DOI: 10.22122/ijbmc.v5i1.116

International Journal of Body, Mind & Culture
Cross-Cultural, Interdisciplinary Health Studies

Paradigmatic Crisis and Humsnistic Medicine

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Theoretical Study

Abstract

The biomedical model had proved its effectiveness in treating acute diseases and has caused widespread developments in some fields such as genetics and macrobiotics. However, it has showed its shortcomings in treating chronic diseases and the psychocultural conditions affecting health. These have led to the arising of a paradigmatic crisis in all levels of biomedicine. At this point, a significant question arises: "Is it possible to incorporate all human dimensions in a medical model?" It seems as if biomedicine considered man as it-experience; that is, it had an objective, evident-based, and positivist view; while the I-experience -the phenomenological world of the patient- had no roles in disease prognosis, diagnosis, and treatment. Through the systemic model of medicine, the patient can become a major part of the therapeutic team, which, while he/she stands on one point of the health continuum at any given time, has crucial roles especially in chronic conditions and preventive care. Through such models, the patient-physician relationship transforms into an essential healing technology.

Keywords: Biomedical model, Phenomenological world, Systemic model, Health continuum

Citation: Goli F. **Paradigmatic Crisis and Humsnistic Medicine.** Int J Body Mind Culture 2018; 5(1): 3-13.

Received: 5 Nov. 2017
Accepted: 20 Dec. 2017

Introduction

'Nothing that can happen to man is inhuman.'
Michel de Montaigne

In this essay, I intend to provide a short history of the current condition of medical discourse and illustrate a modern tendency which is observed in its folk, ethnic, and professional contexts (Helman, 2000). This tendency is observed in the form of various phenomena in medical texts and institutions, and in health beliefs and behaviors of the people in the society (Ogden, 2004; Conner & Norman, 1996) but the variety and diversity of their representations usually prevent us from seeing the systematic movement behind it.

In other words, we first try to reveal the instability of the transformation which is called leniently "paradigmatic crisis" in medicine. Next, we explain the claim that this crisis and the problems which arise from seem to create a movement toward medicine's being humanized; that is, considering and incorporating the human being's psychocultural dimensions as well as his biological aspects in medical knowledge and services. We discern this movement not only in medical textbooks, interdisciplinary studies of medicine such as medical sociology, anthropology, philosophy, and ethics, and in scientific paradigms of medical knowledge but in peoples' tendency to take part in self-help associations, self-therapies,

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and alternative and complementary medicine. We should acknowledge that biomedical model which recognizes all health issues as interpretable to objective, measurable, and biological ones has still maintained its dominance evidently, but barely. Nevertheless, a paradigmatic crisis has emerged in all levels of medical discourse with the increasing growth of hermeneutic and humanistic tendencies (Wulff, Pederson, & Rosenberg, 1990).

In the following, first I try to display some scenes of this crisis to give a glimpse of the gaps that have emerged in the body of the medical paradigm, and then, I explain the historical and genealogical link between medicine and human sciences. In the end, we will take a glance at the horizon of medical discourse centered on humanizing the medical practice and knowledge.

The gaps in biomedical model

Now that I have used the appealing, but inspiring, word "paradigm" to explain the dominant model of biomedicine, it is preferable to examine first the extent to which the usage of this term is suitable and valid for medicine. Then, we can deal with the disorders and abnormalities which have occurred in this science.

The term "paradigm" – which is presently used and pronounced easily and ubiquitously – was first coined by Kuhn in the sense of "tacit knowledge" – that is, knowledge which includes basic concepts, recognition of the field of research, fundamental theories, and the accepted methods of research in a science – in his controversial book "The structure of scientific revolutions" (Lakatos & Musgrave, 1970; Kuhn, 1996).

However, Kuhn had basic sciences – specifically physics and chemistry – in mind and even mentioned in his book that professional activities in fields such as medicine, technology, and law whose existence are due to an external social need are not necessarily triggered by a paradigm (Kuhn, 1996).

