vocation (the maintenance of wellness, the health of the body and soul), thus, attempting to determine the way to best practise medicine. In fact, the approach to this science results from the way the doctor-patient relationship is founded. The association of medicine with humanities gave rise to the so-called medical humanities – which can be properly understood only in the context of the philosophy of medicine – and attempted to move the emphasis from technologization to humanization.

In this paper, we will try to argue that the notion of *self-care* has a filiation rather in the humanistic model of medicine, which considers the patient from the holistic point of view and is patient-centered, than in the biomedical model which is evidence-based. An ideal model for the practice of medicine can hardly be found since the agreement between the partisans of medicine as a (pure) science and those of medicine as art is still a problem of the future. Of course, the project of the visionary Pellegrino considers medicine as a science that cannot be separated from humanities which necessarily has to be studied by association with them since it has an internal morality. Thus, his studies include relationships that medicine establishes with itself and also with the exterior: “the healing relationship, medicine as a profession, the patient's good, the role of autonomy, the love of money, and the importance of the virtue-based normative ethics for health care” (Engelhardt & Jotterand, 2008). Furthermore, medicine is considered as a single and unique science, a sort of *tertium quid* (an intermediate discipline), in which the technology of healing must be covered by the doctor's artistic and human skills (Pellegrino & Thomasma, 1981).

Following Pellegrino, Marcum (2008: 301) suggests “that modern medicine must undergo a revolution in terms of transforming its *logos* and *ethos* by grounding them in *pathos*”. Passion, with its roots in *pathos*, offers the possibility to medicine to manifest itself in its humanistic side. This “strong motivation not only for the patient *vis-à-vis* healing but also for the physician *vis-à-vis* medical practice”, considered by the author

“especially in terms of professional transformation from physician *qua* medical mechanic to physician *qua* wise and loving healer” (Marcum, 2008: 324-325) creates a strong foundation for the integration of the self-management program into the humanistic type medicine.

The patient, with their ambivalent position of recipient of medical services, but also actively involved in and aware of their responsibility for the process of management of a chronic disease, expects “transforming medicine from a technical profession that addresses disease into a vocation disease that responds with wise and loving compassion to the patient's illness experience and the suffering it brings” because, as Marcum asserts, “true physicians are healers even in the absence of any technology, for they respond not simply to the disease *per se* but to the suffering that cripples not just the patient's body but also his or her life” (2008: 325).

In order to argue the humanistic filiation of the *self-care* practice, we shall first elaborate the argument of the metaphysical basis – the time-space coordinate – based on which sciences in general, and medicine in particular are founded, then we shall notice Foucault's special role in distinguishing the spatialization of medicine, biopolitics and the importance of the body in the emergence of the biomedical model. The last part shall include the description of the features of *self-care* practices, rather integrated into the humanistic model of medicine than into the biomedical one, and, implicitly, the difference between the two models. The approach method analyzed will be a descriptive method, combined, where appropriate, with the comparative one.

2. Questioning the time-space coordinate as a metaphysical foundation for sciences

It is most likely that an answer on strengthening the biomedical model as a norm accepted in the medical world can be provided from a metaphysical ground. It is important to follow the relationship between time and space in the passage from modernity to postmodernity, which offers us a clue for interpreting the transformation of medicine.

In Antiquity, the issue concerning the status of the Being gave birth to two great schools and, implicitly, to two types of cultures, Eleatic and Heracleitic, which succeeded until the modern times: either the reality is unchanging and the becoming is only an appearance,

believed the Eleatics or, as Heraclitus states, everything flows as nothing really exists, but everything becomes (Dumitriu, 1987: 123-124).

