Critical Dialogues in the Medical Humanities

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Edited by

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Cambridge
Scholars
Publishing

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This book first published 2019

Cambridge Scholars Publishing

Lady Stephenson Library, Newcastle upon Tyne, NE6 2PA, UK

British Library Cataloguing in Publication Data
A catalogue record for this book is available from the British Library

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ISBN (10): 1-5275-3463-4
ISBN (13): 978-1-5275-3463-6

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ACKNOWLEDGEMENTS

This volume would not have been possible without the engaging interdisciplinary dialogue initiated at the conferences organised by the London Centre for Interdisciplinary Research. The editor would like to thank the LCIR for having trusted her with the edition of this volume, and acknowledge the ongoing support and tremendous help of its Director Olena Lytovka. To her goes my most sincere gratitude.

INTRODUCTION

EMMA DOMÍNGUEZ-RUÉ

All of us – either as medical practitioners, healthcare providers, or healthcare users – have some insight into good doctoring; namely, pick the doctor with the longest waiting list at your local healthcare centre. From that awareness, one can infer that we all realise, maybe to various degrees, about the importance of Medical Humanities. As Jack Coulehan aptly defines them, "medical humanities relates to, but is not identical with, the art of medicine, for which nowadays we often use the word 'doctoring.' Doctoring requires communication skills, empathy, self-awareness, judgment, professionalism, and mastering the social and cultural context of personhood, illness, and health care" (2008). In that light, and as Martyn Evans and David Greaves discuss (1999, 1216), the Medical Humanities should not just attempt to add the humanities to existing medical knowledge, but actually try to integrate them into medical practice. In other words, and as Femi Oyebode asserts, to "refocus medicine" in such a way "that it comes to incorporate within its ambit what it means to be fully human" (2010, 242).

As Rita Charon sustains in her foundational book *Narrative Medicine* (1998), medical practitioners can highly benefit from incorporating sources and methods from the humanities to better accompany their patients in their illness, thus contributing to more humane – and ultimately more effective – medical care. As this volume hopes to illustrate and as Charon et al. have discussed (Charon et al. 1995; 122, 599–606), literary accounts of illness can enlighten a doctor's perspective on a clinical case, while adopting the role of listener to the narrative of a patient's disease can help a doctor understand patients and their distress more deeply. As Oyebode similarly writes, "fiction can inform physicians of the power and implications of what they do; and understanding narrative structure can help physicians grasp patient's [sic] stories more fully among other things" (2010, 7). However, Jakob Ousager and Helle Johannessen have pointed out that there is scarce evidence of the positive impact of integrating the Medical Humanities into the curricula of Medical School undergraduates, which might in turn "pose a threat to the continued development of

humanities-related activities in undergraduate medical education in the context of current demands for evidence to demonstrate educational effectiveness" (2010, 988). Anna Taylor, Susan Lehmann and Margaret Chisolm have similarly remarked that, even if the significant benefit of integrating the humanities in medical practice has been widely accepted, "very little has been done to evaluate its use in practice", while pointing out that "future studies should focus on gaining qualitative and quantitative data regarding impact of curricular interventions on learners and/or patients" (2018, 6). In this respect, Johanna Shapiro et al. (2009, 197) have proposed a "cross-disciplinary, collaborative recontextualization of medicine" in order to take the scholarly traditions in the humanities to the core of medical education, so that "these disciplines be seen not only as 'nice' but also as essential." As Shapiro et al. contend, "we will be able to use the humanities' intricate and sympathetic knowledge about the human condition (*sophia*) as well as its [sic] ability to examine particularistic, experiential knowledge (*phronesis*) to help ensure a morally sensitive, narratively sound, and deeply professional clinical practice (*praxis*)" (2009, 197).

It is with this purpose in mind that *Critical Dialogues in Medical Humanities* modestly attempts at illustrating ongoing discussions in and about the Medical Humanities with studies on different approaches to the relationship between medical science and/or practice and the humanities – including reflections based on fiction, art, history, socio-economic and political concerns, architecture and natural landscapes. The first section in the volume, "Evidence-based and Patient-centred Healthcare", includes three chapters that explore the ways in which healthcare and medical practice can be positively influenced by removing the focus from the technical knowledge of the medical practitioner. In "Action Competence as a Key Notion for Patient-centred Care", Arto Mutanen discusses how medical practice is often seen as a combination of technical competence (based on medical knowledge) and ethical competence, and examines the nuances of trying to define and evaluate the latter. The author proposes the notion of action competence as a valuable tool to balance the technical and ethical competence of the medical practitioner and establish a relationship between the doctor and patient that enhances caring and thus contributes to developing clinical practices in which human dignity is a crucial value. In "Utilization of Gynaecological Care and the Role of the Gynaecologist in Cytological Prevention in the Light of a Nationwide Survey in Poland", Włodzimierz Piątkowski and Anna Dudkowski-Sadowska present the results of a socio-medical study that analysed Polish women's experiences in relation to their use of gynaecological care, while underscoring the

