

Critical Thought, Medicine as Civic Science, and Bringing Care Back into Health Care.

What are the social sciences, humanities, theory, and critical thinking allowed to contribute in our society in the age of biopolitics and bio-citizenship?

by

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„If the story of the so-called [...] natural sciences provides any guide, I would expect a *decline* in the prevalence, and the passionate insistence, on a non-theoretical kind of 'empiricism'. I would expect this rather than an increase. In this regard, we're in the middle of something of a new wave right now, [a backswing against the 'negativism' of the late 1960s, which partly came from the New Left with its often narrow] concept of 'relevance'. But there are other sources as well. In this country, if you read a sheet like *Science* (or a number of other things), you find that many people in the sciences are much worried about [fund cuts], including the tendency in recent years for both government and foundations to cut down support for so-called basic science. They only support things that have prospects of fairly quick and practical payoffs. Now, on this point the budget officers of the [...*conservative*] administration and the New Left are in the same camp. Which we don't expect to find too often. [Both contributed to the emphasis on short-run results, with its negative attitude toward more basic and more theoretical efforts.] They both like to see abstract, general theorizing cut way back, if not eliminated, and with really practical stuff put in its place. Their ideal scientist would be a Pasteur, who was a very great man. But if medicine had had to depend only on Pasteur-type clinical research, I don't think it would have advanced nearly as much as it has. [...]

And my guess is that the pendulum will swing back, but on how long this would take, who knows?

I also happen to think that, *for the social sciences, the biological models are considerably, closer than the physical ones*. Physics has tended to be our ideal-type of a theoretical science; and the logical structure of biological theory is quite different.

[...]

My guess is that most of sociology [...*and critical thinking*], when it gets to be more theorized will look much more like genetics than classical mechanics. I think that's going to happen, although the timing again is questionable. And there may be parallels to the loss of Mendel's work for a generation in biology. In other words, people don't bother about theory for a generation or two, and then suddenly will begin to revive again. I think theory is simply too much in the cards for it simply to be forgotten indefinitely, but I am sure a lot of my [...] colleagues will not share this view.“

- Talcott Parsons, 1973, Brown Seminar [*additions, A.S*].

„A famous pharmacologist said in his Inaugural Lecture at the university of Heidelberg some thirty years ago, with a bit sarcasm that 'we have a dozen or so truly effective medications; the rest of them is the product of the fear that is experienced by people who are sick and of the interests of the pharmacological industry.“

– Karl Jaspers, 1953, *The Idea of the Physician*

The present essay is focused on working towards the so-called Triple Aim Agenda, *Excellent Health, Higher Care, Lower Costs*, by *providing* a tentative and tour de force discussion of two questions a) What sort of research should we know from the field of social science? b) What is the focus the perspective of critical thinking?

It follows this structure, providing a tentative summary or statement at the beginning of each section:

Preface on “What is Medical Enlightenment?”

1. Precedents of „Schools“ that have effected a change in a culture or an industry
2. Identity Formation of Medical Students and the metaphors we live by
3. Self-care vs. (Enabling) Care for the self
4. Usances? The Problem of System Integration of Change
5. Why Use Rhetorick of Empowerment and Why use Rhetorick of Enablement?
6. Medical Concept Formation and the Concept of the Body

Conclusion: Towards a Program of Medicine Studies

Literature

Preface on “What is Medical Enlightenment?”

Our goals Excellent Health, Higher Care, Lower Costs require that all participants in medical decision-making, doctors, officials, patients, caregivers convene in an effort not just to adopt what is collectively considered “best practice”, but which they in their individual communities “dare to discern” (latin: Sapere Aude!) to be the “appropriate best practice”. This precarious effort to discern the appropriate best practice to achieve the triple aim represents a new Medical Enlightenment.

When Immanuel Kant „defined“ what he considered to be subsumed under the heading *Enlightenment*, he described a program or an attitude that could only be achieved in public and between cooperating partners in a community. The idea that a person could achieve the “use of one's capabilities for understanding” (*Sapere Aude!*), a function of the powers of reasoning. The use of which was a matter of communicating with others and, therefore, of learning together.