Therefore, it seems that it is not infallible to ascribe the word "paradigm" to medicine and generalize the course of genesis-development-transformation of paradigms to the field of medical knowledge and practice. It is worth mentioning that the degree of validity of what Kuhn illustrates for the lifetime of paradigms has been disputed and needs more explanation. On the other hand, as Gadamer has explained in his article "Hermeneutics and psychiatry", medicine and law cannot be considered rigorously as sciences (Gadamer, 1996b). The teleonomicity of these sciences, their interdisciplinary nature, and their excessive intermingling of subject and object cause us not to be able to reduce the knowledge of medicine to a science, especially in its positivist sense (Wulff et al., 1990). Although the science of medicine which mostly includes basic medical sciences is a part of this discipline, it also includes technology, management, clinical decision-making models, and many other heterogeneous parts which are not recognized as science.

Even if we would like to use leniently the word "paradigm" for medicine, perhaps it is more suitable to use the term "paradigms" since, for instance, physiology, clinical medicine, and health education cannot be ascribed to one single paradigm. The non-homogeneity of knowledge structure and medical practice is in itself a detailed lengthy discussion which needs more space to be explained. Nevertheless, from this perspective, medicine's lack of precision and its lack of a defined paradigm is by no means its weakness. Conversely, it indicates its more humanistic embedding, more complicated structure, and more hermeneutic nature. Perhaps it has been revealed so far that when we speak about the paradigm of medicine, as some experts of medical philosophy have done, we do so leniently. Moreover, it presents a more analogical and general sense of the exact application of the term in Kuhn's philosophy and in fact, like what some other

medical theoreticians have done, it is just a petito principia of the concept for representing the current state and course of medical discourse.

If we would like to talk about the paradigm of biomedicine, we should know that this model has been based on fundamental concepts such as health and diseases – just as the paradigm of humeral medicine was founded on basic concepts such as humors and tempers. Furthermore, it identifies a boundary between medical and non-medical affairs. For instance, it accredits the effect of prayers to theology and the role of belief to psychology and knows them to be out of the realm of medicine even if such events are encountered everyday in medical practice. This paradigm recognizes fundamental theories such as the mechanical model of disease as the core of its practice and employs specific research methods such as objective observation, statistical surveys, and clinical trials for this purpose.

The reader may now ask: "Well, why is it that today we find a wide body of studies in public media and even in reliable medical journals which, for instance, study Qi (a basic concept in the traditional Chinese medicine), suggest the effectiveness of prayers on health or that of psychological components on somatic health, or have employed hermeneutic and qualitative methods for health-related conditions?"; "If the biomedical paradigm actually rules over medical discourse, what is the reason for such studies?" I would instantly answer that I see these movements as instances of reactions to paradigmatic crisis; that is, a response to the excessive insufficiencies of biomedicine – especially in treating chronic conditions – and reaching the limits of this paradigm.

The hopes we had for the promises of biomedicine even in the last two decades, "which many still have" and have been advertised by many medical commercial institutions for apparent reasons, went up in smoke. We hoped to provide biological explanations for cognitive, emotional, and behavioral phenomena, and, most importantly, self-awareness through detailed identification of the structure and performance of the brain. Nevertheless, despite all the extensive and valuable achievements in this field, we have encountered epistemological and methodological obstacles which indicate that these problems cannot be resolved even with developments in technology and knowledge (Dreher, 2003; Jaynes, 2000; Gadamer, 1996a). We anticipated the success of human genome project in decoding the genetic code by which we hoped to recognize all physical, behavioral, and even cognitive aspects of the human being; just as by having the length of one of the sides of a square, we can obtain its area, surface area, and so on. However, these studies, albeit all its great achievements, have reached epistemological dead ends which indicated that epigenetic factors and the controlling role of the environmental organization – that is, the person – should also be taken into account. That is, to know the whole person, we should know the whole person. Mere knowing and considering of the parts, despite its usefulness, is not helpful and the human being cannot simply be identified with the wide formula of his genes; although using genetic technology, we can replace aged parts with new ones and we are, to an extent, able to prognosticate the chance of the manifestation of physical and even behavioral attributes (Capra, 2004). On the other hand, some generally unexplained phenomena by the biomedical paradigm – which are usually denied and ignored in the pre-crisis phase to the most possible extent – have reached an influential extent that has made rising of a crisis inevitable.

