



Why Cannot Biomedicine Tolerate Man?*

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Theoretical study

Abstract

Today, anyone who has travelled a little through history or reflected on social systems knows that although they are established and designed to satisfy our needs and demands, they have needs of their own which guarantee their life and may precede our needs. Hence, these systems, which were supposed to serve us obediently like the magic lamp genie, make us serve them in different ways. Medicine is one of such social systems which were undoubtedly established to satisfy our vital need to care and cure. To exist and develop, medicine needs to know and control personal and social conditions, and to satisfy these, it needs knowledge, money, and, perhaps prior to all of these, it needs to be trusted. To be known, man should be completely uncovered, observable, and dissected into his parts and the relationship between his parts should be explained in simple models. And to direct the condition toward maximum health, man should be converted into a statistical entity and his individual differences, conditions, and narratives have to be ignored so that he becomes predictable and, consequently, controllable creature. The story of relative, and almost necessary, conflict between man and medicine is as simple as it is explained. Before we go any further into the discussion, we should remember that a real man, with his whole phenomenological world and new-emergent and unique properties of autonomy and consciousness, may suddenly behave like a joker and disturb all the rules of medicine's play. It is natural that such subtleties cannot be tolerated by a materialistic model which is relied on knowledge of mechanistic organization of parts. The aim of this theoretical essay is to increase the readers' awareness of biomedical model restrictions and organized cruelties it imposes on man in practice and theory. The discussion of alternate models which we are turning to recently are dealt with in other essays.

Keywords: Biomedicine, Social systems, Phenomenological world, Consciousness, Autonomy, Alternate models

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Introduction

Was it not enough simply to observe the dead as one observes the living and to apply to corpses the diacritical principle of medical observation: the only pathological fact is a comparative fact? (Foucault, 2003, p. 134)

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Fear of facing the self, along with the fear of death, can be identified as the most deep-seated fears of man in the onset of the era of self-awareness. This is the fear due to which no one, except Oedipus who was a devoted seeker of his own identity, could answer the enigma of the sphinx; the answer was man himself. In the dawn of awareness, this fear made man see his reflection in water as a mimicking creature or a twin in the water; thus, he could evade encountering the self. This autophobia transformed the history of human beings into the history of man's projection of his weaknesses and powers onto the under-worlds and upper-worlds. In

this way, as Hafiz explains, his fate becomes roaming and begging for his latent pearl from those lost in the beach of the sea" in continuous futility (Sonnet 143:2).

Sometimes, when man is exhausted of his wanderings in his projections, he becomes rebellious and tries to control and move the wheel of fortune according to his will. This is where magic, and then science, come to help man to dominate others (other human beings, nature, destiny, or even god). As the condition for self-knowledge and self-construction is having conversation with the other and even relative and transient transcendence of the structural self and impulsive desires, the effort to dominate others means escaping from encountering the self. By negating others or dominating them, man can make efforts to actualize his boundless desire for power and pleasure without hesitation; the desire to "have" more of something and the will for infinite regeneration of the desire to "be", which due to non-fulfillment transform into anger and simply into the desire of "non-being" (Epstein, 1995).

Diverse domains of knowledge and modern techniques serve to extend these demands rather than to help interpret and guide man's desire to higher levels of awareness and being needs. It is worth noting that due to the diversity and incompatibility of demands, man who had once been reduced to his demands is once more reduced to just one of them and, instead of actualizing his own whole, tries to define all of his wishes - at least in every moment - in accordance with one demand. In other words, for the sake of that one desire, he hides or represses his other desires (Fuery, 1995; Maslow, 1943).

Although since ancient times, desire and fear have been known to be obstacles to man's transcendence (Campbell, 1991), they are actually our motives in life. They are disparate and non-attuned forces whose mere product is boundless futile fluctuation between "inclining to" and "escaping from"

unless they are consciously and intelligently guided. But is man actually an inclining to-escaping from machine that no teleonomy and unity can be conceived of for?

If man is actually such a being, modern medicine as a system to defer his death and to extend his inclinations and escapes is the best way of treating him. If we identify the quantity and explicit function of life as the ultimate of medicine, social functions, pleasures, visual aesthetics are its fundamental qualities which transform man into something pleasant and useful.

