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8  Plessner’s Theory of Eccentricity

A Contribution to the Philosophy of Medicine

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Although Plessner did not directly deal with medical anthropology or the philosophy of medicine, aside from some essays written during his youth, his ideas have certainly had significant influence on these two disciplines. His definition of man as a positional and eccentric being actually includes the concept of health, disease and the doctor-patient relationship, which has certainly contributed to the controversy in contemporary medical anthropology, influencing writers such as Gadamer, Jonas and Habermas.¹

Being a body, having a body: The lack of equilibrium in human nature

In his most important work, The Levels of the Organic and Man [Die Stufen des Organischen und der Mensch, 1928] (Plessner 1975), but also in Laughing and Crying [Lachen und Weinen, 1941] (Plessner 1982), Plessner stated the idea of human nature as composite, characterized by man's complex relationship with his own body. From birth, man is called upon to harmonize this contraposition between being a body and having a body as a physical object (Leib-sein and Körper-haben); between being in agreement with his own corporeality, like all the other animals, while at the same time never being completely in agreement with it, allowing a certain degree of external and internal distance. Indeed, thanks to a particular characteristic in his limit (Grenze), man is simultaneously “a body,” “in the body” and “outside the body” (Plessner 1975, 293). He is eccentric, which means that “he is confronted with his own existence as something he controls or expels, which he uses as a means or an instrument: he is within it and, to a certain extent, coincides with it. To man, corporeal existence is therefore a relationship, not univocal but twofold, between him and himself” (GS VII, 67).

¹ Cf. Gadamer 1993, Jonas 1985, and Habermas 2001. We have consulted the original work by Plessner and Weizsäcker. Therefore all quotations in the text have been translated from German into English by the author. The bibliographic references relate to German works.
This means that man can prove to be both, an object and the inside of this very object (GS VII, 75); not only a part of the outer world, but also that, which the outer world appears as; as a body as well as within the body. Certain human phenomena like laughing and crying attest strong emancipation in a person’s bodily processes and thus the precarious nature of this union. Nevertheless, man is like an animal that is bound to its physical existence, despite the conflict. “In man’s relationship with his body, this conflict is more frequently the basis of his existence; it is the source but also the limit of his strength” (GS VII, 63).

Struggling with this conflict is something that makes man completely different from other animals, as they cannot experience their interiority, and are not aware of their closure from the world; thus they do not need to overcome any conflict within or with the outer world. The animals’ being and having a body coincides. Their sense of being a body in the world is closed off entirely. It is not possible for them to perform something for which the instincts are not equipped and that could place them in a difficult situation. As Plessner stated: “donkeys do not venture on ice” (GS VII, 61), while man is constantly called upon to achieve his own oneness, to reconcile his being and having a body, what he is and what he wants to be, all of which he can never fully achieve. But it would be wrong to think that man must choose between these two aspects of his existence. As tempting as it may be to accept this dichotomy, the specificity of human life consists precisely in finding a harmonious balance between being a body and having a body:

If man cannot make a decision between the two aspects, that is, whether or not to relate to one centre, he must in any case find a relationship with both. But this relationship is not fully achieved in either position. Man is not just a body, nor does he just have a body. Every requirement in physical existence demands harmony between being and having; between within and without (GS VII, 69).

Downgrading to the animal level or upgrading to the level of angels are not practicable hypotheses. The compound nature of man does not allow him to reject or to embrace just one of the two poles, relating to one centre while ignoring the other one. This leads man to the constant search for his own identity, precariously balanced between being a part of nature or being outside of it; he is destined to expressivity intended as the original way in which he makes up for the fact that he never totally coincides with

2 If not in the definitivum of religion (cf. Plessner 1975, 364).
himself. Thus, expressivity does not only represent man's way of making up for his deficiency, but also the fundamental motion produced by history, creating a new cultural world, thanks to which nature discovers its true meaning. His constitutional lack of balance, and his needy, fragmented, exposed being, forces him to transcend towards another homeland, where his artificial and cultural actions finally allow this natural being to be in harmony with himself (Plessner 1975, 339).