The time-space coordinate of representation is also concerned with the so-called issue of universals, expressed as the ratio between words, concepts and things, an issue discussed intensely since the time of Plato and Aristotle and which came to be debated in the Middle Ages by realists and nominalists. The realists accept that the ideas, concepts, definitions that aim to identify essences are covered in reality and are not only conceptual, logical or semantic constructions of the mind. The nominalists do not accept that the language on universal concepts denotes an independent extra-linguistic reality. Thus, the debate involves the ontological status of the language on essences in comparison with that of individual objects (de Libera, 1996). It has a strong effect on the epistemic problem tackled by sciences. How do we get to acquire knowledge? Until the late scholastics, the reality of things (of objects) was considered before the act of knowledge in the sense that we could assert a truth about something without that thing being wholly understood from all the perspectives. Therefore, there is a way of permissible mental or conceptual overcoming of categories in which the mind attempted to place things.

However, starting with Descartes, the beginning of a paradigm shift occurred. In his attempt to find a safer way of acquiring knowledge, Descartes resorts to mathematization, mathematics being the only one which can convince through the certainty and evidence of its reasonings. It is interesting that the examples for argumentation are taken from applying mathematics into practice, for example in fortifications, cartography, optics, all these being related to spatialization². When we consider the assertion of *cogito* within a context, as the basis of all knowledge, we can notice that it is built in relation to benchmarks of physicality, location, scope, therefore it is about a spatialization, a stillness of the time flow and the relation to something that is static so that thinking can occur (Descartes, 1998). This is a shift in thinking and knowledge from the focus on time to the focus on space.

² The term of “spatialization” is used by Michel Foucault in „Naissance de la Clinique”, Presses Universitaires de France, 1963 and by Catherine Pickstock in “After writing: The liturgical consummation of philosophy”, Oxford: Blackwell, 1998. I did not have the possibility to obtain the latter paper.

Kant reserves the definition of the pure forms of the intellect to the notions of space and time and notices the fact that the process of understanding phenomena and their form “is a hidden art in the depths of the human soul” and “a priori determinations in accordance with time-rules”, determinations that relate “according to the order of the categories (...) to the sum total of all time in regard to possible objects” (Kant, 1998: 273, A141, 276, A145). On the one hand, time is “the form of inner sense”, which determines the ratio of representations within man; it “cannot be a determination of outer appearances” and “it belongs neither to a shape or a position”. On the other hand, time cannot relate to itself as to a real object and therefore, it needs otherness, an exteriority; it results that “the representation of time is itself an intuition, since all its relations can be expressed in an outer intuition” (Kant, 1998: 163, A33-B50). Thus, according to Kant as well, space acquires primacy over time.

However, Heidegger is the one who reproaches Kant that, although he investigates the dimension of temporality (of the being) as pure intuition, he still does not associate it with a thematic ontology of the Being (of the *Dasein*), as he guides himself according to a common (that is Cartesian) understanding of time. For Heidegger, “the simple apprehension of something objectively present in its pure objective presence [*Vorhandenheit*], which Parmenides already used as a guide for interpreting being – has the temporal structure of a pure *making present* of something”. Time has a fundamental ontological function in determining the Being, even through the adoption of the Parmenidian paradigm and reaching a constant permanence opposing the becoming. We can notice here that Heidegger pleads for a priority of time over space (1996: 22-23).

These authors are very important for establishing the metaphysical basis of sciences, in particular medicine. The metaphysical platform of sciences is formed between the ontology of temporality of the Being and the epistemology of the object, of the thing. Nevertheless, it seems that once with Descartes, spatialization produced a preeminence of the object-based epistemology, which can be measured, over the ontology of temporality. From this point of view, Heidegger, through Nietzsche, is only a return to the Parmenidian ontology of permanence of the Being.

Michel Foucault, an author concerned with the necessary a priori conditions of knowledge and who identifies the concept of power as essential for the fact of the foundation and of being founded, as well as for understanding the relations of subjectivation and objectivation, was to play an important role in diagnosing the process through which, in modern medicine, “rational inference and emphasis on the history of a disease are replaced by pathological anatomy” (Scott, 1987), in particular in the paper from 1963, *The Birth of the Clinic: An Archaeology of medical perception* (2003). Among several similarities between Heidegger and Foucault revealed by Dreyfus (1992: 86) there is also the congruence between being technological (Heidegger) and the biopolitics or biopower (Foucault):

