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The Path to Humanizing Medicine

A nurse rushes over to the side of a woman who is seated in the emergency room and violently trembling. Noticing the severity of her condition, the nurse hastily retrieves the attending physician, who recognizes the patient immediately upon his arrival. The ailed woman's name is Vivian Bearing. She has recently been diagnosed with stage-four metastatic ovarian cancer, and has spent a significant amount of time being monitored by both of the present medical personnel while undergoing rigorous chemotherapy treatment over the past few months. After being quickly briefed on Vivian's statistics of temperature, pulse and respiration, the doctor determines her possible illness and sends her to the lab for further testing.

Although Bearing has been experiencing increasingly severe side-effects to her treatment—weakness, nausea, vomiting, and now, fever and neutropenia—her doctors remain adamant in their decision that she is following the best course of action available, given her condition. However, Bearing's nurse-caretaker has also noticed the continued suffering caused by the treatment process.

"I think you need to talk to Dr. Kelekian about lowering the dose for the next cycle," the nurse announces out of concern for the patient. "It's too much for her like this," she tries to reason with the doctor. But, she is immediately dismissed.

"Lower the dose? No way. Full dose. She's tough. She can take it," the young physician asserts, before dictating his last orders: "Blood cultures and urine, stat—wake me up when the counts come from the lab" (Edson 45).

In this scenario and brief moment of dialogue, Margaret Edson, in her play *Wit*, has managed to crystallize the essence of the dominating culture of medical interactions encountered within western, industrialized nations. This presiding trend has been dubbed by scholars such as James Marcum and Adele Clarke, as the "Biomedical Model" of medicine: we observe the way in which information of the patient is transmitted in terms of numerical, scientific data between the medical experts; lab work and technological intervention are used as the primary means of gauging the individual's condition; finally, there is an overt hierarchy, which consists of the physician at the top, his subordinate nurse, and the patient at the lowest level—unable to answer for themselves and possessing no clout in their course of treatment.

Shirlee Passau has dissected such power dynamics within the hospital, as depicted above. She relates the structures found in such settings to one reminiscent of a family within a western patriarchal society. The role of the nurse becomes a continuance of the "wife-mother", who is

expected to take on a passive, care-taking role, assumed to be latent within all women (204). Her job is not only to provide emotional care to the patient—the naive “child” who cannot fend for their own health—but, she must also support the doctor by following his orders to completion. The physician commands authority within the hospital as the father figure, a status used as a means of justifying his aggressive, “masculine-paternal” methods when providing health care—even at the cost of the patient’s anguish (205). Most importantly however, role of the doctor, in comparison to that of the nurse—whose abilities are judged to be “inherent”—is one based on rigorous scientific training and the acquisition of knowledge, which hold him to a higher standard within society (206). Examining such classifications, Passau brings to light the results of this engendered divide. That is, as medical history progressed, “male scientific medicine” developing parallel to “female nursing”, healing was split into two functions: curing and caring; the former based on study and intellect, and the latter based on intuition and emotion (208).

It can be argued that the doctor has long been viewed in western society as the paragon of knowledge. He has come to represent the unified mastery of the natural world, conquering the fields of academia, the body, notions of wonder and bafflement, and even Death. However, this rigorous training has come at a price. In exchange for his unparalleled scientific intellect, the physician has been conditioned to never to cross the emotional threshold that may compromise his work. Emotion is not ruled by science; emotion belongs to the realm of the nurse. The work of a doctor on the body of his patient is based on detached empirical observations: science.

As noted by the scholar Peter Bowler, the seventeenth century brought with it a time known as the “Scientific Revolution,” when new methods of acquiring and circulating knowledge began to develop, bringing forth what was to be “nothing less than the birth of modern science” (23). The science from this time was one that was “new because it was based on an entirely different set of assumptions about how we might best go about acquiring knowledge in the first place;” it emphasized methods of experimentation and empiricism, placing man at the center of knowledge (39). The scientist ascended a position of power. He was one who used his own intellect and observations as the basis of learning, and construct new ideas and theories based on his own experimentation. The drive of this new movement was one of progression. The young novelist Mary Shelley captured this sentiment quite succinctly in her own writings: in other studies you go as far as others have gone before you, and there is nothing more to know...[however] in a scientific pursuit there is continual food for discovery and wonder” (55).