significance of developing the socio-psychological competences of the medical practitioner as substantial to improving gynaecological practice. Finally, Stephen Wallace problematises the controversial issue of vaccine policies in an article that bears the provocative title "Enemies of the People: Just Who is Entitled to use Evidence-based Critiques of Vaccination?". The plight of Thomas Stockmann, the protagonist of Henrik Ibsen's *Enemy of the People*, is used as a metaphor to illustrate the reaction to critical views against vaccination and poses the question of who is actually endorsed to sanction or censure certain health policies.

The second section, entitled "Defining Medical Space", offers three innovative perspectives on spaces for healing, which include traditional medical spaces and beyond. Cindy Avila uses art to analyse operating rooms and, by extension, surgery in "Operating Room or Operating Theatre? Defining 'Surgical Theatrics' on the Surgeon's Stag". The author makes a close description of two paintings from the end of the 19th and 20th centuries respectively, which serve as an apt illustration to her examination of certain aspects of surgery that reach beyond medical matters. In "Spa Architecture in Szczawno-Zdrój", Maria Skomorowska carefully and thoroughly describes the development of the Polish spa Szczawno-Zdrój in Silesia (Poland) since its inception in the nineteenth century to the present, detailing its progress and change in order to adapt to the needs of its patients. Similarly, Daria Słonina makes a comparative study of hospital gardens in Poland and the United Kingdom in "The Garden as a Twenty-first Century Panacea? Trends in Shaping Gardens at Hospitals. A Case Study of Complexes from England and Poland", where the structure and elements of hospital gardens serve the author to comment on the healing potential of this often neglected space in medical institutions.

"Exploring Medical History", the third section in the volume, includes three interesting chapters that trace attitudes and beliefs in relation to illnesses and their treatment – and thereby the evolution of medical practices – through historical periods, including intimations of the future. Krzysztof Jagusiak and Maciej Kokoszko offer a detailed account of the medical properties of the onion according to Byzantine writings in "The Onion (Allium Cepa L.) in Late Ancient and Early Byzantine Medical Literature (I–VII Centuries AD)", where the authors use the onion to exemplify the various uses and treatments based on the natural properties of plants in ancient Byzantium. In "The Changing Face of Glaucoma in History", Tereza Kopecka describes the development of medical treatment for glaucoma while at the same time illustrating the human side of the disease in a moving and sensitive way through the written accounts of a

family affected by glaucoma over various generations. Finally, the section closes with interesting speculations about the future of medical care. In "Anthropology in Social Sciences and Popular Prose between Futuristic Fear and Advanced Algorithms: Human Obsolescence or Opportunity after Alliance with Artificial Intelligence, Nanotechnology, Social Robotics, and the Automation Economy?", Konrad Gunesch analyses recent scholarly writings on the impact of new technologies. Using examples from contemporary fiction, the author discusses whether developments such as automated healthcare providers signal human unreliability in front of the infallibility of machines, or rather the need to reconcile technological advance with a more humanistic view of science.

In the final section of the volume, "Literary Portraits of Medicine", four chapters interrogate cultural attitudes to illness, doctoring and patients through the lens of fiction. In the first chapter, "Hunger Divine: Religious Elements and Cultural Assumptions about the Female Body in American Women's Narratives of Anorexia", Emma Domínguez-Rué uses contemporary examples of American confessional literature to examine notions of religious ascetics – transgression, punishment, reward, denial and control – and the extent to which fiction can reveal the negative impact of certain cultural values attached to women's behaviour as well as their role in triggering eating disorders. Emanuela Ettorre interrogates 19th century medical science through a Victorian sensation novel in "Wilkie Collins' *Heart and Science* and the Axiological Indeterminacy of Medical Discourse", where she illustrates the author's use of sensationalism to disclose how the medical profession displayed the moral ambivalence of the period. In "'[T]he Darker Side' of Medicine: The Victorian Novel and the 'Scientization" of the Medical Professional", Adrian Tait also uses Collins' narrative *Heart and Science* as well as other Victorian works to consider modern medical knowledge and its impact – not only on the doctor/patient relationship but in the gradual dehumanization of the doctor himself. In the last chapter in the volume, "The Mute Body: Illness and Family Crisis in Late Imperial Chinese Fictional Medical Narratives", Ying Wang uses examples from Chinese medical narratives to examine sickness as a metaphor, which not only causes suffering and alters the sick person's identity, but also potentially destroys family dynamics and ethics, and even brings about political disruption.