The three anthropological laws: health and illness

Plessner's three anthropological laws clearly express this natural composition that man must deal with, highlighting the human condition is characterized by natural artificiality, mediated immediacy and a utopian standpoint (GS VII, 63). All of these concepts try to underline the work and tension that nature subjects man to. Such a characteristic is the source of all great cultural constructions, the origin of perennial ‘transcendence’ and the basis of all human evolution, but it is also man's intrinsic instability and precariousness, his groundlessness and structural alienation – even in his look (GS VIII, 93) – his being without a homeland (Heimatlos) and based on nothing. The two opposing poles immediately become dangerous and negative, should either of them be regarded as something absolute. To be wholly natural or wholly artificial, immediate or mediated, rooted or eradicated, any of these radical endpoints are bad for man's health. It is as if the balance he is entitled to as a human and eccentric animal were substituted by a balance he has no right to – that is, the animal balance completely absorbed by itself and its own environment, the pneumatic one, completely detached from its own body. “He cannot be entitled to unlimited openness to the world. This is only possible for one who were incorporeal or having a pneumatic body, like the angels described in medieval religion” (GS VIII, 187).

Partial openness therefore assures mental health and humanity in that it does not rule out reconsideration of one's own world, stopping man from disintegrating and from being held hostage by an unbearable opening. The third anthropological law, in particular, gives us a glimpse of the possibility of eradication of the utopian (or atopic) standpoint, which may somehow result in behavioural disorders. This law represents, more so than the other two, man's vulnerability, and his innate dangerousness, which consists precisely in total absorption in his centrality (or rootedness) or total loss of centrality (or eradication).
Taking man's structure, as we can deduce it from Plessner's anthropology, we can hypothesize not only man's ideal structure and health, but also his pathological predisposition and the type of vulnerability he is subjected to.

We could even state that the idea of health can play an important role in the understanding of man's anthropological statute. Health thus becomes a criterion of the human condition: this does not mean that eccentricity in itself is synonymous with pathology. If that were the case, we should claim that man as such is pathological. Instead, it is the typically human way of being vulnerable to disease and health that is closely bound to his eccentricity. Being able to exist outside of his centre gives way to new forms of imbalance and new ways of experiencing and managing such an alteration.

A healthy way to deal with one's body and the world would therefore be to manage how to balance the tension between the two poles, allowing both to coexist. A healthy man is he who accepts the "game" of life (Krüger 2000, 289-317) and manages to stay in balance between naturalness and artificiality, mediacy and immediacy, rootedness and utopia, without thinking he can find salvation by suppressing one of the two poles. The same applies to Romano Guardini's "polar opposition" and Simmel's "axial rotation of life" [Achsendrehung des Lebens], whose concepts Klages (Fischer 2008, 87-88) found he could compare to Plessner's eccentricity. This does not mean there is a universal standard for health: the balance between opposing poles can change according to each individual, his age, evolutionary phases, but even according to historical context. As Martin Buber (Buber 1947) pointed out, periods in history alternate: there are periods in which a sense of rootedness, of coincidence and of setting up a home prevail and periods, which may be open to risk but are also more creative, in which a sense of non-coincidence with the self and eradication prevail; such eradication can reach an extent that man experiences his relationship with himself, his body, his mind and the world around him in an unnatural, painful and unhealthy way. Indeed, health is not a statistic average between the two extremes, but rather the balance which comes from feeling well, and in this balance, as Gadamer said "we are resourceful, open to knowledge, forgetful of ourselves, and hardly feel overwork and stress" (Gadamer 1994, 122).

Thus, health is like a condition of intrinsic adequacy and agreement with oneself, which is truly only present when it is absent, that is, unnoticed. It is the feeling of immediate coincidence with the self, despite our mediacy; of naturalness despite our artificiality; of transcendence despite our rootedness. In this state of mercy, our body does not send us messages; ideas are no longer cumbersome and the world does not appear hostile, but actually quite friendly.
In conclusion, being healthy can be understood as mastering the dual situation of being a body and having a body without any major conflicts, to the point where we may even forget about the dichotomy. To conclude in Gadamer's words, it's like learning “to ride a bicycle” (Gadamer 1994, 170), a sudden establishment of balance, that hides, however, the constant effort it takes to reconcile opposing tensions.