This is a well-known aspect of Kantian philosophy, a program that shaped intellectual life and history for more than two centuries.

What is less well known today is the fact that Kant's thought, and that of some of his earliest followers, was deeply immersed in the medical discourse of the time and affected not only the development of 19th century physiology and pathology, it is also embedded into the whole of Kant's philosophical ideas (Wiesing 2008). Kantian writings directly influenced a few very influential 20th century scholars, often medically or psychologically trained, who criticized of the way that biomedical research and practice have abandoned the individual human being and his/her needs and, subsequently, created perhaps more problems in social medicine than the ones they actually solved, such as Hans Jonas, Karl Jaspers, Talcott Parsons, or Michel Foucault. Their work presents a starting point towards delineating a better way of structuring health education for both experts (health care administrators, politicians, and medical doctors), affected laymen (patients, parents), and intermediary actors (journalists, web-providers, secondary caregivers such as nurses, kindergarten and school teachers, sports coaches). This program (or motto) of a new *Medical Enlightenment* is steered by three aims: *Excellent Health, Higher Care, Lower Costs!*

1. Precedents of „Schools“ that have effected a change in a culture or an industry

Medical history of the past century has experienced a continuous pendulum swing between a diagnostic concepts centered and a phenomenological patient centered approach towards medical practice – the prior associated with the name of Emil Kraepelin and the latter with Karl Jaspers

In truth, however, Jaspers successfully introduced a practitioner-centered model, accounting for the subjective demands of the situation, the need for experience and the objective concepts of training, that could address the individual needs of the patient while upholding the necessary detachment that a practitioner embedded in a system needs.

a) Jaspers versus Kraepelin, a century of pendulum swings

In the late 19th century, the prevalent way of treating patients with mental disorders in Germany was structured by the ideas of a man named Emil Kraepelin. Kraepelin enjoyed world-wide fame as the eminent voice in psychopathology and the theory of medicine. His symptom-catalog approach was taught and practiced widely and subject of nearly every textbook. In the early 20th century, a group of clinicians from Heidelberg returned the individual patient to the center of medical and psychological practice. Their successes gained them enough influence to claim editorship over a new generation of medical encyclopedias and textbooks, and a progressive era in medical research and practice followed. The physician and psychologist Karl Jaspers was one of these clinicians, even though he is remembered today mostly for his later career as a philosopher. Jaspers was the first to introduce the idea of the doctor-patient dyad as an interactive system, accounting for the effects of the doctors attitude on the patients health, and the patients need to learn to restrain emotional reactions and become an educated and, therefore, reasonable participant in the healing process. While Jaspers's account of health and illness begins and ends with the patient (*phenomenological approach*), Kraepelin treats any disorder he defines from a summation of certain symptoms as a natural kind, and patients displaying a certain set of symptoms are diagnosed and, subsequently, treated in accordance with the resulting catalog (*operational diagnostics*).

Jaspers discourse is superior for the fact that he argued that in the actual situation of having to make a diagnostic or therapeutic decision, a trained doctor must stand right in-between both perspectives: the subjective and the objective, the phenomenological and the operational, the empathic/involved versus the detached. This precarious intermediary situation is not to be avoided, instead, it is the natural place of the medical doctor, who must reconcile his training with his experience. For a long time, Jaspers's approach guided many young practitioners through his essays and text-books. Additionally, Jaspers's suggestion that young doctors need to be exposed to guided experience

during training before practicing on their own was a very fertile suggestion.

In the second half of the 20th century, a group of Neo-Kraepelinians gained dominant editorial positions and influenced the creation of the DSM III and DSM IV to reshape the clinical landscape towards pure operational diagnostics once more and to a point where it has been argued that the “phenomenological approach” is dead (Andreasen).

