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Autor: María Grace Salamanca González

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Instituto de Estudos Filosóficos
Departamento de Filosofia, Comunicação e Informação
Faculdade de Letras da Universidade de Coimbra
3004-530 COIMBRA, PORTUGAL
http://www.uc.pt/fluc/uidief |
iestudosfilosoficos@gmail.com

Care as the human condition

María Grace Salamanca González

Summary: Human beings, and their lives, are impossible to be understood without otherness. It is only in the contextual, particular and historic interactions that we can try to comprehend society. Changing our point of view to understand the world is not only desirable due to its theoretical accuracy, but it is also urgent for its moral, ethical, and political implications. Nonetheless, we have a philosophy built on an individual anthropology, rooted on independence and autonomy as inner conditions, which leads to individualistic epistemologies and ethics, and, therefore, to the naturalization of privileges and inequalities shown; for example, in our visions of health, sickness, attention, or inattentiveness´ dynamics. In this paper we will explore come consequences of accepting the ontological foundation of the ethics of care for biomedical ethics, focalized on examples from the Mexican research laboratory: Actores Sociales de la Flora Medicinal en México.

Keywords: ***Relational ontology, ethics of care, biomedical ethics, relational politics, founded theory.***

La justicia, la democracia, la paz y los derechos humanos están derogados y negados para la mayoría de la humanidad, sin esperanza o proyecto de que la civilización, el progreso y el desarrollo signifiquen una alternativa para resolver los problemas. Pablo González Casanova

Justice, democracy, peace and human rights are revoked and denied for most of humanity, without hope or project that civilization, progress or development will mean an alternative to solve problems. Pablo González Casanova

The ethics of care from its beginning has questioned, based on life as it is lived by women, some of the principles that construct philosophical approaches to morality. Today, I will take only one of those concepts to be studied under the scope of the work we do in the research laboratory in México[1].

There, working with anthropologists, physicians, and biologists we have faced some ethical, epistemological and philosophical questions, all of them born from the exigencies of reality and they demanded practical and immediate answers. What is proposed here follows the methodology of founded theory, which will start the philosophical reflection based on empirical work (Flick 2007, Corona, S. & Kaltmeier, O. 2012, Rodríguez et al. 1996).

[1] The Program is called “Actores Sociales de la Flora Medicinal en México” within the Instituto Nacional de Antropología e Historia. Website: https://pasfminah.wixsite.com/misitio

I will share some examples, as to why it is desirable to think biomedical problems from the ethics of care´s perspective, in particular, and why it is desirable to think of reality from a relational perspective.

From an individual to a relational ontology

Through the history of philosophy, we have different ways of understanding what it means to be human, and we can simplify the image by taking two approaches: either we think of the human as an isolated, grown up (male in most of our models) and we start there all of theories (what he is, what he can do, what can we demand of him, etc.), or we question the male auto-sufficient model as the starting point of our reflection. In other words, when we picture this "human" in our heads what does he look like? Is she able to be alone in the picture?

The ethics of care questions our initial model. If we have to imagine this "human" she will have to be able to explain the babies, the kids, the women, and the elderly. Soon we will realize that maybe "theoretically" we can think of them isolated, but in reality, no one can sustain, on her own, her existence. Therefore, in order to explain what the human condition may be, we are sent to rethink our idea of the "human model", and then, to question its fundamental ontology, the fact that we talk about humans as insolated, independent entities (Tronto 1993, 2013).

Nonetheless, most philosophy is rooted on an individual ontology (with its adult male as human model), in which we can see it implicit throughout history, in the classic debates on empiricism vs rationalism and the individual of the social contracts, etc. We establish the norm of "one human", and by the facts, we think about him as isolated, as self-sufficient. Then, we build epistemologies, ethics, and politics with him as a model (Clement 1996).

One of the first steps of the ethics of care is to question that model: genre, age, and the very fact that we believe he/she is able to stay, to live, on her own. I will not elaborate on how this relational ontology is conceptualized, because it has been done precisely through the history of philosophy (Levinas 1997, Held 1993, 2006, Tronto 1993); and because at the end, we can "theoretically" agree or not with their statements, which are based on axioms necessarily. What I want to share with you are some empirical, field examples, in which it is shown that this shift in our perception (from an individual to a relational ontology) can help us to better understand and respond to the biomedical problems we face.