In fact, it was an attempt to redefine notions of “wonder” that rapidly became the primary motivation of the scientific insurgence that was taking place. Initially, “wonder” had defined an approach to learning. It described a sense of intermediacy, “akin to a sort of suspension of the mind between ignorance and enlightenment,” and had predominantly been explained through early discourses of mysticism or religion (Weschler 89). It was not until the conception of Positivist theory that such ethereal explanations were rendered inadequate among the ever-growing community of modern thinkers. Positivism held that to the knowledge acquired by scientific methods and analysis, was the only type of knowledge to “concern itself with truths about the world”—science is the sole

basis upon which "fact" can be determined (Sturken & Cartwright 117). This theory generated the idea that undeniable (scientific) truths could be proven, given that an individual follow a set of criteria to ensure his objectivity and bear scientific evidence. The path to obtaining scientific fact was based upon methods of classifying, quantifying, and calculating empirical data in the most detached and mechanical ways possible; the scientist attempted to make as rational and logical connections as possible.

One such example manifests itself in the "Cabinets of Wonder" that became in vogue among scholars during the 17th century. These proto-museums were domestic exhibitions of the owner's rare "treasures", which many times consisted of organic, bizarre paraphernalia, the origins of which could rarely be distinguished. In many ways, these collections became a form of visual experimentation. For example, by means of imposing a taxonomical order on the hoard, "grouping similar 'strange' and 'wondrous' specimens together," scholars and scientist alike sought to ground these objects of mystery within the rationale of science (Weschler 83). Understanding how such articles were related to one another, taking into consideration physical characteristic and visual features, served to root their definitions in the natural world, rather than using mystical justifications.

The application of scientific theory on the human body also grew to newly heightened degrees. Previously, as described by the scholar Michel Foucault, notions of the body were intrinsically tied to those of morality and the soul. The human body was a vessel of sin. Through it, "insinuations of the flesh," such as acts of sexual delinquency, could manifest themselves; one's body—its secular thoughts and physical actions—was an onus in need of atonement (19). However, new ideas of secular empiricism began to revolutionize ideologies of the body and its relationship to the mind. Research would replace repentance, and eventually, science would become an increasingly dominant lens through which the medical eye examined the body.

One major theoretical contribution of the time—that would later have immense impact on the practice of medicine—was introduced by the natural philosopher Rene Descartes, who proposed an "unambiguously mechanical" picture of the universe and its human inhabitants (Bowler 35). According to Descartes, all animals and humans alike were nothing more than complex machinery; the only difference between the two was in that "humans possessed an animating soul that controlled their bodies through the medium of the pineal gland," the mass of tissue behind the third ventricle of the brain that was responsible for secreting hormones (Bowler 36). Needless to say, the presentation of such a detached, un-spiritual view of humanity did not coincide well with the previously dominant beliefs governed by religious doctrine and mysticism.

While Descartes employed a purely mechanized framework of the body, the inclusion of a morally accountable psyche in his theory was necessary given the times. The church had long assumed the throne of power in regards to dialogues of 'personhood', and they had mandated that "person was synonymous with mind"—one could not exist without the other being present (Cassel 211). By acknowledging the existence of both entities, but rendering them mutually exclusive, "Cartesian dualism made it possible for science to escape the control of the church by assigning the

noncorporeal, spiritual realm to the church, leaving the physical world to the domain of science" (Cassel 211). From this moment in history, a paradigm shift took place in the scientific and medical world, which had (essentially) free reign to explore and uncover the body, devoid of mental and spiritual ties or consequences. The human body became an object to study, like any other.

However, as time lapsed, a problem would arise as this strict dichotomy continued to carry over into medical practices centuries later, leading to the degradation of healthcare in a society with a new set of philosophical relationships and needs (Cassel 211).

