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A new path for humanistic medicine

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Abstract According to recent approaches in the philosophy of medicine, biomedicine should be replaced or complemented by a humanistic medical model. Two humanistic approaches, narrative medicine and the phenomenology of medicine, have grown particularly popular in recent decades. This paper first suggests that these humanistic criticisms of biomedicine are insufficient. A central problem is that both approaches seem to offer a straw man definition of biomedicine. It then argues that the subsequent definition of humanism found in these approaches is problematically reduced to a compassionate or psychological understanding. My main claims are that humanism cannot be sought in the patient–physician relationship alone and that a broad definition of medicine should help to revisit humanism. With this end in view, I defend what I call an outcomes-oriented approach to humanistic medicine, where humanism is set upon the capacity for a health system to produce good health outcomes.

Keywords Humanistic medicine · Narrative medicine · Phenomenology · Biomedicine · Health systemic · French cancer plans

Where should we look for humanism?

Narrative medicine [1–3] and the phenomenology of medicine [4–12] are two popular humanistic approaches in the philosophy of medicine. They argue for what they call a *humanistic* medicine, a medicine that heals as well as it cures patients, where compassion and empathy are key features of the patient–physician relationship.

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Their target is what they call the biomedical model [2, 9, 10], which they contend is at the root of a practice of medicine that is not as humane as it could be. Although humanistic goals are certainly honorable, I am not satisfied with the main approaches within the humanistic medicine literature—more specifically, narrative medicine and the phenomenology of medicine—and I wish to introduce a new approach.

Both narrative medicine and the phenomenology of medicine face problems regarding their definitions of the biomedical model. Although they follow distinct strategies of criticizing it, they fail to give credible accounts of this model, both approaches criticizing what essentially amounts to a caricature. This is the primary reason to improve the current humanistic approach.

Accordingly, I give a sense of what humanism means in the current literature. As I argue, the version of humanism endorsed by narrative medicine and the phenomenology of medicine fails to go beyond a compassionate and psychological approach. Thus, by identifying key features of compassionate humanism, such as empathy, emotions, and psychological intersubjectivity, I argue that the compassionate approach is too weak, particularly in its reliance on an unnecessarily narrow definition of medicine. Other definitions of medicine and humanism can help to improve humanistic medicine.

The questions I address are simple: where should we look for humanism, and what exactly is and should be humanistic in medicine? I argue that humanism should be studied not only at the level of clinical encounters but also at the level of health systems. In other words, the topic of humanism should be oriented within a broader picture of medicine, which includes health systems and public health. This broader picture enables an approach that goes beyond compassion and intersubjectivity alone. Concrete examples from the current French health system are given to illustrate the sense in which public health and/or health policy can be humanistic. I then turn to defend what I call an outcomes-oriented approach to humanistic medicine, which I argue allows the meaning of humanism to be expanded beyond its current use.

Humanistic approaches to medicine: an overview

Ten years ago, James Marcum compiled a series of approaches in the philosophy of medicine fitting the label of humanistic medicine or humanistic approach to medicine [13]. Behind these labels is the nineteenth century's old opposition between humanism and scientism and the recent loss of faith in biomedicine and the biomedical model:

> Why should modern medicine provide such competent technical care and yet fail to provide the humane care patients also need? [13, p. 393].

Many voices have indeed raised concerns, in popular media and elsewhere, against what is sometimes perceived as inhumane care. While the philosophy of medicine

has often concerned itself with defining the concepts of health and disease, it has less often focused on addressing the larger issues of healthcare and what the practice of healthcare ought or ought not to be. Marcum argues that the philosophy of medicine should turn to study the basis of medical practices by looking at topics such as emotions in clinical practice, intersubjectivity, and the individual experience of illness. For lack of a better word, as Marcum confesses, “humanistic” is meant to designate those approaches that focus on medicine as a human interaction and emphasize the subjectivity of the patient [13, p. 393]. As noted by Miriam Solomon, these approaches sometimes claim that medicine should “care for the whole person” rather than “treat the disease” [14, p. 11]. Many authors share this belief [2, 3, 6, 15–17].[1]

The emphasis on patients’ subjective experiences is one of the key positions taken by proponents of humanistic medicine. Havi Carel has, for instance, argued that the current debate over the definitions of health and disease problematically neglects to consider the first-person perspective on those concepts [6]. According to Carel, neither a naturalistic account that focuses on disease as a biological dysfunction nor a normativist account that focuses on how society understands disease can give a voice to the individual patient [6, p. 9, 13]. In advancing the importance of subjective experience, humanistic approaches intentionally move beyond definitional questions of health and disease in order to instead tackle the conceptual foundations of medical practice. On this, they seem to draw inspiration from authors like George Engel [15] and George Khushf [18] (though often only mentioning the former). Engel and Khushf are two of several authors who noticed the problematic nature of the debate surrounding the concepts of health and disease. Khushf has recently argued that the only way out of the loop of this debate is to study the theoretical frameworks presupposed when carrying out the conceptual analyses. He argues that in doing so, one would realize that both naturalists and normativists share a common biomedical model. According to him, reframing the debate and studying the theoretical models that underlie the concepts should prove more successful than continuing a never-ending cycle of conceptual analysis.[2] Humanistic medicine proponents seem to have followed Engel and Khushf’s impulses into a broad criticism of biomedicine and the biomedical model. However, this rejection of the biomedical model is often purported to be nonradical; most proponents of humanistic approaches maintain that they wish merely to complement this model, not to replace it [6, p. 11]. This avowal remains inconsistent: how can one accuse the biomedical model of being dualistic and reductionist about illness and disease while at the same time wishing merely to complement it? Keeping this issue in mind, does the humanistic criticism of the biomedical model prove successful? This question is answered shortly.