Before the discussion goes any further, two points have to be noted. First, our intention is not to confirm the ideal of life-escaping asceticism and blind opposition to desire, but is to accept all dimensions of human beings, including their longing for pleasure, permanence, transformation, and, of course, not to identify man with these desires.

The second point is that when we talk about today's medicine and criticize it, we do not advocate shamanistic or traditional medicine, or returning to a previously promising time or even the belief in the existence of such a time. Although, if such a time had existed when man had been reflected from head to toe in the mirror of knowledge, that picture is not representative of today's man. Hence, the technophobic trend of returning to the past and nature is not the remedy either.

However, it should be acknowledged that in a time not long ago, there were sages who were concerned about human health and held their practice and thought exclusively on quantity, performance, and pleasure. Although they attempted to improve these components of man's life, they used them to serve the autonomous man in the path of his self-completion and consciousness evolution. For the same reason, it must be emphasized that today's medicine is missing meaning and wisdom and its instrumental and formal aspects have been dramatically developed.

Today, it is not sages, but economic agencies, drug dealers, and medical equipment

companies which determine the main strategy for this incomplete discourse of health. On the other hand, it seems that the identity of the medical guild has preceded its humanistic and professional mission (Callahan, 2009; Illich, 1976; Kennedy & Kennedy, 2010; Sharpe & Faden, 1998; Doyal, 1983).

The question that arises is: "what happens if man as a conscious lifeworld - and not as a desiring machine in its commonest sense - becomes the object of medicine?"

Does biomedicine tolerate such an object? It can be predicted that if man is regarded as an object that is not disintegrable to all of its parts like a machine and our knowledge of it is not generalizable to all other machines either, and, in addition to desire and reaction, it has the capacity to act (autonomous behavior), it undoubtedly disrupts simplistic knowledge of medicine.

Perhaps the use of the term "simplistic" for such an exact, widespread, complicated, and positivist knowledge as biomedicine seems unfair. Nevertheless, if we say that this knowledge de-faced and de-souled man to make him testable and knowable for the sake of research methodology and practice, you may agree with the use of this term.

It should be kept in mind that our intention in the present text is criticizing, not explaining why we have passed this rout in history and paid the cost of surpassing deductive generals to reach a more or less clear and inductive understanding. The current discussion aims at showing that these systematic disorders have appeared in the medical discourse, while, today, we have more comprehensive systemic perspectives in terms of philosophical, scientific, and clinical domains, and thus, we are not forced to follow the biomedical model anymore. Although we would not like to deprive ourselves of the possibilities this empirical approach has created for knowledge and medical technique, we would like to use it more efficiently.

The story of bearing the burden of the conventional biomedical model is the story of the hermits who were passing across a

dessert while pulling a boat along with great effort. A passer-by asked them: "What is the use of this boat in the wilderness that makes you carry it with so much difficulty?" They answered: "Because this boat has passed us across the river a few days ago!"

Of course, keeping our instruments and methods sometimes long after they inscribed their patterns on and played their roles in our life is not novel, neither in the domain of the psyche nor in the context of history. However, one day, a passer-by should come and inform us that keeping these once-efficient instruments and method is not necessary anymore.

Having presented these two reflections, I would like to explain what I mean by defacing and desouling of human beings in biomedicine. Then, I deal with three great catastrophes which occurred in medical methodology and engaged mankind as the object of medicine to make him knowable, predictable, and controllable and to provide such honorable science as chemistry or physics with the purpose of promoting man's health:

First catastrophe: objectification

Second catastrophe: normalization

Third catastrophe: medicalization

Perhaps the three catastrophes can be summarized under the term medicalization of life. However, if we look more deeply and if we consider the definitions provided for the concept of medicalization, we will understand that this process specifies something medical and intra-systemic while the other two processes - objectification and normalization - are metamedical issues which determine the biomedical model and the worldview it raises.

Prior to explaining the occurrence of these three trends in biomedicine, I believe it is necessary to note two other points to clarify the discussion and prevent from invalid impressions.

First, in any critical and theoretical method I follow in this discussion, I have not regarded medicine as a single paradigm. Because, currently, at least the three

experimental (in basic sciences and laboratory sciences), rational (in clinical medicine), and phenomenological paradigms (in the field of health management and training, and psychosomatic medicine) coexist unequally in medical universities and are practiced under the domination of the first two paradigms which are the two wings of biomedicine (Wulff, Pederson, Rosenberg, 1990). Nursing schools and departments are among some of the majors in the field of medicine which are based on the biopsychosocial view. However, students and professionals in these fields soon find out they should be content with working in the margins of the biomedicine domain. Despite the great ideas and ideals which they read in their textbooks, if they cannot tolerate to be marginal or if they are very ambitious to do important and effective works which are not considered socially worthy and prestigious, they have to quit their jobs and think of a more respectable profession!