It is strongly arguable that this mind-body dichotomy that stemmed from the Scientific Revolution can be directly traced to that of the care-cure dichotomy in healthcare today, which is at the forefront of shortcomings produced by the biomedical model of medical practice. Based on these early divides of science, the physician is unable, or unwilling, to take into account the patient's entirety: mind and body. Instead, our medical experts chose to focus on the mechanical body, which can be seen and touched. He will administer the proper drug regiments to help you (your body) "beat" cancer, but if the adverse side effects, constant confinement and excruciating pain lead you to loose hope in yourself and your very life, then you had better start talking to a therapist—or even a priest.

Thus, "curing", the act of eradicating disease, is only applied to a part of the individual and does not overstep the boundary of the physical body. The physician takes no account of the patient's mental anguish or stress throughout the process—the "care" aspect—as he, the doctor, has been fostered in a scientific background that employs traditional methods of objectivity; the sole aim is "to diagnose a disease rather than to understand a patient" (McWhinney 874).

The detachment between a physician and his subject is something that has been cultivated from introductory medical studies with a cadaver, says David Reiser, who notes that a scholar of medicine cannot so easily forget the realities of death. Although the lay population may be privy to the occasional momentary shock and epiphany over traumatic instances of death, the physician is works on the cusp between life and death; for him, death is the norm (23). Death has been viewed as one of the ultimate wonders of humanity. Vanessa Shwartz captures this fascination with the loss of life in her description of the 19th century Paris morgues, outside of which crowds of people would gather to observe the corpses on display. The initial goal of the morgue was to act as a "depository for the anonymous dead," in an effort to crowd source the identity of the body, however, these pubic displays quickly transformed into a "spectacle of the real"—an intrusion into the banal of everyday life (Shwartz 49). Viewing the exhibition of corpses served as a reminder to the lay audience of their temporal state, captivating them for the moment, after which they were free to resume their normal state of ignorance (Shwartz 48). The physician on the other hand, cannot afford such luxurious views of death, for it is in close proximity with this force that he works, constantly aware of the delicate threshold that divides it from life; if he is too sensitive he might become paralyzed from action. And so, he is immediately instilled with a detached sense of objectivity through the ceremonious dissection of the

cadaver, and in doing so, "the medical student first learns that if in one dissociate one's thoughts from one's feelings and one's intellect from one's emotion, they can do almost anything;" he may even be able to cure the most profound disease (Reiser 25).

However, by adopting this mindset, physicians may not be providing the necessary care that is needed of their patients. In fact, many times their treatment methods may exacerbate the patient's feeling of illness. Following an intense round of chemotherapy, Vivian comes to a realization as she is being placed in isolation because her immune system has been placed into a critical state as a result of the treatment. "I am not isolation because I have cancer," she notes, "I am in isolation because I am being treated for cancer; my treatment imperils my health" (Edson 47). Modern treatment methods have become a source of suffering; they not only threaten the patient's mental wellness, but at times they may also jeopardize physical conditions as well. Yet, especially in regards to the former, this fact is being severely neglected by medical professionals who seem to be solely focused on the targeted disease itself. In doing so, according to critics such as Cassel and Ian Mchwinney, the physician is not only failing to meet the expectations of his patients, but moreover, he may also "do things that cause the patient as a person to suffer" (Cassel 212). Suffering is created in relationship to pain and disease, but it lies in the greater context of mentality and emotion, whereas disease is bound to the realm of the body. The focus has been shifted away from the person, and the body reduced to a locale of disease. Marcum comments in further detail of how this mindset has negatively influenced the biomedical model:

"According to the biomedical model, the patient is a machine composed of individual body parts that, when broken or lost, can be fixed or replaced by new parts. Moreover, disease, whose cause can be identified by scientific analysis (and imagery), is an objective entity...The notion of health involves the absence of disease or the normal functioning of body parts" (11)

