Two philosophies

The human condition seems to be an integrated somato-psycho-social phenomenon. During my undergraduate training, I needed to find boundaries within this whole in order to limit my considerations to understandable sized portions. It was only in my years of practice that I managed to put these all together again.

The simplest conceptual model which relates the integrated human condition to the practice of medicine is shown in Fig. 1.

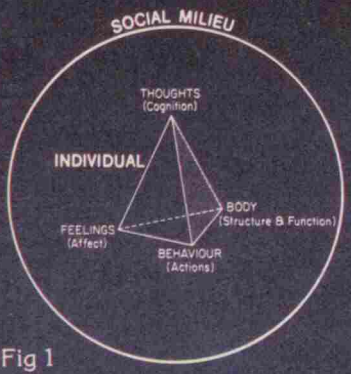


Fig 1

The individual is seen as an integration of thoughts, feelings, behaviour and a physico-chemical structure and function. Each of these aspects influences each of the rest. In addition this individual is immersed in a social milieu, and interacts with that social milieu at all 4 levels.

One part of the social milieu is the healer, which may be a doctor. Different healers or doctors intervene at each different level on this model, but the essence is that AN INTERVENTION AT ANY LEVEL AFFECTS THE WHOLE INDIVIDUAL (i.e. AFFECTS ALL OTHER LEVELS)

The effectiveness of the intervention by a healer seems to depend on a matching of needs and expectancies of the helper and the helped, i.e. how the helper will help, and how the helped will be helped.

Looking back on my learnings during my undergraduate and post-graduate years I have realized that these two learning phases were based on two different sets of beliefs or philosophies, of medicine. In order to demonstrate the differences between these, I should like to present the two as polar opposites.

At one pole is the philosophical approach which could be called DUALISTIC ME CHANISTIC MEDICINE; an at the other pole the philosc phical approach which coul be called HOLISTIC HUMAN ISTIC MEDICINE.

There are three main diffe rences between these tw approaches.

1. DUALISM

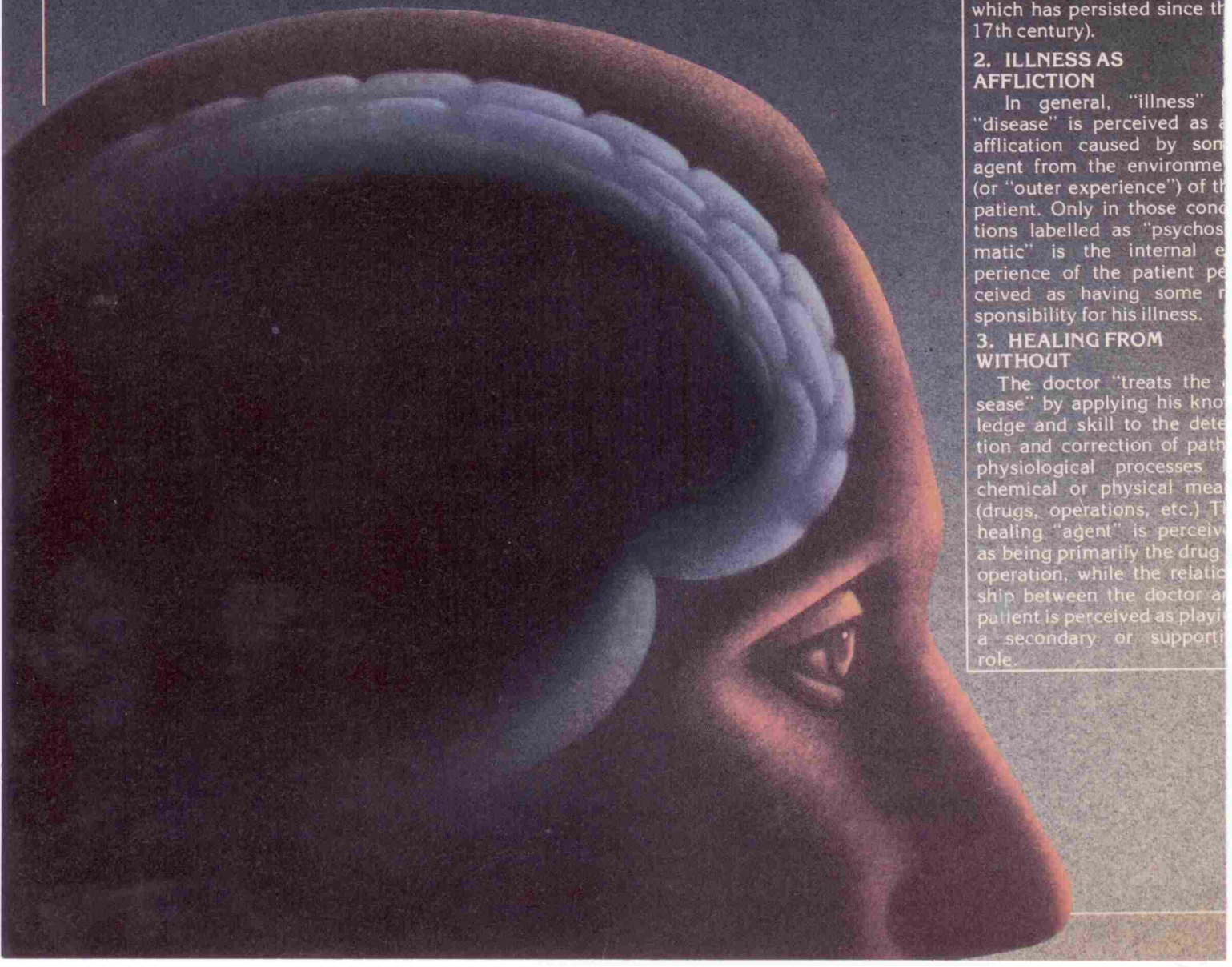
People are perceived as h ving a mind and a body whic are separate entities. In only small number of disease (called "psychosomatic" is an overlap between thes perceived. Thus, doctors pe ceive their role as being treat the bodily ailments the person; any disturbir thoughts or emotions a perceived as a separate entit to be treated separately by psychiatrist or counsello (This is the fundamental ph losophy of Cartesian Dualis which has persisted since th 17th century).

