Medicine, Health Care and Philosophy (2007) 10:363–372
DOI 10.1007/s11019-007-9079-x
© Springer 2007

Scientific Contribution

Medical humanities: stranger at the gate, or long-lost friend?

H. M. Evans
Centre for Arts and Humanities in Health and Medicine, Durham University, St Hild's Lane, Durham DH1 1SZ, United Kingdom (Phone: +44-191-334-8245; E-mail: h.m.evans@durham.ac.uk)

Abstract. ''Medical humanities'' is a phrase whose currency is wider than its agreed meaning or denotation. What sort of study is it, and what is its relation to the study of philosophy of medicine? This paper briefly reviews the origins of the current flowering of interest and activity in studies that are collectively called ''medical humanities'', and presents an account of its nature and central enquiries in which philosophical questions are unashamedly central. In the process this paper argues that the field of enquiry is well-conceived as being philosophical in character, and as having philosophy – albeit pursued over a larger canvas – at the core of its contributing humanities disciplines. The paper characterises humanities disciplines as having an important focus on human experience and subjectivity, of which the experiences and subjectivities at stake in health, medicine and illness form an important sub-set, the preoccupation of the medical humanities as a whole. Claims of interdisciplinarity (as distinct from multidisciplinarity) are noted, but such claims need to be recognised for the high and stern ambition that they embody, and should not be made lightly.

Key words: humanities, interdisciplinarity, medical humanities, philosophy of medicine, subjectivity

In *The Curious Incident of the Dog in the Night-Time*, author Mark Haddon (2002) describes a fairly ordinary sequence of domestic unhappiness through the utterly extraordinary eyes of a logically clever, but emotionally severely disabled, teenager suffering from a form of Asperger's or other quasi-autistic disorder. The result of his condition is a quite unforgettable re-ordering of the world into bizarre yet internally consistent categories, including what is for the reader a heartbreaking systematic misperception of parental love as murderous threat; the book is a chronicle of how so disabled a child can somehow craft his own day-to-day survival. After reading this book I asked an experienced child psychiatrist whether he felt that the author had succeeded in capturing the ''interior'' of an autistic or Asperger child's experience. His answer was: ''not quite'', but that even with its inaccuracies he remained very glad that the book had been written, because in his view it made available the intensity of the problems of Asperger's and autism to a wide audience, and would generate sympathy and understanding of the condition. (I will from now on use the terms ''autism'' or ''autistic'' as an un-scientific shorthand to cover the range of Asperger's-like and other autistic conditions in general. The points I wish to make do not depend on the distinctions between these terms.)

The psychiatrist's answer – that the book had ''*not quite* succeeded'' – is an interesting one, for it implies the possibility of success. This in turn implies a number of moderately striking things, among them that, with sufficient professional experience, it is possible for the clinician to gain genuine insight into the interior of someone else's experience even in such notoriously inaccessible conditions as autism. That assumption is implicit in his being able to give a cautious approval of the book's partial accuracy – if I may use the term – i.e. partial accuracy with respect to a strange (and, in this particular case, damaged) form of self-experience and self-understanding. Of course this is an unusually difficult form of something that is somewhat difficult in even an *ordinary* case – namely, to get a sufficient degree of access to

someone else's experience, through what they write or say about themselves, for *us* to be able to talk about how successfully they have conveyed their experience, or how accurately they have represented it. The familiar obstacle is (depending on your position within the philosophy of mind) that since anyone's own experience is something that only he or she actually has, it can never be more than *inferred* by third-parties, that is, everyone other than that person.

However, the attempt to infer it – in the ordinary case – is obviously necessary a thousand times a day; and presumably it is no less necessary in trying to understand the perplexing case of autistic experiences. The psychiatrist's answer presumes this, too. He could hardly try to work clinically with autistic children and their parents if he had *no* ambition to understand something of the qualitative reality of autistic experiences, since without such understanding, the clinical role becomes reduced to something like advising the affected parents on the practicalities of crisis management.

The further implication of this verdict of partial accuracy is the possibility that the book could have succeeded in transmitting experience *among* third-parties: that is, an originating third-party such as a well-informed author could not only access such an obscure experience but also convey it accurately to other third-parties, namely ourselves as readers.