Based on empirical studies clinical experience, and a thorough understanding of the history of science, medicine and humankind, a group of scholars of Harvard University created the Human Relations movement on the basis that the individual human needs and contributions cannot be eliminated from either industrial production or medical practice (on both the patient's and the doctors side). Based on their findings they effectively and successfully restructured both Medical and Leadership training at Harvard Medical and Business School.

b) Harvard's Industrial Relations Program, Fatigue Research and the Medical School

In 1926, an Australian psychologist who had begun his career as a lecturer in the history of philosophy and psychology was invited by the famous physiologist Lawrence J. Henderson to work with him in the newly created Industrial Relations and Fatigue Research Programs at the Harvard Business School. Together with a heterogeneous bunch of scholars, they created the famous Hawthorne Study, among others. They promoted the idea that effectivity in industry could not be achieved without accounting the human factor, thereby countering the ideas that were the core of Taylorism. Their work effectively changed the landscape of American higher education and human and social relations became part of research and education for several decades, in particular at Harvard with sociologist Talcott Parsons, who had studied with Jaspers in Heidelberg, social reformer Alexander Meiklejohn in Amherst, who had received medical and psychological training and nearly single-handedly created the field of medical sociology, creating the concept of the sick-role as a unit for the analysis of what it means to be sick in American society. .

What's more important for us to look at, in the form of of historical precedents, are two things:

a) Henderson effectively taught a generation of medical students and the social and human factors at play in doctor-interaction became a pillar of his teachings. To promote this effect, he invited Parsons repeatedly to speak on similar matters before students of the Medical School.

b) Chester Barnard was a successful CEO at AT&T, who was also asked by government officials to negotiate labour disputes, and who introduced the crucial distinction between efficiency and effectiveness and the need for a communication/cooperation perspective into business and

leadership training at universities with his book *The functions of the executive* – a classic read by some of Americas most important figures in the history of business and governance, which disappeared after the scare of the 1968 generation for its frequent use of the word *authority*. Barnard was a close friend of Henderson and involved in the inner workings of the Human Relations idea at Harvard, where he spoke frequently before students. It is a less well-known fact that his work is based on the discussions he had with Henderson, Mayo, &c. on medicine, biology, and psychology. The mutual benefits of the interactions between governance, business and medicine through the lens of “communicative cooperation” are represented in the successes of the Human Relations Movement at Harvard and the effects it had in both the Business School and the Medical School.

2. Identity Formation of Medical Students and the metaphors we live by

Metaphors play a crucial role in the formation of self and identity of medical practitioners. Whether doctor understands himself to be a savior, an explorer, a regulator, etc., will effect the way s/he devises and executes medical practice. Just like some forms of organization studies suggest, "best practice", like any practice, is made up of narrative structures that can be found condensed in the creative force of metaphors. This potential is presently not well understood in the case of medical practice and, therefore, rarely used productively.

In 1999, a German medical sociologist, Christine Schachtner, published a study on medical practitioners, based on a novel application of the ideas presented by George Lakoff and Mark Johnson in their seminal *Metaphors we live by*, and by Anselm Strauss's first application of his *grounded theory* approach, which was study of the problem of dying and the medical and nursing community. Schachtner shows that certain metaphors and their embedded narratives that doctors pick up as a description for their profession, attain a creative force over the way a doctor practices medicine. This leads to the argument that narratives and metaphors, because they play such a crucial role in the formation of a professional identity of medical practitioners, should be studied and employed more strategically in the context of training and education of future practitioners.

Additionally, it can be argued that the boundaries that exist between patients and doctors can be negotiated in the form of the same metaphors and narratives, for patients, too, create their patient identity and, subsequently, their patient career in the form of a narrative. However, it is a crucial problem that, in the "trained eyes of the doctor" (*deformation professionnelle*) and the eyes of "system of health care" the patient is processed as a body/organism in parts through narratives that have been detached from the patient's personal narrative, as Y.M. Barilan has shown.

Since the patient's health is dependent on both his organism/body and his individual circumstances, a reconciliation is necessary.

The idea of the introduction of community represents a significant challenge here, because it is not a new perspective but a perspective we have lost.

