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SELF-CARE: CONCEPTS AND HEALTHCARE RATIONALES

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SUMMARY: Chronic diseases like heart disease and diabetes are driving a global healthcare crisis, requiring extensive and costly care. Self-care is emerging as a vital strategy, urging individuals to proactively manage their health. Rooted in ancient practices and modern empowerment movements, self-care is essential for sustainable healthcare, complementing professional medical systems and improving long-term health outcomes.

“... learn how to feel joy... look toward the true good, and rejoice only in that which comes from your own store... I mean your very self and the best part of you.” – Seneca to Lucilius in Letter XXIII

Introduction

In 2005, the World Health Organization declared that a global crisis in healthcare was looming (WEF).¹ Until the twentieth century, infectious diseases were the greatest threat to human health. Now, however, chronic, non-communicable diseases (NCDs) account for over half the global disease burden: cardiovascular diseases, diabetes, obesity, cancer, lung diseases, and depression account for the greatest percentage of these, with cardiovascular disease alone causing roughly half of

NCD deaths. These chronic diseases require longer-term and more costly healthcare interventions than the short-lived infectious diseases that previously plagued humanity. Self-care, the WHO concluded, must become an essential bridge to plugging the gap and developing sustainable universal healthcare systems.²

Basic self-care has, of course, always been practiced by all peoples since the dawn of time: cleaning,

clothing and feeding oneself are the mundane and necessary activities that we perform for ourselves and those in our care. Since ancient times, however, the notion of caring for oneself has been elevated beyond basic survival skills: *epimeleia* (ἐπιμέλεια) or “(diligent) care (of the self)” was seen to be the dominant principle in the “art of living” or *techne tou biou* (τέχνη του βίου)³ and was considered to be the most important task in life by philosophers such as Socrates. The soul (ψυχή), he argued, being immortal, was the only entity which could be held accountable after death for the actions of the body during life and so the greatest care needed to be taken while it was alive to ensure the purity of one’s soul.

Furthermore, the ability of humans to “care for self” was a gift from the gods bestowed on them by a generous Zeus while all other creatures were simply programmed to carry out their survival duties. Mankind’s freedom arises from this ability to choose to “care for self”, this “privilege-duty”.⁴

As Foucault points out, *epimeleia* and the practice of medicine drew on a shared set of notions such that ancient Greek philosophers called themselves “physicians of the soul”: the ills of the body became a portal for curing the ills of the soul, and the ills of the soul could be forestalled by curtailing various proclivities of the body (such as excessive eating or sexual activity).

Epimeleia required a person to commit to a set of practices and their routine applications – fasting, periods of “fancied poverty”, meditations, self-reflection, discussing your progress with a mentor, making yourself available to discuss with others their own *epimeleia* insights, problems, and progress – while cultivating a constant habit of vigilance of one’s own thoughts and actions “like a night watchman”⁵ to form a detailed “knowledge of self”.

The goal of *epimeleia* for a person in their lifetime (as opposed to their soul’s reckoning in the afterlife) was to detach themselves from the concerns of the material world so as to experience *epistrophe eis heauton* (επιστροφή εἰς εαυτόν) – the

“conversion to self”, the relationship with one self. This, when achieved, was said to give a person access to a joy which once attained, can never be taken away or destroyed and “knows neither degree nor change”.

With the arrival of Christianity, many of these practices were incorporated into Christian spiritual practices and have remained, in one form or another, in Western society up to the present day. These practices are, of course, not exclusive to the West – we find these practices in other, non-Western spiritual and social traditions though with different narratives of origin.⁶

From the 1950s and 1960s, the idea of self-care was radically rejuvenated: it took on the mantle of empowerment of ordinary individuals against the authoritarian organization of medical care between governments, insurance companies, hospitals and pharmaceutical corporations.⁷ The US black civil rights movement called for black and other marginalized communities to make self-care an act of political resistance and self-preservation against those in power who did not wish for their individual or collective well-being – famous examples of community action included the Black Panther Party provision of free breakfast programs for school children and setting up their own community medical centers.⁸ In this context, “self” referred not just to the individual but also to the disenfranchised group the individual belonged to.

