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Scientific Contribution

Medical humanities and philosophy: Is the universe expanding or contracting?

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Abstract. The question of whether the universe is expanding or contracting serves as a model for current questions facing the medical humanities. The medical humanities might aptly be described as a metamedical multiverse encompassing many separate universes of discourse, the most prominent of which is probably bioethics. Bioethics, however, is increasingly developing into a new interdisciplinary discipline, and threatens to engulf the other medical humanities, robbing them of their own distinctive contributions to metamedicine. The philosophy of medicine considered as a distinct field of study has suffered as a result. Indeed, consensus on whether the philosophy of medicine even constitutes a legitimate field of study is lacking. This paper presents an argument for the importance of a broad conception of the philosophy of medicine and the central role it should play in organizing and interpreting the various fields of study that make up the metamedical multiverse.

Key words: academic disciplines, bioethics, medical humanities, models, philosophy of medicine

Introduction

Cosmologists debate the question of whether the universe is expanding or contracting. They have puzzled about an unresolved consequence of the big bang theory known as the flatness problem. At issue is how much matter there is in the universe. If the amount of matter is small enough, the universe will go on expanding forever. On the other hand, if there is a critical amount of matter, gravity will eventually stop the expansion and cause the universe to condense toward a ''big crunch,'' possibly followed by a re-expansion. In the 1980s, Alan Guth developed his ''inflation theory,'' which sees the origin of the universe in a tremendously rapid period of expansion in a tremendously short period of time, and there are now several versions of inflation theory. The one developed by Andrei Linde, known as the ''bubble theory,'' proposes the possibility that other universes, presently unknown, might also have inflated, thus making our universe only one ''bubble'' in a much vaster ''multiverse.'' While these ''parallel universes'' exist simultaneously, the finite nature of the speed of light makes it impossible for us to see into any of these other universes. Even in the midst of this explosion of theories, however, the question of whether our universe will continue to expand forever or collapse in a ''big crunch'' remains unanswered because we have no way to predict how much energy the universe contains (Siegfried, 2002, pp. 127–182).

I want to suggest that even though there are obvious limitations to the analogy, this image of a multiverse is an illuminating one for the present state of the medical humanities. ''Medical humanities'' is a term that is usually taken as a collective for various disciplines that study the human aspects of medicine, as opposed to the technical aspects. It includes such things as philosophy, theology, history, literature, and art, insofar as they are concerned with understanding medicine and medical practice. ''Medical humanities'' is also sometimes understood in a broader sense to include law, sociology, anthropology, and psychology. Work in the medical humanities seems to be expanding at present, but it is not at all certain whether this expansion will go on indefinitely or whether the enterprise will shrink or even collapse in upon itself. We just do not know how much energy there is in this academic world, and the data from which we might draw such conclusions at times seems as complex as the data from which cosmologists draw their speculation about the universe.

The medical humanities constitute a kind of academic multiverse, although it is a multiverse composed of the academic universes that are the traditional academic disciplines, and hence they interact more than the universes of Linde's bubble theory. What makes these universes cohere as a multiverse is that they share an appreciation of medicine as a human endeavor that reaches beyond its technical and scientific aspects. Their subject might aptly be called "metamedicine," which was the wonderfully descriptive and alliterative original title for the journal *Theoretical Medicine*, lately expanded to *Theoretical Medicine and Bioethics*. This titular evolution is, perhaps, a good indication that the "metamedical multiverse" is indeed expanding.

If we take the medical humanities to be a metamedical multiverse composed of the universes of philosophy, history, literature, etc. insofar as they concern themselves with medicine, there arises the question of how these various universes influence each other. I want to explore some models that describe these influences, and argue that the philosophy of medicine has a central role. Philosophy has always been the discipline that seeks the assumptions behind all human endeavors and the very essence of those endeavors; philosophy attempts to give an integrated account of these endeavors. Thus, philosophy of medicine seems the most likely candidate to serve as an integrating force in metamedicine. But we must also take note of a great gravitational force – some might say a black hole – that sometimes seems to be sucking many other metamedical studies, and even entire universes, into itself: bioethics. I will be particularly interested in the relationship of bioethics and the philosophy of medicine and the question of whether bioethics will ultimately doom philosophy of medicine to be lost in space.