A somewhat distinct presumption in the psychiatrist's stance is the value of wider sympathy and understanding of the condition of autism. However intuitive such a presumption may appear, there is a question about where exactly that value lies. Would we be happy, for instance, if managerial decisions about funding and resources were openly based upon the extent to which the book-reading public sympathised with the plight of a particular group of patients and their carers? Surely not. Perhaps instead it lies in the likelihood that readers of the book will be more tolerant of the problems caused by autistic behaviour – and more supportive of the parents who routinely deal with those problems. But even this is problematic, in that whilst tolerance *per se* seems to be a good thing, we surely want it to be based upon a genuine and honest understanding, and not upon an inaccurate, picturesque, imagined or otherwise deficient representation. This seems to require, in the present case, that the book actually succeed in opening a genuine window into the autistic child's world. "Not quite" succeeding, in the psychiatrist's words, seems to be an imperfect basis for greater tolerance.[1]

The reason I have opened with this example, and spent some time on it, is that it raises a number of questions with which I think the fledgling field of the medical humanities is concerned. Let me briefly review a list of the more obvious of these questions. First, how far is clinical medicine based upon scientific observation and intervention? What resources other than scientific observation and intervention are available to the clinician?[2] Is clinical medicine directly, or only indirectly, concerned with the experiential aspects of health and illness? In either case, how do we train doctors and other clinicians to address these experiential aspects (and hence do doctors need experience of life, as much as they need scientific knowledge, in their clinical practice)? How should we seek to understand and explore those problems of life and experience, including physical and psychological illnesses, that arise from the particular configurations of our bodily make-up? The suffering of any illness, not just the suffering of ingrained emotional deficits associated with some psychological disorders, is an intensely subjective matter. What kinds of knowledge and enquiry therefore are best suited to taking subjectivity seriously, and investigating it? Perhaps more radically, can there really be genuine knowledge of another person's subjectivity? And if there can, how is it to be achieved? Furthermore, how can it be usefully *transferred* – for instance, making an exploration of the autistic child's subjectivity a matter for a gain in the understanding of others?

Other epistemic questions as well are implicit in the psychiatrist's answer. What is the role of *values*, be they moral, social, aesthetic and so on, in our identification of the normal and the pathological? What kind of science-of-the-human is constituted by medicine in either its early modern form or its current, highly technologised form? Is it central or peripheral in the context of other sciences? How are we to consider a form of scientific *object of study* – the patient – that is also a thinking, experiencing *subject*? How should we understand such a science in a context that is increasingly dominated in an epistemic sense by, on the one hand, biophysical categories including those of molecular genetics, and on the other hand, statistics and the relationship between probabilities at a population level and the individual patient – who supplies, perhaps, the *only* context in which these questions are finally important? And so on.

All of these questions present, constitute, or point towards, problems and enquiries that are recognisable in the philosophy of medicine, and I acknowledge the need to clarify the relations between philosophy of medicine and the field of medical humanities. But the fact that these questions are indeed recognisable in itself suggests that from the standpoint of philosophy of medicine, medical humanities begins to look a little more like a long-lost friend than simply a stranger at the gate.[3]

To continue the enquiry, I will try to present an individual perspective upon the field's origins and its contemporary nature. This perspective involves the frequent occurrence of irreducibly philosophical questions; in this paper I can only notice them and not address them substantively.

Origins

To begin with the field's origins, it is perhaps worth noting that the expression "medical humanities" is initially an American one, referring to primarily education concerns within the medical curriculum, and more particularly to bringing the study of humanities topics, principally literature and literary techniques, to the *teaching* of medicine; part of the aim was to develop clinicians' powers of listening and interpretation (Hunter et al., 1995). One difficulty the expression presents is that one always has to explain that "medicine" means other aspects of health care as well.

Another difficulty – and this implicitly brings us to the question of the field's current nature – is that some people regard medical humanities as of interest only within medical education, and indeed as essentially *being* a mode of medical education. So, to the extent that they are engaged at all in medical humanities, British medical schools have tended to maintain the original American approach of focusing on such things as literature, creative writing and film as vehicles for interpretation skills and self-expression alike. One development of this in the UK focuses on postgraduate and continuing education, using familiarity with the humanities and creative arts as a personal resource for hard-pressed clinicians facing the demands of professional life.[4] Another development emphasises the cathartic benefits to *patients* as well as carers, of writing creatively about their experiences (Bolton, 2001). These resources are no doubt all good things to have, but they do not in themselves plausibly constitute a field of study.

A further suggestion that has been made during the early evolution of medical humanities is that it is the attention we pay to (in the British sense) all the non-scientific (though not unscientific) aspects of medicine, or even simply all that concerns "the human" within medicine.[5] The trouble with this suggestion is that it is so dismayingly wide that it would be difficult to see how it could possibly be the name of a coherent activity or enquiry.