In this light, the doctor has become like a mechanic working on the body of a damaged car, staying clear of the inner workings of the human emotional psyche. The truth of the matter though, is that effects of disease are in no way bound to the body alone. Family dynamics may be shifted; work may be inhibited, inducing mental stress; all of the roles that a patient assumes in their daily life are affected by illness, which consequently produces a psychological crisis to some capacity. Taking this into account, why then is it acceptable for the doctor to be absolved of his commitment towards aiding the patient in their battle against disease across *all* aspects of their lives. The biomedical model's greatest strength has become its greatest weakness. Based on traditional principles of the scientific method that stress objectivity and visual observation, the biomedical model has trained physicians to target disease and employ methods of treatment with great precision. However, it is also severely lacking in other areas, often times leaving the patient feeling like they are little more than a body part to the physician.

Viewing the person as a composition of compartmentalized units seems to be rooted in the structure of anatomical studies and the role it has played in developing medical practice. It wasn't

until the 16th century, as a prelude to the Scientific Revolution, that the practice of anatomical dissection would come to flourish. Previously, the study of anatomy had been dependent on the transmission of knowledge that stemmed from a hierarchical structure, passed down from previous scholars, such as Galen and his anatomical and physiological theories, which were widely indoctrinated since the 4th century (Van Dijck 121). However, the growing scientific model of self-acquired knowledge prompted individuals to challenge such dogmatic practices. An anatomist by the name of Andres Vesalius would challenge these widely upheld doctrines. Vesalius "noted errors in Galen's anatomical descriptions and relied, instead, on empirical evidence," based on his own observations within the interiors of the human body, and made his knowledge public (Van Dijck 121). As others began to adopt a similar enlightened view, a more direct and experimental approach to understanding the body became popularized. Science fueled the idea that if one were to cut open the body, it would then reveal its secrets to observer.

Beginning in the 15th century, anatomical dissections were publicly displayed in designated theatres, a conspicuous act that marked society's gradual acceptance of the practice as a legitimate, scholarly and medical one. However, notions of the mind and body continued to remain dissonant. Bodies donated to public dissections were those of former criminals and convicts, used in an attempt to estrange or distance the viewer from the individual (Van Dijck 127). This estrangement only served to reinforce the Cartesian dichotomy; with no remorse felt towards the errant bodies, observers could solely focus on the human as flesh and bone, not a person. So the practice continued, and as anatomical procedures became more refined, they became further incorporated into the medical sciences as part of the core curriculum for physicians.

Around this same time of anatomical exploration, art would also come to play a key role in science, though the resulting fusion would only serve to reinforcing ideas of the segregated body. Visual culture began following similar trends towards objectivity, catalyzed by the "movement toward science, such as "Cartesian mathematics and rationalism", which had become dominant modes of knowledge by the closing of the Renaissance (Sturken & Cartwright 157). With the dawn of the Scientific Revolution, the artist "embraced the idea that it was art's social function to reproduce human vision in an instrumental manner," objectively recreating the scene before him (Sturken & Cartwright 160). This was especially the case in regards to depictions of the body. Artists and creators assumed their roles as visual scribes of anatomy, visually cataloguing the body for the progress of science and medicine. An example of such is demonstrated in an engraving by the German print-maker Albercht Durer, which depicts a "draftsman looking through a grid at a curvaceous model, attempting to render her body within the laws of perspective," in order to produce "objective" art (Sturken & Cartwright 159).

Not only was great detail given to the external features of the body, but the same focus was also applied internally as well. Detailed drawings of human innards became a common coupling with dissections, producing biological roadmaps to guide the physician in his bodily inspections. Furthermore, as images of the body became ever more prevalent among the medical-scientific and lay

communities, ideas of normalcy began to shift. The construction of a new "standard" body began to take place through the visual.

But, it would be photography that brought this 'the revolution of normalcy' to fruition. Offering what appeared to be a trace of the "real", or objective existence, it aligned perfectly with the ideologies of positivism upon which science was based. Allan Sekula observes that standards of normalcy solidified as the mechanized process of photography "came to establish and delimit the terrain of *the other*, to define both the *generalized look*—the typology—and the *contingent instance* of deviance and social pathology" (7). Sekula points to the example of Alphonse Bertillon of the late 19th century, who used standardized methods of photography to establish his "mastery of the criminal body" by anatomically typifying convicts through images (33). Such regulation would become even more pervasive in the medical realm, as photographs "provided visual records of phenomena and experiments," and were used to "document diseases, to perform diagnose, and to record and graphically represent scientific data" (Sturken & Cartwright 356).