For instance, there are years which any reliable clinical trial of therapeutic intervention has to be compared with a placebo. When the therapeutic intervention is more effective than placebo, not necessarily with greater cost-effectiveness, it can be presented as a therapeutic factor.

As you know, placebo is an ineffective

harmless substance which is given to an individual as a drug. This phenomenon is one of the most widely used and important research components of today's research in biomedicine. Therefore, we are talking about a very widespread phenomenon not a random one or a rare exception.

Based on the experiences of my colleague physicians and researchers, I know that, despite their recurrent exposure to this ubiquitous and measurable phenomenon, they have given little thought to it and have not understood the range of its effectiveness and theoretical and clinical outcomes. They rarely considered the problem that this common research tool suggests a truth that can suddenly ruin the foundations of all they have studied in medical university.

The reason for this is very simple; if all psychological and physical phenomena are due to biological mechanisms, how can a cognitive element; that is, "the belief in effectiveness"; be the reason for a series of physical mechanisms? How can thought move a series of pathogenic mechanisms or, inversely, a terrain of healing mechanisms? Where is the point or phase at which the word transforms in to the molecule?

Now that you see a simple belief in placebo can have such salient effects on health, you can imagine how an individual's belief system can control all his/her health aspects and how the systemic and conscious changing of this belief network can bring about a fundamental transformation in the health system and a revolution in medical knowledge.

Other phenomena such as hypnotherapy or other psychotherapeutic approaches have been indicated to have impressive effects on many physical and psychological diseases. This led to the formation of fields such as psychosomatic medicine and health psychology. The fundamental mechanisms of these phenomena are not exact, quantitative, and objective but their effects are measurable and explainable (Kradin, 2008; Ogden, 2004; Wulff et al., 1990).

This is also the case for complementary and alternative medicine. For instance, we see that by penetrating needles in some points of body which have nothing to do with neurological pathways, an individual is anesthetized and undergoes a surgical operation or a resistant pain is hindered. Even if these points related to neurological pathways, they had no such effects. Such phenomena are ignored, called non-medical, and de-emphasized for years, to the extent that they finally find a position in therapeutic programs and at last a space is provided for their investigation in reliable medical journals (Faas, 2001).

Evidently, the epidemiological shift of the disease from acute and infectious diseases to chronic and systemic ones is another problem which causes the medical paradigm to change. Biomedicine is more efficient and competent in treating acute and emergency diseases. Its interventions for controlling chronic diseases have increased peoples' living years with (chronic) disease. This has considerably de-highlighted the role of the pathogenic factor. On the other hand, it considerably highlighted the role of cognitive–behavioral factors, our way of dealing with the disease, and lifestyle; that is, the issues which biomedicine was made to borrow from psychology and other humanistic fields.

It also seems that the defensive mechanisms of a paradigm, just as it works in the individual mind, more or less cause the paradigm to ignore, deny, suppress, or justify the impressions which are not compatible with its structure. Nevertheless, this collective mind, just like the individual mind, encounters these impressions and it is at this point which crisis rises. First, the normal and seemingly pure and homogenous science transforms into a heterogeneous science with alternative theories and diverse methods. Ultimately, a theory which can cover the most facts of that science and better satisfy most practitioners and people arises, develops, and becomes pervasive and dominant as the new paradigm. Most

thinkers and philosophers of a science not only absolutely distrust the empirical ideal of a uniscience which encompasses all empirical, humanistic, and mathematical sciences, but they even tend toward pluralism in the domain of one single knowledge. It is for this reason that today we hear and see the terms "medicines' and "psychologies" rather than "medicine" and "psychology" in reliable books and papers (Leddy, 2005; Watson, Dossey, & Dossey, 1999; Kim & Berry, 1993).

Nevertheless, as we see and many medical anthropologists have also confirmed, movements and development in a discipline like medicine which deals with peoples' everyday life cannot be clearly explained by such a unidirectional analysis. Most often, clients who use medical services are ahead of scientists and politicians and make them recognize social tendencies to manage and organize them.