Therefore, our criticism is not of all the current deep movements in today's medicine, but the mechanical model of biomedicine which maintained its dominance in spite of the abundance of scientific observations which questioned its validity and the more significant and effective theoretical models which exist.

An abundance of literature has been written on the causes of this paradigmatic resistance including economical, guild, cultural, scientific, and theoretical causes which shows how dominating discourse restricts knowledge development and systemic approach in spite of sufficient evidences which show its inefficiencies. Therefore, our work aims to extend the field and shift the focus of attention in the scope of valid research on medicine and select a theoretical model which includes most parts of our empirical knowledge, helps us make more efficient clinical decisions, and provides the possibility of utilizing many therapeutic modalities which their effectiveness are proven but the mechanical model of modern

medicine does not allow their wide and effective use.

In respect to such effective therapeutic modalities, we can name psychosomatic medicine and health education as instances. The cost-effectiveness of these therapeutic modalities has been confirmed in many contexts and their priority to biological interventions has been proven in some domains. They have, also decreased the need for costly and highly invasive biological interventions in many cases. However, due to the aforementioned paradigmatic biases, and specifically economical ones, these modalities have had little contribution in research, advertising, and treatment (Straus, Trimble, 2001; Frisch, 2006; Gould et al., 1995; Ornish et al., 1990; Schuler et al., 1992; Varnauskas, 1998).

Another important point is that I do not intend to present an absolute philosophical criticism in this study, and I do not approve creating a liberating and idealistic anarchism by ruining medicine as a system of care and power but I am seeking for a more humanistic, comprehensive, and moral model which can make health services more efficient. Many great philosophers and thinkers of the twentieth century, specifically in the years after the Second World War, criticized the discourse of medicine as a system which determined the destiny of individuals and society. By this, they aimed to prevent unwanted effects which are by-product of unconscious application of every other system.

From Ivan Illich to Joerge Canguilhem, Michel Foucault, Jacques Derrida Hans-Georg Gadamer, Niklas Luhmann, and Jürgen Habermas shed light on cultural, social, and even the long-term effects of the mechanical model of biomedicine on health from different aspects. Although these thinkers belong to different thinking traditions, all of them agree on the idea that modern medicine is insufficient in seeing, exploring, and analyzing the problems of human beings and its epistemological and methodological restrictions do not allow

listening to human experiences and providing effective practices to enhance the quality of life. Therefore, it has been converted into an instrument to impose power and control, restrict man's autonomy, and transform man into a measurable and expectable object.

In his book "The birth of clinic", Foucault (2003) explains an apparently deep and simplifying view of medicine in a biting criticism:

"But what now becomes of its visible body, that set of phenomena without secrets that makes it entirely legible for the clinicians' gaze" (p.159) and "What was fundamentally invisible is suddenly offered to the brightness of the gaze, in a movement of appearance so simple, so immediate that it seems to be the natural consequence of a more highly developed experience. It is as if for the first time for thousands of years, doctors, free at last of theories and chimeras, agreed to approach the object of their experience with the purity of an unprejudiced gaze." (p.195).

Years before Foucault, Kierkegaard, the great philosopher of the nineteenth century, correctly criticized modern medicine and indicated how a specific and real human being was interpreted as a statistical human being and his complicated world was reduced to material phenomena.

He explains that examinations and studies are conducted ruthlessly, the physician promises to provide a statistical list report as soon as possible to obtain the mean, because when someone knows the mean, everything becomes evident. Therapeutic view makes man regard every phenomenon as merely materialistic and physical (Wulff et al., 1990).

Mishler analyzed clinical relationships in depth and in details based on Habermas's theory of communicative action. He believes that giving voice to the medical system has suspended the opportunity of giving voice to the patient's lifeworld and has suppressed psychosocial aspects which are very

determining in the health of the individual and society. He explains that giving voice to medicine makes sense in a biomedical model. This model which is reflective of the scientific and instrumental structure of biological sciences eliminates the psychosocial context of the events which helps provide a complete understanding of the patients and their problems. This is while the effectiveness of medical practice depends on such an understanding (Barry, Stevenson, Britten, Barber, & Bradley, 2001).