Medical humanities

The most common understanding of medical humanities takes the field as an attempt to "humanize" scientific medical practice. David Greaves (2001, pp. 15–19), however, finds fault with most approaches to medical humanities because they maintain the traditional separation between medicine as an art and medicine as a science and side with the arts aspect to humanize the science aspect. Greaves (p. 22) distinguishes between medical arts, which attempt to humanize the physician, and medical humanities, which attempt to humanize medicine. He calls for a new conception of medical humanities that is humanistic in that it brings a "philosophical outlook" to both the science and the art of medicine. Greaves understands "philosophical" not in the restricted sense of philosophy as a field of study, but rather as an attitude of critical reflection. Medical humanities, then, promotes a humanistic perspective that attempts to unite the art and science of medicine.

This is a laudable goal, but what remains at issue is whether it is possible to conceive of medical humanities as a field unified enough to accomplish such a goal. Furthermore, we might well ask whether it is even desirable to conceive of medical humanities as an interdisciplinary field itself, and thus more than a metamedical multiverse of distinct academic universes reflecting on medicine. I have doubts about such conceptions, which will become more evident with some discussion of the notion of interdisciplinary fields and, in particular, bioethics.

Interdisciplinary and multidisciplinary fields of study

It is my contention that medical humanities do not constitute a field of study. Rather, "medical humanities" is a name given to the multiverse consisting of many academic universes that reflect on medicine, in both its theoretical and practical aspects. The medical humanities bring well-established disciplines such as philosophy, literature and history to a critical reflection on medicine.

This is not to say that the various fields that constitute the medical humanities are pure academic disciplines. For instance, the history of medicine is quite well established as a field of study, but it includes a disparate group of members, including both historians and physicians. The question of whether philosophy of medicine constitutes a distinct field has raised considerable controversy not only because it includes practitioners from both medicine and philosophy, but also because there is disagreement about exactly what subject matter constitutes the field.

Although medical humanities all attempt to lend a humanistic perspective to medicine, they do so in diverse ways. One doing a philosophical study of the logic of medical diagnosis, for example, approaches the task in a way that is very different from one studying a short story about a doctor puzzling about making a diagnosis that has important implications for a patient. Both shed light on the process of diagnosis, but the light comes from

quite different directions and is refracted in quite different directions.

That the medical humanities comprise many distinct academic disciplines and fields should not be seen as a liability, for this is precisely what makes the medical humanities such a rich human endeavor. It does, however, contribute to analytical complexity and controversy about how the parts relate to the whole.

When members of various disciplines meet to address topics of mutual interest, one might well ask how they see what they are doing. In *The Birth of Bioethics*, Albert Jonsen (1998, pp. 24–26) discusses the origin of the now superseded Society for Health and Human Values. The society was focused not only on ethical issues in medicine, but on the medical humanities, which included art, philosophy, history and literature. At the time it held its first annual meeting in 1970, it served as a meeting place for some "otherwise lonely figures," those few people who came from the disciplines of theology, philosophy, literature and art, and were now teaching in medical schools.

That society always struck me as multidisciplinary. That is, people from the various academic disciplines and the various health care professions came together to talk about their common interest – how to keep a human focus on an increasingly technological practice of medicine. Some people may have called themselves bioethicists because bioethics is what they did for most of the day, but they still identified in a more fundamental sense with their training as theologians, philosophers, physicians, nurses, etc. That sense of multidisciplinary cooperation is increasingly being supplanted by interdisciplinarity. Renée Fox and Judith Swazey (2005, p. 367) call bioethics "a multidisciplinary field with interdisciplinary aspirations." The distinction I am making here, which may not be exactly the same as that of Fox and Swazey, is this: a multidisciplinary endeavor is one in which people from several disciplines come together to talk about a topic of common interest. An interdisciplinary endeavor is one in which the endeavor itself is seen as growing from one comprising several distinct disciplines into a new "interdisciplinary discipline." In other words, multidisciplinarity is the meeting of people from different disciplines, who all retain their own sense of working in their own disciplines, while interdisciplinarity requires that each person be versed in several disciplines.