It should be mentioned briefly that, in spite of its common core, humanistic medicine comes in several forms and relies on different arguments. Along with narrative medicine and the phenomenology of medicine, humanistic approaches include virtue ethics [20], alternative methods of understanding the illness experience, such as

[1] Quoted by [14].

[2] See also [19] for a detailed criticism of the use of conceptual analysis in the philosophy of medicine.

hermeneutics [4, 21, 22], and works on the value of empathy and emotion in healthcare [16]. Overall, humanistic medicine agrees that the patient should be understood as living in a specific social and cultural environment, and likewise the physician's practice should be understood as involving cultural and emotional skills on top of scientific competencies. In Marcum's words, humanistic medicine refers to "a variety of humane or humanistic models … in which the patient's human dimension is reinstated into the patient–physician relationship" [20, p. v].

The aim here has been to give a sense of the broader picture of humanistic approaches in the philosophy of medicine. In what follows, however, I restrict my arguments and my criticism to narrative medicine and the phenomenology of medicine only. I focus on one key component of those approaches—their criticism of biomedicine. Both approaches have gained popularity in the field and feature in recently published handbooks in philosophy of medicine [23, 24].

A humanistic consensus with problematic targets

The apparent humanistic consensus against the biomedical model should not conceal the fact that each humanistic approach usually has a different target in mind. Since their targets are different, as I show, it is at best misleading for humanistic proponents to give the impression of a common campaign against biomedicine. The result is confusion over the weight and pertinence of the consensus against the biomedical model. In this section, I delve into further detail on the two criticisms of biomedicine posed by narrative medicine and the phenomenology of medicine, and I briefly argue that they are off the mark.

For narrative medicine, the problem with the biomedical model is that it is scientific. Kathryn Montgomery Hunter claims, for instance, that

> despite its success, medicine's identification as a science has had adverse effects…. It encourages physicians and patients alike to focus narrowly on the diagnosis of disease rather than attend to … the care of the person who is ill. [3, p. xix]

Meanwhile, Rita Charon argues that unlike narrative, biomedicine—which she also calls "scientifically competent medicine" [2, p. 3] or "scientific knowledge" [2, p. 9]—is unable to understand particular events as instances of a "singular and meaningful situation" [2, p. 9]. She also argues that "the price for a technologically sophisticated medicine" seems to be a healthcare that is "consumed with the scientific elements" of biomedicine, at the expense of human experiences such as pain and suffering [2, p. 6]. Accordingly, proponents of narrative medicine generally argue that a new approach should be introduced in order to deal with aspects of health that extend beyond the scope of the biological and the purely scientific.[3] Yet

[3] The reduction of science to biology alone is often found in the narrative medicine literature. Science is described as capable of dealing only with the biological aspect of disease.

an important question remains: if science does indeed have such adverse effects on patients, how can complementing it with a narrative approach remedy those effects?

As many scholars in the philosophy of medicine have recognized (see, e.g., [14, p. 12]), different epistemological approaches can indeed be useful, both in their terms for medicine and their practice. This position seems to satisfy methodological pluralism, a view in the philosophy of science that holds there is more than one scientific method [25–27]. According to proponents of narrative medicine, however, the difference is stronger. They argue that medicine is an art (as opposed to, and in addition to, a science), which entails listening to and understanding patients' stories of illness. Their main claim is that narrative theory enables doctors to understand their patients' stories and consequently to become better healers. For instance, Charon proposes that narrative medicine will "lead to more humane, more ethical, and perhaps more effective care" [2, p. vii].[4]

One major problem with this position is that it seems difficult to argue that today's medicine (in wealthy countries)—albeit scientific—is concerned about only the physical bodies of patients. What about social workers or physician-led prevention? As Maël Lemoine has argued, it seems difficult even to distinguish a purely scientific medicine from its normative counterparts [29]. Charon describes science as a value-neutral, objective, and theoretical undertaking that is fundamentally incompatible with subjective experience—that is, in her view, incompatible with psychological states, values, and individuality [2, p. 6–7]. What about psychiatry and psychology? They both deal with psychological data, behaviors, and subjective experiences. Even more problematically, it is important to emphasize that an up-to-date philosophy of science, such as that exemplified by John Dupré's pluralism [30] or Helen Longino's [25, 26] and Solomon's [14, 31] feminist and empiricist works, provides a very different image of science. Since the works of Thomas Kuhn [32, 33], science has been understood not as a value-free and objective knowledge but as a messy, normative activity that nonetheless retains its epistemological legitimacy. Claiming that the "coldness" [2, p. 10] of the practice of science is incompatible with anything social, normative, or psychological presumes a traditional logical positivist (or logical empiricist) philosophy of science that is worryingly outdated. Charon, for example, seems to take for granted that stories and narration are specific to an art or a practice and by nature antithetical to science. However, as Solomon observes, narration and telling stories are "quite common in science" [14, p. 179]. For instance, most theories of evolution from the end of the nineteenth century make great use of stories, since narrative and progress (or lack of progress) are very important to their accounts. As Solomon argues, stories are often used to discover and think about causal connections, which makes their use in science unsurprising [14, p. 179]. The stereotypical picture of biomedicine and science criticized by

[4] By contrast, Ashrafunnesa Khanom et al. merely claim that narrative inquiry will lead to more "humane discourses in the context of health services research" [28, p. 555].

narrative medicine is closer to a straw man than anything else, which, in turn, seems to cast doubt on the weight of its main claim to humanism.[5]

Turning now to the case of the phenomenology of medicine: the target of this approach's proponents is not science per se but rather a philosophical position, naturalism, against which they juxtapose the stories and descriptions of the first-person experience of illness.