There is also a sense that medical humanities is a kind of *medical counter-culture*: a response to some forms of dissatisfaction felt by patients concerning how well their doctors listen to them, or dissatisfaction felt by doctors towards the somewhat dehumanising effects of large-scale, industrialised health care (Macnaughton, 2001). In this sense, such dissatisfactions (and they are not unreasonable) rather resemble some of the origins of medical *ethics* – that is, a kind of consumer voice of protest, *seeking* a critical counter-culture of this kind. This in turn invites a further resemblance to some of the early critical enthusiasm for medical ethics, before it met the twin dangers of being either turned into a respectable academic discipline or devoured by the law and legalism.

Perhaps this is a good point at which to review other parallels between medical ethics and medical humanities. "Medical ethics" is an ambiguous phrase with at least two denotations: on the one hand sets of practical and professional duties and their consequences (i.e. what actual, particular doctors ought to do in real situations, conveniently dubbed "normative medical ethics") and on the other hand a set of intellectual questions and enquiries which have been collected together as an academic field (i.e. how we might think about and understand what doctors in general ought to do in typical situations, sometimes called "critical medical ethics"). Now we might at first glance suppose that the phrase "medical humanities" is ambiguous in the same way.

I have discussed this problem at greater length elsewhere, and here I will merely summarise that discussion. The phrase is ambiguous between a form of enquiry and an approach to practice. The former denotes a specific branch, particularly aimed at medicine, of the broader area of enquiry known as "the humanities"; this critical and reflective undertaking corresponds to the critical form of medical ethics. (Such enquiry naturally includes questions in metaphysics and epistemology, insofar as these are natural components of any genuinely critically reflective examination – such as philosophical examination, whose importance we

shall recognise below – of medical practice and medical theory, which inevitably presuppose some metaphysical and epistemological positions on matters concerning, respectively, the nature of embodied human experience in health and illness and the sources of our knowledge of such experience and its bodily foundations.[6]) It contrasts with the advocacy of particular ways of actually doing medicine, that is, practising humanely and with due concern for the humanity of the patient; this exhortatory discourse corresponds to normative medical ethics. Unfortunately the problem for this latter interpretation of "medical humanities" is that it appears suspiciously like a truism of a rather pious kind.

It would certainly be a truism if humane practice were intrinsic to the concept of medical practice. However, this can be contested – as can the somewhat parallel presumption that ethical practice (of which humane practice might be thought to be a manifestation) is internal to medicine. In taking the relief of suffering as being an *internal* goal of medicine, Cassell (1991), for instance, seems committed to the idea that medicine in practice must be both ethical and humane *by definition*, a view whose consequence would be that if we fail to practise medicine humanely or ethically we fail to do medicine at all rather than just doing medicine badly, which seems on the face of it the more natural way of putting the matter.

If, prompted by caution, we disregard the normative interpretation of "medical humanities" as referring to particular (humane) ways of doing medicine then we are left with the still-valuable denotation of a critically reflective field of intellectual enquiry, and in this too, there is a useful parallel with medical ethics. I find persuasive the suggestion that medical ethics' concerns can themselves be taken up amongst the "human" (*not* humane, be it noted) concerns of medicine. In this sense, medical humanities adopts part of the agenda of medical ethics but pursues it in a broader and perhaps more diffuse form.

Of course "ethics" is the specific name of only *one* area of values, and there are other areas that are at stake in modern medicine and healthcare – social values, political values, spiritual values, aesthetic values, epistemic values, perhaps sexual or gender values, even gustatory values. Despite their obvious relevance to clinical medicine (think of public health, palliative care, aesthetic and reconstructive surgery, the fashionable preference for population-level evidence and so on), some of these have received relatively little attention, and I have a sense that this reflects a wider neglect of the philosophy of medicine – at least in the UK where, it seems to me, most philosophy of medicine is done in conjunction with medical ethics, perhaps actually as *part of* medical ethics. That is a legitimate place to do philosophy of medicine, of course, since critically undertaken value enquiry with regard to medicine is as fully a part of philosophy of medicine as is the pursuit of any of the other cardinal components of philosophical enquiry – epistemology, logic, metaphysics and so forth – directed at our understanding of medicine, whether undertaken in an analytic or an interpretative spirit.[7] Moreover from the philosopher's viewpoint it is an enduring boon that medical ethics has provided this opportunity, since through its relatively high profile medical ethics makes some philosophical questions apparent, and even accessible, to a wider public. Medical ethics is, as one might put it, the most brightly illuminated shop window display of *any* form of philosophical enquiry.