Jaspers, and in his wake Parsons (both mentioned above), have repeatedly argued that the healer, from ancient times way into the 19th century, had a social status and, respectively, function of the magician/priest/shaman/holy-man, which means an integrative function that did serve to facilitate boundary negotiations through the introductions of rituals aka narrative structures. The problem today is that the narratives of medical practice and the narratives of patients' lives have become disentangled. We need to find ways of reembedding the narratives of medical practice in the social

lives of patients in an integrative function, without detaching medical practice from the administrative structure of health care organization. The effort, in short, is to promote among medical students the idea that the *effectivity* of individual medical decisions and the *efficiency* of their practice on an administrative level can be mutually increased through becoming embedded in the community within which they serve. Convening as a community effort should, respectively, be perceived as a performance of a narrative structure and integrative metaphors need to be devised that become part of both public health promotion, medical training and convening.

However, it may be argued that in the current system (e.g. reimbursement problems, legal issues such as malpractice law suits) doctors may have no incentive to enter that fray.

That may be the case or not, however, secondary caregivers and intermediaries need be included in the process of change one way or the other and it might be found that the implementation and success of change rests strongly on their participation to begin with.

First of all, these people often have a less detached role in the community than doctors presently do, second, they are often a trusted source of information for doctors, respectively used as information gatherers. A good portion of therapy decisions regarding children with ADHD are made on the recommendation of nurses. It has been a subject of criticism by associations representing nurses that they receive insufficient training and as a consequence, it has often happened that a child with bipolar is misdiagnosed with ADHD. This emphasizes the decisive role that nurses as intermediaries play in the current system (Stokowski 2009).

3. Self-care vs. (Enabling) Care for the self

There are two types of relation between care and self:

Presently, public health and health care operates on a regime of “self-care”. This means that all responsibility for precaution and prevention, as well as for the acquisition of respective abilities to reduce and manage life-course risks, lies with the individual patient. Respectively, an individual has to take care of his/her own health and must operate under the idea that s/he is always a potential patient, responsible for promoting his/her health, to reduce costs, and seek out and install his/her own care.

The “care for the self” model suggests that the “self-care regime” wrongly supposes that individuals come equipped with motivation and incentive to obtain the necessary abilities to do so. Instead, the community must provide motivation and incentives first, then opportunity to obtain these abilities. Only then can responsibility be assigned and demanded. Finally, it requires some form of (informal) enforcement from within the community.

The constitution of the patient self and the doctor self are dominated by communicative processes that are the same on a theoretical level and occur within the same social context, a health and care environment, which are steered by the same types of rhetoric, which are currently the rhetorics or *politics* of risk reduction and risk management. Stuart J. Murray, is one of those following Michel Foucault, who have enlightened us to a crucial difference in the relation between care and the self with regard to the determinative criterion that constitutes their relation.

Choosing health itself as that criterion may not be sufficient or even practical for proliferate our triple goal of Excellent Health, Higher Care, Lower Costs. Instead, we should aim for the criterion of a “good life”. Once we have chosen the latter as the determinative criterion, we find that the present system of relating care and self is highly ineffective because it lacks the community aspect! Wherein does this become apparent other than the caveat that any critic of our position would immediately provide, namely that, unlike health itself, a “good life” is a qualitative, nearly inquantifiable, vague and negotiable criterion. However, exactly herein lies its advantage and the need for community and communicative cooperation to facilitate the negotiation, since it does affect boundaries for its vagueness.

Thereby it does require the active participation of all actors, including patients themselves, in those negotiations and, subsequently, this necessitates the “education of patients” towards enabling their participation, and it requires agents that provide patients with the education to make an “an educated contribution”, such teaching agents would be, first and foremost, experienced medical practitioners (or caregivers).

One more aspect needs to be introduced. It has long been held to be a “best practice” that patients participate in their health care. However, in the current “health”-determined process, this meant that they are expected to take responsibility for their own risk reduction and management.

A “good life”-community negotiation of boundaries requires them to be enabled/empowered first and then to take their life-course into their hands.

Respectively, the care/self-relation can be defined in two ways, according to Murray (2007):

“The first I call 'self-care', a model that has dominated public health policy in recent years [...that] relies on a model of selfhood that is drawn from the tradition of liberal humanism.”