> I found phenomenology—the description of lived experience—to be the most helpful approach to augmenting the naturalistic account of illness. [6, p. 10]

Philosophical naturalism,[6] as it is commonly called, comes in different forms, according to whether it is intended to be a metaphysical or an epistemological thesis.[7] On the one hand, metaphysical naturalism is a thesis about the ontology of the world: only what science can account for exists. On the other hand, epistemological naturalism states that science has an epistemological priority in the knowing of the world but does not claim anything about the reality or the existence of that world. As argued by Jonathan Sholl in the philosophy of medicine, metaphysical naturalism might correspond to a thesis about the existence of diseases, while epistemological naturalism might amount to a thesis about the demarcation between health and disease or, more simply, to a thesis about the understanding or explanation of disease [36, pp. 395–396]. The proponents of the phenomenology of medicine do not, however, refer to such a distinction, and sometimes they appear to conflate the two theses. For instance, in the following quotation, S. Kay Toombs ostensibly equates the question of defining the concept of disease with that of the existence of disease:[8]

> The traditional biomedical model focuses on the disease process. Illness is conceptualized as an objective, abstract entity, in some way separated from the one who is ill. [9, p. 235]

She also takes it upon herself to criticize what she calls the "the prevailing reductionist Cartesian paradigm" [10, p. 201]. Very often (although not always) Carel and Toombs, along with Fredrick Svenaeus, describe naturalism in terms of a reductive physicalism—namely, a radical form of metaphysical naturalism that states that only the things that physics (in this case, biology) can account for exist. For instance, Svenaeus writes the following:

[5] It should made be clear, however, that this critique does not aim to cast doubt on the whole narrative medicine enterprise: extremely well-done and interesting analyses of patients' stories exist (see, e.g., [28]). My target is merely the key theoretical basis of the narrative approach: criticizing biomedicine. It should also be noted that narrative works do not have to make specific claims against biomedicine or in favor of humanism, although they often do.

[6] The term "bald naturalism" is also found; see [34].

[7] The terms "ontological" and "epistemic" are sometimes found in place of "metaphysical" and "epistemological," respectively; see [35].

[8] Although I agree that it is not clear, see below.

> For the standard doctor there will consequently be no illness, no medical suffering so to say, without a disease. [37, p. 223]

In other words, in the biomedical model, an illness does not exist without a biologically identified cause. On top of being a slippery claim—do physicians really think biological dysfunctions are the end of the stories of illness?—this type of reductive physicalism, though existing elsewhere in philosophy, is not supported by any author in the philosophy of medicine. For instance, even Christopher Boorse, the main proponent of naturalism in medicine, famously does not reduce illness to disease—with his most important conceptual move being to distinguish them—and thus does not support reductive physicalism [38]. Élodie Giroux has described Boorse's approach as a non-reductive naturalism [39]. In this way, it is misleading to argue, as Carel and Toombs do, that naturalism necessarily reduces illness to biological dysfunctions. As Sholl asserts, naturalists would all agree (as would Boorse) about the need to complement their naturalist approach with first-person descriptions of illness [36, p. 397]. This is why I agree with Sholl that the phenomenology of medicine's indictment of naturalism is unfair and close to a straw man [36, p. 395]. Neither reductive physicalism (Carel and Svenaeus) nor reductive Cartesianism (Toombs) is a view that is defended in the philosophy of medicine, and there is no reason to think that either one is somehow unconsciously enforced by health systems and physicians.[9]

Overall, the humanistic consensus against the biomedical model loses its force as soon as it becomes apparent that the coalition has neither a clear, unified definition of the biomedical model nor a coordinated, cohesive position regarding its criticism of the target. What is the target of this humanistic consensus: naturalism, science, or both? If the target is naturalism, then one is left wondering which and whose naturalism. If the target is science, then criticizing an old-fashioned positivist viewpoint is not enough. I have argued that current criticisms of science and naturalism found in narrative medicine and the phenomenology of medicine are problematic, if not simply straw man arguments. The definition of science as objective, value free knowledge and the definition of naturalism as reductive physicalism are close to caricatures. Furthermore, it is not clear how humanistic proponents can pose such strong criticisms of science and naturalism while at the same time wishing to complement them. Although my critique does not claim to be exhaustive, it casts some doubt on the consensus of humanistic approaches against the biomedical model. As I show in the following sections, it is unnecessary to pit science against art and to target something as ambiguous as the biomedical model in order to defend a humanistic approach to medicine.

[9] It should be noted that my argument here stands only against the criticism of biomedicine found in the current approaches to the phenomenology of medicine. The phenomenology of medicine encompasses a complex and rich bundle of claims, the descriptions and assessments of which are outside the scope of this paper.

How humanistic is humanistic medicine? The current compassionate approach

As Marcum acknowledges, "humanistic" and "humane"—but also "human" and even "humanness" [10, p. 202]—are not usually distinguished in the humanistic literature [20, p. v]. While *human* may refer to the human condition or the intrinsically social human life, *humane* denotes a concern for alleviating suffering and connotes emotions such as compassion or kindness. The word *humanistic* is polysemous: it can refer to humanism, a philosophy that centers on humans, their dignity, values, and freedom, but it can also mean something closer to humanitarian or humane, designating a concern for human welfare and compassion.[10] The use of such straightforward definitions has yet to be found in the current literature. It is possible, however, to extrapolate and draw a general picture of what those concepts are typically intended to mean. Three imperatives are useful for describing the degree to which humanistic approaches are humanistic. These imperatives correspond to each prominent claim put forward by humanistic proponents in order to humanize medicine and its practice.