About a decade ago, I was invited as an expert to take part in a plan which later was called "organizing the traditional/complementary and alternative medicine", which led to the approval of a program in the health committee of the congress and founding of the Office of Traditional/Complementary and Alternative Medicine in Iran's Ministry of Health. This program initiated because people had started to show a very peculiar tendency toward complementary and alternative medicine. As a consequent, many profitable non-expert people were satisfying this new-emergent demand of the society and an increasing part of medical services were provided by such people out of the control of formal medical institutions. As it is evident from introducing the problem, the initial phase of the program was nothing more than the planning to eliminate a series of interfering and chaotic factors. After two years of presenting abundant valid scientific resources, WHO and NIH's organizing programs, and the programs which conducted in developed countries, we at last succeededd – barely – in convincing health committee members that this social movement has been developing for about three decades in all developed and developing countries and has had many positive effects on health in many cases, and for this reason, developed countries often implement some laws and educational programs for its widespread organization and we should do the same.

The fact is that it is people who often understand the occurrence of social revolutions, even those occur in the paradigm of medicine, sooner than its practitioners and politicians. This is due to the natural adaptation of human beings that when medical practice of society does not satisfy his needs and some fields take care of themselves rather than him, he finds a way to take care of himself. To what extent is peoples' interest in traditional/complementary and alternative medicine due to their desirable therapeutic effects and to what extent is it due to the communicative and induced components which are institutionalized in them? Is this movement merely an uprising against biomedicine's technocracy and its communicative and humanistic poverty or is it a selected intelligent movement? More anthropologic, clinical, laboratory studies are needed to provide an evidence-based explanation of such widespread social phenomena. These studies are now formed in many fields and have led to the generation of considerable therapeutic programs.

Nevertheless, such controversies regarding the phenomenon called the paradigmatic crisis of biomedicine are not so determining. Whether the fate of biomedicine is to be united with alternative models or whether it is to transform to a systematic and integrative model such as the biopsychosocial model this crisis will continue, as its course indicates this in the last decades.

New-emergent relations of human sciences and medicine

Perhaps many ask "what has happened in these decades, especially in the last twenty years, that has caused the performance of this abundance of studies in the shared disciplines between medicine and human sciences and the formation and spreading of some disciplines like medical anthropology, medical sociology, medical philosophy, and medical ethics?" Day by day, we see more great philosophers who talk about theoretical issues in medicine. Today, the philosophy of science is not considered to be equal to the philosophy of physics as it was considered in the first decades of the twentieth century. In line with these newly-emerged theories, a considerable abundance of books and journals are published specifically on subjects related to the philosophy of medicine. If we review the history of science from the renaissance era until now, we see that paradigmatic developments in medicine have usually occurred more or less one century before that in physics. The wave of development has taken the same amount of time to be conveyed from physics discourse to medical discourse. Our medicine is still under the dominance of Newtonian physics and Cartesian dualism, while physics has passed this threshold years ago.

As Kuhn mentions implicitly, the followers of a science usually become philosophical at the time of crisis. But at the time of the establishment of the paradigm, no one pays attention to such matters and its practitioners are busy with completing the puzzle of the new-emergent paradigm and planning for actualizing its promising ideals.

The reason for this is clear: Prior to the crisis, the paradigm does not show itself and is not seen; just like looking through a pair of glasses, the world is observed from framework of that paradigm and behaviors are conducted from that position. As far as one uses a clean pair which is right for his/her eyes, he/she does not become aware of its existence, but only looks at the world through them. However, when they are dirty, they become the subject to be discussed, recognized and managed.

I have taught courses in medical philosophy, philosophy of medical ethics, and medical anthropology for student of medicine and residents of psychiatry and community medicine for the past ten years. I have to confirm that such courses still have no roles in training of physicians, the efficacy of their thoughts, and their therapeutic interventions. Nevertheless, at least these messages are heard by students among the stream of information on biomedicine's technocracy, and may sometimes make them contemplate such issues and now and then, may cause a transformation in their attitude toward health and medical practice. This launches the occurrence of a transformation in the future.

It is worth noting that such discussions are so extensive in pioneering universities that independent departments are devoted to Nevertheless, it does not seem that we have reached the critical threshold for the emergence of a transformation – although through this process, some considerable changes have been taken place in medical discourse and institutions.