Evans and Macnaughton (2004, pp. 1–2) define a discipline as "a self conscious field of sustained, systematic inquiry with its own distinguishable subject matter, questions, and methods." Interdisciplinarity, then, is the engagement of disciplines with subject matter that "somehow both straddles the disciplines and falls between them." They suggest that the most important characteristic of interdisciplinarity is *emergence*. That is, particular problems and their solutions become evident, or emerge, only in the interaction of different disciplines, not within the disciplines by themselves. Furthermore, the participants that begin in different disciplines begin to share each other's metaphors.

My contention is that medical humanities is losing its multidisciplinary focus and moving more and more toward becoming interdisciplinary. This is coming about, I believe, because of the increasing acceptance of bioethics as a new discipline itself, an "interdisciplinary discipline." Bioethics, with its self-contained theoretical debates about such new ethical theories as "principlism," matters of informed consent arising from legal cases, and incorporation of principles such as double effect from moral theology, has provided a new *lingua franca* for medical humanities. Bioethics engulfs other disciplines, especially the philosophy of medicine, into itself. To see how this model has come to be so prominent, it will be helpful first to look at the development of bioethics as a new discipline.

Bioethics

Most observers trace the origins of bioethics back to about 1970. Of course, reflection on the ethics of medicine goes back at least to the time of Hippocrates, some quite specific ethical thought developed around medical issues in the Middle Ages, and medical ethics was developed systematically in the early nineteenth century, but present-day bioethics is seen to be different. Albert Jonsen (1998, pp. 3–33) finds the "birth of bioethics" rooted in the rapid changes in medicine following World War II. This prompted several conferences during the 1960s to reflect on the moral dimensions of these changes, followed by the establishment of two centers, the Hastings Center, outside of New York, and the Kennedy Institute of Ethics at Georgetown University in Washington. These centers provided a permanent home for discussions about the burgeoning questions of bioethics. A third organization, the previously mentioned Society for Health and Human Values, bolstered the development

of bioethics as a discipline by instituting a series of annual meetings of interested persons.

Warren Reich (1994, 1995) has argued that the word "bioethics" came into being independently at about the same time in two places, but with slightly different understandings. At the University of Wisconsin, Van Rensselaer Potter used the word to focus on a discipline that would study evolutionary and cultural adaptation in the context of the new biology in order to enrich human lives and prolong the survival of the human species. This conception of bioethics would embrace environmental concerns as well as medical ones. It was, in this sense, a holistic view. Potter regarded bioethics to be involved in "the search for wisdom," that is, for knowledge about what would enable good judgment about what was valuable for survival.

At Georgetown, on the other hand, André Hellegers was using the word to designate an academic discipline that would also focus on the interaction of science and ethics, but more narrowly on the realm of health care. The Georgetown model would seek to "resolve moral problems in three areas: (1) the rights and duties of patients and health professionals; (2) the rights and duties of research subjects and researchers; and (3) the formulation of public policy guidelines for clinical care and biomedical research" (Reich, 1995, p. 20). Reich (1995, p. 30) concludes that the word "bioethics" was what gave rise to the field of bioethics in part because "the word itself symbolized and stimulated an unprecedented interaction of biological, medical, technological, ethical, and social problems and methods of thinking."

Albert Jonsen (1998, pp. 327–342) argues that any discipline is characterized by the presence of a central theory, or sometimes alternative theories, principles, and a methodology to order, analyze, and evaluate the discipline's content. Bioethics has this to the extent that it has been formed into a body of knowledge that can be taught, and while it does have some elements of emerging theory, it is still not a discipline with any universally agreed upon methodology. As Jonsen (1998, pp. 342–344) says, bioethics is a "*mélange* of disciplines," including philosophy, theology, law, social sciences, and now more and more the arts and literature.