What will humanize medicine? According to most authors, the first imperative is that emotions of both patients and physicians should play an important role in medicine and its practice. "Practitioners of humane medicine" [13, p. 396] should try their best to empathize with their patients and to understand their patients' psychological and emotional needs. Only then will they be able to properly understand their stories and their suffering. Charon writes that what people seek is "a form of health care that recognizes suffering, provides comfort, and honors the stories of illness" [2, p. ix]. Furthermore, like Jodi Halpern [16], Charon argues that empathy—or what Halpern calls emotional reasoning—has an epistemological virtue on top of its social and emotional import. In comparison to the neutral physician, the empathetic practitioner is able to better heal and treat her patient. Charon and Halpern give extensive examples from their own practices as physicians and psychiatrists. If the exact nature of empathy is ambiguous—is it something like an emotion (Charon) or more like a reasoning process in its own right (Halpern)?—authors agree upon the importance of patients' emotions.

The second imperative follows from the first one: in humanistic medicine, patients should not be reduced to their biological bodies but regarded as physical and psychological beings. Carel writes that beyond their bodies, patients are "psychological, social, cognitive, emotional, existential, and temporal" beings [7, p. 42], hence the extensive use of the concept of the "person" found in the literature (see especially [17]).[11] It is important to emphasize that for humanistic proponents, insisting on the

[10] I discard two other meanings: humanism as in the study of humanities, and humanism as in the intellectual movement during the Renaissance. Although less relevant, these two connotations are often implicitly present in the background, especially, for instance, in the case of narrative medicine and other types of medical *humanities*; see [17, pp. 31-32].

[11] See also Carel [6, p. 54]: "The complaint that seems to appear near-universal in this context is: why am I not treated as a person?".

subjective experience of the patient means insisting on her psychological state; for them, the subjective and the psychological are one and the same.[12] The psychological is, in turn, often conflated with the cultural, social, cognitive, and so on—that is, with every non-physical or non-biological human aspect. Authors criticize the dehumanizing face of biomedicine, a model under which they say patients are taken only as physical bodies, and their emotional and psychological—as well as existential[13]—needs are not met. A less central imperative is the idea that what should matter in medicine is each individual patient per se and not in general. (The insistence on the individual is a recurrent theme especially in the literature of narrative medicine, but echoes are also found in the phenomenology of medicine.)[14] Of course, it is the particular psychological individual that is valued, not his particular physical body. In fact, it seems here that concepts such as individuality, subjectivity, and particularity are all somehow reduced by humanistic proponents to psychological or mental states. The problem is that much of psychology does not focus on the subjective experience, nor does it necessarily focus on particular individuals.[15]

The third and final imperative for humanistic medicine is that medicine should be defined as a fundamentally intersubjective practice. The medical encounter is primarily characterized as an interaction between two subjects: the patient and her physician. Therefore, the humane face of medicine, as humanistic proponents call it—or *humanism*, as I call it—should be sought in the patient–physician relationship by definition. As Solomon points out, humanistic proponents seem to hold that humanities (in this case, phenomenology and narrative art) are by definition more humanistic than science and thus should be preferred for the task of humanizing the medical relationship [14, p. 193].

In brief, for humanistic medicine, humanism seems to entail the following: given that both physicians and patients are individual psychological beings, interactions between them should be characterized by mutual respect as well as empathy and/or compassionate feelings. It might be said that humanistic proponents advocate for warm fuzzy doctors.[16] I will argue that the type of humanism that is defended here is indeed rather weak. My main idea is that such a definition of humanism—call it the compassionate or psychological approach to humanism—cannot be correct.

[12] Much of psychology, however, is not focused on the subjective experience, as elaborated below.

[13] Daniel Sulmasy would also add patients' spiritual needs [17].

[14] Solomon sees in this theme the cultural importance of individuality in the Anglo-Saxon world, especially in the United States [14].

[15] It should be noted that there is a whole movement in psychology called *humanistic psychology*. This movement, introduced by Carl Rogers [40] and Abraham Maslow [41], aims to emphasize the subjective individual and the importance of the self in psychology. Although humanistic psychology is beyond the scope of this paper, my argument against the compassionate use of humanism in narrative medicine and the phenomenology of medicine could probably be applied against the use of humanism in that movement as well. However, I see no reason to restrict medical humanism to what humanism means in that specific psychology movement.

[16] Despite Carel's insistence that she is not asking for warm fuzzy doctors, it is unclear how exactly she can avoid the criticism. "My revolt against the attitude towards illness that is common in the medical world is not a sentimental one. I am not suggesting that health professionals' precious time be wasted on feel-good chatting…. Could some genuine care be introduced to the exchange?" [6, p. 50].

Humanism cannot and should not be reduced to the ordinary nature of intersubjective encounters. The main reason for moving away from the compassionate approach to medical humanism is its reliance on a problematically narrow picture of medicine.