I would like to mention that the bridge between ontology to field work has still some parts waiting to be built, ones that we need to make the path clear and explicit. A relational ontology demands a relational epistemology, anthropology, ethics and politics. This coherence is not only necessary for theoretical accuracy, but also if our claim is to answer reality, we need this clarity to face the always changing and demanding circumstances we face and to be fully responsible for our decisions.

The ethics of care, for their consequences

Why are we sick?

We all have had the experience of being sick. Therefore, we have asked ourselves the causes of our suffering. In this first example, we can approach the understanding comprehending the disease as aleatory, as contingent and particular, or we can see it in a relational perspective, asking ourselves if in any given community am I the only one presenting the illness.

In our current medical theories, we share the assumption (based on empirical information) that groups of people sharing territories, water, hygiene habits, language, gastronomy, and culture tend to share diseases as well.

We can aim to answer the root of disease for an individual perspective or from a relational one. In the research program we have tried both, and I would like to share some experiences regarding the second one. We follow a sociocultural epidemiological approach to reality, which establishes bounds not only with various medical disciplines, but claims for transdisciplinary (Hersch Martínez 1992, 2013).

When we are working with a community to co-create better understanding of their health problems, we do one dynamic that involves working in teams to draw the "tree of disease". As imagined, we start with the leaves, which in this case show the health problems the community is facing. During a second moment, we ask them to discuss what may be the cause or causes for those problems (the tree trunk), but we do not stop there. Next, we ask them to question the causes, one more time, to find the roots, which are normally hidden but sustain the tree.

1. Image taken from the photographic collection of the Mexican research program "Actores Sociales de la Flora Medicial en México"

In the image, we observe the problems this community is identifying are: dengue, respiratory and intestinal infections, and pollution. The principal cause they found is the lack of a proper sewer system, and when asked for the cause, they answered: lack of interest, lack or organization, lack of a vigilance committee, and because of the division created by political parties.

We can see in this example that when we ask our participants for their very personal and biological problems, with some reflection, we can see they are shared and very soon they get interdisciplinary, leading to political roots.

There are some remarks to be made about this exercise. The first, refers to the socio-cultural shared nature of our problems, and how its irruption in the public sphere and discourse opens ways to political engagement and action. The second, refers to the epistemological implications. Who has the explanation on health problems? Who has the last word? What changes if we change our comprehension of disease from individual to relational? (Hersch Martínez 2000, 2013, Hersch Martínez & González Chévez 1993, 2011)

In this example, the shift to a relational comprehension is made by changing our perspective from the individual to the community, but it is not the only way to do it. There are important movements in medicine to understand one individual disease not only in its biochemical substrate, but also to incorporate the sociocultural context of that person and their experience of the processes, which will be further elaborated in the next example (Hersch Martínez 2000, 2013, Hersch Martínez & González Chévez, 1993 2011).

Attention and inattentiveness dynamics

When in the doctor's office, and asked what is wrong, or when did the disease begin, how do we know when to start? How do we establish the relationships and causalities to explain our current state?

This individual ontology has led to individual epistemologies and anthropologies that judge unnecessarily to elaborate on the social circumstances of the individuals and to the essentialization of diseases. In medicine, it is predicated that current events have one direct cause, in the recent past, and are able to be traced by biology or chemistry alone.

Even if we accept that epidemiology is an actual branch of medicine, in our treatment of patients we deal with them in individualized manners, and with almost no attention to their lives, histories, and habits. This fact has many faces and could be studied from many perspectives, in which the theory of complex thinking (Morin 2000) has a lot of literature on the topic. I would like to give two examples.

The first has to do with a publicity ad, located in Mexico City. It was the announcement for one public clinic and had the logo of a famous soda company, not only that, but also the waiting room of that same clinic had all chairs sponsored by the same enterprise. Therefore, should we take into consideration the social habits of humans to understand their health conditions? In this case, is it relevant, to the public health of a country, the elevated consummation of soda, when diabetes is one of the biggest problems? Or should we consider the disease as particular and isolated in an individual?