In the last stage of their thinking, both Heidegger and Foucault realise that man is, indeed, being wiped out, but this only reveals a long-term process which is by no means encouraging. Heidegger and Foucault see us as caught in especially dangerous practices which, both suggest, produced man only finally to eliminate him, as they more and more nakedly reveal a tendency towards the total ordering of all beings - a tendency that became possible as soon as the Greeks forgot the truth of being and substituted the will to truth. Heidegger calls this current understanding of Being technological, and he is concerned to show how it distorts our understanding of things; Foucault calls it disciplinary biopower and focuses primarily on how it distorts the social order and our relation to other human beings. Both hold that it distorts our understanding of ourselves and leads to a pervasive sense of distress.

Therefrom it does not result that the German philosopher or the French one oppose to technology or welfare, but only, as Heidegger says, *the technological understanding of Being*. While Heidegger prioritizes the temporal dimension on subject, object and space in the interpretation of the Being, Foucault supports an interpretation of the power element from the perspective of the priority of space over time (for Foucault, space is political and time is historical).

3. Foucault, the spatialization of medicine and biopolitics. The body, not the person

In the Preface to *The Birth of the Clinic*, Foucault (2003: ix) announces us that he writes “about space, about language, and about death (...) about the act of seeing, the gaze”. The pathological anatomy,

found in the anatomic and clinical method, establishes as historical basis of inauguration of a positive structure “in which space, language, and death are articulated”. The end of the 18th century is the time for a philosophical twist in the analytics of finitude. The ground of negation of the infinite is invested with a positive role in medicine, where the anthropological structure becomes limit and origin at the same time, a manner to relate the modern human being to their original limits. Through their bodies, individuals allow a space where they are the subject and object of knowledge. With these findings, Foucault notices the fundamental leading and ordering role of medicine “in the over-all architecture of the human sciences: it is closer than any of them to the anthropological structure that sustains them all”, as well as “an importance that is not only methodological, but ontological, in that it concerns man’s being as object of positive knowledge” (2003: 196, 197-198).

The Birth of the Clinic describes an overlap of the primary, secondary and tertiary spaces (Foucault, 2003: 15, 16) through which the practice of medicine attempts to manage bodies (corpses), diseases and death. The theoretical medical knowledge from tables and classifications encounters the qualitative space of the disease and of its manifestation in the body. The tertiary space, “a whole corpus of medical practices and institutions confronts the primary and secondary spatializations with forms of a social space whose genesis, structure, and laws are of a different nature”. It is a space where the disease is allowed to evolve naturally, either towards healing or not, as “the more complex the social space in which it is situated becomes, the more denatured it becomes”. However, the space of the body, in its deadly form, becomes seminal, according to the metaphysics of the pre-eminence of space over time, according to which the invention of the clinics works: the life time, through its stop, provides a zero moment, a moment of death, where medical knowledge may occur in its genuine form. A static element, the corpse and death, a process that is to stop, are necessary and they meet in a dead body and provide unsuspected research possibilities (Foucault, 2003: 141)

The technique of the corpse (...) this conceptual mastery of death was first acquired, at a very elementary level, by the organization of clinics. The possibility of opening up corpses immediately, thus reducing to a minimum the latency period between death and the autopsy, made it possible for the last

stage of pathological time and the first stage of cadaveric time almost to coincide. The effects of organic decomposition were virtually suppressed (...) so that the moment of death may act as a marker without density that rediscovers nosographical time, as the scalpel does organic space. Death is now no more than the vertical, absolutely thin line that joins, in dividing them, the series of symptoms and the series of lesions.

In the space of the clinic, when the disease detached from the metaphysics of the evil or from its perception against the nature, death started being a part of the medical experience, integrating epistemologically, so that medicine could claim itself to be a science of the individual. The experience of individuality is related to the experience of death, as a result of the failure of the occidental human being to identify himself as discursive existence.