A narrow definition of medicine

Humanistic approaches use a single framework to understand medicine: the patient–physician encounter. They worry that physicians fail to account for the patient as a subjective psychological being in the practice of their science. I argue that narrowing medicine to the dyadic medical encounter is unnecessarily restrictive. The ideal of the patient–physician encounter is arguably driven by an individualistic view of science in which the physician/scientist possesses medical knowledge and makes it her art to apply this knowledge to particular situations. However, drawing on contemporary philosophy of science presents an alternative picture of medicine, which views science as a social activity with multiple actors, human or non-human, and more broadly as a network of systems. Such a definition of medicine includes the health services and institutions that are necessary for patient care—namely, any research, clinical, and organizational activities that have an impact on health. William Stempsey, for example, writes that beyond the clinical encounter, medicine also serves as a metonym for healthcare:

> Medicine is the encounter of one who suffers from disease with one whose goal is to restore health. Yet the complexity of this encounter far exceeds its simple description. Medicine is sometimes taken broadly to include the work not only of physicians, but also of nurses, physical therapists, radiology technicians, and so on. In other words, "medicine" is a kind of shorthand for "health care." [42, p. 380]

More broadly, medicine may be understood as a country's health system.[17] Moreover, a health system may be defined by both its health care services and its health insurance system. The financial basis of a health system—its health insurance system or lack thereof—indeed has a crucial impact on health and thus plays a part in the services and institutions necessary for healthcare. Medicine includes not only health practitioners but also health administration workers, institutions, the policies they enforce, and the economic model they rest on. The World Health Organization gives a similar definition of health systems as any activities (people or actions) which aim to "promote, restore or sustain health" [43, p. 5]. The question of medicine's definition is indeed closely related to that of its aim. What is the aim of medicine?[18]

[17] Health systems are indeed extremely different from one country to another.

[18] This question can be understood in different ways. Whether medicine's aim is to treat illness or to promote health is not directly pertinent to my argument, so I will not address this here.

Proponents of humanistic medicine usually assert that the goal of medicine is humanitarian because it consists of alleviating suffering and taking care of the individual patient's welfare. However, while welfare can be construed on an individual level, it can also be understood from a populational perspective. In a larger sense, the goal of medicine amounts to alleviating suffering in the population and increasing its general welfare; or in a utilitarian vein, the goal is to maximize the amount of welfare in a society and treat suffering caused by illness as much possible. Of course, the question is whether the aim of medicine should be public health, individual health, or both. Including public health in a definition of medicine's goal is likely to be uncontroversial, although the current philosophy of medicine has not yet debated or lingered on this issue. In this way, one can go beyond the narrow picture of medicine taken up by humanistic proponents. To summarize, the definition of medicine does not have to be restricted to the patient–physician encounter, but it may also be expanded to include the whole healthcare system's activity. Moreover, the aim of medicine does not have to be restricted to the health of one individual patient, but it may also be expanded to include public health. The argument here is both philosophical and naturalistic:[19] in today's Western societies, medicine is inseparable in practice from healthcare, just as individual health is inseparable in effect from public health.

Unsurprisingly, humanistic approaches' narrow view of medicine corresponds with a compassionate and intersubjective understanding of humanism: the ideal picture of the patient–physician relationship is the consequence of a narrow individualistic view of science and medicine, and the meaning of humanism is, in turn, restricted by the ideal picture of the patient–physician relationship. Does broadening the purview of medicine and its goal to include health systems and public health clash with humanistic ideals? I argue precisely the opposite: broadening the purview of medicine beyond the patient–physician relationship helps to revisit humanism beyond a compassionate and psychological approach. The question is twofold. First, can a health system or health policy be compassionate and/or tailored to the needs of individual patients? Second, can a broader approach to humanism follow from a broader understanding of medicine and its aim?

Public health and health policies: a better framework for humanism

One might first think that including public health in the definition of medicine moves the medical model further from the ideals of current proponents of humanistic medicine. Indeed, their understanding of humanism, which values the subjective psychological states of the individual over all else, may seem to clash with the aim of public health, which focuses not on the individual but on populations. Yet because public health promotes prevention and analyzes health determinants in different populations, it does not, for instance, reduce patients to their biological

[19] I refer to the naturalistic trend in the philosophy of science according to which, briefly speaking, science is what scientists do.

bodies. Remember that the reduction of the patient to her physical body is one of the leitmotifs of humanistic arguments against the biomedical model. Instead, the public health approach is largely “biopsychosocial” [15], since it places individuals in their economic, social, and cultural environments in order to understand health determinants and health inequalities. Despite consistently referring to Engel’s biopsychosocial model, humanistic proponents almost never mention distinct social and cultural questions [3, 10, 13, 37]. For instance, in Carel’s 2008 book, the chapter devoted to “social” questions covers interactions with family and friends [6, ch. 2]. Such an approach is intersubjective and psychological—admittedly important—but not distinctly social, and therefore insufficient. By focusing on health inequalities, contrary to current humanistic approaches, the public health approach seems equipped to take the social aspect of medicine at face value.[20]

Another disadvantage of an individualistic view of medicine is the weight that is places on the shoulders of individual practitioners. Charon in particular is too quick to cast the physician as a multitask helper: a psychologist, a therapist, a social worker, even a friend. To illustrate the importance of narrative skills, she tells stories about several patients with social or psychological problems and how she took care of these problems. She recalls giving psychotherapy to one of her patients for several weeks, despite not being a therapist or psychiatrist. About a grieving patient, she writes that she

> will see her next week, and the week after that, not to fix anything but simply to watch with her, to listen to her, to behold, in awe, her faith and power and love. [2, p. 11]

Viewing general doctors as multitask helpers is problematic largely because it makes medical practice rely on the goodwill of each practitioner—practitioners who often lack the necessary training and competences (or simply lack the will). Health policies and collective work, less sensitive to individual will, have a larger impact than the practice of a single physician. Looking at a few examples of medical policies can help to broaden the question of humanism in medicine: how exactly can a policy be humanistic, and in what sense?

