Viewing a Person Through the Body: The Relevance of Philosophical Anthropology to Medical Education

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Although the revival of medical humanities in the past three decades has emerged primarily in the US and the UK, continental Europe has a strong tradition in espousing the medical humanities, such as by advancing the anthropological movement in medicine and philosophy. In this paper, we argue that philosophical anthropology deserves a separate focus in medical education from medical ethics and philosophy of science.

The focus of the paper is on the philosophical aspects of the human body to view a person 'through the body.' First, a short description of the anthropological movement in medicine is discussed, including its central motive 'to introduce the subject into medicine.' Next, the ontological and moral relationship between the person and his or her body is addressed. Drawing examples from anatomy, a so-called hemicorporectomy, organ donation, and aesthetic surgery, the concept of bodily integrity is expounded. These ideas can encourage medical students to discuss their own moral experiences during medical training and should be taught to enhance their philosophical understanding of medicine and health care.

Key Words: Philosophy, Bioethics, Personhood, Human Body, Education

INTRODUCTION

Doctors must acquire a great deal of medical and behavioral knowledge before they can enter medical practice, but they also have to develop a philosophy that regulates the way they communicate and apply this knowledge to the people they are treating. All the human elements involved in the understanding and practice of medicine have to be brought together, and this integration is a central goal of the medical humanities [1].

Although the revival of the medical humanities in the last three decades has been centered on the US and the UK, continental Europe also has a strong tradition in the medical humanities, including the so-called anthropological movement in medicine.

At the moment, medical ethics is the major element of the medical humanities content of the medical curriculum. In this paper I argue that philosophical anthropology deserves a place in medical education alongside medical ethics and the philosophy of science. There is a necessary connection between our understanding of the
nature of human beings and our understanding of the principles of morality. Philosophical anthropology tries to understand what a human being is, while ethics focuses on what a human being ought to do. These two areas cannot be separated, as I will try to explain in this paper.

I will focus on some philosophical aspects of the human body with which I am familiar and which are relevant to medical education.

This involves trying to view the person ‘through the body’.

This paper is meant as an introduction to medical-philosophical anthropology. Because it is concise and schematic it cannot cover the more detailed philosophical problems, so I have added an extensive list of relevant literature which could help the reader to acquire a deeper understanding of this discipline.

First, I will give a short description of the anthropological movement in medicine. Subsequently, in the section ‘Person, Body and World’, I will deal with the ontological relationship between the person and the body, taking dementia as an example. Then, in the section ‘Bodily Integrity’, I will focus on the moral relationship between the person and his or her body, taking some episodes of human anatomy, a so-called hemicorporectomy, and the uprightness of human beings as examples. Finally, I will draw some conclusions about medical education.

The Anthropological Movement in Medicine

Medicine has maintained a long-standing dialectical relationship with philosophy. In broad terms, one can distinguish three episodes in the history of the 20th century philosophy of medicine [2]. In the epistemological phase (1900–1925) all kinds of philosophical presuppositions of medicine as a science were discussed. In the anthropological phase (1925–1960) the focus was on medicine as a practice involving the personal interaction between doctor and patient. In the ethical phase (from 1970 onwards) researchers concentrated mainly on ethical problems.

The anthropological phase consisted of a new movement in medicine which coincided with the emergence of philosophical anthropology in Western Europe.

The anthropological movement in medicine consisted of a group of mostly German (and some Dutch) physicians who supported the idea of an anthropologically oriented medical science and medical practice. Well-known representatives are Viktor von Weizsäcker (1886–1957), Ludwig Binswanger (1881–1966), Erwin Straus (1891–1975) and F.J.J. Buytendijk (1887–1974) [3,4]. If one were to summarize the central motive of the anthropological movement, it would be with the phrase ‘to introduce the subject into medicine’ [5]. This slogan also has methodological, conceptual and medical practical implications [6]. It means that the human subject must have a place not only in the theory, but also in the practice of medicine.