As Richard Meakin and Deborah Kirklin have noticed, if knowledge of Medical Humanities has proved to be beneficial for a better medical practice and is to be incorporated in curricula, not only suitable assessment methods must be implemented but the degree of efficiency of practitioners

must also be properly verified, while more interdisciplinary work between medical and non-medical professionals is needed:

> educators will need to develop appropriate evaluative methods, not only to assess student achievement but also to demonstrate the effectiveness of this form of teaching in meeting the educational objectives laid down ...The first step towards achieving these objectives needs to be the sharing of ideas and experiences throughout the field and across disciplines. (2000, 49)

In our modest attempt to generate interdisciplinary work in this field, we hope the chapters contained in this volume will make a further contribution to an ongoing dialogue between medicine and the humanities that continues to enrich both disciplines. As Kirklin and Meakin quote from Chekhov, "the sensitivity of the artist may equal the knowledge of the scientist. Both have the same object, nature, and perhaps in time it will be possible for them to link together in a great and marvellous force which is at present hard to imagine" (2000, 49).

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PART 1

EVIDENCE-BASED AND PATIENT-CENTRED CARE

CHAPTER ONE

ACTION COMPETENCE AS A KEY NOTION FOR PATIENT-CENTRED CARE

ARTO MUTANEN

Introduction

The notion of action competence is well-known in health and medical sciences as an essentially reactive notion: if the health condition of a patient collapses, then the problem is how to restore the action competence of the patient. The intention of any intervention or treatment is to restore the patient's action competence at least partially. This kind of characterization brings to mind the essentially reactive notion of resilience. The reactive characterization is not a bad one as such, but the reactive characterizations of a human's action competence see a human being as an object: an object of (restoring) operations or of healing activities. Action competence can be naturally understood as an ontologico-methodical notion: a human being is not merely a being with action competence, but he or she acts under his or her own power. This is the actual potentiality of a human being, which becomes the self-expression of a human being. Thus, a human being does not have an action competence which can be "objectively" characterised as more or less complete. This entails that medical care does not just restore or perform operations on a patient, but is a form of caring in which a medical doctor is a knowledge-based person with a high degree of responsibility. This emphasises human dignity as a fundamental value of medical care.

Medical Philosophy

In the philosophy of medicine, notions of health and disease have played a central role. Even if they are of extreme importance, there is no generally agreed characterization of notions. The lack of a generally accepted characterization does not refer to the intellectual laziness of

philosophers of medicine but the extreme complexity of the topic. Notions of health and disease are connected to the very foundation of humanity. Moreover, these notions are interlinked. That is, a healthy person does not have a disease while a sick person does have a disease and hence is not healthy. However, which one of these notions is the most fundamental? The relationship between notions is similar to the relationship between modal notions: a person is healthy if he or she does not have a disease and a person is diseased if he is not healthy. Here we say that a person is diseased if he or she has a disease. The characterization shows the complexity of the relationship between health and disease: in this notion, health is the lack of disease – i.e. a person is healthy if for all the diseases in the world a person does not have one of them.

This is complicated and cannot as such be of methodological help for medical scientists or clinical practitioners. The reason is that the search for all diseases is not reasonable. However, it never takes place in practice (either in a scientific lab or in clinical practice). This may be helpful in some abstract sense, but does not provide any methodological advice.