The thalidomide tragedy and other pharmaceutical disasters disrupted the belief that all modern synthetic medicine was *ipso facto* a panacea for all ills. This, and the removal from the market of medications marketed as safe but with deadly side effects (such as Phentermine and Celecoxib) contributed to the disillusionment with pharmaceutical medicines for many.⁹

People from a wide cross-section of society came together to seek health promoting options outside conventional healthcare. They learned and taught others how to grow food free of harmful pesticides and fertilizers. They revitalized the ancient art of treating common illnesses with medicinal plants for

oneself and one's loved ones. Much of this self-care was organized by ordinary people into social collectives to care for themselves, for each other and for the wider community. These grassroots movements were highly influential and helped to inspire political and social change with the primary healthcare movement as well as spawn a multi-billion dollar "self-help" industry.

Thus, the ancient practices of *epimeleia* have become the stalwarts of today's "self-help" industry. We are all familiar with the notions of fasting, healthy eating diets, meditation, physical fitness regimes, and self-examination through psychotherapy, self-help books and wise friends even if we do not practice these things ourselves and whether we are spiritually motivated or simply health-conscious (or both!).

Yet still, as the WHO decries, there is an epidemic of chronic ill health and the consequent exorbitant cost—economically and socially—which governments and policy makers must address. To this end, the WHO has urged the necessity of enlisting patients or health consumers to undertake as much of their own care as possible.

With this in mind, the WHO views self-care as a complement to and extension of health systems¹⁰, defining self-care as "the ability of individuals, families and communities to promote and maintain their own health, prevent disease, and to cope with illness – with or without the support of a health or care worker."¹¹ It views the *epimeleia*-type practices outlined above – with their emphases on psychological and spiritual well-being, empowerment and self-fulfillment as "people-centered".

Meanwhile, self-care interventions which aim to manage and control specific disease or health outcomes as set out by the WHO, or by individual governments, are known as "system-centered". Here, patients are seen as partners, to greater or lesser degrees, in the task of healthcare for themselves. The dominant paradigm from this perspective is summarized by a Kaiser Permanente pyramid, as shown below.

The self-care interventions that systems-based self-care employs include evidence-based, high-quality drugs, devices, diagnostics and/or digital interventions that can be provided fully or partially outside formal health services and that can be used with or without a health worker.¹²

The BMA¹³ sees all of these approaches as a "self-care continuum" (Fig 2) and that the choice of patients to seek professional care rests with them until "pure medical care" becomes compulsory, as in emergency trauma or compulsory psychiatric care.

It also differentiates between various types of self-care: (i) those strategies aimed at promoting behavior change as disease prevention strategies – for example, motivating people to adopt healthy lifestyles, including stopping smoking, cutting alcohol intake, eating a balanced diet, and taking more exercise; (ii) educating people so that they feel confident to treat themselves for minor ailments, such as headaches and nosebleeds; and (iii) empowering those patients with long-term conditions so they can be informed, active and fully-engaged in their own self-care.

These approaches can be summed up in Fig 3: "Self care in the context of interventions linked to health systems"¹⁴ During the Covid-19 pandemic, we saw an explosion of self-care measures as part of an essential global response to the threat of the virus. Education around hand sanitation, mask-wearing, and social distancing were key features of self-care interventions, as was self-testing. Healthcare is set to become ever more digitized.

Concerns around the potential pitfalls of promoting self-care behaviors include the worry that patients will not seek expert medical advice soon enough and will try and manage their symptoms on their own. However, this ignores the reality that patients already have the freedom to pursue whichever health path they wish to follow, regardless of what expert opinion might suggest.¹⁵ Despite this, there is a legitimate concern about patients being encouraged to develop autonomy about self-care to the point where they no longer involve the health

professional, such as through increased use of self-monitoring devices and over-the-counter treatments.¹⁶

As practitioners of the theory of Endobiogeny, whether physicians or other health professionals, we are usually operating outside of institutional normative healthcare—which is primarily symptomatic management sick care. One group of patients enter our practice motivated for self-care but seeking expert guidance or orientation for greater personalization. Others seek our assistance once conventional treatments have failed them. Both groups are more motivated than other types of patients to take on the changes we often ask of them as part of their treatment of terrain. This includes dietary changes, sleep hygiene, emotional well-being, exercise regimes, herbal infusions, decoctions, tinctures with their unctuous taste for the uninitiated. This is all part of our therapeutic repertoire, and sound like a familiar echo of *epimeleia* practices!