The self in this model is supposed to be rational, free and guided by conceptual reason *sui generis*, and it is a monistic entity. Moreover, the present concepts of evidence-based best practice assume the same type of self-constitution of the actors that have to employ best practice, aka the actors have no room for boundary negotiation aka appropriation, between “established” best practice and the actual situations they face. Individuals are expected to acquire and themselves to acquire abilities of self-care.

The second model, “care for the self” means that the community task is to equip the individual

(patient) with the ability – hence *en-ablement* – to take care of the self and to find or create motivations and incentives to do so, and, finally, to create communicative structures that sanction (positively and negatively) the taking over of responsibility. The direction of fit is essential: Only an individual who has been equipped by the community can take over responsibility, responsibility cannot simply be expected from an individual.¹

Finally, like socialist welfare state models, the self-care model represents an ideology: Responsibility in the self-care model lies with the individual, in the socialist model it lies with community alone. However, in the care of the self model, it is subject to negotiation between the actors in a community. Therefore, responsibility is fleeting and volatile, it is a matter of agreements that are fluid, insofar as they are adaptive to changes in the situation, and have their unique temporalities, meaning they *responsibility regimes* are not meant to be fixed in time but are expected to change if the situation changes gravely.

4. Usances? The problem of system integration of change

The most effective agents of change and boundary negotiation are civic networks. Between rigid conventionalizations and bureaucracies on the one hand, and fluid epistemic virtues and abstract reference frames, members of civic networks and heterogeneous intersectionalities, negotiate transitory, aleatoric sets of practical rules that enable goal-oriented actions in complex settings. The skills necessary to negotiate and impress such usances are a combination of communication and governing skills, which are also the marks of good (community) leadership.

In a recent refinement of a theoretical model for the analysis of decision-making processes, I have introduced *usances* as a theoretical concept that accounts for the types of agreements that actors create in practice to allow systemic integration over limited periods of time.

It is suggested here that this is turned into a practical application for community formation. It should be kept in mind though, that *usance* is used a heuristic device to guide us towards solutions.

The *general and historic* meaning of **usance**, as pertains to our model, is best defined as

„a trade custom or regulated exchange relation that exists between merchants and traders within a bounded space and location of clearly defined legal rules, laws, and legitimation principles and/or within a specific realm or sphere of

¹ The lack of a socialization process is the common source of failure of all de-ontological ethics derived from the Rawlsian model.

expertise or trade“.

With regard to reimbursement, the doctor-patient interaction falls within these parameters. It is suggested that doctors must seek to engage communities and negotiate “contracts” and “intervention regimes”.

In a sense, the old “family doctor” model did this implicitly. It was a given that family members would a) be patients of the same doctor, therefore securing the doctors income, b) the family members were instrumental in the education and enforcement.

Respectively, new bounded spaces, such as the family as a unit, must be found wherein “convening” will lead to the actors come up with *usances* that work towards enabling the patient(s) and, subsequently, promoting the triple goal of Excellent Health, Higher Care, Lower Costs.

For example:

It is not customary in Germany to inoculate people against Hepatitis. Even though it is a significant health risk and very costly on the health care system in Germany, the inoculation is only suggested and within the responsibility of individuals to take on their own money. To make matters worse, doctors can obtain the inoculation on in packages for ten patients, which they have to pay for themselves first. Meaning that they would need the security that ten people will want to be inoculated and pay for it within the time the package is allowed to be used.

Respectively, some doctors have come to suggest to patients who want the inoculation that they promote the inoculation among their friends and family, and get a minimum number of paying participants. Here the doctors have an interest in the promotion of a practice, which is otherwise a financially risky venture despite patient needs. In order to obtain the inoculation, the patient and the doctor have to find an agreement – the *usance* – wherein the patient helps promote a good practice. The patient needs to be educated by the doctor about the advantages of the inoculation and spread that knowledge.

Another example has emerged recently in the discussion of avoiding infections by bacteria with multiple-resistancies in hospitals, such as the Methicillin/resistant Staphylococcus Aureus (MRSA). With new forms of such bacteria emerging and an increase in infections in Europe and the US, a recent case of three toddlers dying in Germany and three people travelling from India to the US infected with a multi-resistant bacterium have recharged the debate and steered attention to a comparison with the Netherlands (which neighbors Germany), where the number of infections is comparatively low.