To convince worried minds and responsible views upporting this enlightening movement, perhaps it is worthy of note that although being aware of what is generally called medicalization of life and an intervention for modulating its effect is currently necessary, we should acknowledge the truth that medicine in its historical movement and, of course, mankind in his movement toward self-awareness had to inevitably pass this rout.

In the following, three man-eluding and man-hurting techniques are mentioned. I hope you do not to consider the current condition as a tragic and inescapable fate, and I believe that I am not talking about a historical deviation and an evil creation, but I am only representing a kind of restriction and methodological inertia.

A. Objectification

Observable human being, measurable human being: We have come a long way from the time the great Francis Bacon (1606–1626), in the history-making program of "renovation of sciences", stated that medicine in the new era should not be based on invisible forces (powers) and qualities (humors) but on physics and chemistry, until today that medicine has become valid through figures and images which illustrate human being's life and – in medical anthropological terms – patients are transformed into paper patients. But it seems that we are still descendants of the enlightenment era (Helman, 2006; Helman,

2000; Goli, 2004).

Hellman, a well-known physician and anthropologist who wrote many influential books on medical anthropology, explains the process of reducing man to objectified data. He believes that when a physician learns more about the body, he listens less to what the patient expresses. "Paper patients", which are printed by diagnostic technologies, replace the human patients' and their stories. It often seems that technodoctors are slaves to this technology, not its masters.

To establish medicine on such sturdy bases, it was necessary to reduce man to body and body to its parts in order to first make whatever related to human beings observable and secondly make it reducible to its parts so that its amounts and changes would be measurable. It can be simply perceived that for medicine to have this exactness and validity, human beings (therapists and patients) had to pay costly expenses and it was necessary for man to become something completely observable and measurable. Therefore, all diverse dimensions of man's life (experiences, intentions, states, and his relationships) had to be analyzed as characteristics, epiphenomena, and states of this object. Otherwise, they had to be ignored or de-emphasized or were simply, with agnosticism or humor, recognized as being outside the realm of medicine (Stanford Encyclopedia of Philosophy, 2015).

Even an inanimate object has its own emergent particularity which explains its unique characteristics and cannot be predicted through knowledge of its parts – in the same way that no chemist can claim that unique properties of water can be predicted by completely knowing the properties of oxygen and hydrogen. However, to have exact and explicit knowledge, there was no way other than disregarding the reverence of man and even deprecating him as a mere object, and viewing him as completely knowable based on knowing the sum of his parts. Therefore, de-personalization of man

and not honoring his new-emergence, even as an object, was necessary for his converting into an appropriate object for biomedicine (Ahn, Tewari, Poon, & Phillips, 2006; van Regenmortel & Hull, 2002).

In this way, direct and anatomical microscopic observations and detailed study of inanimate bodies and, later, half dead and passive bodies became the foundations to understand man. Even after development of physiological studies and direct and indirect observation of animate processes of human organism, structural boundaries which were specified by studying inanimate bodies lasted as the presupposition of such observations and physiological processes were regarded merely as the relationship between these presupposed parts. It is only in recent decades that we are witnessing the emergence of the physiological inclination which sometimes deals with explaining the functional correlation of processes, explaining and differentiating the stream of vital processes, rather than presupposing conventional anatomical boundaries (Carlson, 2012; Sherwood, 2003).

Considering man as an object of one thousands of parts which gathered together to live for a few days due to nature's blind will, was the last step to transform man into something predictable and obedient and medicine to an absolute science. In this way, man became measurable and his qualities and states could be interpreted by figures.

It is evident that when something observable exists, an observer should also be present and this is the very story of disintegrating human beings into two pieces of subject and object. The story, like normalization, started from medicine and extended to human sciences. Today, we are witnessing the extravagant form of development of these technologies and their multidimensional interventions in lifeworlds. Of course, this disintegration causes a state of bipolarity in subject and object. It appears that this bipolarity has extended from medicine to other fields such as law and

social studies. Due to this bipolarity, the physician completely goes into the frame of subject as the knower, the agent of change, and locus of knowledge, and the patient, voluntarily or inevitably, accepts playing the role of object and fits himself into the frame of what is to be known, the object of change, and the locus of disease. Perhaps a few moments later, they exit the scene of the clinic and each one plays the opposite role. This shift of roles is an obligatory fluctuation for today's human being. The division between the roles is so accepted that it is not generally doubted that perhaps the physician can be in the position of being known and altered or whether the patient can be the locus of knowledge (Schweitzer & Schlippe, 1743).