On the other hand, disease awakes us from our peaceful co-existence with the world. When we are ill, the dichotomy is suddenly present and the previously evolved union between the self and body ceases. It is as if eccentricity, normally able to recognize the *Körper* and *Leib* as identical or united, weakened and allowed the two poles to become separated. The person's wholeness becomes fragmented. This occurs mainly in psychiatric illnesses; it is as if man were unable to maintain a balance between his *animalitas* and his utopian spirit, his eccentricity and his centrality. Man is temporarily defeated in his attempt to fit into the world through his dual nature. Dialectic in the three anthropological laws is temporarily suspended in favour of a spectrum ranging from a proliferation of possibilities to decrease in the distance from the self. This decrease in eccentric distance determines relative autonomy in the being body and the having body, which compromises man's connection with the world. The ill body and ill mind are different means of disturbing their peaceful co-existence. Through physical pain and suffering, man’s ill body and mind draw attention to the self until man is completely absorbed and goes back to coinciding with them. The “being a body” can expand until it coincides with the entire world, thus becoming the only experience one can sensibly talk about. In this case, it is the healthy counterbalance of the “having a body” that ceases. In the opposite case, it is the healthy counterbalance of the rootedness in a body that ceases (GS VIII, 213).

According to Plessner, disease in an eccentric animal is not just the analytical assessment of an alteration, that is, the measurement of diversity coming from the outside, but rather the deterioration of eccentricity, the interruption of “spontaneous” identity, the disappearance of balance, which can no longer be neglected. While laughter and tears represent temporary interruption linked to external events, sickness and pain reveal structural vulnerability within the eccentric being (Gadamer 1994, 62-63). There is a disturbing element, a symptom that makes us aware of our bodies and our minds, to such an extent as to make them inconvenient or troublesome. The reconciliation between being-a-body and having-a-body becomes a critical endeavour. Such a loss of integrity disrupts the normal ability to react and relate to the world; the entire concept of being-in-the-world is changed.
The common result is retrocession of one’s existence, a mutilation of future prospects. In any case, however strong the division and the tendency to be re-absorbed into one of the two dichotomies or to lose total union may appear, the ill person still maintains a part of his eccentricity, that is, a residual ability to distance himself from his own illness. In case of physical illness, the person tends to refuse his illness, making it foreign rather than recognizing it as his own, feeling as if “something were inhabiting him” (Spinsanti 1991, 79). He must free himself from it. In the case of mental illness, one’s distance from the illness becomes indispensable for the patient to recover, so that he does not identify himself totally with his psychic world. Just like man’s humanity allows him to distance himself from himself and thus become mentally disoriented, this human condition also assures that this disorientation is not definite or total. That which allows man to go mad also allows him to regain his sanity. This is one of the main assumptions in anthropological psychiatry.3

The limits of medical intervention: Habermas

Apart from the actual use Plessner derived from the concepts of eccentricity, being and having a body, and the three anthropological laws, they are all useful tools at the disposal of medical anthropology. More specifically, they seem to throw light on such controversial ethical issues, such as the doctor-patient relationship and the new frontiers of genetics.

The role of doctors and medicine is to guarantee harmony between being-a-body and having-a-body, to preserve the balance between each of the three spectrums: mediacy-immediacy, naturality-artificiality, and rootedness-eradication. Overlooking this means raising a number of ethical questions regarding the limits of medical intervention. Current questions regarding man’s ability to manipulate the human genome without compromising the patient’s dignity, arise precisely at the same moment when man himself becomes an object of manipulation. The absolute power of science to intervene on the corporeal aspect of life (to reduce man to his Körper) makes us forget that the artificial must be in agreement with the natural. In other words, that with which we are provided artificially (and which will be

3 Psychiatric anthropology originates as criticism of the notion of complete insanity. Supporters of this tradition besides Philippe Pinel are well-known scholars like Eugen Bleuler, Jakob Wyrsch, and John Strauss. Pinel who all support the notions of “nosodromic” and “partiality of insanity.”
an integral part of what makes us human) must enhance and not obstruct the immediate and natural being-a-body. When the body is modified genetically or with prostheses, it shouldn’t stop health from withdrawing into the background, or forbid artificiality to be natural. As Jürgen Habermas pointed out, “[i]nsofar as man’s body is part of this sought-after intervention, the old phenomenological distinction by Helmuth Plessner, ‘being a body’ (Leib-sein) and ‘having a body’ (Körper-haben) becomes extraordinarily present-day. The previous distinction between the nature we are and the organic features we acquire vanishes” (Habermas 2002, 15).