Of course, we should have in mind that by being philosophical in this era of medicine, we mean becoming aware of the philosophical foundations we stand on and the theoretical window through which we look at the human being rather than seeing the link between medicine and human sciences because this link existed before and will exist in the future. Even in the most practical parts of medicine, we inevitably deal with human sciences. The dominance of human sciences imposes its determining roles latently on clinical decision-making, research, and educational technology. For this reason, Michel Serres believes that every scientist who claims to have nothing to do with the philosophy of science is unknowingly following an outdated philosophy of science.

A few years ago, after a session I had with

residents of psychiatry in a psychosomatic medicine class, a friend of mine – a professor in psychiatry – unexpectedly accused me, in an ironic and critical voice, of teaching my own pure attempts to philosophize medicine. He believed psychiatry was an evident positivist science which had scientific objective achievements. He claimed that all technical developments and knowledge progression started at the point when philosophy and medicine were separated in the ninetieth century. "Do you want to let the genie out of the bottle again?" he asked me.

"I do not intend to do so, since this genie has never been in the bottle, but among us and our activities", I replied. Then, I reminded him of what I had seen a few days ago. I saw him blaming one of his students for ignoring the economical, occupational, and cultural status of his patient when writing his case history. While he was leaving, he pointed his finger at this student and emphasized, "biopsychosocial! Never forget this. It is only in this way that the patient's case history makes sense in psychiatry."

"The biopsychosocial model is a philosophical model conveyed from systems theory and systemic biology to medicine. If you knew its true meaning, you would understand that this model is deeply against the materialistic view in psychiatry and the reductionism that you were advocating a few minutes before. This model was originally formulated as a reaction to the shortcomings of materialistic and dualistic views in biomedicine. Of course, if you knew that positivism itself is a philosophical model, perhaps you would have not seen philosophy and human sciences as chaotic in the ordered, polished showcase of medicine." I continued.

Many studies have been conducted on the links between medicine and human sciences. Some thinkers even believe human sciences have been emerged from the ancient and normative discourse of medicine (Shawer, 1998). Evidently, on the path of the development of these disciplines, this relationship was mutual and they were never separated from each other.

The enlightening "is–ought problem" of Hume which states that we should separate the world of "is" from the world of "ought" does not have the validity it once had. We have many reasons and evidences which show that even the most exact and objective empirical studies are not without value-judgment (ought) (Von Schlippe, Schweitzer, & Lizenzen, 2012, Putnam & Putnam, 2008).

A glimpse at the process of every empirical research is sufficient to discern merging of sense and belief or, in a traditional way, the object and subject. In empirical researches, data are obtained through pure observation. Furthermore, the collected data do not produce meaning unless they are made up in a way to be transformed into the form of information. However, in order to employ the information in a specific subject, we need theories that can articulate our information about that subject. To combine our knowledge of something with that of another thing in order to obtain an integral knowledge, we need a model to harmonize and articulate these theories. Thus, it is clear that what becomes observable in order not to be mingled with speculations and value-judgments does not become meaningful and applicable. When we approach higher levels of knowledge organization, these speculations become more expansive and penetrative. This becomes more appealing when we see that the process of knowledge production is not often a bottom-up inductive process. It often involves a top-down control which is imposed on practice and empirical knowledge, that is, first a paradigm which is more or less founded on a restricted range of theories and ideas becomes dominant or a hypothesis, for whatever reason, is considered. This hypothesis then controls our observations, expectations, and research methodology. As Popper (2002) explains at the beginning of "Conjectures and Refutations: The Growth of Scientific

Knowledge", the intermingling of theory and trial, the problem of the priority of the subjective component (hypothesis) over observation (objective component) is the same chicken or egg causality dilemma. Nonetheless, the most unbiased and direct scientific observations cannot be uncontaminated by subjective and speculatory components.

Ibn al-Haytham (965-1040 AD), the father of optics, describer of the vision theory, and an empirical scientist, advocated an attitude in science which was a very pioneering view at that time. He believed that only a science can be promising that its material is tangible and its form is rational (Hunke, 1960). That is, he believed that empirical science emerges from the intermingling of sense and thought, but perhaps his Aristotelian thought did not allow him to see that our sense, better to say perception, is not uncontaminated by our beliefs and cognitive and emotional tendencies.