Anthropological medicine is also called ‘specifically human’ medicine. In discussing ‘specific humanity’, Max Scheler (1874–1928), one of the founders of the discipline of philosophical anthropology, distinguished between two concepts of the human being, the one being empirical biological, the other philosophical [7]. The first one is a natural systematic notion in which human beings are a part of the natural kingdom and described in terms of their specific biological characteristics – the upright posture, the naked skin, and the frontal position of the eyes. The second is a so called essential notion of a human being, which in Scheler’s philosophical anthropology implies that human beings as spiritual
beings have a special position in the universe that is entirely different from that of any other animal. What is important to note here is that for anthropological thinkers these two approaches to understanding human beings are strongly interrelated. The so-called essential features of being human cannot be considered in isolation from biological characteristics, but are – in a sense – grafted onto them.

One of the most important themes of anthropological medicine and philosophical anthropology is ‘bodiliness’ [8,9]. The common denominator of various anthropological views of human beings and the human body is the rejection of a Cartesian dichotomy between the body, conceived of as a material, mechanistic structure, and the soul or spirit, conceived of as an immaterial substance [10]. The anthropological thinkers did not reject the notion of an objective body altogether, but argued that there are other, more fundamental approaches to the human body. From the anthropological perspective the body is not considered as a material object, but as a lived, animated and subjective body. Maurice Merleau Ponty (1994) talks about the ‘lived body’ – that is, the subjectively experienced body – as our access to the outside world and as the world’s access to us [11].

Another central notion in the anthropological view of the subjective body, is that there are as many subjective bodies as there are different subjective experiences of the body, or different bodily activities. According to Von Gebsattel, human beings have a working, marching, fighting, athletic, dancing, and sexual subjective body, dependent on the situation [12]. These various situations transform our experience of the lived body as we stand up, sit down, or lie down etc. Emphasizing the multiple aspects of the subjective body, the anthropological thinkers stress the importance of approaches to the human body other than the purely medical scientific ones, by including – for example – the aesthetic and moral aspects. They try to apply these alternative viewpoints to medical science and practice.

## Person, Body and World

There is a huge literature about what we mean when we say someone is a person. In the Anglo-Saxon tradition the emphasis is very much on psychological criteria such as rationality and consciousness. In this context, Hughes talks about the ‘Locke–Parfit view of the person’ (LP view), because John Locke and Derek Parfit have contributed much to the development of this view of the person [13]. This so-called LP view of the person has been criticized by many authors. Instead of recapitulating the various arguments against the LP view of the human person, I will focus on the alternative, for which Hughes has summarized the outlines. This is the so-called situated-embodied-agent (SEA) view of the person. The SEA view regards the human person as an embodied agent embedded in history and culture. According to the SEA view, the person is best thought of as ‘a human agent, a being of this embodied kind, who acts and interacts in a cultural and historical context in which he or she is embedded’ [13]. This point of view has been mainly developed by French continental thinkers such as Jean-Paul Sartre, Maurice Merleau-Ponty and Paul Ricoeur. The key elements of an existential phenomenological view of human beings is that their bodiliness is embedded in a specific situation and historical context. Human beings are ‘embodied selves’ who create their own world.

### 1. The lived body

The lived body is the body as it is directly experienced [11]. It is immediately and often unconsciously, felt,
sensed, tasted, heard and seen. The lived body is the expression of one’s existence and is concretely lived in by oneself. It is through one’s lived body that one manifests oneself to the world. Whether we are consciously aware of it or not, the lived body is present as a ‘true companion’ in our personal existence. The lived body possesses its own knowledge of the world, which implies the existence of a ‘tacit knowledge’ that functions without conscious control. On a subconscious level my body provides me with a lot of information about the world.

This Merleau-Pontian idea of the lived body can be further explained by the metaphor of ‘the body as a text’ [14]. The human body can be seen as a subject, that is, as an interpreter (writer or reader) of texts, and as an object, that is, as a text to be interpreted. The body is a subject of experience when it functions as an interpreter in its own right, when it speaks for itself. The body interprets not only itself, but also everything in the outside world with which it is confronted via the senses. This is what Merleau Ponty means by the notion of ‘tacit knowledge’. The content of these bodily interpretations of the world does not necessarily need to be known by the person. The human body may be considered the author of a text, but also the reader of the text that is constituted by what is happening in the outside world. The body is an object of experience, when one experiences one’s own body. In these situations, one is more or less aware of one’s own body, which can then be described as a text to be interpreted. Then the person, the I person or another person, is the reader.

2. Sedimentation of personal habits in the body

Many contemporary authors have elaborated on the concept of the lived body [15]. I will mention only two of them, whose theories are relevant to an understanding of the relationship between person and body in cases of severe dementia.