A knowledge-economy, decision-making model such as my own (delineated in detail elsewhere), distinguishes between constraining factors such as rigid conventionalizations and bureaucratic rules and enabling factors, such as creative theoretical reference frames, methodical pluralisms, and such. In practice, actors assemble their decisions and strategies between enabling and constraining forces.

In truly pragmatic and effective cultures, actors coordinate and negotiate best practices on a local level, creating negotiated solution regimes (*usances*).

In the case of the three dying toddlers in Germany, both the German public and political decision-makers immediately rallied in a cry for more rigid health laws. Specifically in the face of the horrifying numbers in Germany. With 18 million people attending hospitals for treatment every year², 800,000 people are infected while in hospital, 40,000 of which end up dead.

International experts pointed out that the relative numbers are significantly lower in the Netherlands, based on a major difference in the system, while the laws are basically similar – respectively, the conclusion would be that what needs to be changed is not the laws but the practices.

German health officials, all crying for tougher laws, immediately countered with a whole array of reasons why the Dutch health system, in their opinion, is full of failings – none of which, whether right or not, had anything to do with the hygiene and MRSA problem.

Why the Dutch system seems to work is that hospitals actually afford people in charge of governing hygiene regimes, who negotiate localized pragmatic solution with every hospital department to enforce hygienic regimes, whereas Germans are satisfied that a law is in place and it is *Verboten!* (prohibited) to violate that law³. There are no enforcing or negotiating agents in place locally.

I am not trying to say that this certainly complex case can be explained and resolved in a short paragraph and with the concept of *usance* alone.

However, I try and illustrate that descriptive, such as the one I suggest, that show how knowledge is produced and used in organizations and interactive decision-making, and how pragmatic solutions can be negotiated and implemented, help us find best practices that enable actors to create future solutions or improve upon existing ones with a clear goal-orientation. Secondly, I want to stress that solutions work best if negotiated and implemented at local levels, strengthening the role that civic networks play (Baldassari/Diani).

5. Why Use Rhetoric of Empowerment and Why use Rhetoric of Enablement?

2 <http://www.faz.net/s/RubCD175863466D41BB9A6A93D460B81174/Doc~E45E50EE94E2A416F960FF69E0E9ADB2D~ATpl~Ecommon~Scontent.html>

3 According to a famous anecdote Germany's former minister of the interior (now finance minister) Wolfgang Schaeuble once answered criticism over the use of voting machines, which were proven to be open for software attacks, with the answer that this wasn't true but even if, it is *Verboten* to interfere with voting. The same line of argument was made by government officials recently, when reporters proved that new passports with digital chips containing private data could be hacked easily and would lead to massive cases of identity theft.

A former teacher of mine in the 1980s repeatedly made fun of this traditional attitude of Germans, stating that Germans don't even bother with nature, what they can't face they just declare *Verboten!* So, is there AIDS in Germany? No, that is *Verboten!* One is reminded of the current fundamentalist Iranian president declaring that “there are no homosexuals in Iran”. Some people, it seems, chose to ignore reality rather than deal with it. Only, sometimes, reality has the nasty habit of biting back.

Empowerment is an empty concept for it does not equip people with skills to make educated choices. Access to information and informed consent alone do not require people to understand the information. People need to be enabled to use information.

In regard to practices of care, I have come to see a problem with the recent discourse of empowerment (see also above section on enabling care).

Recent literature on empowering patients, a special case of empowering consumers, has sometimes been overly enthusiastic in claiming that patients (consumers of care), like consumers in general, only need to be guaranteed access to information and they will have the power to determine their own course. Supplemented with the idea of the “invisible hands”-theorem for free markets, it is assumed that an optimum state for both individual and society will install itself.

Here is one problem with this kind of freedom: Are consumers/patient *able* to use this kind of access and are they able to make their (free) choice.

Both, psychology and philosophy would say: No!