But Jonsen (1998, p. 346) has a further insight that is illuminating: he says that bioethics might well be considered a "demi-discipline." That is, only half of bioethics is like ordinary academic disciplines. The other half is a public discourse involving people of all sorts and professionals of all sorts arguing about bioethics, teaching it, and struggling to make practical decisions about how to deal with suffering. Bioethics, then, is a discipline unlike other purely academic disciplines, and more like a professional endeavor. From its earliest days, bioethics was shaped by the realization that its focus would be to help physicians to make hard decisions. It would have to move out of the ivory tower of academe and become as much a profession as an academic discipline. More than thirty years ago, Daniel Callahan (1973, p. 73) concluded his discussion of bioethics as a discipline: "The discipline of bioethics should be so designed, and its practitioners so trained, that it will directly – at whatever cost to disciplinary elegance – serve those physicians and biologists whose positions demand that they make the practical decisions."

Bioethics, then, has grown past its academic origins, if, indeed, its origins were academic. It has become, as Carl Elliott (2005, p. 380) puts it, "a self-contained, semiprofessional entity whose place in the bureaucratic structures that house it has become distinct – both from the traditional academic disciplines from which it emerged and from the clinical disciplines that it has sometimes aspired to resemble." As a result, it has become possible to work as a bioethicist without necessarily working as a professor, physician, or anything else. The bioethicist has come to garner "a certain amount of deference within the institution," dispensing ethical advice that many people working in the hospital feel they cannot ignore.

Judith Andre (1997, pp. 161–165), a philosopher by training but now engaged in bioethics, reflects upon bioethics precisely as a practice. By "practice," Andre means something like Alasdair MacIntyre's notion, developed in his book, *After Virtue*. As a practice or near-practice, Andre argues, bioethics should be evaluated not only for its scholarship, but more broadly for its practical impact. Does bioethics make the world a better place for the sick, and indeed for all of us? Andre argues that bioethics is not a subfield of philosophy because bioethics does not simply supply philosophical insights to health care. To be a practitioner of bioethics demands that one master a body of scholarly knowledge specific to bioethics, but also that one develop "interpersonal and institutional skills" that are necessary to communicate with people from a range of disciplines and walks of life. Andre's description is an apt one for what has become known as clinical bioethics. Indeed, interpersonal skills are probably more important than scholarly knowledge when it comes to

negotiating conflicts between family members. But Andre's comments only serve to confirm Jonsen's characterization of bioethics as a demi-discipline.

The term "bioethics" may have been born in the United States, but the practices of bioethics are engaged in throughout the world. Culture does, of course, shape discourse. Henk ten Have (2000, pp. 28–31) has noted that while some southern European counties have maintained a stronger emphasis on traditional medical ethics as "medical deontology," i.e., codes of conduct that are mixtures of ordinary moral rules, professional codes of conduct and rules of etiquette, northwestern European countries and the United States have emphasized problems in the doctor-patient relationship and moral issues created by the health care system, as well as public policy issues resulting from biomedical advances and research. Academic culture also shapes bioethical discourse. The different philosophical methodologies in the Anglo-American academy and in Continental Europe have also shaped the discourse differently, with Americans talking largely about justice, for example, while many in Europe focus on the notion of solidarity.

This diversity raises the important question of how different discourses and disciplines shape the universe of bioethics, and some scholars have been at work trying to analyze the situation. Edmund Pellegrino (1997, pp. 11–19) has described five models of how the disciplines that contribute to bioethics relate to one another. In the *traditional model*, ethics is taken as a philosophical discipline and bioethics is seen as a branch of philosophy. He sees this as closest to the "Georgetown model," as described by Warren Reich. The problem with this model, as Pellegrino points out, is that it is too narrowly conceived and risks missing the insights that the various other humanities can contribute to bioethics.