According to Cspregi [16], there is a dynamic and complex relationship between the human subject and the world, a relationship in which sensing and moving, space and time, reason and emotion, capabilities and opportunities are intrinsically related. ‘Just like the heart in the organism, the living body is the source of an irreducible, autonomous, and creative dynamism, indispensable for the multiple relations we entertain with the world’. Our past experiences, the painful as well as the pleasant ones, are ‘inscribed in the body’.

According to Matthews [17], a person cannot be defined in terms of consciousness alone, because consciousness cannot exist on its own. Being the person we are cannot simply be equivalent to thinking I am that person. It is rather the other way around. I can think of myself as me only because I am me. Persons are beings who express their subjective thoughts, feelings and so on, in bodily form, in speech, in gesture, in behavior, in interaction with the world.

These physical expressions are subjective. The concept of the lived body implies (1) that personal life emerges from ‘prepersonal’ bodily existence, and (2) that our bodily existence has to be understood as the expression of our individuality. Our individuality expresses itself not just in the communication of language and consciously recalled experience, but also in our body language, our habits of behavior, our characteristic gestures, and so on. What still remains of a person, when conscious and explicit experiences are gone, is all that originally had been conscious and reflective, but has subsequently been ‘sedimented into habits’ [17].

Matthews gives a nice example which can elucidate what I mean by ‘viewing the person through or behind the body.’ He talks about an elderly woman with dementia who recalls little of her past life and is barely
aware of where she is now. Nevertheless, one part of her past that she still retains is her ‘ingrained sense of politeness,’ which is expressed in certain of her spontaneous ways of behaving. For example, she still recognizes, if not in her conscious memory, the need to keep a conversation going, the importance of not allowing an uncomfortable silence to fall. This recognition leads her to fill in with something to say even when she has lost the thread of what she was saying earlier. For those who have known her for a long time, this familiar characteristic is a part of what makes her the person she is, a surviving fragment of a once much richer identity. In persons with dementia some of their adult individuality survives in the habits of behavior which have become ‘consolidated’ in the course of their development to adulthood and beyond.

What struck me in this case is the idea of a consolidation of earlier personal habits and characteristics in the body. What do we mean when we say that a character trait, individual preference, or previous experience has been consolidated in the body? Can certain behavioral patterns be interpreted as a kind of ‘bodily autonomy’, which is a remnant of what once was ‘real’ or ‘rational’ autonomy?

3. Bodily autonomy

Though there are many conceptualizations of the term autonomy, it is usually thought to have close ties to the concepts of decision-making capacity and competence. It seems as if autonomy and the body belong to two entirely different categories. Yet there are authors who propose one or other form of ‘bodily autonomy.’

The first cluster of interpretations that can be found in the literature can be summarized under the heading autonomy of the person over the body. There the body is considered more as an object among other objects in the world than as the core of an individual’s own being. The self or person is – as it were – ‘disembodied.’ A common justification for the equation of bodily autonomy with control over the body is the idea of ownership. Following Ricoeur, one can distinguish between two senses of ‘belonging’: (1) belonging in the sense of what one owns or possesses or has, that is, ownership, and (2) belonging in the sense of who one is, or identity. This first cluster of interpretations is based on the first sense of belonging [18].

The second cluster of meanings of ‘bodily autonomy’ can be summarized under the heading autonomy of embodied persons. The idea of ownership and control over the body has been criticized from many different angles. Mackenzie articulates the concept of bodily autonomy in terms of the phenomenological notion of an integrated bodily perspective [19]. She argues that bodily integration rather than control over the body forms the basis of bodily autonomy. According to her, a person’s body belongs to that person in the second sense mentioned by Ricoeur, in being the basis of that person’s identity, rather than in the sense of ownership. The givens of human embodiment – birth, sex, reproduction, illness, old age, decay and death – are the condition of human selfhood. Coming to terms with these givens is part of the exercise of being an embodied person.