Abraham Flexner, who played a significant role in shaping the curriculum of North American medical schools, stated that the doctor's understanding of the "normal" body is "the starting-point of his efforts to master the abnormal," which is epitomized in the concepts of "disease" or "illness" themselves (24). It is largely the case in Western society, as with the Cartesian mind-body dichotomy, that there is a distinct line drawn between a person being healthy or ill. The Flexner model dictates that the superior methods employed in constructing such notions are through the study of hard-sciences, such as chemistry, physics, and especially, biology (25). As we have demonstrated thus far, this model has ultimately been the predominant one adopted by most Western medical colleges, forming a somewhat symbiotic relationship with the biomedical model—the two continually perpetuating one another. However, this trend has not gone without opposition. On quite the opposite end, George Engel believes that the "dogmatic" methodology of the biomedical model has created a critical miscalculation in the way physicians approach medicine (130). Engel proclaims that "the boundaries between health and disease, between well and sick, are far from clear; and that they will never will be so, given that these terms are "diffused by cultural, social, and psychological considerations" (Engel 132). It is the physician's responsibility to take these peripheral factors and definitions into account when he is engaging with the patient to prescribe a method of treatment. In fact, forgoing such considerations is a failure to perform his duty of assessing the full range of influences, which may shape both the nature of patient and the illness, before coming to a established conclusion.

In order to ensure that proper medical attention be given to patients, Engel has proposed the "Biopsychosocial Model" as a potential solution to override the shortcomings of the biomedical model, and has been accepted as one of the most widely popularized alternatives adopted by counter-culture physicians in modern day. As its name implies, this model crosses the Cartesian divide, stressing the psychological factors affecting the mind of the patient. By these means, the physician must "take into account the patient, the social context in which he lives, and the complementary systems devised by

society," which all have influence over his condition, as opposed to solely examining the body through the lenses of the hard-sciences (Engel 132). Based on this model, there are three overlapping spheres that construct the "illness" of a patient: 1) *bio*-- physiological factors; 2) *psycho*-- the individual's own mental state; 3) *social*--the societal context in which the patient exists. The biopsychosocial model not only manages to break down the mind-body dichotomy, but it also adds to it the crucial aspect of cultural or societal conditions, which are also determinants in the construction of an individual's self-identity and health. By utilizing a medical system such as the biopsychosocial model, which takes into consideration the entirety of a person, the physician may not only acquire the ability to cure disease, but also "heal" their patient—a phrase that in "its deepest sense" is equated to "the restoration of wholeness... something that happens to the whole person" (McWhinney 875).

The concept of healing is a potent one; constituting the eradication of "spiritual anguish" along with physical disease. Surely accomplishing such results is no easy endeavor, as noted by both McWhinney and Engel himself, who is first to note the biopsychosocial model is "surely not complete" and can not stand alone as a cure-all for Western medicine — although it is a start (132). However, before this model can truly reach its full potential, there must be a reconsideration of the differences between disease, illness, wellness, and health. Arthur Kleinman adds to this, renouncing society's distinction between *disease* and *illness*, as it is believed that the latter "represents personal, interpersonal, and cultural reactions to disease or discomfort," which constitute a subjective experience, lying beyond the realm of the physician (141). The art of healing lies in the realm of subjectivity, which has been the enemy of science, and subsequently, medicine. It must be stressed, however, that one of the first steps to be taken in hopes of accomplishing the goals above must be in our efforts to redefine the divides between illness and health in our society to include a greater social and psychological context; those factors which affect a person's sense of "wholeness" and balance. Once the physician is aware of these new ideas of illness and "how they influence a patient's psychosocial life, the humane physician can more adequately attend to a patient's suffering rather than only to the pain caused by a diseased body" (Marcum 397).