Death is therefore multiple, and dispersed in time: it is not that absolute, privileged point at which time stops and moves back; like disease itself, it has a teeming presence that analysis may divide into time and space; gradually, here and there, each of the knots breaks, until organic life ceases, at least in its major forms, since long after the death of the individual, minuscule, partial deaths continue to dissociate the islets of life that still subsist (Foucault, 2003: 142)³.

The outlining of the biomedical model in medicine is integrated into Foucault's description of the relation between individual and society under the concept of "biopolitics", through which the author understands "the endeavor, begun in the eighteenth century, to rationalize the problems presented to governmental practice by the phenomena characteristic of a group of living human beings constituted as a population: health, sanitation, birthrate, longevity, race ..." (Foucault, 1997: 73).

Nikolas Rose (2007) takes over the discussion on biopolitics and leads it to the field of debates of biomedicine from the 21st century, entitling it *The Politics of Life Itself*. The author identifies five great mutations that occurred in the space of contemporary biopolitics and redefined the political and medical practices and perceptions. *Molecularization* is a *style of thought* from biomedicine that imagines life at

³ Foucault quotes Broussais, *De l'irritation et de la folie*, Paris, 1839 edition, vol. I, p. lxxv.

the molecular level and allows new practices of intervention at the level of intelligible vital mechanisms that apparently are no longer constrained by a norm of the natural order. *Optimization* refers to current life technologies that do not bear any longer a constraint of the polarization health-illness – even if it remains – and is concerned with ensuring an optimal state for their subjects.

The concept *subjectification* is related to “biological citizenship”, which claims a redefinition of the conduct “the duties, rights, and expectations of human beings in relation to their sickness, and also to their life itself” and “reshape the ways in which human beings relate to themselves as *somatic individuals*”. These phrases suggest a greater attention for corporeal existence. The above-mentioned mutations resulted in the emergence of a new type of management of the human conduct and claimed the occurrence of a *somatic expertise*, namely of certain “multiple subprofessions that claim expertise and exercise their diverse powers in the management of particular aspects of our somatic existence”. Among these are geneticists specializing in particular classes of disorder, specialists in reproductive medicine, stem cell therapists, but also “pastoral experts whose role is to advise and guide, to care and support, individuals and families as they negotiate their way through the personal, medical, and ethical dilemmas that they face”.

Together and within these mutations was delimited a new economic space, the bioeconomy and a new form of capital, the biocapital, which circumscribe the perimeter biovalues and form the *economies of vitality*. Contemporary biopolitics entails a transformation of conceiving life, strongly related to bioeconomy, while its vitality may be decomposed “into a series of distinct and discrete objects (isolated, delimited, stored, accumulated, exchanged, accorded a discrete value, traded across time, space, species, contexts, enterprises) in the service of many distinct objectives”.

The birth of the clinic and biopolitics, evoked by Foucault, continued with the contemporary extensions of biopolitics, commented by Rose, are overwhelming examples of the primacy of valuing space over time, phenomenon that we called spatialization, according to Foucault. In this respect, the spatialization of medicine raises great questions on the type of the metaphysics of medicine. Bishop (2009: 329, 347) claims that medicine denies itself a metaphysical thinking, and when it has it, it is a metaphysics of efficient causation: “for Western medicine,

indeed perhaps all scientific and technological thought, the important bit about the world is how to manipulate it in order to get the effects that we desire”. Using Kant’s and Heidegger’s line of arguing, Krakauer (1998: 534, 535) notices that:

medical science does not just produce and then prescribe health technology as a means to master its objects. Rather, technology, in a more fundamental sense, prescribes beings as objects in such a way as to make possible and produce medical science. Technology in this sense mathematizes the world. It finds the ontology which makes all things calculable, predictable, masterable, and which therefore makes possible all natural science, including medical science. [...] By defining human health and propriety, and by maintaining and policing the limits which it establishes (...) physicians as health technicians are standard bearers of western metaphysics. Health technology, purposefully or not, guarantees that metaphysics qua metaphysics cannot be called into question.