In the third interpretation of ‘bodily autonomy’ that I want to put forward, the body is considered to have more authority than in the two other interpretations [20,21]. Instead of referring to control over the body, I will use the term in the sense of autonomy of the body, analogously to the meaning of the term ‘autonomic nervous system.’ Although higher brain centres can control autonomic functions, the autonomic nervous system is not directly accessible to voluntary control. This means that some body parts possess an autonomy that can only indirectly be controlled by higher brain centres. The meaning of bodily autonomy that I want to put forward
is a combination of this biomedical notion of bodily automatism and the phenomenological idea of the lived body. Considered from this combined perspective, the human body lives its own life, to a high degree being independent of higher brain functions, conscious deliberations and intentions.

Tacit bodily knowledge is based on the consolidation of life narratives. Although automatisms are gradually lost, persons with severe dementia still have routine actions stored in their body. Behavioral patterns of persons with severe dementia may be interpreted as remnants of what once has been ‘real’ – that is, rational – autonomy. They have nothing else at their disposal apart from these bodily movements. Although the body in severe dementia increasingly shows dysfunctions, it still remains a lived body and a body in which previous forms of autonomy have been inscribed.

Bodily Integrity

From time immemorial not only the ontological, but also the moral relationship between a person and their body has been the subject of intense philosophical debate. The human body, living or dead, has a moral value surpassing that of non-living, vegetative, or animal ‘material.’ Much of the effort to regulate the medical and non-medical use of the body is embedded in a moral language of sanctity, dignity, and bodily integrity [22]. The question of the violability of the human body is fundamental to the practice and theory of medicine and health care.

I distinguish here between a body-oriented and a person-oriented approach based on the presupposition that the notion of respect for bodily integrity should not be identified with the idea of personal autonomy and control over one’s body.

The person-oriented approach is common in modern medical ethics and has been generally accepted in health law. It also appears in policy documents, in which it is argued that in showing respect for the integrity of the body, one shows respect for ‘the individual’s right to a personal life and to self-determination over the body’ [23]. What basically characterizes this (neo)liberal understanding of bodily integrity is that it emphasizes the duty of others to respect the integrity of my body [24].

The body-oriented approach is central to many religious (monotheistic) views of the human body, for example in Judaism, Christianity and Islam, but can also be found in, for example, classic Greek and Roman thought and the philosophies of Thomas Aquinas and Immanuel Kant. This approach primarily focuses on duties due to one’s own body rather than to those of others. From this perspective, the notion of respect for bodily integrity can be opposed to the idea of personal autonomy and self-determination over the body. The body-oriented approach implies that the human body cannot (entirely) be owned or controlled because it has a moral value of its own. Even if people are considered to be the owners of their bodies, they are not allowed to do everything with their bodies that they might want to.

‘Bodily integrity’ is a complex notion. In the literature one can find three clusters of interpretations: biological, subjective, and normative wholeness.

The idea of biological wholeness means that, although the human body consists of numerous body parts, organs, tissues, cells, and sub-cellular components, it is still an anatomical and physiological unity, an integrated whole that is more than the sum of its parts. Biological wholeness refers to the proper function of the body and its parts.

It appears that a violation of biological wholeness does not necessarily go together with a lack of subjective wholeness (and the other way around). It is well known
that people with various handicaps, including missing body parts, still feel ‘whole.’ Diane DeVries, an American woman who was born without arms and legs, but nonetheless had an extremely positive image of her body, once said: ‘I have always had my own ideal. From childhood on I have identified with someone who resembles me, the Venus de Milo. She looks exactly the way I do the stump of one of her arms is even shorter than the other’ [25]. She adds that she cannot imagine the Venus de Milo as she must once have looked, that is, with arms and legs: she is beautiful the way she is now.

The biological and subjective wholeness of the human body is also a normative wholeness. This means that the human body is characterized by dignity, sacredness, or intactness. Thomas Aquinas argues that each part of the human body ‘exists for the sake of the whole as the imperfect for the sake of the perfect’ and that a body part ‘may only be sacrificed to preserve the life of the individual’ [26]. Kant argues in the same vein [27,28]. A mutilation of the human body is permissible only if the intervention is necessary to preserve the whole body. According to Kant, one has not only moral duties toward oneself and other persons, but also toward one’s body: ‘So nobody may therefore voluntarily mutilate himself in the important parts of his body, and still less do so for the sake of gain, without lowering himself’ [29]. He continues by arguing that hair is not an essential part of the body since it grows back again.