2. ILLNESS AS AFFLICTION

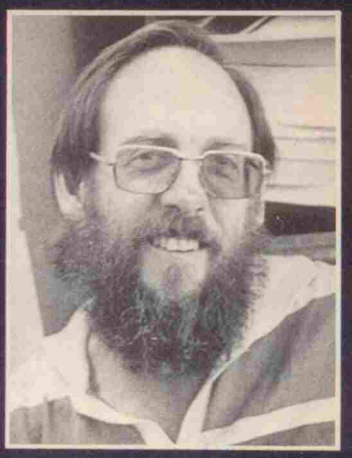
In general, "illness" "disease" is perceived as a affliction caused by son agent from the environme (or "outer experience") of th patient. Only in those cond tions labelled as "psychos matic" is the internal e perience of the patient pe ceived as having some r sponsibility for his illness.

3. HEALING FROM WITHOUT

The doctor "treats the sease" by applying his kno ledge and skill to the dete tion and correction of path physiological processes chemical or physical mea (drugs, operations, etc.) T healing "agent" is perceiv as being primarily the drug operation, while the relatic ship between the doctor a patient is perceived as playi a secondary or supporti role.



in medicine



he philosophical differ-
e between these two sets
eliefs is reflected in our
ent system of medical
cation, which seems to be
ed in favour of the Dualis-
Mechanistic approach. In
ns of the process used, it
ms to be geared primarily

HOLISM

eople are valued as an
egrated totality of
ughts, feelings, beha-
rs, bodily structures and
ily functions. These are
nter-related, and each has
ffect on all of the others.
s, changes in any of these
nents are associated with
can be influenced by)
nges in any of the others.

LLNESS AS
HAVIOUR

ness is preceived as a
sen mode of behaviour at
e level of consciousness.
implies that, at some
l of consciousness,
person seems to choose
e "ill". This choice repre-
s the optimal mode of be-
our within the person's
image of his reality at the
e, and is not valued
atively by the healer.

HEALING FROM
HIN

he doctor "cares for the
on" i.e. clarification and
ng confrontation are used
nobilize energies within
individual to allow for
rnative choices of be-
our. The healing "agents"
perceived to be within
ndividual, and capable of
g mobilized primarily by
doctor-patient relation-
Chemical or physical
ventions are perceived as
g secondary to, and sup-
ive of, this relationship.

to the acquisition and use of KNOWLEDGE. This follows the Aristotelian doctrine in which knowledge is ranked highest in the order of values; skills (especially behavioural skills) are valued lower, and attitudes and values are rarely confronted as educational issues. Thus, the student's education is primarily cognitive (i.e. what he knows) and logical thinking is encouraged.