These are the discussions that are analyzed in medical and research ethics. In addition, to revise them, modern clinical and research models are proposed and utilized based on humanistic and systemic attitudes.

B. normalization

Real human being is sick, no authentic human being exists: The roots of normalization go back to the ancient times before the emergence of biomedicine. Discourses in politics, religion, and medicine contributed to its rise. There is no doubt that human beings need to develop a set of norms proportionate to their nature and their life conditions. However, considering that we are neither talking about agnosticism nor ethical and social anarchism, by normalization we do not mean developing a set of norms. Of course, completely fictional common rules are more close to man's social nature than lawlessness and anomism.

What we call normalization is a mechanism of rejecting human being and repressing reality; a method which by defining a desirable situation or a normal human being negates and labels all other conditions or human beings as abnormal. We can define "normal" or "abnormal" by illustrating and confining the concepts and,

without personifying them, try to make normal states, behaviors, and situations more probable and facilitated. However, in normalization, we do not deal with a value spectrum and a process but with two states of normal and abnormal. The tragic climax of normalization appears when we understand that what is known as the true, desirable, and normal condition can be never reached; we come to this world and die as abnormal, we fear and suffer from abnormalities all our life and do not recognize ourselves as a "true human being" due to our abnormalities.

How has the reference for our perception of human beings become an improbable, if not impossible, imagination? This is a fundamental question which is less attended to when considering a being with a very wide and complicated genetic structure which makes him prone to many abnormalities a being who lives in an environment replete of animate and inanimate substances with potential pathogens. It is not possible that all the food we eat, the air we breathe, and the relationships we grow in from infancy to adulthood to be very healthy. Many latent pathogenic factors, latent killing genes, and abnormal cells exist in the inner environment of the body waiting to become active when triggered by an outside factor or a transient stop in the function of the immune system to create a comprehensive and even fetal disorder. There is never a time that we do not experience physical, psychological, or communicative disorders even in the slightest degrees. Therefore, we should always negate the real human being to prove the impossible human being. What a surprising deception! What a great destruction!

The modern myth of auspicious painless time without any illnesses has been accepted in public and health discourse. Nevertheless, this image has been criticized by medical anthropologists and sociologists in recent years. Foucault explains that:

"The years preceding and immediately following the Revolution saw the birth of two great myths with opposing themes and

polarities: the myth of a nationalized medical profession, organized like the clergy, and invested, at the level of man's bodily health, with powers similar to those exercised by the clergy over men's souls; and the myth of a total disappearance of disease in an untroubled, dispassionate society restored to its original state of health" (Foucault, 2003, pp. 31-32).

Foucault identifies this meta-narrative or the myth of a world without pain as the key concept for the formation of modern medicine discourse (Foucault, 2003; Shawver, 1998).

The fact is that these so-called dis-orders or diseases are actually an inseparable or even an evolutionary part of human order; that is, the real order of human condition not the presumed and abstract order of the utopian human being. Instead of accepting this condition and its systematic and realistic improvement and, more importantly, understanding the social and genetic evolutionary function of the disease, human beings, Don Quixotes-like, have engaged in a futile quarrel with these evil disorders. To present this quarrel as real and to free themselves of these abnormalities, human beings tried to project the abnormalities on demons or on those people who had them. They also rejected such people from society.

Hospitals, asylums, hospices, and poorhouses, which are usually utilized more than for their necessary care services, are just a small part of the mechanism for such rejection. However, more fundamental practices such as eugenetics or the elimination of those who suffer from hereditary defects and reproduction of those who are considered to have desirable and perfect traits were undertaken explicitly by Nazis in the previous century which led to great disasters (Buchanan, Brock, Daniels, & Wikler, 2001; Huxley, 1998).