The notion of health is very complex. It is extremely difficult to put forward a positive characterization of the notion of health. The notion of health is reminiscent in this sense to other, so called, positive notions, such as "human well-being", "human flourishing", or "human dignity". These positive notions appear to be empty in the sense that the characterization of the notion remains very general. Medical doctors need more concrete tools in their clinical practice: the required practical tools can be achieved using the notion of disease as a foundational notion. Each disease has instructions for the treatment of the disease. In fact, Pihlström (2014, 16-17) provides a characterization as:

> We need negative politics because we often 'recognize what is wrong with something without having a clear idea, or any idea at all, about what is right with it'. This, I take it, is right on the mark. Negative politics, however, is needed not for its own sake but for the sake of a 'politics of dignity'. This kind of politics addresses, negatively, not how institutions can promote dignity – they can obviously do so in many ways – but rather 'how to stop humiliation', that is, how to get rid of violations of dignity. The 'positive' notion of dignity itself has little genuinely positive content, and the same holds for the notion of good. (Pihlström 2014, 16-17)

If the notion of disease is taken as foundational, medical care is seen as medical treatment: each disease has a treatment of its own. All this is very welcome: it is important that a medical doctor recognises a disease and can heal the patient. Of course, we may not forget preventive medical care in which people are advised to maintain a healthy way of life. However, this

also holds the presupposition that health is the lack of disease and hence leading a healthy life means protecting oneself against disease.

Medical science and medical practice

Medical science is one of the fields of science. It is subsumed by similar methodological constraints as in all other fields of science. Of course, each field of science has its own methodical constraints which we need not discuss more closely here. As a field of science, medical science intends to achieve new knowledge. The study of medical treatment is part of medical science; of course, medical treatment must be based on medical science. However, medical treatment is not (only) a field of science but is a practical, skills-based activity. What kind of science is medical science? What kind of skills-based activity is medical treatment? These are examples of questions of a philosophical character whose complexity is characterised in Bunge (2013, viii) as follows:

> The aim of this book is to examine some conceptual issues raised by biomedical research and medical practice. For example, why are the traditional medicines mostly ineffective? Are diseases things (entities) or processes? Why do many medical diagnoses turn out to be wrong? (…) Is evidence-based medical practice as novel as advertised? (…) Are placebo effects purely imaginary? (…) Why has cancer medicine failed? (…) Why do 'complementary and alternative medicines' flourish in modern society? And what is to be done about the philosophical schools that deny reality and truth?

The questions are important. However, the presuppositions of the questions may be wrong. Thus, we need to examine the basic ideas behind the questions. It is quite acceptable that philosophical study is basically conceptual. The question about the effectivity of medicine presupposes that we have a good understanding of what effectivity in this case means. Moreover, the first question in the quote above presupposes that "traditional medicines are mostly ineffective". Of course, to verify or falsify the presupposition is an empirical and not a philosophical task. However, Bunge (2013) analyses the questions and their philosophical presuppositions in a detailed way. For example, Bunge asks about "complementary and alternative medicine". It is very interesting how the borderline between (mainstream) medicine and "complementary" medicine or between (mainstream) medicine and "alternative" medicine is decided. Obviously, what we characterise as "alternative medicine" is relative to how we identify medical science. It is a historical fact that the

fields of sciences are historical and cultural entities whose identities change during history. Even if there are clear-cut examples, the specification of borderlines is not a simple task (Lytovka 2014).

In medical treatment the question is not only about science but also about medical care and about the patient. The notion of disease is identified within the context of medical science. However, a patient feels himself or herself to be ill. Illness is something the patient emotionally feels: his or her well-being is reduced. However, this is independent of whether he or she has a disease in the sense specified by medical science. Moreover, reduced well-being has been socially recognised when we may speak about sickness.[1] It is important to recognise that these notions are independent of each other. This is connected to the rightness or wrongness of the diagnosis which depends on the fundamental character or notions of health and disease. The distinction between medical science and alternative (or complementary) medicine is sensitive to the distinction between notions of illness, sickness, and disease.

It is important to recognise that a philosophical study is essentially a conceptual study which may not be identified with a linguistic study. In the philosophy of medicine, we are interested in the proper medical issues, not the expressions of the issue.[2] So, it is reasonable to a degree to consider Mael Lemoine's paper "Defining Disease beyond Conceptual Analysis: An Analysis of Conceptual Analysis in Philosophy of Medicine".

Lemoine (2013, 309) states that the most fundamental task of medical philosophy is to define "health" and "disease". He differentiates between two schools called "normativists" and "naturalists", which "share the belief that conceptual analysis is the right procedure for resolving the matter." So far so good. However, Lemoine (2013, 310) identifies conceptual analysis and the definition of a term. The intention is that definitions "have to determine the logical relations between the terms 'health' and 'disease'" (Lemoine 2013, 310).