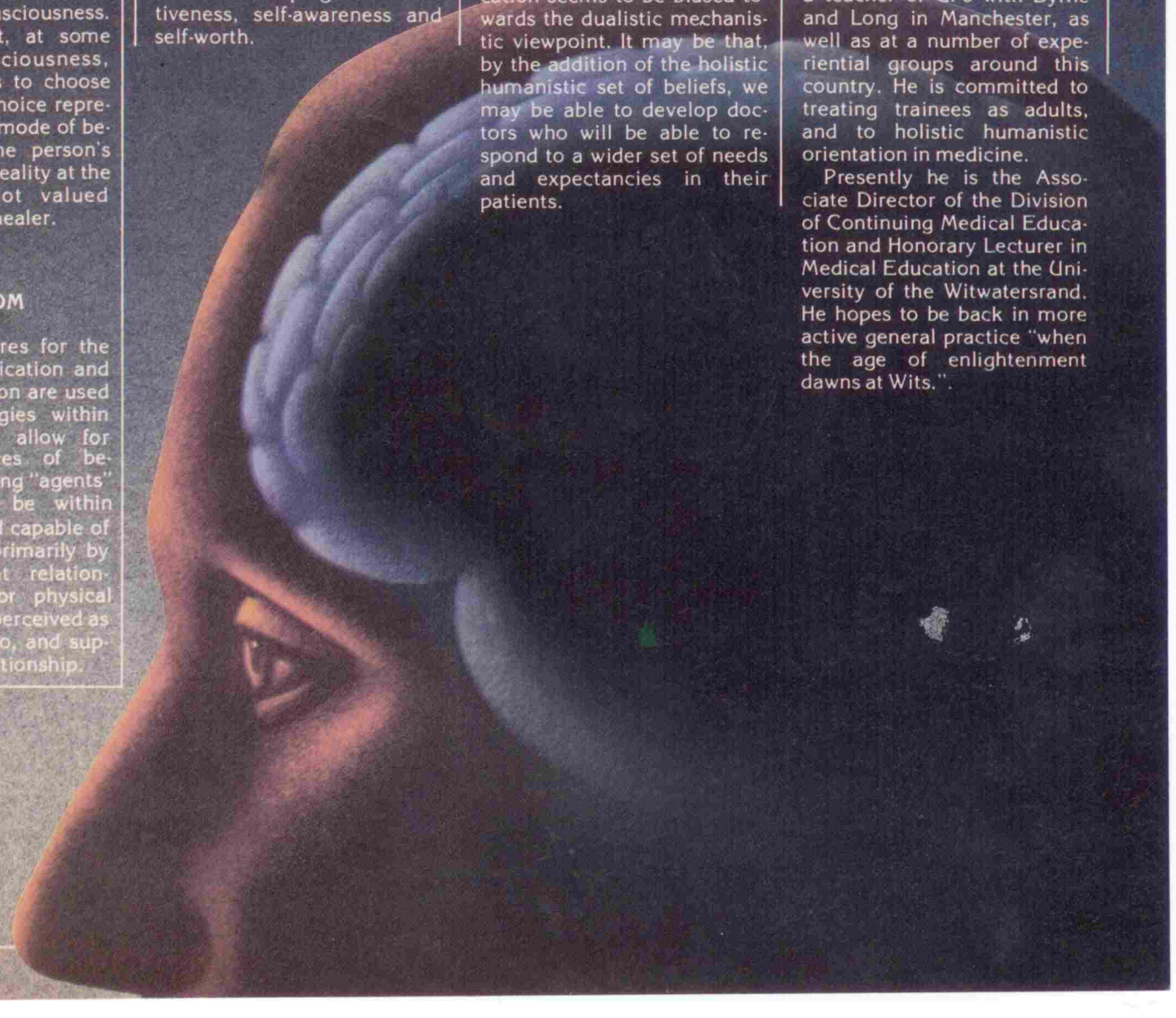
The skill of responding to the patient's and his own expression of feelings seem to actively discouraged. The hypothetico-deductive ("scientific") method is the exclusive method of research and arriving at a "truth", so that he tends to think only in terms of quantifiable data.

An alternative system of medical education (let's call it "Humanistic Education") may be geared primarily towards developing self-directiveness, self-awareness and self-worth.

Cognitive education (what the student knows) could have EQUAL value with affective education (his development of attitudes and values) and behavioural education (what he does), especially in the areas of interpersonal communication and response to the expression of feelings. BOTH the "scientific" and the "experiential" method of thinking could be used to arrive at a "truth". Thus, his thinking will not be limited only to quantifiable data, but also to the non-quantifiable (or qualitative) elements of human existence.

It may be that, by extending such a humanistic approach into our current medical education, we will be able to develop doctors with a more humanistic approach to their patients.

In terms of the content taught, current medical education seems to be biased towards the dualistic mechanistic viewpoint. It may be that, by the addition of the holistic humanistic set of beliefs, we may be able to develop doctors who will be able to respond to a wider set of needs and expectancies in their patients.



ABOUT THE AUTHOR

Peter Cusins MB BCh MFGP (SA). A graduate of the University of the Witwatersrand and the Royal Postgraduate Medical School. After 5 years in hospital and research posts (local and overseas) he says he found he was still not trained for general practice, but became a GP anyway.

He was in active general practice for 14 years during which he trained himself, wrote some papers, and did some research. Noristan awarded him a silver medal in 1973. He obtained training as a teacher of GPs with Byrne and Long in Manchester, as well as at a number of experiential groups around this country. He is committed to treating trainees as adults, and to holistic humanistic orientation in medicine.

Presently he is the Associate Director of the Division of Continuing Medical Education and Honorary Lecturer in Medical Education at the University of the Witwatersrand. He hopes to be back in more active general practice "when the age of enlightenment dawns at Wits.".