One of the documents which indicates rejecting the physically, mentally, morally, and religiously abnormal to guarantee the health of the society is mentioned in the Zoroastrian book "Vendidad" which

commands to expel the humpbacked, lunatic, impious, and epileptic and those with mange, leprosy, and decayed teeth from God's cities or not to allow them to enter the cities since they believed such patients were diseased and stamped by Angra Mainyu (Satan) (Vendidad, n.d, Fargard 2: 29). For a healthy man, it may seem a mere rejection of the patients, but for the one who is suffering and threatened by the disease and for whom the disease is an inseparable part of his life, it is rejection of human being and human life.

Such mythical approach and this utopian intervention, which we know has existed in all cultures and eras from the past until today, is still a presupposition of modern medicine's knowledge and practice. In the current era, we still see that the most pervasive institution of health, the World Health Organization (WHO), defines health as: "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity" (WHO, 1948).

Taking this definition into account, does a healthy human being exist?? Is achieving such a condition possible? Myths are convincing, are simply accepted, and seem justified, fixed, and scientific to a great extent.

Absence of disease in its negative definition is sufficiently ambiguous and its occurrence is impossible in the course of life. In addition, it does not give us any picture of the state of health. The advantage of the modern definition, however, is that it can illustrate individual's health state and emphasizes biopsychosocial dimensions of life. Nevertheless, complete health is an absolutely abstract definition without any explicit instances; it is like null in mathematics (complete health) which is indefinable, but the deviations from this value causes the amounts (diseases) (Schwartz, 2000; Foucault, 2003; Shawver, 1998).

It is only in the last few years that we have witnessed discussions about health continuum as an extension of absolute health until death - two unreachable limits in life; the continuum that everyone, at any level of

the organization and at any time stands on one point of. In addition, the efforts of individual and society, are not to achieve the ultimate presumed limit, but to emphasize the process of continuous promotion of higher health. The baseline for higher health is an absolutely real and specific limit; that is, the current condition of individual's health (Leddy, 2006; Kiser, Lefkovitz, & Kennedy, 2001).

As it evident, at least now, normalization with all its psychosocial side-effects and destructive effects on treatment and research is not necessary or even needed; just as there is no need to presuppose a utopia to ameliorate the condition of society. History shows those who tried to create a paradise on earth, yielded nothing more than an arid hell. Nevertheless, those who improved the human conditions, achieved it through accepting the present condition, relying on realistic goals, and emphasizing the process of development and evolution.

Self-contemplation: 1. Imagine a human being who has been illustrated by biomedicine.

2. Investigate your feelings about such a human being.

3. Let this human being live in your mind for some time:

- In your opinion, where does he go?
 - What is his feeling about his life?
4. Would you like to be such a being?

Notice that you were such a being before, even for some time!

C. medicalization

A somnambulistic ogre or a reverse-working demon? The medicalized human being who was transformed into a peeled and trimmed subject for the science of medicine by the two mentioned processes, had the capacity to be converted into a completely medical product, and as you know, this occurred. The term medicalization which mainly goes back to the critical studies of two social philosophers, Ivan Illich and Michael Foucault, refers to the boundless medicalization process of all

aspects of life; the process which includes senility, death, menstruation, baldness, ugliness, shortness, boredom, anxiety, and addiction in the frame of the reference of medicine. When society is convinced that all of these are diseases, it offers its commodities and services to patients suffering from such diseases. Most often, society makes them understand that they cannot live without being supported under the umbrella or, better to say, in the greenhouse of medicine; at least they are compelled to think they cannot have a good quality of life or cannot live a worthy life. Naturally, mass media guides people into this atmosphere through cultural and economic control. Some of the cultural and social controlling factors can be seen in ads which show actors, actresses, and models having ideal bodies, old people who seem to be youths doing vigorous activities, and happy and blissful people are consumers of these drugs (Goli, 2004).

Illich thinks that medicine, like other social systems, is busy with counter productivity. showing many evidences, he explores how education actively produces foolishness, media produces alienation, and medicine actively generates illness (Illich, 1976).

He describes three levels of iatrogenesis or disorders caused by medicine; clinical, social, and cultural iatrogenesis.

Clinical iatrogenesis refers to pathologies caused by ineffective and venomous treatments and also direct side-effects of evidence-based medical interventions. These are the most well-known side-effects, but not the most important of the three. These undesirable medical interventions receive less criticism since they are representative of the limitation in our knowledge.