The brief, but very revealing, book "The Marriage of Sense and Soul: Integrating Science and Religion" by Ken Wilber (2001), great American thinker and psychologist, deals with the alchemical intermingling of sensory affairs with intuitive, emotional, and rational ones and claims that science, especially psychology and medicine, deserve such a holistic approach.

Briefly, although human sciences and medicine have never been separated from each other, one characteristic of paradigmatic crisis eras is that a collective consciousness about theoretical fundamentals of a science emerges and the collective mind forces that paradigm to seek other theoretical disciplines which can include these new crisis-making observations and provide new fields for knowledge and practice. It seems that such a self-consciousness that medicine is not reducible to a pure experiential science is being generated now.

As medicine is knowledge about the human being, and as de Montaigne states that nothing that can happen to man is inhuman (as cited in Alain de Botton, 2001), we can say that all domains of knowledge which deals with the human being's health is medicine. It appears that affairs related to medical education, epidemiology, economy, methodology, biological ethics, and sociology which medicine deals with today from the one hand, and the abundance of research indicating the mutual relationship which exists between "events and psychosocial actions" and "events and physical actions" from the other, have made the acceptance of these new-emergent disciplines inevitable for discourse and medical institutions.

The problem of medicine's being humanized

I should explicate that by representing the intertwisting of sensation and belief I do not mean merging irrelevant things together and persuading the readers that there are no true scientific criteria or standards. The fact is that all scientific views are not equal in degrees of validity and reliability. Some are more objective and others are more speculatory. In addition, I should confirm that some views are more humanistic compared to others. That is, some methods and views are more concerned with their inner coherence and order rather than their compatibility and integrity with various aspects of human conditions, and some others, although they experience some degrees of inner disintegrity and chaos to answer the questions, try to understand various human dimensions and give more appropriate responses to human needs (Bloom, 2000).

That how to integrate the two tendencies of "being scientific" and "being humanistic" is a fundamental problem in today's medicine. Perhaps this gives rise to the question: Isn't science, especially that of medicine, humanistic that we discuss about it in this way?

Perhaps some, especially physicians and paramedics, regard the term "humanizing" as offending. They may become doubtful and ask: "Has not a respectful profession such as medicine which was always – or nowadays is

often –respected and trusted by people been humanistic so far?" "Why would it need to become humanistic now?"

Prior to explaining the process of humanizing, we had better explain one probable misunderstanding. Our discussion is about going beyond the limits of the mechanical model of biomedicine as a system of knowledge which is the medical society more or less has acknowledged and used. I have witnessed in recent years how skilled physicians have implicitly or intentionally deal with such restrictions and have personally use some interventions to further humanize their profession and provide a more appropriate response to the physical, psychological, spiritual, and social needs of patients. These are neither in their formal training nor a part of their legal duties. Therefore, this is biomedical model that is to be blamed, not the medical practitioners or the governmental institutions in this field of knowledge and practice. To humanize medicine, we need to determine our point of departure and our destination.

If we overlook adjunct psychosocial aspects of today's medicine, we can say that the objects of biomedicine are in fact a machine called body and categorized creatures called diseases which cause various disorders in the function of this machine. It is clear that our therapeutic interventions in this model are based on resisting the effects of these beings or the beings themselves; that is, diseases.

In other words, the object of medicine is the body-mind which is reducible to its parts and quantitative, objective, physical processes, and, of course, categorized disorders which are explainable on the basis of physical disorders. Although biomedicine's reductionism and its being oriented towards disease have provided extensive clinical, laboratory, objective, and scientific explanations for human beings, the problem which arises is that this scientific approach is only applicable theoretically and practically in some functional domains of human organism. Thus, their materialistic and disease-based interventions have mostly been effective in treating emergency, acute, and infectious disorders but have not been so for chronic, behavioral, and psychosomatic disorders because contextual factors and psychosocial responses are more determining in consistent long-term interventions compered to periodical ones. Hence, the mechanical model in medicine can be called scientific, but calling it "humanistic" implies including many contradictions and faults, just as a geometrical portrait cannot be called realistic and normal.