1. Living and dead bodies

It is generally felt that a violation of the integrity of a dead body raises less aversion than a violation of the integrity of a living body. The living human body belongs to ‘some–body,’ to a living person who can be harmed by the invasive actions. Moreover, many adequate reasons exist to justify the violation of the integrity of the living body, the most important one being the well-being of the person. In contrast, there is less reason to perform invasive actions on a dead body. Moreover, in the case of a corpse, the person to whom the body once belonged no longer exists, at least not in this earthly life. There is no longer ‘some–body’ who can experience pain or who can be otherwise harmed. The deceased person might have given permission for or even explicitly requested that a particular invasive action be carried out on his or her corpse, but even then we might hesitate. Like the living body, the dead body also possesses an integrity that may be respected.

A dead body is a body that once was a living body, the body of a (perhaps potentially) human person. Even small body parts which are of recognizably human origin refer to a particular person who once was the ‘owner’ of these body parts. This also holds for non viable malformations of the human body. It may be difficult to recognize a strict human or personal element in these malformations, but these defective human bodies demonstrate a ‘promise of humanity.’ They once had the potential of becoming the body of a human person, but this potential humanity has not been (entirely) realized. We owe respect to a body, because the human body is, so to speak, a symbol of all mankind.

2. The closed and the opened body

When modern anatomy emerged in the late Middle Ages, it was accompanied by a paradigm shift in the attitude to the human body which encompassed not only a change in a cognitive and practical, but also in a moral attitude toward the body. This change has been beautifully described by the Dutch neurologist and philosopher Van den Berg in his book Het menselijk lichaam [30]. Van den Berg distinguishes between the closed and the opened body. The period of the closed body started with Galenic medicine in the second century and lasted until the fourteenth century. In that era the human body was
rarely dissected. The theory and practice of medicine were based on knowledge of the closed body. The era of the opened body started in 1316, when for the first time in medieval history – the anatomist Mundinus performed a dissection of the human body with the intention of seeing what the inside of the body looked like. A well known painting from the year 1345 shows Guido de Vigevano, one of Mundinus’ pupils, starting to open a human corpse. It is one of the earliest illustrations of a human autopsy.

What is striking in this painting is the relationship between the anatomist and the dead person. There is a sense of recognition between them. The anatomist knows the corpse, not intimately – as one might know a family member – but as a member of the larger human community of which the anatomist clearly feels himself a part. The anatomist gazes almost tenderly at the face of the dead person. He gently embraces the body he has started to dissect. His facial expression reflects a sense of hesitation, even apology, for invading his fellow human being’s bodily integrity. Obviously, Vigevano found it a strongly ambivalent experience. He clearly wants to start dissecting the human body, but it is as if he is asking the dead person for permission.

3. Hemicorporectomy

In another book, entitled Medische macht en medische Ethiek, Van den Berg shows us a picture of a so called hemicorporectomy, i.e., the surgical removal of the lower half of the body [31]. The patient is a 29-year-old man who shortly after birth had a meningomyelocele repaired and had been paraplegic since that time, unable to move his lower extremities. There was no sensory or motor activity distally from the spinal level L 1. The lower half of his body was considered ‘useless, a hindrance to any activity due to its weight and deformity’ [32]. Moreover, an extensive cancerous pro-
cess developed in a large decubital ulcer of long standing, overlying the entire sacrum. The doctors considered a hemicorporectomy a possible solution to the otherwise insoluble medical problems of the patient. The patient accepted the doctors’ suggestion. His body was literally cut through. The stomach, spleen, liver, kidneys and the upper part of the bowels were left. The bladder was elevated, turned upward into the anterior abdominal wall, and sutured to it. The other abdominal organs were removed.

Admittedly, hemicorporectomy is an extreme case of mutilation of the human body. Nowadays it is no longer carried out, since the progress of medicine has provided us with more effective and less mutilating solutions for medical problems like the one above. However, what we can learn from this exceptional case is that something like bodily integrity exists, which may function as a counterbalance to the medical need to be operated on and the wishes of the patient. Not every invasive action upon the human body which is medically possible and which corresponds to the patient’s wishes is morally permissible.

4. Moral experience of the body

If there is one thing we can learn from Vigevano’s incision and the patient with a hemicorporectomy, it is the hesitation and ambivalence which anyone who carries out an invasive procedure on a corpse or a living body may experience. The same moral hesitation is experienced by medical students at their first visit to an anatomy theatre to dissect a corpse, or the first time they give someone an injection, or make a surgical incision. In each case a threshold is crossed when the integrity of the body is violated.