In the famous Harwood Studies, the group of psychologists working with Kurt Lewin was able to show that staffers and well-educated managers alike will not implement better practices even if they have been explained the reasoning and shown solid data on achieved improvements (see in: Marrow 1969). Only physically experiencing the improvement and coming together on deciding as a group will lead to the implementation of a better practice. In the same fashion, Kant identified *comfortability* as the enemy of reason and of enlightenment, adding that, with only very few exceptions, an individual is not able to overcome this state of comfortability of her/his own but only in community with peers are we able to make a change.

In effect, the idea that just because s/he is given access and the power to decide on his/her own, a consumer/patient is not autonomous. Autonomous in the Kantian understanding, able to chose which rules to follow. To chose between rules, that may be conflicting, one must have additional knowledge or abilities to make that choice. The problem of ability features prominently in recent philosophy of justice as well, such as in the work of Amrtya Sen and Martha Nussbaum. I also sense a kinship with the genealogical attitude of Michel Foucault.

Therefore, and beyond a mere play of words, I argue that it is not enough to *empower* patients/care-recipients/consumers. We must *enable* them, and that means we must provide them with the cognitive means and intellectual tools to make and facilitate not just *informed consent* but *educated choice*. This includes that they are aware that they have to take responsibility for their choices and their consequences. The laziness to actually make a change is often just a laziness to take

responsibility.

With regard to modern society as having entered the age of biological citizenship, I would argue that *enabling* citizens of civil societies in the civil sphere requires the establishment of civics, learning what it means to be a citizen, that is informed by biomedical knowledge and skills for selfcultivation, aka *biocivics*.

Of course, given biomedicine's problematic history, with eugenic programs, racism, etc., it is understandable that people are cautious and have some reservations, with regard to the question whether or not medicine and biomedical leaders should also take on such a role in civil life.

As Kevin Dew has recently shown, Durkheim may have had such a concept in mind in the late 19th century, which is still applicable today. I would argue that, since biomedical accounts and ideas have already recreated large sections of modern civil society in a biomedical image, it would be only prudent to bestow more explicit responsibilities of civil leadership as well. After all, it is not medical knowledge itself that created the evils of racism and fascism but rather the lack of accountability and civics that led to the evils that resulted in much cruelty and horror.

A medical culture of civics that *enables* care, responsibility, empathy and compassion on the basis of critical thinking is, in my view, much more likely to promote tolerance, justice and a good life, than blind faith in empowerment. In other words, in a cultures focused on *enabling* care, empowerment will happen on its own. The same is not true vice versa.

6. Medical concept formation and conceptions of the body

The areas that we have to tackle by proper theoretical explication (indeed, there is little that is more practical than good theory, no?) I consider those where we find the most contested and conflicted positions and problems. Those are the areas hardest to translate for lay people, because experts often adhere to ideologies and dogmas, not pluralism.

Areas that are contested are concept formation in science and in medicine and how it affects practice (see summarized Nordby, Schramme, Broome, Khushf) and the problem of the body and the mind dualism and psychosomatics, and the question of so-called Placebo-effects is also a crucial area (Wiggins/Schwartz) Finally, how to achieve the bridging of the lay-expert gap itself is the most important problem(Nordby, Goldberg). The problem of holism and the “doctrine of complete grasp” are the issue at hand, following Tyler Burge's contributions in analytic philosophy.

In my opinion, only a pluralistic attitude and education on both sides will eventually foster relief.

But there is one thing that I am convinced of. We need better training for intermediary agents

between doctors and patients. These agents are nurses, coaches, personal trainers, nutritionists, acupuncturists, chiropractics, teachers, and journalists. They have often the first access to medical knowledge that they must use for their profession, and they have an educative role to play by integrating “body knowledge” into heir practices and that of their audience/customers.

They can help patients and care-recipients, because they are not mere experts who reside in the necessary jargon or require the same kind of professional distance some doctors find necessary.

With regard to acquiring and discussing new knowledge, they have an easier access to the care-recipient and they are not expected to make decisions for them in the way doctors are. Even though, in the process of creating information orders, they often do that implicitly. But that is also why they are responsible parties and can effectively act as *biocivic* agents and help *enable* care-recipients.