All of these “care of self” practices requires a long-term commitment to behavior changes to achieve lasting resolution or improvements to our patient’s chronic health conditions. For this to occur not only

do we need an “activated patient”, we also need to be able to guide our patient’s transformation¹⁷, for true behavior change is nothing less than transformative. There is an increasing body of evidence validating the therapeutic efficacy of self-care practices. But, knowing which practices to recommend is arguably more art than science. Thus, learning consultation skills for motivating behavior change should be a core element of our own training.¹⁸

The benefit to ourselves as practitioners and to our patients of supporting their self-care is evident: long-term improvements in their chronic conditions leading to an improved quality of life and confidence in their ability to procure deep, positive change is a joy for both patient and practitioner to witness. Indeed, perhaps such change is the portal the body provides to the soul that the ancients talked about, and which can afford us a glimpse of the ultimate joy of *epistrophe eis heauton* – a meeting with our own self. ✱

Images

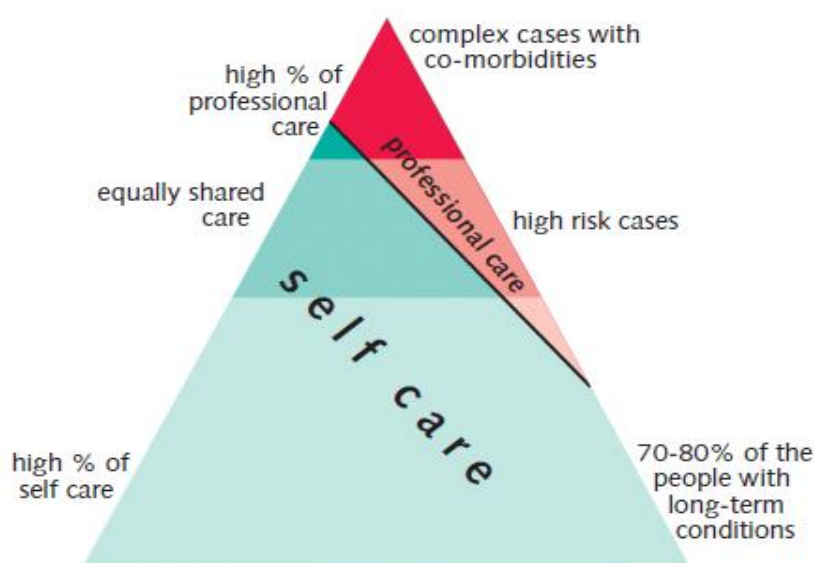