The consequences of spatialization and mathematization in sciences may certainly be found in the medical sciences and have implications for the understanding of the relationship subject-object, the relationship between people, things, disease, health. Generally, it is about the comprehension of the dichotomy biomedical model – humanistic model in medicine and the place where we integrate *self-care*. If knowledge is entirely based on the object and if only what is measurable may represent the standard for knowledge, then epistemology suffers a fracture and goes before ontology. Perhaps the most important consequence of this materialization of knowledge, in the sphere of medicine, is the fact that the body becomes an object that is subject to a measurement, an inspection, an examination. The body is no longer a part of the person, being objectivized and treated separately from the spiritual part of the person. Moreover, the ideal model is a corpse, that is subject to the best examinations and, implicitly knowledge.

4. The integration of self-care into the human model as its actualization

The hypothesis that, obviously, for a patient suffering from a chronic condition, *self-care* has a higher compatibility with the humanistic model from the philosophy of medicine, being in fact and partially, its actualization, can be justified starting from the comparison between the

characteristics of the two models as well as between the basic principles towards which the first model, *patient-centered*, respectively the second, *evidence-based* model, is oriented. The humanization of medicine does not mean rejecting the biomedical model, but trying to go beyond it, to emphasize all those issues related to the non-corporeal side of medicine: for example, the relational and communicative side (the patient is a text to be read within a context), the informational side on the part of the patient (their history and personal information), the patient empowerment (the effort involved when fighting the disease).

The chronic conditions, through their very names, require a long-term or a lifetime relationship, between patient and doctor or the system providing health care. The period during which the patient's illness lasts, which coincides with their period of life (starting from the moment when the disease is diagnosed) is to be redefined through a partnership relationship between them and the doctor (system). However, WHO (World Health Organization, 2002) notices that "health care systems have not kept pace with the decline in acute health problems and the increase in chronic conditions" and "have not noticeably evolved beyond the conceptual approach used in diagnosing and treating acute conditions".

The health system claimed by WHO is mainly a product of the biomedical (allopathic) model that has become dominant for the modern medical knowledge and practice since the end of the 19th century and the beginning of the 20th century. James Marcum (2008: 10) characterizes the biomedical model as one in which "the patient is reduced to a physical body composed of separate body parts that occupy the machine-world" and the concern of the doctor, detached emotionally, "is to identify the patient's diseased body part and to treat or replace it, using the latest scientific and technological advances in medical knowledge sanctioned by the medical community." In these interventions, the objective is to heal or save the patient from lasting injuries or even death.

Marcum (2008: 17-31) summarizes the metaphysical and ontological positioning of these two models. The way the biomedical model works results from the metaphysical position based on the mechanistic monism (the patient is a collection of parts and specific functions are a result of a combination of these parts), accompanied by a presupposition of reductionism (the reduction of non-physical disciplinary terms and theories to the terms and theories of the physical

sciences) and an ontology involved in materialism (the world and everything in it is corporal or physical in nature and there is nothing in it that is not physical). Biomedicine assumes naturalism, namely it asserts that “natural phenomena are the products of natural events and forces and that human reason can comprehend these events and forces” and proclaims determinism (only one possible natural world as determined by a natural order).

Evidence-based medicine [EBM] (Marcum, 2008: 308-310) is at the center of the biomedical model and is intended to revolutionize the old paradigm based on “unsystematic observations and traditional medical training that focuses exclusively on pathophysiology and clinical experience”. EBM emphasizes the systematic observations obtained from RCTs (randomized clinical trials) and their interpretation through MA (meta-analysis), attempting to provide the best possible medical care by combining the information and clinical and experimental observations with the theoretical and logical explanations. Sackett et al. (1996: 71) defines EBM as “the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients”. In an attempt to be as rational as possible and based on evidence, EBM “links clinical and public health policy to a systematic examination of the quality of supporting scientific evidence” and “emphasises comprehensiveness and applies systematic criteria to ensure that all relevant evidence is considered, rather than being cited selectively, and that the quality of studies is evaluated fairly, regardless of preconceived biases” (Woolf, 2001: 39). From all the features, it results that EBM allows neither the doctor nor the patient to have an intuitive dimension regarding the medical theory and practice.