The key to this transition, as Michel Foucault would argue, is embedded within the dominant discourse ascribed to the community. According to Foucault, the discursive culture of a society grants access to a particular vocabulary—one that is reflective of current social trends, and influences not only how we discuss the matter at hand, but also how we act upon it. "The medical examination, the psychiatric investigation, the pedagogical report, and family controls," all represent frames of discourse identified by Foucault, which "function as mechanisms of power" that bring forth notions of truth or fact (45). To simplify his terms: how one speaks of a subject will subsequently influence how one acts upon the subject. This idea extended by the individual, into the whole of society as well; discourse has a tremendous impact on how policies and practices are implemented. However, these dominant notions are not permanent; they can be resisted and changed. Other factors such as institutions, groups and even individuals, take part in shaping the discourse that constructs our ideas of illness.

Take for example the women's health movement of the 1960-70's, which managed, for a brief length of time, to successfully combat the biomedicalization being imposed on the female body. Ratcliff points out that pregnancy, menstruation, and lesbianism were all considered, at one point, to be medical diagnoses, but such presumptions were based on the dominant standard that being used critique these afflictions—the heterosexual male body, which did not account for a "diversity of human experience" (Ratcliff 4). The medical insurgency that followed derived from women's frustration towards the estrangement of their own bodies: what they believed were misdiagnoses and misconceptions of the female body. The women's health movement was an attempt at reclaiming the self—despite the dictations of (male) medical experts, who claimed to know better. Ratcliff gives a summary of the spirit of the crusade:

"Participants in the movement have criticized the health care provided to women; voiced frustration with the traditional paternalistic doctor-patient relationship; challenged professional authority and expertise; objected to the medicalization of childbirth, menopause, and other natural processes in women's lives; criticized the privileging of technology and intervention over prevention and self-care; educated each other; provided alternative forms of care; and effectively lobbied for changes in the health and care of women (284).

By means of self-education, examination and open discussion of health concerns, the women of these decades were able to use their knowledge as leverage to mobilize groups into rethinking the medical structure, leading to such accomplishments as: the banning of harmful prenatal drugs, increased access to educational material, and social attitude of feminism that continues today in lives of select individuals. When an individual is diagnosed with an illness there is a crisis of personhood that takes place, the body, in many ways, may become alienated and foreign to its owner. The activists of this time were able to work as a community to empower themselves against such crises, but they had to do so by butting-up against the dominant medical arena. It is a shame to think of how much more compelling and enduring such a movement could have been, had doctors assumed a more supportive role, taking more into account not only physical, but mental disparities that may be involved in the context of medicine.

The idea of patient empowerment that is the crux of the women's health movement is apparent in yet another model, which has robust promise in dislodging modern medical trends. It is the Patient-Centered model. John Rogers describes this system as one in which each patient has an ongoing relationship with a personal physician, who has been trained to provide "first-contact, continuous, and comprehensive care" all throughout the entirety of the patient's medical history (Rogers 697). As the doctor furthers his relationship with patient on both a professional and personal basis, he is able to lead a team of additional medical specialists in order to address any specific medical complexities as they arise. This way, medical treatment "integrated across all elements of the complex health care system," simplifying the process with the patient in mind (Rogers 698). This model

reconfigures the traditional hierarchical structure, putting the patient in the highest priority position, rather than the “all knowing” impersonal doctor. Moreover, the brilliancy of this model lies in the consistency between the doctor-patient relationship, which may have a higher tendency to promote bi-directional communication, as well as emotional and medical support. Ideally, this setup reconfigures the idea of healthcare into an open dialogue between the physician and his patient, and the notions of health become dynamic and fluid, governed by a sense of well being, rather than being solely regulated by the body itself. McWhinne also advocates such a model, believing that “the physician using the patient-centered method invites and encourages openness by the patient”—an aim that is sought in order to “understand the patient’s expectations, feelings and fears,” that evolve out of being stigmatized for their illness (McWhinney 876).