Before we leave the question of the origins of medical humanities, it is worth including a cautionary note (one which may be somewhat familiar in medical ethics as well), namely that the very imprecision – so far – of what medical humanities comprises, can appear to offer a home for what one might call disciplinary refugees: that is, enquirers who for one reason or another are not comfortable within the traditional confines of their own discipline or practice, and have moved into the area of reflective enquiry into medicine, hoping to claim the academic equivalent of political asylum. The benefits of intellectual creativity that such a diversity of individuals in theory offers may be offset by the adverse impact of too many varying influences upon a field of enquiry that is not yet itself sufficiently mature to be entirely confident of its own general nature, still less its detailed identity and purposes.

Unfortunately amidst a clamour of voices, one has rarely the luxury of waiting for silence before adding one's own voice. All I can therefore do in the remainder of this paper is offer a personal contribution to the discussion of the nature of medical humanities as a field of enquiry.

Nature

In the personal conception of the nature of the field of medical humanities which now follows, I will try to begin *descriptively*, reporting on what I see when

I look at the field, whilst acknowledging that the report inevitably involves a somewhat editorial selection on my part and, as such, is liable to develop *prescriptively*, advocating a particular conception.

The simplest pattern that I can impose upon a varied field of activities claiming to constitute, or at least to affiliate to, medical humanities is to divide those activities essentially into three kinds. The first two kinds concern *substantive activities* within organised health-care, as well as academic or theoretical *reflections upon* those activities.

- First, there are those activities collectively known as "Arts in Health" including the therapeutic uses of creative arts activities such as writing and painting; and including also the use of creative arts and co-operative productions of public art as a way of helping to create and sustain healthy communities. An example of the former would be the encouragement of creative writing on the part of sufferers of chronic illness – or their carers – in an attempt to confront and give meaning to symptoms (Bolton, 2001). An example of the latter would be the use of stylised visual rituals, such as the lantern project in Wrekenton, near Durham in the North East of England, in which illuminated symbols of the heart at the core of a healthy community are produced collectively in community-based workshops and then paraded together in an annual and spectacular festival of lanterns (Robson and White, 2003). As mentioned, for me this area of medical humanities includes commentary, analysis and critical reflection upon arts-in-health activities.
- Second, there are those activities geared towards and embedded within Medical Education, including actual schemes of study for medical undergraduates and postgraduates, periodic study resources for Continuing Medical Education, and the general notion of offering personal resources, through art, literature and creative self-expression, for what I earlier referred to as "hard-pressed clinicians facing the demands of professional life". Examples of modules devoted to the study of literature, film, fine arts, history and philosophy can be found in many medical schools, normally as options,[8] and as part of continuing medical education through, for instance, the Medical Royal Colleges in the UK.[9] Again this area should be taken to include academic commentary and analysis concerning such activities.
- The third area is more obviously an academic or theoretical undertaking *through and through* – namely, the task of attempting better to *understand human nature* through the lens of a critical examination of technological medicine and its limitations. Examples of enquiries here could include the implications of molecular genetics for our concepts of free will; scrutiny of the role of technology in medicine in an age in which imaging the body's interior is taken to have category-forming authority and explanatory power (Hofmann, 2001); or the two-way relationship between new surgical techniques and contemporary standards for so-called "ideal" bodies and faces.[10] This is not only the most clearly theoretical of the three broad areas of work; it is also the most irreducibly philosophical of the three. Whilst I do not want to suggest for a moment that only philosophers can undertake it, I do want to suggest that in undertaking it one is doing something that, whatever else it is, is usually also philosophical in spirit.

So, if we try to identify the nature of the medical humanities in terms of its characteristic preoccupations, then these three broad areas seem to me to describe it. But an equally important question concerns *who is* actually so preoccupied: Which *are* the contributing disciplines to the field? Well, almost by definition they are neither physical sciences nor, for the most part, social sciences. No doubt the division of human enquiry into discrete disciplines is a historical and conventional one that is in some respects unhelpful, but we are stuck with it and we might as well start from where we find ourselves. So, we are left with the humanities disciplines, whose conventional members include literature studies, history, philosophy, fine art, drama, critical theory, historiography, theology and religious studies, linguistics, music, law and so forth. The least generalising of the social sciences (the qualification is important as we shall shortly see) such as ethnography or that borderline humanities/sciences discipline, psychology, might also be included in an eclectic conception.