An example of policy: French cancer plans and supportive care

The cancer plans, installed in France since 2003, have led to—or have tried to lead to—what might be called patient-centered care in oncology; specifically, they led to the diffusion of supportive care for cancer patients. *Supportive care* is legally defined as necessary care and support for sick patients on top of their surgical,

[20] It is not necessary to defend Engel’s biopsychosocial here. It is enough to show that public health—albeit being a scientific approach that relies on statistics and the study of populations—does not reduce patients to their physical bodies. This also illustrates that focusing only on patients as individual psychological beings is insufficient even on humanistic approaches’ own terms as it clashes with their social environment.

chemotherapeutic, and/or radiation treatment. Supportive care primarily involves palliative care, that is, the management of pain, tiredness, and nutritional, digestive, and respiratory problems. It also deals with body-image issues (e.g. how to cope with hair loss) and social issues. A range of professionals, from nutritionists and psychiatrists to beauticians and social workers, may participate in such supportive care. The explicit objective of supportive care is to provide a better quality of life for patients by implementing a holistic approach to patient care that encompasses physical, psychological, and social needs. Although the implementation is far from perfect, it allows such costs as a beautician's appointment and/or a wig to be partially covered by national health insurance. This example points out the limitations of an individualistic view of medicine, focused solely on the physician: team and interdisciplinary work should not be overshadowed by the ideal of the patient–physician relationship. It is also important to recognize the institutional, legal, and financial actors necessary to implement such care. Actors in medicine may be human, but they are also institutional—for example, the French cancer plans catalyzed the creation of a body called the French National Institute for Cancer (FNIC) in 2005. The FNIC is notable because it incorporates all aspects of cancer care, research, and patient advocacy into a single body, enabling the institution to monitor the success and failure of its plans [44].[21] Patient-centered holistic care—and potentially even compassionate care, as demonstrated by my next example—does not have to be restricted to the goodwill of one physician, and probably should not be if one expects it to be efficient and available to all.

The cancer plans also led to the provision against rationing new cancer drugs in France. As a result, most new cancer drugs are quickly made available to cancer patients who could benefit from them. This expedited availability means that patients do not have to wait for market authorization, and it also means that new drugs are reimbursed by national health insurance. For example, in 2005 the new drug Herceptin (trastuzumab) was made available in France through a temporary protocol only 5 months after successful trials were conducted in the United States.[22] This timeline was possible thanks to negotiations between the FNIC and relevant health authorities. This case offers an example of a compassionate use of drugs, or in the case of France a temporary authorization for use.[23] Not rationing new experimental treatments is, of course, a choice; here, it is a political choice in the shape of health policy. But is it a compassionate choice? The answer is unclear, although it does seem to be a humanistic choice insofar as it focuses on a moral value: justice. The cancer drug was indeed made available to all people in France, and not just to those who could afford it. Yet the choice was made not by an individual doctor caring for an individual patient but by a political and normative collective enabled

[21] The Institute is unique in French health policy. It is distinct from the government and open to private sector organizations like professional and patient associations as well as to health insurance funds.

[22] Herceptin is used to treat breast cancer.

[23] It should be noted that it is often administratively difficult for a patient to go through this protocol in cases where there is no political will to facilitate the procedure for one specific drug or in the case of early or pre-trial drugs.

by complex institutional and operational work and legal negotiations. The decision also followed the most recent scientific research, the latest successful trials, illustrating how humanism does not have to work against science or the biomedical model. The reasons behind this political choice are far too complicated to list in full, but they are distinct from those found in the empathetic process of a patient–practitioner relationship. Such decisions and the negotiations enabling them can have a crucial impact on a person's life—even one of life or death. Thus, decisions and negotiations are a distinct part of medicine that should be accounted for in a humanistic approach.

Additionally, it should be noted that large public health decisions will always involve an economic compromise—indeed, valuing justice also means maintaining that resources should not be monopolized by one group of patients. For instance, Australia initially determined that reimbursement of Herceptin was not cost-effective and chose to omit the drug from its Pharmaceutical Benefits Scheme [45, p. 3689].[24] However, after intense public pressure by organizations such as Breast Cancer Network Australia, the Australian government eventually decided to create a separate taxpayer-funded Herceptin Program. Since then, several reports have investigated the difficulty of obtaining affordable and timely access to cancer medicines in Australia in comparison to other OECD countries.[25] The questions raised are thus not only normative but also operational: should countries give equal access to a drug? How should they decide, and how long should their decision take?

Current humanistic approaches rarely connect humanism to broader ethical or political projects. For instance, when Charon talks about a "more ethical" care [2, p. vii], she does not specify in what sense care should be more ethical and how narration increases this ethical dimension. Such topics as consent, autonomy, and justice go unmentioned. My argument is twofold: first, humanism should be applied to health systems as well as to the dyadic medical encounter; second, applying humanism to health systems necessarily raises fresh ethical and political questions, specifically regarding justice and equality. A type of humanism that prompts ethical and political questions, thus a broader type of humanism, is not unheard of in philosophy and elsewhere. Humanism can be understood as a broad spectrum of values and beliefs that is not restricted to an individual-centered or psychology-centered approach.[26] For example, moral humanism defends respect for the fundamental rights of human beings and takes justice as its foundation. Such a view of humanism finds its roots in the French Enlightenment; at that time, liberal and social reformers

[24] The Pharmaceutical Benefits Scheme provides subsidies for prescription drugs to residents of Australia.