Gayle Stephens has related these discussed concepts to a clinical-level, grassroots movement in medicine: the establishment of the Family Practice and the Pediatrics Physician in western society. Stephens names these two fields as a prime examples of “counter cultural” shifts within medicine, wherein “social reform, rather than science and technology, was instrumental in the development of both disciplines,” which strongly went against the grain of biomedical rationale (629). Both Family Practice and Pediatrics promoted a regular and continuous dialogue between the physician and his patient(s), so that that he was able to consider the patient’s needs first, backed by uninterrupted knowledge of their medical and social history. Whereas physicians operating under the biomedical model—whether aware of their habits or not—are more likely to place significant focus on technology and advancement of instruments that enhance capabilities of examining the *body*, not necessarily assessing the patient as a whole, these progressive clinicians recognized the importance of the patient-doctor connection, and how it can be used as a tool to enhance the practice of medicine to a more consistent, deeper level. As Stephens succinctly states it: “there was simply a need for some physicians to devote themselves professionally to a social goal,” in order to create a branch of medicine that took into account all the “nonscientific things that are part of the human experience,” including the doctor’s personal relationship to his patient (Stephens 633).

Form these three instances of resistance, or brief moments of epiphany, it is becoming clear that there are two trends that may prove to be the savior of our western medical malady — that is: returning a sense power and importance back to the patient; and placing a higher priority on the individual’s psychological and social influences that may compromise the status of their health.

Speaking towards the latter, Engel would insert that a return to ‘systems theory’ is in order for the world of medicine. He demonstrates via a chart, that there is a hierarchical structure of organized systems that make up the natural world, which he has separated into twelve tiers: the first and smallest tier consists of the molecule, each subsequent level encompassing a greater biological and social circle until finally concluding at the “biosphere” (535 *Clinical Application*). Engel argues that in order for the biopsychosocial model to take effect--or for that matter, any of the discussed adjustments--physicians must take into account the true idea of the “person”, which lies at the center of the model, and “represents at the same time the highest level of the organismic hierarchy and at

the lowest level of the social hierarchy" (535). With this in mind, there are two realms that interpose a person as a unit of being—three realms total, when taking into account the individual's own psychos. If the physician proclaims that he or she is in a field of helping *people*, curing *people* or aiding *people* in any form, then they must be accountable for taking into account the *person*, not just one-third; else you have a hospital filled with Vivian Bearings—neglected, distraught, and suffering from their own prescribed "treatments," as they call it.

A remarriage between the external and internal must be established when observing a patient, for a person does not exist as an isolated unit. However, there remains an inhibition against this outward trajectory. As medical technology continuously allows for the viewing of the body on an ever smaller, ever more internal scale, it drives the physician towards operating within Engel's inner most circles: cells and molecule. Adele Clarke and her scholarly peers argue that the "increasingly complex, multisited, multidirectional processes" brought about with the "practices of highly increasing technoscientific methods," have become in the crux of biomedicine (47). There have been increasing steps towards delving further inside the body — beginning with early anatomy, to the microscope, to endoscopy. "Seeing the unseen" has become a recursive motif throughout the history of science and medicine, but it is one that has been recently reconstituted and "newly energized with the introduction of digital imaging and rendering techniques" that have opened our eyes to previously unknown levels of the body (Sturken 348). We are now able to explore, observe and diagnose bodies on a level that surpasses physical human capabilities, producing what Clarke, Sturken and Cartwright, have all referenced to as the "molecular gaze" in modern Western medicine. Aided by technology, "we have begun to experience our bodies at the scale of the molecular, as scale that we cannot exactly see but which we conceptualize through systems of scientific representation," such as images, codes, and numbers (Sturken & Cartwright 349). In doing so, we have further reduced the person as a unit, to fragmented bits of information, continuing to abstract the idea of the human relationship to the body.