In other words, today we can acquire genetic features (Körper) that can change the basis of our future harmony between being-a-body (Körper) and having-a-body (Leib) and thereby limit our immediacy. We would then be in the presence of absolute supremacy over any potential artificiality (prostheses, genetic manipulation), which, becoming a natural part of man, would impose the conditions of balance in the future. In other words, in the future, ordinary human balance will be the result of the prosthesis or eugenics employed. Mediated artificiality will then determine the natural immediacy and therefore the limits of compatibility.

Despite that, Plessner asserts that man is an “[e]ccentric being, with no balance, no time or place, eternally exposed to nothing, constitutively out of his element, having to become something in order to find balance; he can only find it with the help of extra-natural things which derive from his creation” (Plessner 1975, 334).

In any case, it should not be forgotten that the ultimate aim of the supernatural is achievement of harmony, existing in a second nature, “tranquillity in a second innocence” (Plessner 1975, 334). If the objective is withdrawal from unbearable eccentricity, then any technical support should not assume the characteristics of what is merely produced by man, but what is discovered, that is, “the right move” (Plessner 1975, 345), allowing man to be in tune with himself and his world, giving way to new innocence. “His existing beyond must guarantee the vital immediacy between self and the surrounding field” (Plessner 1975, 350) deep down. The right move is the one in which reality, represented even by the human body, is not “submitted to the subject, conditioned by his own observations, experiences and calculations” (Plessner 1975, 358). It isn’t the counterimage of his possibilities, but the compromise – well known to doctors – between personal centre and reality itself. The move is creative and successful when “it manages to

4  Authentic self-realization is based solely on the unity of anticipation and adaptation.
adapt specifically to the objective world" (Plessner 1975, 345). This is also expressed in the law of mediated-immediacy.

Thanks to Plessner's assumption, the doctor traces those limits (to self-exploitation) beyond which the intervention is no longer ameliorative for the person, but becomes instrumental and arbitrary instead. These limits protect what Habermas called the “unreceptive and inviolable” nature of man (Habermas 2002, 23). If the critical phenomenon is the disappearance of the boundary between we are naturally and the organic features we give to ourselves, Plessner helps us understand that there is a limit we should not cross. In summary, we can say that we are the features we give to ourselves, but we give to ourselves the features that are in line with our nature. No intervention should be allowed to undermine the future possibility of an eccentric relationship, which is balanced between being-a-body and having-a-body; in such a relationship, the complexity of the body should not be perceived and health should somehow return in the background. This could be the case for all of preventative gene therapy approaches, and invasive therapies or prostheses. Such an assumption is also in line with the awareness of medical anthropology, which, since Weizsäcker (1986), has been trying to save the relationship between doctor and patient from the subject/object type of model.5

The doctor-patient relationship

The fact that medicine has progressively made man the object of technology (Technisieerung der Menschennatur) (Habermas 2002, 43) is evidence of an imbalance towards mediacy and artificiality, to the detriment of unity. This has had repercussions on the role of medicine, specifically for the role doctors play.6 Medical science tends to be undermined and absorbed by processes that make technology autonomous: the procedures employed when applying technique to the practice of medicine make any intervention and personal evaluation, in which the doctor and patient take part entirely, superfluous. Thus, it is technique itself that imposes the conditions to its application, freeing both the doctor and the patient from having to take part. Therefore, in the relationship between doctor and patient, an ontic or positivistic approach prevails, guaranteeing a scientific approach, but at

5 Refer to the four possible ways of interpreting the issue of the patient’s welfare covered by Pellegrino and Thomasma 1988.

6 Refer to the need for doctors to reconsider their notion of death in Jonas 1985, 120.
the same time reducing the patient to being merely an “object to be studied” (Jaspers 1991, 16-42). This approach confirms the notion that medical science tries to dominate and regulate nature and its course rather than re-establish health in a patient or restore his balance. Using depersonalizing technological equipment, introducing a single case in the general case history, reducing the individual to a species or just a bureaucratic file, etc., all these practices represent a gradual detachment in the doctor-patient relationship taking place in today’s society. Such a detachment conjectures disease as a quantitative alteration, health as *restitutio ad integrum*, the patient as an object of study and the doctor as a cognitive subject. This unbalanced medical practice makes such detachment necessary and even desirable so that any interference deriving from the doctor-patient relationship may be minimized. Weizsäcker regarded such a practice as negative, defining it as “therapeutic nihilism” (Henkelmann 1991, 17-75) in that, such an effect generates a “paternalistic” relationship model in which only the patient’s body is treated and the patient obeys, by behaving as is asked of him, putting his own personal unity aside 7. Reducing the patient to only being-a-body, in turn, brings the doctor’s sentient unity to a cognizant and objectifying aspect. The doctor only limits himself to treating the patient’s corporeal dimension.