A putative list is all very well – although of course people will disagree over the inclusion of some of these, and over the exclusion of a larger number of disciplines not mentioned here (how about cultural anthropology or feminism studies?) – but we need to go on from this to ask, Do they have anything in common that makes them either characteristically *humanities* disciplines or specially able to contribute to medical humanities study? I will try to respond to this by suggesting that there are indeed two related characteristics of humanities disciplines that do make them especially useful for addressing the human side of medicine.

These are, first, a concern with experience – with recording and understanding and interpreting individual human experience (Evans, 2002b) and its qualitative dimensions, or, if you like, a concern with the world as it is humanly encountered, rather than as it might be detached and merely dispassionately observed, which is more plausibly the goal of the natural sciences.

The second characteristic of the humanities for me follows from this (at least in broadly Western culture where, currently, conventional humanities subjects as characterised above, and the medical humanities as a manifestation of them, are primarily to be found). This second characteristic is a concern to take subjectivity seriously – the individual point of view and its qualitative content, its unique antecedents and its idiosyncratic repertoire of meanings and connotations – as well as taking seriously its necessary reflection of, and embeddedness in, the many *interpersonal* contexts of society, including those of clinical medicine.

This second characteristic invites us to suppose that the specific observations of a given individual in context are as interesting – in the sense of providing grounding, meaning, implication and a guide to our future attitudes and actions in relevantly similar circumstances – as are the homogenised observations collected together under the natural sciences. It allows that for many purposes characteristic of clinical practice (such as the decision of whether or not to prescribe a marginally effective drug with unwanted side-effects), a single telling example of a vivid experience that is to some extent recognisable to us is, in principle, as powerful as population-derived evidence telling us which probabilities are compelling as guides to action (Sweeney, 1996).

The point is that both the objectivising gaze of science and what we may call the subjective-tolerant gaze of the humanities do indeed contribute to our reasoning as guides to future action. I should like to attempt a generalisation here – a generalisation that, if plausible, helps to rationalise the place of the humanities in our understanding of medicine, health and illness: perhaps the sciences provide constraints upon what is a *rational conception* of future action – they provide the basis for our beliefs. At the same time, perhaps the humanities provide models of *motives* for future action – they provide possible bases for our attitudes (what Stuart Hampshire (1989) called our conceptions of the good lives that are possible for us).

Having suggested the broad content of the field of medical humanities, and characterised the humanities disciplines that engage in it, I would like to add something about the *modus operandi* that is at any rate claimed for Medical Humanities. This is its alleged interdisciplinarity. Most promotional references to medical humanities advertise this as a characteristic feature. However, I suggest that interdisciplinarity is a very ambitious goal, and that it is claimed on many more occasions than it is actually realised. This is arguably a further feature in respect of which medical ethics and medical humanities are somewhat alike.

First, however, what is at stake in attaining a proper conception of ''interdisciplinarity''? Principally at stake is the way in which the various contributing disciplines are thought to relate to one another as they jointly engage medicine and health care. How do these actually *constitute* medical humanities as a field of enquiry?

The essential question here is whether the contributing disciplines remain as independent of one another as, inevitably, they must begin. For example, the question of the status of neurasthenia (in some respects, the late-19th-century counterpart of myalgic encephalopathy) as a genuine disease invites commentary from history of medicine (in terms of the emergence and refinement of an identifiable condition attracting medical attention), literature studies (in terms of the coalescing of references to the condition around certain prominent artistic or creative individuals at a particular historical period, and the value-assumptions that began to be tied to the condition) and philosophy (in terms of genesis and maturation of the concept ''disease''). The question is whether these several enquiries are, or could be, or should be, undertaken in radical independence of each other; or, if not, the contrapuntal question is that of precisely how they should inform one another. Are they a mere sequence of set-piece investigations to be sampled piecemeal according to the interests of the external inquisitor, or are they the fused components of a more richly-layered and above all *emergent* enquiry, whose substance, concerns and specific questions would not be apparent to the contributing disciplines on their own?

This is of course a puzzle about what kinds of knowledge are possible when distinct disciplines collide, about whether their respective methods are mutually intelligible, about ''how other disciplines see and name the objects in their world, and to what extent we can view that world with them: in effect, learning to see simultaneously through our own eyes and through theirs'' (Evans, 2007).