Fig 1 Chronic disease management and shared care

The Self-Care Continuum

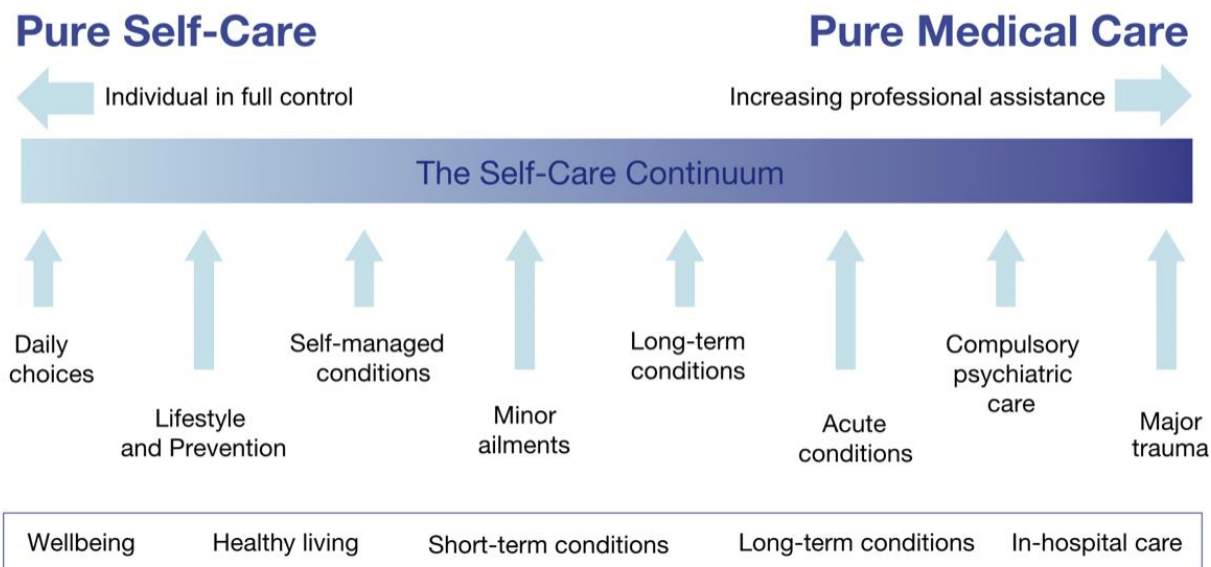


Fig. 2: Self-care continuum. Source: www.selfcare.org

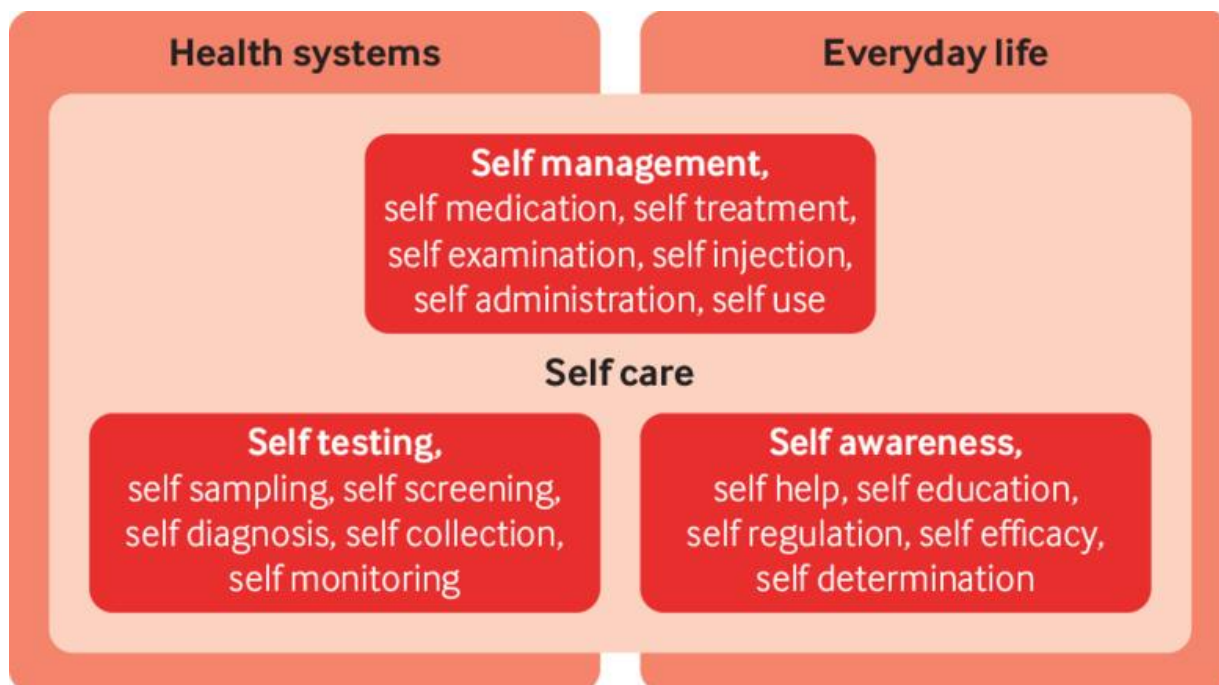


Fig. 3: Self care in the context of interventions linked to health systems. Source: c.f. Reference 14.

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Disclaimer: No conflict of interest declared.

About the Author

Elizabeth Mara Baughman has been a practicing medical herbalist for almost 30 years, having been in the first student cohort in Europe to graduate with a degree in Herbal Medicine (from Middlesex University). The year she graduated she met Dr. Lapraz in London and since then she has been dedicated to the study and practice of Endobiogeny. She teaches herbal medicine at the grassroots. She has been the creator and project manager for many projects including "Farmacia Viva." More recently, she has been collaborating with the Idle Women charity in teaching community herbal medicine to refugee women in North-East England, creating the first women's physic garden in the UK and writing a book "Endobiogenics for Beginners". She lives in Norfolk, England with her two sons.