Organ transplants can generate similar sensations. In a multi organ donation procedure, the human trunk is laid wide open, from the clavicle down to the pubic bone. As
never before in medical history, we can see the vital functions of an ostensibly living human body. Although the sight of the open, still functioning human body will not worry professionals such as transplantation surgeons, it would definitely be an intense moral experience for lay people. Thus, transplant medicine offers a critical opportunity to reflect on the meaning of our bodily integrity as well as on the way modern medicine may enrich or threaten our sense of ourselves as corporeal persons. Given the centrality of the body to clinical practice in general and to transplant medicine in particular, it also involves an understanding of bodiliness which takes serious account of the integrity of bodily life [33].

5. Human uprightness

In the introduction I argued that there is a necessary connection between our understanding of the nature of human beings and of the principles of morality, and that philosophical anthropology cannot be separated from ethics. The example of human uprightness can illustrate how – for anthropological thinkers – the so-called essential features of being human cannot be considered in isolation from biological characteristics.

From time immemorial upright posture has been seen as one of the essential characteristics of human beings. Biologically oriented philosophers such as Helmuth Plessner (1892~1985), Adolf Portmann (1897~1982), Erwin Straus and F.J.J. Buytendijk describe the human posture as specifically upright. In their view, human posture cannot be considered from a single isolated biological, anatomical, physiological or evolutionary perspective, because it demonstrates specifically human aspects [34].

In Straus’ view, everything in the structural plan of the human body is organized for and by the upright posture [35]. The upright posture involves a specific attitude toward the world. Standing upright establishes three kinds of distance: (1) distance from the ground, which enables us to move freely, but substitutes precarious elevation for the safer proximity to the ground of other animals, (2) distance from things, which allows us to confront those things and look at them from afar, (3) distance from our fellow human beings, which permits us to meet others ‘face to face’ in various social relationships. Upright posture essentially characterizes human beings and elevates them literally above other animals. Other animals share sight with human beings, but the human upright posture transforms seeing into beholding. All animals see, but not all are ‘bound to behold’ [36].

Straus refers to the fact that the German term ‘aufrecht’ has both a physical and a moral sense. This also holds for the English term ‘upright.’ He writes: ‘The expression “to be upright” has two connotations: first, to rise, to get up, and to stand on one’s own feet and, second, the moral implication, not to stoop to anything, to be honest and just, to be true to friends in danger, to stand by one’s convictions, and to act accordingly, even at the risk of one’s life. We praise an upright man: we admire someone who stands up for his ideas of rectitude. There are good reasons to assume that the term “upright” in its moral connotation is more than a mere allegory’ [37]. In Straus’ view, the moral sense of the term ‘upright’ is more than simply figurative. It is as authentic in its own way as is the physical sense. According to him, a human being must be upright in both senses of the word. Straus’ view is typical of the normativistic stance of many anthropological thinkers.

The anthropological view of human uprightness demonstrates the richness of a phenomenological approach of the human body. Man must be upright in the double sense of the word. This approach might enrich, for example, our understanding of patients with chronic...
low back pain [38] who find it difficult to adopt an upright posture.

CONCLUSION

According to anthropological thinkers, medicine is primarily an encounter between two people, patient and doctor. ‘To introduce the subject into medicine,’ is their key slogan. They make an effort to understand the typical human aspects of the human body and to see the person ‘through the body,’ and their writings illustrate our moral responsibility toward our own body and the bodies of other people. All these issues are relevant to medical practice, and in consequence—to medical education. They can help the student to place the theory and practice of medicine in a wider philosophical and ethical context.

Many medical disciplines focus on the human body, which—from the medical-technical approach—is an object that is to be manipulated. However, there are other (aesthetic, moral, etc.) aspects of the human body that are relevant to medicine. The notion of bodily integrity, for example, may help medical students to discuss their own moral experiences during their medical training ranging from a first anatomical dissection to acquiring specific skills as a surgeon. Aesthetic surgery and organ donation are examples of health care areas where the integrity of the body is explicitly at stake. All these approaches should be taught to medical students in order to enhance their philosophical understanding of medicine and healthcare.

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