(Best) Practices and knowledge, often based on complicated theories, are inseparable. Educated choices rest on integrating practice and knowledge with understanding what a good, healthy and successful lifestyle is on an individual basis. This can come with easy choices, such as whether a certain diet should contain pasta or not, but it can also come with hard ones, such as whether to accept a stem-cell based therapy, or even if a radical chemotherapy prolonging life for just two months is really better than dying in a way the patient deems dignified.

Sometimes choices affect a single person, sometimes a whole community, for example if a local general practitioner decides to share his practice in with a group of people who provide different services, from yoga and mindfulness training to diet counseling. All such actions change how the people involved think about health and care. How they think about and practice care is what we seek to change for the better, while we agree that a sustainable strategy here will eventually improve health and, as a consequence, lower cost. It is therefore necessary begin to think critically about health, care and cost.

Conclusion: Towards a program for Medicine Studies.

I propose to install university programs in medicine studies, based within the humanities and social sciences, to create a curriculum that enables practitioners and intermediaries to serve as agents of change in their communities towards the realization of the Triple Aim Agenda.

The problems I merely skim over here do not have easy, quick, and simple solutions. We need dynamic, sustainable and long-term processes that can effect changes that matter. One essential step is, in my opinion to create a curriculum of research and education that is focused on the concept of *enablement*, which addresses primarily two groups of people: care practitioners and intermediary

agents alike (doctors, nurses, health administrators, school teachers, coaches, journalists).

I suggest the creation of programs of medicine studies – like programs of applied ethics, Science and Technology Studies (STS), gender studies, - which are set within the humanities and social sciences not medical faculties. The complete reasoning of this setting I cannot go into here, but to come up using a rather awkward metaphorical device. Medical Schools are focused on technology/hard skill, whereas the curriculum of medicine studies must focus on soft skills and on intermediating skills, as well as on building civic networks from a heterogeneous group of people, which medical schools simply do not offer the environment for.

The goals of such programs in medicine studies are to enable people to work as agents that can close the lay-expert gap and to keep the channels of information free from undue influence. They must form active civic networks engaging heterogeneous layers of society. They must promote leadership and role-model skills to help the proliferation of lifestyles that enable people to care for themselves. Practitioners must learn to take care and cultivate themselves. They must learn to understand the problems of decision-making both they and the people they are to care for or keep informed face, in terms of economic, ethical and social contexts. Practitioners must understand “best practices” in governing and managing health systems. In short, medicine studies must help practitioners become active community leaders with excellent interpersonal and good entrepreneurial and managerial skills to supplement their original technical training as medical practitioners. In this regard the teaching and research of medicine studies is focused not on clinical practice or biomedical research itself, but on the entirety of practical contexts, social, economic and theoretical prerequisites and the individual consequences that medicine is embedded in, each of which touch upon the pragmatics of the intertwined problems of decision-making, identity formation, and communication of knowledge in today's civil society (Alexander 2006, Rose 2006).

To facilitate these goals, the curriculum must be made up of three pillars:

- 1) History, Philosophy, and Anthropology of Medical Cultures and Ethics
- 2) Somaesthetics&Psychosomatics: Training in Cultivation and Maintenance of the Physical Self and its Mindfulness
- 3) Studies in Environment, Organization, Knowledge Economy, and Leadership

In the future, we will have to discuss and come up with a program that can succeed in bringing these aspects to life and achieve the Triple Aim Agenda.

Peter Wilkin (2009) has recently published a study on how the different layers of analysis and practice come together. Looking at the process of historic industrialization and current

globalization, human anatomy&physiology, the rise of cases of lower back pain (LBP), the rising health care costs and significant economic in GDP owing to LBP, he was able to identify industrial chair-making as one source of the problem. He could also show how networked people: doctors, designers, pupils and school board members could work together locally in creating better chairs and create healthier students with higher productivity. This is exactly the kind of combination of analytical work, local change and system integration that is required to be systematized towards realizing the triple aim agenda. It is also not something that I see in proliferation without the creation of programs that attach these layers, or, in other words, we need to create and institutionalize intersectional programs, and medicine studies is just such a suggestion.

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