No doubt true interdisciplinarity is sometimes achieved, but so far the more convincing examples appear to emanate from elsewhere than the medical humanities. A good example is arguably constituted by chemical process technology, in which those who, for commercial reasons, were interested in improving the mechanics of fluid flow and heat transfer in the production of polymer plastics, had initially no established field to draw upon at all (Evans and Macnaughton, 2004). Proceeding empirically, they engaged mechanical engineers to help them with pencil and paper calculations; the engineers in turn recruited methods from physics involving so *many* simultaneous calculations that non-linear mathematical modelling from computing science became integral to the emerging field.

A key feature of this process is that at each stage new *questions* emerged that could not have been asked, let alone answered, by the contributing disciplines in isolation. I think it is plausible to suggest that *emergent questions*, whose range of aspects cannot be found in any single contributing discipline, are one indication that genuine interdisciplinarity has been achieved. The full complexity of fluid mechanics was neither soluble by *nor apparent to* the paper-and-pencil generation of chemical and mechanical engineers who began the field; the relation between on the one hand real fluids traversing real locations and on the hand mathematical representations of activity at notional and infinitesimally graded locations would at earlier stages have seemed arcane to both fluid mechanics and computer scientists.

It is I think more difficult to point to either emergent questions in particular or genuine interdisciplinarity as a more general attainment within medical humanities at the moment. The mutual implications, for our understanding of perception, between neurology and phenomenological philosophy become apparent and real only when these two forms of enquiries collide. More generally, patients' subjective experiences are foundational in their seeking medical care in the first place, yet the *forms* of experiences of the self occupy a surprising range; some forms are perhaps even made possible when disciplinary perspectives co-engage. Consider, for instance, Oliver Sacks' incorporation of the notions of music and musicality into his understanding of proprioception as a neurologist, an incorporation that informs his experience of his own bodily recovery and our appreciation of music's diagnostic and therapeutic possibilities (Sacks, 1986, pp. 108–110). As for interdisciplinarity as such, one place where one might look for interdisciplinarity is where the methods of literary and philosophical analyses are combined – as has been fruitful in medical ethics and indeed ethics more generally. Examples might include the attempt to understand the processes of creative imagination in the evolution of scientific medicine, or the attempt to chart the complexities of paying attention to the character of the moral agent in expositions of virtue ethics. I am not here going to comment on the success or otherwise of any particular claim to interdisciplinarity. I merely want to insist on how difficult it is, at the same time as noticing how routinely and, I fear, *casually* it is claimed on behalf of Medical Humanities.

Notwithstanding this sceptical note, the foregoing (taken as a whole) suggests to me that we can say something about the characteristic projects of work likely to fall under the Medical Humanities. My suggestion is that at least such work as attempted any of the following four tasks – and it is straightaway apparent that they all have a philosophical flavour – could be thought of as constituting Medical Humanities work.[11] (That is to say, the attempt on these tasks provides a sufficient, although presumably not a necessary, condition for constituting Medical Humanities work.) The tasks are these:

1. To illuminate the practice of medicine (and, perhaps, medical theory) using ideas and insights distinctively associated with humanities or social science disciplines; especially doing so in a way that is not usually accessible through scientific descriptions and explanations.

   Examples: any kind of value enquiry concerning medicine. This obviously includes medical ethics.

2. To illuminate what one might call "the human side of medicine" in a form that takes seriously the ways in which medicine, illness, suffering, disability, and (for that matter) health are *experienced*

   Example: pathographies – the recording and interpretation of illness experiences; bringing creative and expressive arts to bear upon the experience of illness, in the therapeutic (and sometimes diagnostic) context

3. To attempt the understanding of one or more 'subjectivities' within the experience of medicine, or of health, illness, suffering or disability; and (from this) work that makes such understanding

transferable to our understanding of *other* subjectivities: such that we gain something which we can meaningfully relate to other insights gained on other occasions of comparable enquiry, allowing us to be systematic, albeit in a rudimentary way

> Examples: the broad swathe of those enquiries in history of medicine, philosophy of medicine or medicine and literature where individual experiences are made available to others through description, analysis, representation, in the hope of learning something about ourselves – and about "the human condition"

4. To use some aspect of medicine (that is, health care, etc.) specifically to achieve some gain in our understanding of the human condition, or of embodied human nature

> Example: philosophy of medicine generally, especially philosophical enquiries into embodiment and experience; or similar enquiries within medical anthropology and ethnography

What would be the point of the foregoing work? Why would we seek to undertake it? I put these questions somewhat rhetorically – since all of these kinds of work, especially the last area concerning gains in our understanding of embodied human nature, should commend themselves to all serious scholars and above all to philosophers. But rhetorical or not, we can I think see that work of this kind does help us to do a number of worthwhile things.