[25] See [46, 47].

[26] In fact, individual-centered approaches are traditionally suspicious from a humanistic point of view. For instance, Jean-Paul Sartre's existentialism (and subjectivist approach) was strongly criticized by tenants of humanism. His famous short book, *L'existentialisme est un humanisme* was written precisely to address their attack.

believed that virtue could be defined by human reason alone, a belief that dovetailed the defense of progressive social reforms.[27]

From a foreign perspective, European health systems are sometimes described as generous. They are especially generous in the case of cancer drugs, some would say, which are extremely expensive treatments. Yet *generosity* and *compassion* seem to imply that the act of providing healthcare for cancer patients is neither an ethical nor a legal imperative, that it somehow goes beyond what is necessary. Unnecessary actions are in a way unjustified—and unjust. Therefore, those health systems are better conceived not as generous but as humanistic. For some countries, healthcare is regarded not as a product, a technique, or a gift, but as a right enshrined in the law. In France, health has been a constitutional and human right since 1946 [48][28] and with the building of what is called social security. Maintaining that health is a right means that a person can expect to be in her best possible health state—that is, she can expect to live in a safe environment with access to necessary healthcare services. According to the current French public health code, patients are entitled to receive the best care and treatment possible [49].[29] As such, the implementation of temporary protocols for new experimental treatments is not a compassionate use of drugs. These protocols are not the result of compassion; rather, they are technical administrative devices forged out of respect for the law,[30] which is based on the belief that the best treatments possible should not be rationed or delayed.[31]

A comparison: humanistic physicians versus humanistic health systems

Before turning to the defense of my approach, it is useful to compare in detail the humanistic approach I have just criticized with the outcomes-oriented approach I have proposed to defend. The former approach champions the idea of humanistic or humane physicians and practitioners, while the latter approach champions the idea of humanistic health systems—or, if one prefers, health devices or plans of action. A system should not be mistaken for an uncaring or uncontrollable process. Health policies, administrations, and the like are not occult actors. It is possible to act on them through political decisions.[32] Whether it focuses on physicians or systems,

[27] This reformist and progressive view of humanism can be credited to Pierre-Joseph Proudhon and to later thinkers such as John Dewey, Charles Francis Potter, William James, Karl Jaspers, and Maurice Merleau-Ponty.

[28] Article 11 of the Preamble to French Constitution of 27 October 1946, Fourth constitution of French Republic.

[29] Article L11110-1 of French Public Health Code, law of 4 March 2002.

[30] Compare this to the polemical compassionate use of drugs in the recent Ebola pandemic, where pre-experimental drugs were given in and out of clinical studies [50, 51]. In these cases, drugs were given not because they were the best drugs available but because no other drugs were available. Here "compassion" is taken in a strong emotional sense.

[31] It goes without saying that the "best" treatments are determined by physicians based on scientific data and not by lawmakers. Furthermore, there are obviously limits to the resources that need to be compromised.

[32] I do not mean to imply that doing so is easy, but it seems clearly possible.

humanistic medicine addresses three issues: the definition of medicine's goal, the conditions of possibility for such a goal, and the prominent values underlying this goal.

Under the humanistic physician's approach, the goal of medicine is taken to be the best care possible for the patient—including emotional, existential, and psychological care. The conditions of possibility for such a goal are the physician's goodwill, time,[33] intuitive and/or professional talents, and overall good relationship with the patient. The prominent values supporting this kind of humanistic medicine are, among others, autonomy, freedom, compassion, empathy, and respect.

Under the approach I defend, the goal of humanistic devices is ensuring not the best care possible for the individual patient but the best care possible for all patients. The conditions of possibility for such a goal are the historical and ongoing design of the medical device and the possibilities of top-down and bottom-up initiatives (i.e., a national health system, including the financial aspects). The prominent humanistic values supporting this approach are justice, access, public health, and human rights.

Of course, these approaches can be closely intertwined. The health system approach need not contradict the patient-centered approach; rather, it can attempt to implement it. Conversely, the goodwill of a physician is important when orienting a patient through the possibility of an administrative device—for instance, introducing the patient to supportive care. By comparison, asserting the existence of a legal system, with administrative and other factors influencing or guiding that system, does not mean rejecting or ignoring the protected rights of each individual in that system. Consequently, I do not wish to suggest that a patient–physician relationship approach and an outcomes-oriented or health system approach are mutually exclusive. Similarly, I do not wish to say that the approach I defend exists only to complement current humanistic approaches, since this stance would mean embracing the current humanistic approaches' distorted views of science and intersubjectivity. Furthermore, since one of my claims is that the intersubjective nature of the clinical encounter depends heavily on structural and policy-based decisions—or, put differently, that the clinical encounter cannot be separated from the whole of medicine—my approach does not aim to serve as a complement either. Rather, it absorbs and transforms the question of intersubjectivity and the physician–patient relationship in medicine. This absorption permits an approach to the physician–patient relationship that extends beyond mischaracterizations of medicine and science. For instance, it would take into account the impact of external factors on the behavior of health professionals.[34] This idea has yet to be implemented, and strategies for its implementation are outside the scope of this paper. In what follows, I introduce in more detail the approach I wish to defend: an outcomes-oriented approach to humanistic medicine.

[33] However, Charon argues that narrative skills allow physicians to work faster.

[34] It should be noted that ethics has already provided extensive analyses about how the clinical encounter should and should not occur.