This example highlights one key aspect, which is decisive to the prognosis of a patient what we consider “a cardinal factor”, and how we understand causality would have a determining effect on the therapeutic choices; in addition, the very simple decision of whether to consider an isolated individual or not, will change the whole picture.

The second example has to do with our political regulations and their consequences on the individual health experiences. In Mexico, we do not have a current and effective regulation on how pesticides are stored, sold, and used. As a result, it is a manner left to individual free choice. Does that political gap have an impact on the environmental and health problems of populations, or not?

In other words, when deciding whether to consider things from an individual or relational perspective we are implying a certain epistemology, which will allow us to hierarchize, discriminate, and decide. Furthermore, part of what is at stake is precisely the hidden decision/ imposition of what is at stake (De Sousa Santos, 2013).

Invisible actors

Considering biomedical ethics from an individual perspective also obscures the fact that no one suffers alone. No one is ill on their own (Pierron 2010). Given our relations to others, we are always situated in a way that what happens to us affects others, regardless of whether or not it actually changes their conducts.

This analysis, as the others, can be seen in many examples, and, again, I will focus only in one perspective. The fact that nobody treats themselves alone given the fact that there are others surrounding us, taking care of us (Held 2006, Tronto 2013).

In the research program, another dynamic done to show this is to gather people to think together about their medical conditions, with three questions as references: What are we getting sick of? With what are we being treated? And who is treating us?

In many of these communities we are able to confirm that they are not only recognizing the role of the doctors, nurses and biomedical personal, but also the *other* caregivers, such as their moms and grandparents.

The individual ontology hides the possibility to see how the others are affected by what happens to us. It emphasizes how we are independent and should not be affected by others, nor seeing affection as a sign of weakness (Held 1993, 2006, Tronto 1993, 2013). From this perspective, if my son, mother or husband is sick, that should not have any influence on my job schedule or performance. We have heard enough of how we are supposed to put our lives (and relations) on hold at the entrance of our office.

Further implications: The role of laboratories and our medicine by analysis

This individual ontology does not only affect our comprehension on the human condition, which can be materialized in its implications surrounding health, sickness and death, but it also affects the production of knowledge employed to understand diseases.

Another branch to be developed is how this assumption of one thing is able to sustain itself has affected our understanding of organs´ functioning, and on how virus and bacteria work. As if they were able to be conceptualized in isolation, and as if the assumptions made in abstraction were able to be applied in the cultural implications that surround the phenomenological experience of pain or illness.

We should be aware of the number of spheres affecting our life and their implications on how we decide what to take into consideration and what to ignore as a non-determining variable. In the case we are studying, is it relevant that most of the clinical trials are funded by the private sector? Should we consider the role of pharmaceutics in the construction and publication of medical knowledge? Is it important to incorporate in our researches the presence of pharmaceutical agents in hospitals and doctors´ offices? Should we incorporate the ties between this production of knowledge and the edition of books for medical education? In short, what is a "reasonable reduction" of a problem and how will the simplifications affect the outcome? What interest tend to be hidden and which intentions or finalities? (Hersch Martínez 2000, 2013)

Conclusion

In Latin-American public health there is a concept to show the consequences of inequalities on our health paths, which is called "preventable deaths", referring to deaths that with our current knowledge and technology should not have occurred, and if they did it was out of "other" sociocultural dynamics affecting them, such as long distances to get to hospitals, lack of proper materials or personnel, lack of the economic resources to buy the treatments (Hersch Martínez & González Chévez 1993, 2011).

There is the field of action and power of the ethics of care, due to the fact that its relational perspective makes it possible for a complex decision-making process, because it sets the field for relational epistemologies and ethics (Corona, S. & Kaltmeier, O. 2012). By emphasizing the importance of relations, we are able to discover and create new answers to the urgent challenges we face in our world.

The ethics of care invites us to include more voices to our official stories (Adichie 2009), and it is through those stories that shape our world and our decisions. By accepting that invitation we can hopefully create a world where all worlds are possible. By taking that invitation we may be taking one step towards a world where each one can be their preferred identity in the voice they chose to represent, a world where true diversity is achievable, not only for the individual, but also for the societies (Enríquez 2002, Enríquez 2013); the ethics or care may be an alternative to achieve justice, democracy, peace and human rights in our world.

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