To begin with some fairly conventional objectives, the first three of these areas clearly help us – as commentators or as clinicians or, for that matter, as patients who necessarily contribute to the clinical consultation – to take human *values* seriously, including ethical values. They help clinicians and students alike to develop their own personal values. The second and third areas may help in developing clinicians' interpretative sensitivity and their skills of listening and communication. Through the engagement with creative and expressive arts, they may also indirectly provide clinicians with personal resources for facing the demands of clinical life.

The fourth of these areas – fittingly enough for work that is essentially philosophical – serves I think more radical goals:

- asking how technological medicine's picture of human nature/the human condition contributes to our self-understanding, and whether other pictures are available (for instance, from the humanities);
- from this, asking whether technological medicine spurs humanities disciplines to extend (or revisit) their own research agendas;
- exploring disciplinarity, interdisciplinarity, and the varying nature of knowledge and evidence in medicine, sciences and humanities
- stimulating and encouraging a sense of wonder at embodied human nature.

I believe all of these goals are worth pursuing. To varying extents, each of them is reflected in current work in philosophy of medicine. I would describe this area of Medical Humanities as, in effect, pursuing philosophical questions in medicine over a larger, a more colourful and no doubt a more disordered landscape. If I may so put it, the "long-lost friend" has indeed been a stranger, but at others' gates; it is returning now with tales of these colourful and disordered landscapes.

Finally, if the field is to develop credibly then, I would argue, its constitutive research enquiries must strive to be mutually coherent. Literary insights, historical investigations, philosophical reflections and linguistic analyses directed towards, say, culturally distinct experiences of nausea and their appropriate medical and psychological management (or towards the meaning of the epidemiology of psychological disorders, or towards the notion of "functional illnesses", or towards the question of whether myalgic encephalopathy is genuinely comparable to late-19th-century neurasthenia, or towards radical deconstruction of the clinical consultation, and so on) should be seen to bear upon common objects in compatible terms. Unfortunately I do not think we can always claim that this happens as yet. There needs to evolve at some point a rudimentary structure, within the field of Medical Humanities, that minimally orientates the modes of attention of different disciplinary enquiries and focuses them together upon an object or concept that is recognisable to all the enquirers and has a shared meaning as well as, putatively, *a shared denotation*. Research in medical humanities needs to produce some sense of accumulated gains in understanding, and not just an unstructured "heap" of observations and remarks that are individually valuable but nonetheless essentially fragmentary.

I do not suggest that this is easy, but few worthwhile things are easy. Elsewhere I have suggested that in the biomedical age we might recast Blake's powerful rendering of the human

constitution, famously the constitution of ''impassion'd clay'', in terms of our being ''meat with a point of view'' – the combined biophysical and existential realities of our embodied state, in which our subjectivity is fused with our objective, external being. Understanding this fusing is among the most philosophical of the tasks to which, in my view, the Medical Humanities are properly addressed.

This suggests that those who, as I do, prefer the ''long-lost friend'' conception of Medical Humanities to the ''stranger at the gates'', will recognise the centrality of philosophy among its contributory disciplines. Indeed I would go so far as to say that for those of its practitioners who are philosophers, the Medical Humanities amount to ''Philosophy looking at the Humanities looking at Medicine''. Further, the philosopher sympathetic to this view will sense that philosophy of medicine is the queen of those humanities disciplines co-engaging our embodied human nature. This is my sense, too. However, philosophy is not the only such discipline, and its task in the medical humanities is perhaps to encourage, to inspire, to learn from, to respect and, when necessary, politely to marshal the others. Whether this is finally a responsible and sustainable view, rather than unwarranted disciplinary arrogance, is something we shall find out only when the field of Medical Humanities progresses towards maturity.