The characterization of fundamental notions is, of course, the very basic task of any philosophical – and scientific – approach. However, Lemoine's idea that in the methodology of science explicit definitions of fundamental terms or the field of sciences play a central role, may be somewhat misleading. As Tuomela (1973, 69) says "[i]n the methodology

[1] The distinction between illness, sickness, and disease was given by Professor Helen Lambert in her lecture at the International Conference on Medical Humanities in Warsaw (March 10, 2017).

[2] The linguistic turn may seem to contradict this. However, linguistic philosophy was interested in the proper subject matter not language as such. See, Rorty 1967.

and philosophy of science questions of definability of concepts have traditionally occupied a central place". However, we are not interested in the explicit definitions of the terms "health" and "disease" in a medical theory. In fact, Lemoine (2013) says that the intention of definitions of notions of medical science is to provide the "necessary and sufficient conditions" of notions. This refers to so called "explicit definitions" which in the philosophy of science (and in logic) are understood as relative to a given theory. In fact, Lemoine (2013) refers to the context-dependence of definitions, which implies that he is not just interested in searching for a definition within a given theory but also for a general characterization which can be applied in different contexts, which is a fundamental task in any scientific approach.

The philosophy of science in which the search for definitions was one of the most central topics was related to "linguistic" philosophy – i.e. philosophy in which linguistic questions were central. For example, the so called analytic tradition was one of the most central traditions in this linguistic approach. In the analytic tradition, both the logical tradition (Frege, Russell, Carnap) but also natural language philosophy (late Wittgenstein, Austin) can be seen as examples of linguistic philosophy. Linguistic philosophy was quite a general attitude towards philosophy which included logical positivism, analytic philosophy, but also continental philosophy, such as Derrida's constructionism (Hintikka 2007).

The search for linguistic definitions is of course an important task; but it is fundamentally theoretical in nature. However, medical science is not only a theoretical approach; it is also connected to clinical practice and medical treatment. Therefore, the linguistic approach may make a distinction between theory and practice – i.e., separating "medical science" from "clinical practice".

Lemoine (2013) also provides a kind of Socratic method in his search for a definition. For Socrates, definitions were not linguistic or stipulative but real definitions. Real definitions were not only definitions of a given term, but something that provides the real or true characteristics of the thing defined. So, in cases such as health, a definition truthfully says what health is, but also provides a prescription to retrieve health for a diseased person. It is not clear how far Lemoine (2013) follows this kind of Socratic idea, but still his characterizations are of great interest.

Boorse (1977; quote from Pörn 2000) characterises the fundamental notional problem as follows:

> It is a traditional axiom of medicine that health is the absence of disease. What is disease? Anything that is inconsistent with health. If this axiom

> has any content, a better answer can be given. The most fundamental problem in the philosophy of medicine is, I think, is to break the circle with a substantive analysis of either health or disease.

The idea behind the search for definitions is to determine fundamental factors of the field. It is important to rethink and to provide new characterizations of the central notions, as Ranta (2017) shows. We need to know what health is and what disease is; to achieve that goal, these notions cannot be interdependent.

The layman may think that the fundamental notion must be "health": however, it is not easy to give a positive characterization of "health". It is easier to characterise disease as a fundamental notion and health as the "lack of disease". Even if we do not know what health is, we know when we lose it. This is also in balance with medical science in which a foundational notion is disease. However, as Bunge (2013) noted, we have to analyse what kind of "thing" is a disease.

It is not a trivial task to specify foundational notions of medical sciences even if notions of health and disease could be inter-definable: it may be logically equivalent to characterising a human being either as "healthy" or as "a person who does not have a disease". However, it is not the same for the person himself or herself, whether he or she is characterised as healthy or as a person who does not have a disease. Health is a central factor of humanity and human well-being, so a disease is a deviation from health. Health is connected to a good life or to the good of man. On this topic, Von Wright (1996, 86) says that it is a topic of "the utmost difficulty" and "[p]erhaps the best I [GHvW] can hope for is that what I say will be interesting enough to be worthy of a refutation". So, it is not a surprise that, in medical science, efforts are put into the study of diseases with the intention of specifying concrete practical instructions for clinicians.

In medical science there is also preventive treatment, which intends to prevent diseases before a patient has them. Moreover, medical clinicians work on behalf of patients and heal them. To have a deeper understanding of the relationship between a medical doctor and the patient, we have to consider the characteristics of medical science and clinical practice. The relationship between a medical doctor and a patient is realised in clinical practice. A clinical practice has a history of its own, and this history has its consequences for present-day practices. There may be different kinds of historical periods identified with their own clinical practices (Engeström 1999). Some of the intellectual framework of clinical practice comes from medical science, which is connected to more general scientific development. The present-day biomedical mainstream has a long history,

which has some consequences for both clinical practice and caring traditions.