As far as the humanistic model (Marcum, 2008: 22, 25, 29) is concerned, it is related to a holistic metaphysical position, an Emergentist (emergentism) metaphysical presupposition and an organicist (organicism) ontological commitment. Holism maintains that “the whole in terms of its properties cannot be reduced to the properties of its parts”. Emergentism is very important for the humanistic medicine and refers to “the appearance of a higher order property from lower order properties”, where “the higher order property is not reducible to or deducible from the lower order properties”, as in the case of reductionism. The humanistic dimension accepts the “patient” dimension in its system, therefore “it emphasizes structure or

organization in contrast to composition” and “entails organic unity, especially in terms of the organismal unit”.

The features of the humanistic model (Davis-Floyd & St. John, 1998: 82) are considered more as an attitude than as a paradigm. Mind-body connection; the body as an organism; the patient as relational subject; connection and caring between practitioner and patient; diagnosis and healing from the outside in *and* from the inside out; balance between the needs of the institution and the individual; information, decision making, and responsibility shared between patient and practitioner; science and technology counterbalanced with humanism; focus on disease prevention; death as an acceptable outcome; compassion-driven care; open-mindedness toward other modalities.

According to these features, the humanistic model supports the patient-centered medicine [PCM] and, at the same time, aims to recognize all the EBM model merits related to the empirical bases of medicine. It is imputed to EBM that patients who are enrolled in RTCs meet the inclusion criterion, namely the one that is based on a very strict criterion defined by the diagnosis of the disease analyzed although there is the risk that they may have symptoms that do not correspond to this criterion. PCM maintains that personal information about the patient, their history, individual characteristics, the life context are very important elements in the diagnosis of a disease, features that EBM considers as “a nuisance that might disturb the results of the study, instead providing valuable extra information”. For example, “patients who are too old, too young, too illiterate, or suffer from comorbidity or concurrent psychiatric disturbances are excluded from the study, because the statistical power could be reduced by those characteristics (Bensing, 2000: 19). The PMB model is neither *disease-oriented* as the patient represents more than their disease (Bensing, 2000: 21) neither a *doctor-centered* approach, namely it does not emphasize only the interpretation of the data provided by the doctor, diminishing the human relationship and the role of another partner taking part in the examination, namely the patient. Sweeney et al. (1998) pleads for a third dimension, the patient, when making the clinical decision, in addition to RCTs and the clinical interpretation derived from the physician’s experience. The patient has the right to decide what to do or not regarding diagnosis or therapeutic interventions, in the sense that the physician has to provide to the

patient information that should help them make the right decisions, after previously having known the patient's preferences.

PCM complies with the principle of patient autonomy and proves its humanistic orientation and the biopsychosocial perspective: "it deals with the content of the consultation, the choice of topics that should or could be addressed, according to patients' needs and expectations" (Bensing, 2000: 21). The human model of medicine based on PCM takes from the psychotherapeutic theories the physician's need for adequate communication behaviors, i.e. an affective behavior in order to stimulate the patient to communicate their emotions, feelings and the experience of the disease.

Evans (2003: 9) notices a highly important thing for the human model of medicine in the context of using the communication skills from doctor to patient: an effective examination is carried out in a moral environment from which the responsibilities of both parties result. The correct decision on which PCM insists is made when the patient's history is taken into consideration and, consequently, there is a balance in the decision-making process.

We believe that the concept of *self-care* is linked to the humanistic model in the management of the quality-of-care crisis achieved by the latter since it is based on some presuppositions and acts with means that offer a more dynamic character. The metaphysical and ontological assumptions of the humanistic model fully welcome, in a special way, those actions from the *self-care* program, actions involving the physician-patient partnership.

The holistic approach involves the concept of person (mind-body), not merely the interest in the body as an organ with its parts broken down, or the equivalence of the mind with a simple organ. Accepting the patient as a person in the process of treating or improving the disease is fully in line with the policy of self-management. If the biomedical model is suspected of a certain alienation of the patient from the physician, the human model attempts the very humanization of the relationship between physician and patient, namely the very efficiency of the partnership in self-care.