Notes

1. *Perhaps* imperfectly grounded tolerance is better than nothing, if that is all we can get, but its wider consequences might involve more harm than good, if these include a more general decline in critical scrutiny of the bases of tolerance; we may end up tolerating things that we should *not* tolerate.
2. I am using the word ''scientific'' in its narrower UK sense. I mean by it the natural sciences, rather than the more general sense of organised knowledge implied by *Wissenschaft*, which extends to the humanities.
3. There are of course other viewpoints. Not all those engaged in clinical healthcare are so sympathetic to the programmes and projects of philosophy of medicine as to admit the value of medical humanities study through this particular door. I have elsewhere commended medical humanities to non-philosophical, expressly clinical, audiences; see for instance my 'Roles for Literature in Medical Education' (Evans, 2003); 'Reflections on the Humanities in Medical Education' (Evans, 2002b); or 'Medicine, Philosophy and the Medical Humanities' (Evans, 2002a).
4. The UK's first Master's in Medical Humanities, introduced in 1997 at University of Wales Swansea, appeals primarily to mid-career medical professionals. See Evans, M., in Kirklin and Richardson (2001).
5. Reported by Greaves (2001).
6. I am grateful to an anonymous referee for emphasising this.
7. The relation of philosophy of medicine to philosophy of science is an interesting one. Some enquiries within epistemology of medicine could readily be seen as an application of philosophy of science as could some enquiries within the logic of clinical reasoning and diagnosis. However, studies of the metaphysics of embodied experience will be more resistant to being captured in this way; indeed on Toulmin's (1993) view the centre of gravity of traditional views of philosophy of science is liable to be itself shifted by taking seriously the epistemology of medicine's objects.
8. See for instance Hampshire and Avery (2001).
9. The Royal College of General Practitioners' regional Faculties support specific study events involving medical humanities, and the Royal College of Physicians of London has published two volumes of papers on medical humanities including Kirklin and Richardson (2001).
10. Holm (2000). In 2005 the UK Arts and Humanities Research Council also sponsored a workshop at Univ. Cambridge on the human face, as one of a series of workshops exploring medical humanities enquiries.
11. Drawn from Evans (2007).

References

Bolton, G.: 2001, *Reflective Practice: Writing and Professional Development*. London: Paul Chapman.

Cassell, E.: 1991, *The Nature of Suffering and the Goals of Medicine*. Oxford: Oxford University Press.

Evans, M.: 2002a, 'Medicine, Philosophy and the Medical Humanities', *British Journal of General Practice* 52(479), 447–449.

Evans, M.: 2002b, 'Reflections on the Humanities in Medical Education', *Medical Education* 36(6), 508–513.

Evans, M.: 2003, 'Roles for Literature in Medical Education', *Advances in Psychiatric Treatment* 9, 380–386.

Evans, H.M.: 2007, 'Medical Humanities: An Overview', in: R. Ashcroft, H. Draper, A. Dawson and J. MacMillan (eds.), *Principles of Health Care Ethics*. (2nd.,). Chichester: John Wiley and Sons, 199–206.

Evans, H.M. and R.J. Macnaughton: 2004, 'Should Medical Humanities be a Multidisciplinary or an Interdisciplinary Study?', *Journal of Medical Ethics: Medical Humanities* 30(1), 1–4.

Greaves, D.: 2001, 'The Nature and Role of the Medical Humanities', in: M. Evans and I. Finlay (eds.), *Medical Humanities*. London: BMJ Books, pp. 1–22.

Haddon, M.: 2002, *The Curious Incident of the Dog in the Night-Time*. London: Jonathan Cape.

Hampshire, S.: 1989, *Innocence and Experience*. Cambridge: Harvard University Press.

Hampshire, A.J. and A.J. Avery: 2001, 'What can Students Learn from Studying Medicine in Literature?', *Medical Education* 35, 687–690.

Hofmann, B.: 2001, 'The Technological Invention of Disease', *Journal of Medical Ethics: Medical Humanities* 27(1), 10–19.

Holm, S.: 2000, 'Changes to Bodily Appearance: The Aesthetics of Deliberate Intervention', *Journal of Medical Ethics: Medical Humanities* 26(1), 43–48.

Hunter, K.M., R. Charon and J.L. Coulehan: 1995, 'Study of Literature in Medical Education', *Academic Medicine* 70(9), 787–794.

Kirklin, D. and R. Richardson (eds.): 2001, *Medical Humanities: A Practical Introduction*. London: Royal College of Physicians.

Macnaughton, J.: 2001, 'Why Medical Humanities Now?', in: M. Evans and I. Finlay (eds.), *Medical Humanities*. London: BMJ Books, pp. 187–203.

Robson, M. and M. White: 2003, 'Ice to Fire', Mailout, June 2003.

Sacks, O.: 1986, *A Leg to Stand on*. London: Pan Books.

Sweeney, K.: 1996, 'How can Evidence-Based Medicine Help Patients in General Practice?', *Family Practice* 13, 489–490.

Toulmin, S., 1993, 'Knowledge and Art in the Practice of Medicine: Clinical Judgement and Historical Reconstruction', in: C. Delkeskamp-Hayes and M.A. Gardell Cutter (eds.), *Science, Technology and the Art of Medicine*. Dordrecht: Kluwer Academic Publishers, pp. 231–249.