Caring

A medical doctor – while carrying on his or her clinical practice – is not a scientist, but a healer who seeks convenient medical treatment for the patient. Of course, medical science is – and must be – a field of science. It is necessary that medical science seeks effective medical treatments and effective (truth-tracking) clinical methods of diagnosis. Such scientific research may refocus its attention from the "person" to the "disease". It must be emphasised that this is not intended as any kind of "evaluative" characterization, but only to denote the fact that a medical doctor intends to provide current medical treatment for the disease. Current medical treatment is characterised as relative to the disease, not relative to the patient, and for good reason.

However, current medical treatment is based on advanced medical science and the mainstream of medical science is biomedical. So, the foundation of current medical treatment is based on biomedical science, as Engeström (1999) has emphasised. This has influenced the intellectual spirit of medical treatment and medical care. It may seem that this is the ideal situation: if someone has cancer, he or she really needs competent medical treatment for cancer. In fact, as Thaler and Sunstein (2008, 207) say, we all "want access to all the best services: doctors, hospitals, prescription drugs", all of which support the present scientific caring approach.

Chochinove (2013, 756) emphasises the need for proper caring: "Despite technical competence, patients and families are less satisfied with medical encounters when caring is lacking." By "technical competence" Chochinove (2013) refers to science-based skills used to carry out science-based medical operations. However, patients also need proper caring and empathy, but it is not easy to embed proper caring into a science-based caring culture.

Reich (1995) writes about the "ethics of care", which forces us to consider the deep historical roots of medical care and medical ethics. There are double traditions of care which may see care as a burden or care as a form of solicitude, and these take on different forms in history. Marcum (2011, 143) characterises these two different kinds of care as:

> The first type, care 1, represents a natural concern that motivates physicians to help or to act on the behalf of patients, i.e. to care about them. However, this care cannot guarantee the correct technical or right

> ethical action of physicians to meet the bodily and existential need of patients, i.e. to take care of them – care 2.

So, according to Marcum (2011) there is a kind of technical care which supposes sufficient competence in medical science and refers to "evidence-based science" as a foundation for technical caring. However, technically good care is not good enough. The patient is not an object of medical operations but a human being who requires empathy, which supposes the patient-centered care of a "patient's bodily and existential needs". These two kinds of care do not contradict each other but are complementary – that is, neither proper technical care nor ethical care alone is good enough. The patient needs science-based care, but at the same time, he or she is in need of contiguity – i.e., that the medical doctor also acts as a decent human and shows empathy towards the patient.

The dual nature of care implies dual criteria of competence. Obviously, a medical doctor must have a high degree of knowledge and good skills based on advanced medical science. Following Marcum (2011), this provides a foundation for technical competence. Moreover, a patient needs a healer with empathy: a medical doctor must have skills to show empathy to patients and, following Marcum (2011), this is termed ethical competence. A competent medical scientist may have only technical competence because he/she may not have a strong relationship with patients. In clinical practice, or more general work with patients, the role of ethical competence becomes greater. However, technical competence "refers to an ability to perform or conduct practical and specific protocols and procedures in a correct and an efficient or effective manner" (Marcum 2011, 148) and, as such, it is always the basis of competence; technical competence is very specific, or "discipline specific" as Marcum says. Ethical competence is a more general "humanistic competence" and a generic skill that can be applied within different disciplines. It must be emphasised that "for the professional clinician both technical competence and ethical competence go hand-in-hand" (Marcum 2011, 151). As Peabody (1927) shows, it may happen that "overly scientific" clinicians fail to recognise the patient and his or her suffering. It is important to understand that "a scientist is known, not by his technical processes, but by his intellectual processes" (Peabody 1927). The intellectual process includes ethicality especially for medical clinicians.

Humanity: Action Competence

The dual character of a medical clinician's competence is easy to accept. However, it is not easy to grasp what this means and how to

uphold the two competences in practice. Technical competence refers to scientific, discipline-specific knowledge and the skills to apply this knowledge in practice – that is, clinical practice presupposes a theoretical basis, but this is not enough. Clinical practice is not only epistemic performance, but also involves face-to-face encounters between the medical doctor and the patient. This is not only a knowledge-based but also an ethical-based encounter, which assumes responsibility, mutual respect and reliability.