It should be confessed that science, due to its nature and structure, committed an analytical violence against human being in order to cut, dissect, and know it part by part. It also had caused another kind of violence in terms of categorizing. To include human beings in its own categories, it cuts them into pieces in a procrustean manner and ignores individual differences or to be clearer, disregards their individuality. There is another form of violence which is known as normal violence. It is the force which persistently pressures man to transform the human condition into a normal one. Medicine is a domain of care which imposes the three forms of violence on the individual and society in a powerful and extensive manner. Moreover, merchandizing violence should be added to this list; the strong force which imposes pressures by pharmaceutical and medical equipment, incorporations, and some health practitioners on health consumers and destroys their quality of life (QOL) in all its dimensions.

Here we do not deal with the coalition of medical institutions with power systems as Foucault claimed (Dreyfus, 1983; Wulff et al., 1990), and how medicine which was supposed to guarantee our health is now systematically producing disease (Illich, 2000). We only explain how the paradigm of biomedicine transforms man from a one-dimensional being to a de-identified and passive one.

The biomedical model, like any other

system seeks to maintain its values. It has negated human being's totality and distorts the human condition for the sake of its own values which are scientific, systematic, and categorical explanation of the human condition.

In fact, biomedicine has depersonalized man and personalized disease because the human being should be simple, objective, and predictable to the extent that he can go under exact biological analysis. Diseases, which are the foundation of our approach to health, should be structured and understandable to the extent that they can be regarded as the agent of various health states. In this way, we can easily say that "diabetes does this and does that" or "we have to treat cancer by this and that". As a consequent, the image of the human being vanished and disappeared, and the image of diseases was highlighted and made conspicuous in the current health discourse. This is the problem that, more than any other, worries philosophers, anthropologists, and, of course, medical experts in this era. This concern becomes more noteworthy when we consider the economical, scientific, and cultural dominance that medicine has over today's society. Many thinkers such as Ludwik Fleck and Richard Castillo, great theoreticians in the field of medicine, have explicitly expressed their worry that if we emphasize on treating the disease prior to thinking of the person in the process of therapy, we will de-humanize medical practice (Wulff et al., 1990).

When heroes and anti-heroes of the play of "medicine" are physicians and diseases respectively and nothing has remained of the ill person (that is, the one who has to wait resignedly to watch who wins at last) other than a battlefield, there is no space for human dignity in medicine. You may ask about the role of physician. The physician, as a human being, is the one who is skilled, competent, and autonomous, and thus, transiently plays a paternalistic role for the patient. Nevertheless, the fact is that the physician is usually nothing more than the agent of the paradigm. For this reason he only thinks in the frame of pre-determined diagnostic, and then, therapeutic guidelines. Now you can realize to what extent the physician-patient relationship is weak and lacks creative dimensions. Physicians often believe in the healing effect of the rapport in treating diseases, but it seems that they know it merely as a decorative element to obtain client satisfaction. They see it as a tool for efficient accumulation of information and correct diagnosis of the disease and/or regard it as a tool which guarantees follow-up of the treatment by the patient. This is the case because the biomedical paradigm has restricted the realm of the physician's practice to finding organic disorders and organic remedies for them, and under the best conditions, to giving advice to the patient to make the interventions more effective.

As it has been explained in this essay, if we want to consider human being with all his biological, psychological, spiritual, and social dimensions to respond to the abnormalities which caused the paradigm of medicine to reach this crisis, to manage the belief system, health behavior and other factors of the psychoneuroimmunologic equilibrium efficiently (Vedhara and Irwin, 2006), to make use of alternative models which have expressively and practically been proven to be compatible with other models in an integrative health system, and to incorporate the human being as a communicative self-awared being who is responsible for his own health into the core of the health system and for all the factors to serve him in the direction of facilitating his healing psychosomatic mechanisms so that his quality of life with all its aspects is considered as the goal of medicine, the metaphor of the "human machine with all its mechanical disorders" which has dominated the medical paradigm for years is not responsive and there is a need for a more complicated, interdisciplinary and, in general, humanistic model.