The *antiphilosophical model*, by contrast, reflects the antipathy of many both within philosophy and outside it to philosophical ethics. It tries to banish philosophy from bioethics altogether and replace it with one of the other disciplines. Pellegrino rightly worries that ethics without a philosophical basis will be reduced to "a species of moral gnosticism or intuitionism," or worse, "moral nihilism and relativism."

The *process model* is a procedural enterprise that "evades the conceptual issues." It emphasizes only the ways in which people go about trying to resolve moral issues. Thus it rejects identification of bioethics with any discipline and instead sees bioethics as a method for deliberation and decision-making. The process of collaborative deliberation is clearly necessary for bioethics, and Pellegrino recognizes this. But as he rightly points out, this is not enough. The purpose of moral reflection is "right and good conduct," and this will not necessarily come from process alone. The process itself must be subjected to critical analysis. Philosophy is the obvious discipline from which to conduct this critical analysis, but historical, psychological, and even scientific analysis may also play roles.

The *eclectic-syncretic model* corresponds in many ways to Potter's "Wisconsin model" of bioethics. Eclecticism recognizes merit in many different disciplines and moral viewpoints and selects from each what it sees as useful. Syncretism then tries to resolve the differences and fuse what it has chosen into a new system. This is, as we have seen, one of the hallmarks of interdisciplinarity. The general problem with this model, as Pellegrino recognizes, is that it robs each discipline of its specific contribution to the bioethical discourse. Ethics interacts with biology, with literature, with the law, with the social sciences, and with other disciplines to create the interdisciplinary bioethics. One prominent incarnation of the eclectic-syncretic model in today's medical humanities is the interaction of literature and ethics. Literature has much to contribute to our understanding of the human condition and of good and evil. It is especially important in its ability to evoke in us emotional responses to ethical demands. However, Pellegrino is right in pointing out that the rich moral content of literature does not confer any epistemological status on literature. As he says, "fictive characters are fictions." Literature can inspire us to be good; but literature can also inspire us to be bad. On its own literature cannot give the type of moral sanction and "complete account" of the moral life that is the very essence of moral philosophy.[1]

Finally, the *ecumenical model* allows philosophical ethics to retain its traditional identity, but also allows dialogue with literature, anthropology, history and evolutionary biology, all of which retain their own distinctive identities. All of these disciplines study the moral life, but each does so from a different perspective. These differences are precisely what make the bioethical dialogue so rich. The non-philosophical disciplines aptly describe the complexity, the context and the psycho-social aspects of moral behavior. Any ethical analysis must take these factors into account. But it is philosophy that has the power to examine "those conceptual elements and principles that transcend

detail.'' Thus, the ecumenical model makes bioethics closest to ethics traditionally considered, but enriches it by drawing in a broader range of human experience and reflection.

I think that Pellegrino's ecumenical model for bioethics is moving in the right direction. The medical humanities enrich bioethics greatly in the ecumenical model, yet philosophy retains a central position among the medical humanities, because it is the discipline that is rightly concerned with critical analysis of the moral claims and methodologies of other related disciplines. I would like to move even more, however, toward a model in which the philosophy of medicine has a central place in the metamedical multiverse. Thus, although the philosophy of medicine can be seen as a universe of discourse itself, it would also be the organizing force for the entire metamedical multiverse, including the universes beyond bioethics.

Philosophy of medicine

Henk ten Have (1997, pp. 105–106) has argued that the era in which bioethics was born and blossomed is also characterized by the virtual invisibility of the philosophy of medicine as a theoretical and practical endeavor. He attributes this invisibility to three interrelated phenomena. The first is the ''ethicalization'' of the philosophy of medicine. Instead of examining the range of philosophical issues raised by medicine, focus is increasingly put on ethical issues by people who ''have renamed themselves 'bioethicists'.'' The second is the ''technicalization'' of ethics. That is, bioethics is now seen as an autonomous discipline aimed at solving practical problems; it is no longer adequately characterized as moral philosophy. The third phenomenon is the anti-realism that is fostered by the stress of privatization, relativism and proceduralism. This is characteristic not only of bioethics, but more generally of post-modernism and in particular the social constructivism that is so prominent in science and technology studies. This is all in general agreement with the way I have characterized bioethics. I also concur with ten Have's (2000, p. 31) call for a ''broader philosophical framework'' for bioethics in order to connect the ''internal morality'' of medicine with the ''external morality'' of the social, cultural and religious traditions in which medicine is practiced.