It is not easy to characterise what this "ethical-based encounter" means; in the clinical room the roles of the medical doctor and the patient are not equal. The medical doctor is the "epistemic authority"; he or she holds superior knowledge about health and about medical treatment. The "face-to-fact encounter" presupposes a reasonable degree of equality, which is related to mutual humanity. In philosophy the classical problem concerning humanity is connected to the relationship between the human mind and body. We do not intend to solve this problem here; it would be absurd to try to solve such a classical philosophical problem. The mind-body problem, in one sense or another, separates the mind from the body. In medical care, human beings should be understood as holistic entities in which the mind and body are in balance, not as a conglomerate of separated parts.

We must recognise that when we are speaking about the epistemic authority of medical doctors in questions of health, we are assuming that diseases are something that "happen to the body" and hence the (epistemic) authority may make essential decisions about medical treatment. However, a human being is an "acting agent". The activity of human beings has been emphasised strongly by Heidegger and other existentialists. However, this idea was not restricted only to existentialists, but was also strongly emphasised by phenomenologists like Brentano and Husserl. Moreover, within analytic traditions, there has been a longstanding practice of analysing human beings as acting agents, as von Wright, Tuomela, Pörn, and Goldman have done. So, the idea that human beings are actors is shared by different schools of philosophy (Toiskallio 2009; von Wright 1996; Tuomela 2000; Pörn 2000; Goldman 1970).

Human action is intentional behaviour in which the mind and body work together. The intentionality of an action is an essential factor that refers to the goals (or aims) of the action and to planning how to achieve the goal. Human action is, more or less, a planned activity, as Aristotle noted. The plan includes a specification of the goal and the means intended to achieve the goal. However, human action is not one-dimensional with a linear behaviour from a clear plan to a goal via clear

and effective means, since a human being may have different and competing intentions and goals. He or she must be capable of choosing, integrating and evaluating several goals and means. Choosing, integrating and evaluating are context-dependent and value-laden processes. This is expressed by Pörn (2000, 24) as follows:

> The kind of agency intended is that of goal-directed action. Such action is a complex set of dynamics in which at least the following phases can be distinguished: goal formation in which the agent settles on new goals or revises old ones; goal integration, another decision process in which the agent forms intentions for the immediate act situation by integrating one or more goals with the circumstances that happen to be obtained in that situation; intentional activity in which the agent translates specific intentions into action; and situation assessment in which the agent evaluates the results attained, reasons for failure or success and the like, and forms value judgements that influence the next round of goal formation. The process exhibiting these phases is intertwined with a cognitive process in which he or she does it.

However, this kind of characterization of action is essentially "technical". It seems that activity is a consequence of mental processes. Of course, conceptually it is possible to separate planning and intending from proper acting. In fact, a practical syllogism that originates from Aristotle's philosophy expresses such a separation. However, the way Aristotle formulates this practical syllogism does not include an "inference step" that leads from intentions and beliefs into action, but the actor "immediately starts to act". It is important to understand that separation is not an easy task. Human activity is a wholly deliberated process which embodies the formal structure of a practical syllogism. Human action is a complicated and confused process in which intentions, plans and actions occur together (von Wright 1996).

We need a model that characterises goal-directed action by "the nature of goal formation, goal integration, intentional activity, situation assessment and belief formation, and [it] specifies how all these factors are joined together" (Pörn 2000, 24). However, this is not good enough. We also need a characterization of human action in which human beings themselves are placed centre stage of the whole action process. The agent is not a programmed machine, but an individual who actualises himself or herself and learns about himself or herself: acting means actualising intentions, but, at the same time, it is an individual's self-realization. The notion of action competence is intended to characterise the close relationship between human activity and human identity; the notion is intended to characterise both the technical and personal aspects of activity.

Technical aspects are just factors that are included in the practical syllogism, while personal aspects interconnect the actions and the personality (the outer and the inner self).

The notion of action competence is of a personal nature. Each person has his or her own action competence, which is not fixed but changes over time. However, an action competence also has an objective aspect; in order to be capable of doing certain actions, an actor has to have some "objective" capabilities. These capabilities are of different kinds: physical, psychological, social, and ethical. It is possible to scientifically study some of the assumed capabilities:[3] however, this shows that action competence is also a methodologically interesting notion. It directs the medical treatment keeping the patient at the centre. Hence, the notion of action competence allows us to consider sensitively the distinction between illness and disease.