When a chronic condition is considered, its onset is gradual, it can have various causes, its duration is indefinite, diagnoses are often uncertain at an early stage and the treatment rarely has healing as a result. The chronic condition necessarily requires a partnership and a period of

time allowed by both the doctor and the patient. The doctor plays the role of a teacher and partner, while the patient is a partner of health professionals and a person responsible for daily management, too. It is precisely the perspective of the organic unity of the human model, which chooses organicism by integrating the patient into the system as an etiological factor in diagnosing the disease and as a therapeutic factor in recovery. By means of the organic unity, the human model overlaps with the requirements of self-care in order to emphasize the patient's role.

Loriga et al. (2006: 5) notice that, in the chronic disease, often occur depression, fear, the concern about the future as well as questions such as "Will I be able to remain independent?", "If I can't care for myself, who will care for me?", "What will happen to my family?", "Will I get worse?". Besides overcoming emotional and physical problems, the patient must learn problem-solving skills and how to respond to the trends in his disease. The patient has tasks related to nutrition and physical exercise, but the fact that he has a chronic condition means that he must learn to "befriend" the disease and find a permanent basis which he can use to solve everyday problems that arise. He will have to learn "managing symptoms, making decisions about when to seek medical help, working effectively with his doctor, using medications and minimizing side effects, finding and using community resources, talking about his illness with family and friends, and, if necessary, changing social activities".

The characteristics listed above related to the human model (Davis-Floyd & St. John, 1998) together with the patient-centered medicine, make it the appropriate framework for establishing, maintaining and improving the doctor-patient relationship so that right decisions can be taken regarding the "friendship" relationship with the disease. In this case are highlighted the doctor's communication skills, empathy, the human relationship, listening with comprehension, making decisions together in a moral environment, shared responsibility and even discussing wisely and with strength of character the possibility of the patient's death as the end of the disease. Consequently, the practice of self-care represents an actualization, a staging of the ideas and of the perspective of the human model of medicine in all those ideas that overlap or coincide.

5. Conclusions

The biomedical model has a strong support in the metaphysics of spatialization found in modern sciences. Since it began at the same time with Descartes and continued by putting the emphasis on the space element from the time-space coordinate of the pure forms of intuition of Kant's intellect, it influenced medicine in a defining way. The metaphysical platform of sciences is formed between the ontology of temporality and the epistemology of the object, of the thing. With Foucault's *The Birth of the Clinic*, medicine becomes a regulating and ordering science for others and the individual allows, through his body, a space in which he finds himself as subject and object of knowledge. The space of body, in its corpse-like form, becomes seminal: the period of life obtains, through its stopping, a zero moment, that of death, the medical knowledge can occur in its true form. The body is not part of the person anymore, it is objectified and treated in a detached way from the spiritual part of the person.

Chronic diseases require a long-term or a lifetime relationship between patient and doctor, therefore the period of the patient's disease is to be redefined through a partnership relationship between them and the doctor. We believe that the approach of the *self-care* concept to the humanistic model more than to the biomedical one is achieved through the better management of the *quality-of-care crisis* by the human model because it starts from some presuppositions and acts with means that give it a more dynamic character. The holistic approach involves the concept of person (mind-body), not just the interest in the body as an organ with its broken parts or the equivalence of the mind with a simple organ. If the biomedical model is suspected of a certain alienation of the patient from the doctor, the human model attempts the very humanization of the relationship between doctor and patient, namely the very efficiency of partnership in self-care. The perspective of the organic unity of the human model, which includes the patient's integration into the system as an etiological factor in the diagnosis of the disease and as a therapeutic factor in recovery, overlaps the self-care requirements to highlight the patient's role. The features of the human model together with patient-centered medicine both make it the appropriate framework for establishing, maintaining and improving the doctor-patient relationship, so that right decisions can be made regarding the "friendship" with the disease.

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Biodata



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