Ten Have (1997, pp. 111–113) finds the origins of the philosophy of medicine in the nineteenth century and coming from a reinterpretation not only of medicine but also of philosophy. This was the time of the emergence of an organized medical profession, which could claim authority because of its scientific basis. But at the same time, philosophy also began looking to science for methodological and theoretical models for philosophical study itself. Thus, by the end of the 19th century, philosophers gave up the quest of constructing grand idealistic systems to explain medical reality. Instead, they shifted their attention to philosophical interpretation of the practices of medicine. Philosophy of medicine changed from a discipline offering alternative and competing theories of medicine, to a meta-discipline. Philosophy of medicine did not lose its connection with philosophy in general, however. The prominent Polish school of philosophy of medicine, for example, identified itself as Polish analytical philosophy and was particularly interested in clarification of language, logic, and epistemology. The Polish philosophers concerned themselves with analyzing very particular problems in great detail rather than constructing grand philosophical systems (ten Have, 1997, pp. 113–116).

Looking at the conceptual structures of philosophy of medicine over the past 100 years, ten Have (1997, pp. 116–119) identifies three major traditions. The *epistemological tradition* grew out of the characterization of medicine as a natural science and its increasing specialization. The theory and practice of medicine became radically separated, and the need for synthesis became a fundamental epistemological problem for the philosophy of medicine. Two epistemological strategies developed. One focused on organizing knowledge by focusing on rigorous methodology. The other focused not on methodologies that could produce objectivity and precision, but rather on appreciating the subjectivity of the knowing subject. The latter recognized that medicine was concerned more with acting than with knowing. The *anthropological tradition* predominated in Germany and the Netherlands from about 1930 until 1960. It emphasized the subjectivity not only of the knowing and acting physician, but also of the patient. Medicine is unique because it attends to the patient as a person. The *ethical tradition* has predominated since the 1960s.

All three of these perspectives should be included in contemporary philosophy of medicine. As ten Have (1997, pp. 119–120) recognizes, medical practice is embedded in society and culture, and so the essential nature of medical practice cannot be understood by the study of medical

science in isolation. This, ten Have claims, has two effects. First, it has changed the relationship between medicine and philosophy. Because medical practice is so directed by social influences and cultural values, it is no longer the province purely of physicians doing meta-reflection on their own practices. Second, medical practice cannot be understood without understanding the cultural values in which it exists. The question for philosophy of medicine is not simply one of what we know, but of what we want to do with our knowledge. For this, the epistemological, anthropological, and ethical traditions in the philosophy of medicine are all necessary.

How these perspectives are organized in the philosophy of medicine has become a matter of academic debate, however. This debate relates directly to the question of what is included in the philosophy of medicine universe – and whether it is expanding to be more inclusive, or contracting to be more exclusive.