Ethicality is connected to the simple idea that an actor is the cause of all he or she does: by acting, the actor literally causes the results and a certain portion of the consequences of the act (von Wright 1963). The actor is responsible for all of his or her acts and their consequences, and this responsibility is actualised on different levels. First, the actor causes the goal of acting by conceptual reasons. Second, the actor factually causes the (factual) consequences of the act and is responsible for all of these. Sometimes the notion of responsibility is understood factually. However, the responsibility is also ethical: the actor is responsible for the act and its consequences – whether they are good or bad. The ethical responsibility entails guilt: the actor is factually and potentially guilty (Pihlström 2014).

Diseases usually reduce the actor's competence to act, and a medical doctor intends to restore the competence to act. In the best of cases, the competence to act can be completely restored, but unfortunately competence is usually only partially restored. The capacity to be restored can be called resilience, which is essentially a reactive notion. The task of a medical doctor can be understood just as to restore the patient's action competence, which entails the technical competence of a medical doctor.

The notion of action competence deeply characterises a person's identity. A disease deeply affects the competence to act and hence also the identity of the patient. A medical doctor should also take this aspect of the patient into account, as each patient has an action competence of his or her own. The disease weakens the action competence of the person. It deeply

[3] For example, studies on physical action competence (Kyröläinen and Santtila 2010) and on ethical action competence (Toiskallio 2017).

affects the patient's inner self; it is not only the objective disease that should be managed. In fact, a patient expects a medical doctor to manage the situation by providing medical drugs or carrying out medical operations which would completely restore their action competence. However, all diseases affect the identity of the patient and make their vulnerabilities known to them: some diseases permanently weaken the action competence of the patient, while some others do not weaken the action competence but may remind the patient that the present state of action competence is not a permanent condition. Moreover, aging and some other changes may have similar consequences. All these may – and usually do – change the personality of the person.

A medical doctor has to take seriously the patient's own action competence and the threats against it. To do this, the medical doctor needs both technical and ethical competence, i.e., empathy and sensitivity. A medical doctor must take the personality of the patient seriously. The action competence offers a concrete context which has both medical and ethical relevance. The two competences are unified within this context, which was expressed by Marcum (2011, 147) as follows: "Although the notion of care or caring has a long history and has defied a precise or consensus definition, caring generally represents a disposition or an attitude in which a person exhibits a deeply felt concern or empathy either for others or even for oneself and then acts accordingly." The American philosopher Milton Mayeroff provides probably the best-known and most widely discussed definition of care or caring: "To care for another person, in the most significant sense", according to Mayeroff (1971, 1), "is to help him grow and actualize himself'."

Closing Words

By taking action competence seriously we may balance the competences of the medical doctor and, moreover, the relationship between the medical doctor and the patient. At its best, this allows us to develop a caring culture in which technical and ethical competences are in balance, which entails that a medical doctor does not simply restore the patient or operate on a patient but involves a form of caring which respects human dignity. At the same time, and more importantly, this allows us to develop clinical practices in which human dignity is a fundamental value.

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CHAPTER TWO

UTILIZATION OF GYNAECOLOGICAL CARE AND THE ROLE OF THE GYNAECOLOGIST IN CYTOLOGICAL PREVENTION IN THE LIGHT OF A NATIONWIDE SURVEY IN POLAND

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Introduction

Handbooks on classical Western medical sociology sometimes contain separate subchapters devoted to gynaecological care and the role of women as patients. In these procedures, as late as the turn of the 19th century, a significant role in relationships between doctors-gynaecologists and women patients was played by moral issues, and there were many binding taboos as well as informal but strictly observed rules – e.g. those concerning "treating" the bodies of female patients. The President of the Gynaecological Society in the State of Massachusetts wrote: "I never found it necessary to uncover a patient for a gynaecological examination". Commenting on the then typical situation, Emily Mumford said: "Most doctors at the time had little understanding of female physiology and anatomy" (1983, 280).

Until the late 19th century, the prevailing view in clinical gynaecology was that a large number of women's diseases were caused by hysteria, psychoses, delusions, and neurasthenia symptoms, and that before starting surgical procedures it was necessary to take measures "to calm down the nerves" of female patients (Mumford 1983, 281). Looking back at the history of gynaecology, its cultural/moral context and the content of professional roles of physicians, a conclusion can be drawn – taking all the obvious differences into consideration – that, even today, the importance of emotional elements such as "attitudes towards a female patient" plays a