According to this model, Plessner expressed the need for an epistemological change in the doctor’s approach to the patient and to life tout court. During his youth, he dealt with this issue indirectly in two essays dedicated to Driesch’s theory on vitalism.

**Sources of medical knowledge**

Between 1922 and 1923, Helmuth Plessner and medical doctor Viktor von Weizsäcker exchanged opinions on the pages of the journal *Wiener Klinische Wochenschrift*. Helmuth Plessner was then 30 years old and a *Privatdoz*ent (unsalaried university lecturer) at the University of Köln and Viktor von Weizsäcker was head of the Neurology Department at the Heidelberg Medical Clinic. The discussion was based on the debate on vitalism8 and

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8 Both had Hans Driesch as professor. Plessner continued with him and Max Scheler to achieve his degree when he meet Weizsäcker personally; he was his professor at Heidelberg.
included reasoning over the different cognitive meanings of *Erklären* and *Verstehen*. Plessner's categories and language were different from those used in anthropological philosophy. Nevertheless, these two essays have provided useful information that has helped us to better understand how Plessner's ideas have contributed to medical philosophy. In fact, their subject of discussion soon moved towards medical theory and its sources of knowledge. Both aimed at understanding, above all, how vitalism and its subsequent rejection of mechanistic reductionism modified a doctor's aims and work. The fundamental idea expressed in *Vitalism and Medical Thinking* [Vitalismus und ärztliches Denken, 1922] and in *On the Knowledge Source of Doctors* [Über die Erkenntnisquelle der Arztes, 1923]\(^9\) is that the acceptance of several fundamental principles related to vitalism (recovery of the body as a total entity (*Ganzheit*) rather than the sum of its parts; the inability to accept the mechanistic theory according to present knowledge (GS IX, 18); return to the idea of individuality force us to radically change the basics of general pathology (GS IX, 7) and the way doctors relate to their patients.

According to Plessner, a body must be perceived by the doctor as a harmonious whole whose health cannot be restored simply by operating on his cells or on single parts.\(^{10}\) Every body appears as an *individuum ineffabile* that can be perceived both in a physical and in an expressive dimension. But for this to happen, the doctor must also, as a whole, relate to the living unity before him without reducing it to a mere physical body. Only a whole person can perceive life from its creative (*das Schöpferische*), enigmatic, unpredictable and original aspect, from the way it interacts dynamically with the world.

“A personal life is not given to a conceptual being who is purely logical, or to a perceiving being, who is calculating. Involvement, sympathy for the life of others and understanding of the others’ motivations, must already be part of the being so that personal life may seem” (GS IX, 50) and its expressions and symptoms may be identified. This requires the doctor to have certain key qualities. He must acquire information from his senses, but he also needs non-sensorial qualities like:

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\(^9\) The essay “Vitalismus und ärztliches Denken” (Plessner 1922) received a comeback from Viktor von Weizsäcker, “Über Gesinnungsvitalismus” (1923), to which followed Plessner’s rejoinder was “Über die Erkenntnisquelle der Arztes” (Plessner 1923).

\(^{10}\) Hence Plessner’s inclination towards the works by Martius, Kretschmer, Koffka, Köhler, and Wertheimer, which were oriented towards establishing man’s individuality: these works started out with a combinational explanation to reach a functional explanation.
sympathy, intellectual and psychological understanding, and intuitive observation. [...] When illness is also affected by the mind, when the person as a whole is involved and the clinical picture shows a steady correlation between physical and psychological symptoms, then diagnosis as well as therapy must be carried out with the help of ‘non-scientific observation.’ ‘Intelligence from the heart,’ kindness towards men, tactfulness, sensitivity, strength of character and the quintessence of his charismatic qualities are diagnostic and therapeutic tools and not a never-ending stop-gap in the eternal discrepancy between scientific evaluation and the actual situation (GS IX, 53-54).

