Medicine at the interface of the scientific and the manifest image of man

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Abstract

Medicine at the interface of the Manifest and the Scientific Image of Man
Despite what the term "manifest" in to contrast to "scientific" image may suggest, Sellars insists in "Philosophy and the Scientific Image of Man" that the manifest image is a conceptual frame in which significant rational inquiry, absolutely worthy of the term "science," has been developed. The real difference with its scientific counterpart is that it involves correlational (vs postulational) methods and an ontology of persons (vs objects). Arguably, this distinction can be cashed out in terms of the difference between sciences that aim at *understanding*, and sciences that rather aim at *explaining* Man-in-the-world.

The debate concerning which methodology and basic ontology is more accurate, or whether they could be combined, is well-known in the field of human and social sciences. But it can also be identified in medical sciences: on the one hand, medicine is an epistemic endeavor that endorses much of the methods of natural sciences in order to successfully explain human's health and disease; but on the other hand, as a solid trend in the philosophy of medicine literature has highlighted, it relies on certain interpretative assumptions concerning what being healthy or sick means for a social, self-reflective and norms-driven creature like man. Thus, medicine probably provides us with a paradigmatic illustration of a rational and cognitive endeavor that requires a "stereoscopic" view of Man. In a trivial sense, it is a "human science," distinct from astronomy or veterinary medicine. But above all, health and disease are human and value-laden phenomena. They exemplify distinctive features that conceptually sever them from the realm of mere natural objects. Thus, one might wonder what "man" (healthy or sick) actually stands for in contemporary medicine. I will argue that it is context dependent, hence its appearance of indeterminateness and equivocality.

To support this hypothesis, we can draw our attention to the important critical turn that started some twenty years ago in most Western countries, acknowledging some inherent limitations of the biomedical and disease-centered model in medicine, while promoting a "patient-centered" model instead. Of course, some ethical and social concerns were involved. But this shift is primarily the outcome of medical factors. In particular, the so-called "epidemiological transition" that started in the late 19th century, referring to the progressive replacement of infectious and acute diseases by long-term conditions in terms of global incidence, has prompted a significant shift in the definition of the goals and methods of healthcare. Obviously, major chronic conditions like type 2 diabetes cannot be addressed the same way an appendicitis is. The former's understanding and treatment require a diachronic assessment

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of the patient's global health state and its psycho-social determinants. The chronically ill "Man" is not an inert object of intervention, but a crucial actor not to be overlooked. To use another Sellarsian distinction, she cannot be viewed as "featherless biped," that is to say from the scientific image's perspective only. She is also to be viewed as a "person," as the manifest image has it. Note that for the latter, persons are not primarily moral Kantian agents, endowed with rights and dignity, and so forth. They are more fundamentally normative creatures, pertaining to communities, and henceforth inserted in the social and logical space of reasons, of shared intentions and principles, "above all, those which make meaningful discourse and rationality itself possible" (Sellars, 1963: 40). Arguably, the challenge raised by the current epidemics of chronic illnesses constrains medical science to accomodate some conceptual elements of the Manifest image. Hence a possible internal clash and the need to avoid or overcome it.

Promising initiatives have already taken place in this regard. For instance, "medical humanities" (apart from bioethics: history, sociology, philosophy, anthropology of medicine) are introduced in a growing number of medical schools' curriculum and research settings. Once more, their goal is not only to achieve more ethical practices in healthcare, but also to foster better medical science and knowledge. However, it is not clear yet whether this division of the cognitive labor keeps on its promises. To illustrate this point,we will consider the complex problem of patients' adherence to treatment. Adherence rates are indeed notoriously poor amongst patients living with a long-term condition (hardly 50%), leading to poor health outcomes and major financial loss for public healthcare systems. Now healthcare professionals disagree on whether this is a genuine "medical" issue, or rather an educational, social or political one. As a matter of fact, in most clinical settings, physicians delegate the burden of patients' therapeutic education to nurses, certified educators, or even patients' associations. This is how, especially as far as chronic illnesses are concerned, medicine ends up divided between various subdisciplines whose "scientific" status is differentially appraised, depending on the image of man they resort to. This may lead to serious epistemological issues and dead ends.
To support the latter point, we will scrutinize the recently coined concept of "patients' experiential knowledge," as the counterpart of professionals' medical expertise. Arguably, patients living with a chronic disease do eventually acquire a perspective on their health and illness that is, by definition, inaccessible to physicians. "Expert-patients" are thus being trained in several countries, where they are expected to work in close partnership with health professionals. The underlying assumption here is that diversity of epistemic perspectives will elicit better medical knowledge, every expertise completing the other. But as sound as this might be, there is no warrant at all that a consistent picture will emerge in the end. The clash between images might as well be even more striking or duplicate. In response, I finally suggest that the import of some elements of the manifest image, in medicine or elsewhere, should be cautious and should satisfy Sellars' own criteria of epistemically significant content: being open to rational evaluation and revision. It is far from clear that all recent trends, like the "patient partnership," or resorting to tools like "narrative" or "existential" medicine, will prove to be relevant in this respect.