Social iatrogenesis includes the social outcome of medicalization. This term refers to medical claims supporting great employers, insurance institutes, dominating social systems, and drug companies for economic benefits which transform non-patients into consumers of medical products. Educational, research, and therapeutic

emphasis on services which are less effective on health due to economic reasons, deemphasizing more important issues such as health behavior changes, and ignoring the qualitative aspects of life are other instances of social iatrogenesis. As it is implied from the aforementioned discussions, a drug agency can hide and deemphasize those evidences which confirm its product is ineffective or dangerous, or pronounce the opposite claims as invalid by imposing hegemony over media and politicians. This represents only one pivot of the social iatrogenesis. Ideological, political, and economical biases of any kind are also included in this category. It is evident that when the greatest database for publication of medical articles, Elsevier, is one of the greatest selling agencies of weapons, such biases in guiding knowledge become completely predictable (Smith, 2007).

In Illich's view, cultural iatrogenesis is the worst form of all disorders caused by medicine since it does not help individuals reach psychological maturity and accept indispensable realities of pain, suffering, disease, and death by developing the culture of health. Instead, it helps them repress and deny such pervasive realities by fooling them and giving them latent or extravagant promises, and induces them to resort to medicine all their life instead of accepting these inescapable transitions in life. There is no day when we do not hear the news that medicine has won over disease and death. Every naïve individual, who hears the everyday successes of medicine, will trust and count on it to the extent that he soon believe in it to the extent that he thinks if he lives long enough, he will see a day medicine eliminates all diseases and consequently death on earth. We disregard the fact that biomedicine was not often succeeded in treating such common and pervasive diseases as cancers, hypertension, diabetes, and autoimmune disorders and has merely increased the duration of living with the disease.

These professional interventions with their

developed and expensive technology have had little role in increasing life expectancy, but have mostly contributed to preventive factors such as water, food, and environmental hygiene, general health, and prenatal and postpartum care, which of course, are not proudly introduced as services of medicine by the media (World Health Organization, 2004; Santrock, 2007). Moreover, we do not address the qualitative aspects of our life; happiness and faith are severely decreasing and depression, increasing with a big epidemic leap, has become one of the most important reasons of debility and death in the two last decades (National Institute of Mental Health, 2010).

Day by day, we see less people who as powerful adults and conscious individuals, replete with the zeal for life accepts death with a dignity deserving human being while are surrounded by their loved ones. Instead, more people prefer to die in the hospital with costly and futile expenses, fear, and inferiority; an event which has become a social tradition (Gilbert, 2001).

Perhaps, some, like Illich, see medicine as a reverse-working demon whose systemic characteristics have caused it to act in the reverse direction of its aims, and others see it as a somnambulistic ogre who does not know where it is going and crushes human beings under its feet in its heedless movement.

That medicine is humanistic and life-oriented which, in addition to enlightening and helping people understand the truth, aims at diminishing pains. Such medicine helps individuals stick to their inclination toward higher health to be able to develop the fundamental qualities of their life - that is, happiness and awareness by promoting citizens' skills and abilities as much as possible and using interventions of health practitioners when necessary.

Can it be saved from the evil of medicine?

Say!

I take refuge to God of dawn

From evil of what he has created

Qoran, Falagh, 1:2

The evidence I have brought from Falagh sura in Quran shows that even God's creation is not without evil! But it is possible to distance oneself from the evil or at least not to actively attend to it. Considering God's confession, we can expect that a knowledge system which tries to be in harmony practically and scientifically with nature, and specifically with the nature of the human being inevitably is a mixture of venom and elixir.

As previously mentioned, our criticism of biomedicine is not the claim that it is not moderate, without side-effects, and always invigorating like heavenly gifts; our criticism is that today, we, as health practitioners, and we, as citizens, need to contemplate the following issues:

a. Why do we continue our utilitarian or negligent practices when researches have confirmed that providing education, housing, job opportunities and altering health behaviors are much more effective than treatments based on exclusive technologies?

b. Why do we still resist confirming scientific evidences which imply that sociocultural factors are critically influential in health?

c. Why do not we replace the idealistic human being with the real one, as the basis of medical practice?

d. Why do we sacrifice the zeal for life for the sake of lifetime?

e. Why do we assume that every defect in our body is a defect in the whole of our being? Cannot this defect be regarded as an evolutionary source for the individual and our species?

f. Do this materialistic attitude and the current inferiority of human condition have nothing to do with the belief system of biomedicine?

g. Is it time to institutionalize a humanistic medicine; a model which does not reject all diverse levels of human organization for the same reason, respects the rules of each level and makes intentions, experiences, qualities, states, and, in general,

lifeworlds more clear and achievable in the fields of medical knowledge and action?