Returning to *Wit*, we can see this phenomenon demonstrated in the speech employed by the young doctor, Jason, while discussing the topic of cancer as a disease. He speaks in absolute awe and wonder, referring to "intercellular regulatory mechanisms" that affect the "malignant neoplasia," one the level of the "normal cell-cell interactions"; but these terms are impossible to decipher by his audience, Vivian, who has not the slightest concept of any of these terms that are being used to reference her own state—her own body (Edson 57). Van Dijck calls attention to the fact that as cybersurgery progresses, further atomizing the person, a "patient's body becomes more a collection of data than a physical body," which threatens the restoration of the medical system as we have defined it (76).

The reality is, however, that this system of "codifying" of "datafying" people into digital information is a system that has already begun to proliferate society, many of us actively partaking in its perpetuation. Scientific discourse has been integrated into the lives of the lay on a regular basis; we all know our blood type, weight, blood pressure, sugar, and other scientific quantities that reinforce our own regulation in relation to the body and disease.

Foucault first introduced this idea of “panoptic power,” a form of self-surveillance, when constructing his theory of “biopower,” which holds that “particular forms of knowledge coupled with technologies” have the power to exert “constant forces of surveillance over living bodies and their behaviors,” especially in relation to medicine (Clarke et al 5). It is arguable that in modern day, the individual has been conditioned to apply self-regulating techniques in the monitoring of our bodies. We know the numbers and statistics that indicate when medical attention is needed. Our bodies, rather than our lives, intuition or sense of wellbeing, mandate our relationship to medicine and when we seek out a physician. The failures of biomedicine are not on the clinicians’ side alone. The major driving force behind biopower is not always so easily identifiable because it is a productive power that we participate, not an authoritative power, and it is shaped by a combination of influential factors. Still, within the realm of medicine, it is arguable that where as previously institutions and individuals (physicians) were the major sources of biopower, today they have been usurped by an even greater, all-knowing entity: technology.

In its progression, medical technology has not only remained imbued within the initial scientific notions that spurred from the 17th century, but it has also exacerbated familiar ideas of objectivity, detachment, the deconstruction of information, and bodies themselves. Furthermore, technology has provided a false sense of empowerment to its wielder, the doctor-scientist, which now leads to the degradation of his own power. While the advent of new technologies allows the body to become ever more transparent in the eyes of the physician, these machines also point to the doctor’s own human incompetence to achieve true objective discernment. The physician who has been conditioned by science, stripped of his humanity, emotions and subjectivity in order to make him the perfect curing machine, finds himself replaced by the very tools used to achieve this Faustian bargain. Ratcliff denotes this shift in the passage below:

“Call to mind an ICU with monitors blinking and beeping, and remember how all eyes (even family members’) go to the monitors-- away from the patient. It requires effort not to watch the monitors...the machine, not the physician (and certainly not the patient), ends up dictating the treatment” (5).

We turn our eyes to technology as our most trustworthy indicator of health, growing accustomed to the scientific images and visual representations of heartbeats, cells, and microscopic units of the human body. We, physicians and laymen alike, have averted our gaze from the individual; we have adopted the molecular gaze as a society.

By now it should be discernible that in order to re-evaluate the philosophy of medicine and restore its humanity, we must first change our philosophical stance on science itself. Edmond Husserl, a 20th century German philosopher, exposed that there are inherent problems at the core of Western science, which have led to the “deep and fundamental problems with the way healthcare is conceptualized” in our society (Lewis, *Narrative Medicine and Healthcare Reform*). Mutually, we have

upheld the idea of science as progress, and thus anything that goes against this notion seems counter-intuitive. But, this must be resisted. Technology has taken throne on medical matters.

This is not to say that technology is the enemy of man, or to advocate for the banishment of such apparatuses as whole; it is simply to serve as a word of warning, in order to mobilize efforts against these trends. As it was previously stated, notions of both discourse and biopower are not immutable; they can be altered with the shifting of foci and the opening of discourse. This movement, however, must take place from grassroots levels—bottom up—in order to make a lasting effect. Humanizing medicine, as its title implies, will require the reinsertion of the human—as an entire being—back into the focus of medicine. The physician must reclaim his soul; the patient must reclaim his mind; humanity must be healed to completion.

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