Herein lies the fundamental reinstatement of the family doctor, whose role is to find the use of medical science for the specific needs of his patient. In the scientific context, which he is a steady part of, “[he] has his own spiritual centre in the art of knowing and treating people; it is on the strength of his tactfulness and general historic education that his service to man becomes important” (GS IX, 25).

The general practitioner should be able to intuitively understand his patients and treat them as objects of science and a subject of the spirit. This is why both science and intelligence of the heart are required. Thus Plessner believed that the approach to knowing a person could not be purely scientific, and the key to treating the complexity of the human being required the hermeneutic skill of a doctor’s whole personality. We can thus state that the doctor’s action must take into account the patient’s being-a-body (Körper) as object of scientific investigation, and his having-a-body (Leib), as an incorporated living, sentient and proprioceptive subject.

These priorities are in conflict with what Plessner defined as double antinomy, which creates tension for the doctor, who must relate to his patient in his entirety while his field of labour continues to become extremely specialized. The first antinomy is based on “the immeasurable gap between life and science, standard procedure and theory, intuition and knowledge” (GS IX, 53). This is because science proves to be limited and concepts relate to life as a whole like a tangent to a circumference: it is always touched point by point, but it is never grasped as a whole. The second antinomy is divided into two definitions (GS IX, 53). The real antinomy, however, is the one between the objectifying character of knowledge and receptivity; comprehensive opening (verstehende Aufgeschlossenheit), thanks to which a “person,” as such, first becomes visible and then easily influenced. Plessner seems to accept Weizsäcker’s altered idea (Weizsäcker 1923, 31) that the philosophy of medicine originates in this irreconcilable situation, not from a
philosophical necessity, but rather from the doctor’s duty to put the patients’ needs first. Medical philosophy would be possible in the intrinsic antinomy that the doctor and patient are subject to, in their relationship.

Plessner did not cover this theme in an explicit way in his subsequent writings, but he did leave us some guidelines concerning the epistemological statute of medical science and the doctor-patient relationship, which I introduced in the first part of this essay. First of all he stressed that medical science should: 1. Reject a summing conception of the human body; 2. Favour collaboration among sciences (GS IX, 50); 3. Keep together laboratory activity and confidence in experimental research, knowing that there is an expressive dimension in life that goes beyond the laboratory; 4. Arouse interest in other methods and ways of operating and intervening therapeutically. For instance, characterology and typology (GS IX, 51)\(^\text{11}\) investigate aspects of human beings that cannot be analyzed quantitatively but serve as experience; 5. Carry out research on the individual (Plessner was particularly in favour of the medical studies conducted by Conrad-Martius and Kretschmer.\(^\text{12}\)); 6. Rediscover the importance of the general practitioner; 7. Appeal to that “intelligence of the heart,” which was not really appreciated by Weizsäcker, to understand the whole phenomenon of that three-dimensional reality (body, corporeality, I) which we call person.

**Conclusion**

As we have seen, relationships among human beings, even therapeutic ones, must take into account the fact that man cannot be reduced to purely physical parameters. Here too, though with the use of vitalistic categories, it is confirmed that life cannot be enclosed within the limits of a body to be analyzed, but must be lived through constant involvement, decision-making and overcoming of difficulties, within the environment. This implies unpredictability and requires the setting in motion of medical knowledge and the wisdom rooted in a person’s sensitivity. A person acts in an eristic manner to protect the complexity that has been defined as the mediate-immediate, natural-artificial way of relating to one’s own life, to one’s body and to one’s world. The individual’s constructive, free, utopian, mediate and artificial

\(^{11}\) They study the layers of human personality which are subject to experience, although impossible to analyze quantitatively (Kretschmer). See GS IX, 23.

\(^{12}\) From which emerged that even from the psychiatric point of view something in the individual remains unexplainable.
dimensions of life all contribute to his own development and decline, as they are natural and immediate. Medical doctors in today’s society should therefore take into account how much the patient’s personality contributes to his illness, and how much he himself contributes to his patient’s recovery. This is why Weizsäcker concluded that disease must always also be seen as a biographical event. Through his vitalistic premise and his anthropological theory on eccentricity, Plessner implicitly contributed to the philosophy of medicine and to philosophical anthropology.

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