Therefore, it is evident that our discussion is not about undesirable and inevitable side-effects of biomedicine but the systematic theoretical, practical, and, in other words, more dramatic biases of active regeneration of evil while there are many evidences - not to mention disorders caused by avarice - that most of these biases are revisable at macro-levels of programing, education, and policy.

Considering what has been said about today's medical human being, it can be implied that nothing has remained from man other than his shape, social function and, of course, the number of his life years. If the man believes this image of himself - which he has believed in it to a great extent - it is natural that his God would be nothing more than money; money in the sense of the potential to reach loved objects which can complete this incomplete object and improve its form, function, and permanence in a way.

Therefore, the dominance of economy on biomedicine is not merely tentative, but it is deeply rooted in this models' materialistic nature and is closely related with its knowledge and practice structure. It should be acknowledged that physicians or institutions which give priority to their own health and spirituality and those of their clients over economical and guild desires, have ventured on a very hard, spontaneous, and, even, revolutionary deed.

Therefore, each block formed in this crooked mold, which views the human being, as a disintegrated and absolutely materialistic being is crooked and, as Nizami Ganjavi (1141-1209) says, *a new block should be made in a new mold*; a mold which describes and manages man in embedding of his dynamic and live relationships; a mold which is called communicative network against biomechanical framework of medicine.

Today, to have a picture of an individual, there is no need to keep him motionless for hours or days in one state to draw the details of his expression in only one position which he is

mostly representative of. Today, we can take pictures of man by powerful cameras in any state or videotape him. In the past, in Foucault's words, it was only death which provided a detailed study of the body and we were practically obliged to generalize our knowledge of the dead body to the living one. Nevertheless, I believe, in line with many experts of medical philosophy and ethics, that today we can analyze human being not as an organized and purposeful collection of parts but as a multidimensional, intentional, and meaning-making communicative matrix which is a member of other larger macro-communicative matrices and is representative, motivating, and, sometimes, producer of these matrices. Signs stream through different physical, biological, psychological, social, and cultural levels and every human being is a unique combination of all these relationships and, of course, is dynamic along with time.

The identity of this being is not explained through the formal differences of its parts but through its specific relational system. At first glance, this description may seem a little confusing. However, it becomes believable when we try to extend and clarify this definition and analyze the human being as a generative network of signs and illustrate the formation of particles, energies, meanings, feelings, thoughts, behaviors, and most importantly, intentional and conscious actions in this network and show how the matter-energy-information-consciousness stream can organize itself in a more healthy and more economical way.

It is evident that consciousness is the most bizarre and disparate element of biomedicine and, of course, the most important reason for this model's inability to tolerate man with all his dimensions. Tolerating the mind - as the phenomenal world - is also almost impossible for biomedicine. Including consciousness as a property which makes reflection, selection, and conscious action possible collapses the deterministic and reactive order of biomedicine altogether. The feeling of being harmed by this systematic

and pervasive bias culminates to the utmost when we understand that this factor can alter not only our interpretation of and our feelings towards ourselves and our health, quality of life, client-therapist relationship, and health and disease behaviors but physiological and pathological cellular and molecular processes (Kradin, 2008).

Therefore, if we want to specify a point of departure for this study, we should say that although biomedicine has provided the widest and most exact set of knowledge to this time, from the subpersonal organizing levels - atomistic, molecular, cellular, of tissues, and vital systems - is by no means sufficient to explain personal and suprapersonal levels such as family, culture, and ecosystem.

Briefly, for medical discourse to dispense with this ontological, epistemological, and methodological isolation, it needs to build a systemic and wise connection with other realms of human knowledge toward all dimensions of health (Turner, 1990; Ainsworth-Vaughn, 2001; Fleischman, 2005). In line with this, we try to utilize today's valid systemic models such as biopsychosocial and biosemiotic models and at least provide an outline for the actualization of a communicative model in medicine; a model which can be the host of a real human being with all his aspects and can investigate health from molecular communications to cross-cultural relationships even though, like any other theoretical or clinical system, it does not have the capacity to include a real human being.

Conflict of Interests

Authors have no conflict of interests.

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