Conflict of Interests

Authors have no conflict of interests.

Acknowledgments

The author would like to thank Sepideh Motamedi for her contribution in translating and editing the article.

References

Bloom, S. L. (2000). Chaos, complexity, self-organization and us. *Psychotherapy Review*, 2(8), 1-5.

Capra, F. (2004). *The hidden connections: A science for sustainable living*. New York, NY: Anchor.

Conner, M., & Norman, P. (1996). *Predicting health behaviour: Research and practice with social cognition models*. Buckingham, England: Open University.

de Botton, A. (2001). *The consolations of philosophy*. New York, NY: Vintage Books.

Dreher, H. (2003). *Mind-body unity: A new vision for mind-body science and medicine*. London, UK: Johns Hopkins University.

Dreyfus, H. L., Rabinow, P., & Foucault, M. (1983). *Michel Foucault: Beyond structuralism and hermeneutics* .(2nd ed.). Chicago, IL: University of Chicago Press.

Faass, N. (2001). *Integrating complementary medicine into health systems*. Gaithersburg, MD: Aspen.

Gadamer, H. G. (1996a). *The enigma of health: The art of healing in a scientific Age*. Stanford, CA: Stanford University Press.

Gadamer, H. G. (1996b). Hermeneutics and psychiatry. In H.G. Gadamer (Eds.), The enigma of health: The art of healing in a scientific age (pp. 163-174). Stanford, CA: Stanford University Press.

Helman, C. (2000). *Culture, health and illness*. culture, health, and illness. Oxford, UK: Butterworth-Heinemann.

Hunke, S. (1960). *Allahs Sonne über dem Abendland: Unser arabisches Erbe*. Munich, Germany: Deutsche Verlags-Anstalt.

Illich, I. (2000). *Limits to medicine: Medical nemesis: The expropriation of health*. New York, NY: Marion Boyars.

Jaynes, J. (2000). *The origin of consciousness in the breakdown of the bicameral mind*. Boston, MA: Mariner books Houghton Mifflin.

Kim, U., & Berry, J. W. (1993). *Indigenous psychologies: research and experience in cultural context*. Thousand Oaks, CA: Sage Publications.

Kradin, R. (2008). *The placebo response and the power of unconscious healing*. New York, NY: Routledge.

Kuhn, T. S. (1996). *The structure of scientific revolutions*. Foundations of the unity of science. Chicago, IL: University of Chicago Press.

Lakatos, I., & Musgrave, A. (1970). *Criticism and the growth of knowledge*. London, UK: Cambridge University Press.

Leddy, S. K. (2005). *Integrative health promotion*. Boston, MA: Jones and Bartlett.

Morin, E. (1991). *Le Paradigme perdu. La nature humaine*. Trans. Asadi, A. Tehran, Iran: Soroush.

Ogden, J. (2004). *Health psychology: A textbook*. New York, NY: Open University Press.

Popper, K. R. (2002). *Conjectures and refutations: the growth of scientific knowledge*. London, UK: Routledge.

Putnam, H., & Putnam, C. U. P. E. (2008). *The collapse of the fact/value dichotomy and other essays*. Cambridge, MA: Harvard University Press.

Shawer, L. (1998). *Note on the birth of the clinic*. Available from: URL: http://www.california.com/~rathbone/foucbc.htm. Accssed 1998.

Vedhara, K., & Irwin, M. R. (2006). *Human psychoneuroimmunology*. Oxford, UK: Oxford University Press.

von Schlippe, A., Schweitzer, J., & Lizenzen, H. (2012). *Lehrbuch der systemischen Therapie und Beratung I: Das Grundlagenwissen*. Trans. Pirmoradi, S. Isfahan, Iran: Shonar.

Watson, J., Dossey, B. M., & Dossey, L. (1999). *Postmodern nursing and beyond*. London, UK: Churchill Livingstone.

Wilber, K. (2001). *The marriage of sense and soul: Integrating science and religion*. Boston, MA: Gateway.

Wulff, H. R., Pedersen, S. A., & Rosenberg, R. (1990). *Philosophy of medicine: An introduction*. (2nd ed.). Oxford, UK: Blackwell Scientific Publications.