An outcomes-oriented humanistic medicine

The hallmark of my approach is first that it neither sets itself against the biomedical model, naturalism, or science, nor distinguishes medical art from scientific medicine. Indeed, both philosophical moves are disputable from the point of view of contemporary philosophy of science. On this view, if there is such a thing as dehumanization in medicine, my approach looks for it not in the defects of the biomedical model—whether that means science or naturalism—but in one particular health system or part of that health system. Biomedical aspects of medicine (e.g., blood testing) are not considered dehumanizing prima facie.[35] Second, instead of relying on individualistic understandings of medicine and humanism, my approach uses a broad definition of medicine: health systems. On both counts, I choose to draw on an up-to-date philosophy of science—a naturalistic and social philosophy of science that views science as a social and normative activity with multiple actors. From such a standpoint, the actions and actors of a health system are a distinct part of medicine that cannot be ignored by the philosophy of medicine. The disparities between the health systems of otherwise affluent countries help to illustrate the importance of a health system's design, or lack thereof, not only for public health but also for individual patients.[36] Furthermore, as shown in my seventh section above, incorporating public health means that this approach includes biological as well as psychosocial factors, thus avoiding a caricatural view of science. Finally, given that the design of a health system is the consequence of political choices, it is not possible to discuss humanizing medicine without attending to deeply normative ethical and political problems, such as health inequalities, justice, and access.

Phenomenological and narrative approaches to medicine—two prominent humanistic perspectives—ask a radical question about medicine: what is a good medicine?[37] Proponents of these approaches worry that biomedicine is insufficient because it does not accommodate patients' experiences and emotional or existential needs. Significantly, they often talk about good doctors but almost never talk about good medicine. They seem to think that the scientific or biomedical question is settled, proceeding to study the relationship between patients and physicians and to consider how to improve it. However, there is a whole complex world in between these issues. What good is the best technical medical procedure if it is not accessible? What good is the best and most compassionate doctor if she is not available or cannot prescribe life-saving drugs? These are crucial questions. Medicine is not a product to be delivered in a physician–patient relationship that must be improved; it is a complex network of actors (human, financial, administrative, and economic) that determines the possibility and the modality of the patient–physician

[35] The conditions and consequences of said blood testing in a particular situation could, however, be studied.

[36] See WHO report on the performance of health systems [43].

[37] Of course, defining what a good doctor or a good medicine should be is ambiguous between *good* as in "efficient" and *good* as in "morally good." It seems that a morally good doctor should be as efficient as possible, but I will leave this question aside for now.

encounter and its outcomes. The important question is: what are good conditions for the medical encounter, and how can they be improved? What is at stake, therefore, is not the intersubjective quality of the clinical encounter but the performance of the larger structure of medicine in which this encounter is situated. In other words, the approach I defend is outcomes-oriented insofar as it focuses on the outcomes and the performance of the health system, that is, on its capacity to answer crucial questions about the possibility and modality of healthcare.

Ultimately, the capacity for a health system to produce good health outcomes is what matters. Insisting on the outcomes of a system also means focusing on the operational devices implemented in order to run this system and how this system plans to provide the best care for all (if indeed it does plan to do so). This insistence thus raises the following blunt question: if a system does not aim to provide the best care for all, in what sense can it be genuinely humanistic, and in what sense can it provide the best of medical care? In fact, it is only through its outcomes-oriented focus that my approach becomes distinctly and radically humanistic: it introduces the goal of access to medicine in light of the quality of that access. Access is indeed the condition of possibility for any medical outcomes and thus becomes the foundation for any humanistic approach to medicine. The closely related questions of access, justice, and health inequalities are highly ethical and political, shaping a moral humanism that goes beyond the current compassionate or psychological humanistic approach. Furthermore, shifting away from an individual-centered approach to humanism is key to developing a humanism that is more faithful to its namesake. Examples drawn from the French health system have illustrated the critical import of looking at specific system devices in order to understand what it means for medicine to be humanistic.[38]

Conclusion: from physicians to health devices, a priority shift for humanistic medicine

There are several flaws in current humanistic approaches to medicine in general, and in the phenomenology of medicine and narrative medicine in particular. Although covering all of these flaws is not the task of this paper, one problem is worth noting: both narrative medicine and the phenomenology of medicine make their case against the biomedical model by relying on an outdated view of science and a caricatural definition of naturalism. This flaw is relevant here because it leads humanistic proponents to endorse narrow definitions of medicine and humanism. While medicine is reduced to the patient–physician relationship, humanism is reduced to a psychological and compassionate approach. Both definitions are lacking and should be expanded.

[38] Examples have also shown that health systems are consistently built on difficult compromises and difficult decisions. Additionally, it should be noted that patient-centered care is one type of humanistic approach that has been successfully implemented in France and elsewhere. They can both emerge from local initiatives or from higher impulses.

A broader definition of medicine, which includes health systems, health policies, and other relevant actors in that system, effects a shift to a more radical and normative sense of humanism. The approach I defend focuses not on the patient–physician relationship but on the conditions of that relationship, that is, on the health system and its multiple devices (administrative, legal, financial, etc.). Such topics as access and justice are therefore given a central place in the discussion. If the intersubjective approach in general need not be dismissed altogether, it can be absorbed, so to speak, by my approach. A priority shift is needed in favor of a less individual-centered position if the goal is indeed to humanize medicine. My aim in this paper has been to give the first impulse to a new framework for humanism and medicine to introduce aspects of medicine that currently go unnoticed in the literature. Further discussion will, of course, be required to explore these aspects.

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