The narrow view

Edmund Pellegrino represents a notable instance of a narrow view of the philosophy of medicine. He and philosopher David Thomasma proposed three ways in which philosophy and medicine interact (Pellegrino and Thomasma 1981, pp. 28–30). (1) Philosophy *and* medicine has to do with "mutual considerations by medicine and philosophy of problems common to both." For example, the mind-body problem set up by Descartes is an important problem for philosophers of mind, metaphysicians and epistemologists, but it is also an important concern for philosophers of medicine, who might have very different views of the problem itself stemming from particular concerns of medicine or medical ethics. In this model, philosophy and medicine address a common topic, but they remain independent disciplines in particular interests and methodologies. (2) Philosophy *in* medicine refers to the "application of the traditional tools of philosophy – critical reflection, dialectical reasoning, uncovering of value and purpose, or asking first-order questions – to some medically defined problem."[2] In other words, this model sees the contributions that the discipline of philosophy has made to critical thinking, framing questions, and other basic work of philosophy itself, and simply applies these methods to issues in medicine. (3) Philosophy *of* medicine is concerned specifically with the meaning of clinical medicine. Philosophy of medicine examines the conceptual foundations and ideologies of the clinical encounter of doctor and patient; thus, it really tries to provide a foundation for medical ethics. In a later paper, Pellegrino added a fourth category – medical philosophy – which is more literary than philosophical. This includes the informal or literary reflections of physicians on their clinical experience (Pellegrino, 1986, 1998). Essays of William Osler or short stories of William Carlos Williams would count as medical philosophy.

Philosophy of medicine, for Pellegrino, then, is restricted to the third model. The first model might take purely epistemological questions in medical research to be outside philosophy of medicine. On this account, such questions are more properly questions of philosophy of science or epistemology. These may have great importance for the practice of medicine, but they are not properly philosophy of medicine unless they directly contribute to the clinical encounter of doctor and patient. The second model is of interest only in the recognition that philosophy has provided methods for clear thinking; their application in medicine is important, but no more important than clear thinking in any facet of human life. The fourth model, medical philosophy, is more akin to the medical humanities in general. Philosophy of medicine proper, for Pellegrino (1998, p. 327), is concerned only with what is "peculiar to the human encounter with health, illness, disease, death, and the desire for prevention and healing." Philosophical concepts are studied only insofar as they relate to the human encounter with somatic or psychological well-being and dysfunction.

Arthur Caplan also sees philosophy of medicine in a narrow sense, albeit a very different one. In actually arguing that the philosophy of medicine does not exist, Caplan (1992) presents a narrow view. Referring to an early work of Edmund Pellegrino, Caplan distinguished philosophy *and* medicine from philosophy *in* medicine. The former includes medical ethics, bioethics, health policy, and medical aesthetics. An example of the latter is the study of professional codes by those in bioethics. But philosophy *of* medicine, for Caplan (1992, p. 69) is "the study of epistemological, metaphysical and methodological dimensions of medicine; therapeutic and experimental; diagnostic, therapeutic, and palliative." Caplan states that this is a stipulative definition. We can, of course, organize our pursuit of knowledge in any way we see fit, but the question is why we should accept this particular stipulation. Caplan's understanding of philosophy of medicine at first appears to be quite broad, but it really is not,

for its primary intent is apparently to exclude much of what others consider important to the philosophy of medicine. It is curious that it is limited to epistemological, metaphysical and methodological dimensions. Why should the philosophy of medicine not include aesthetic and ethical dimensions, when aesthetics and ethics are clearly part of the philosophical universe? Caplan seems to want to limit the philosophy of medicine to just those sorts of questions that the philosophy of science addresses. In fact, even in the argument against the existence of the philosophy of medicine, Caplan (1992, pp. 69–70) slips in this statement: ''In short, the philosophy of medicine is a sub-discipline of the philosophy of science. Thus, its primary focus is epistemological not ethical, legal, aesthetic or historical.''

A reasonable concern that both Caplan and Pellegrino have is in trying to limit the field so that it is not unnecessarily broad. While Pellegrino would narrow the focus to the clinical encounter, Caplan would narrow the focus to medical science. This latter strategy, however, narrows the focus too much. Certainly, part of the philosophy of medicine must concentrate on the issues that Caplan mentions. However, understanding aesthetics is as important to an analysis of plastic surgery as understanding epistemology is to an analysis of pathology and laboratory medicine. Both of these specialties are part of medicine. So, if Caplan's claim that epistemology should be a part of philosophy of medicine is correct, then aesthetics should also be a part of philosophy of medicine.

The broad view

A broader view of the philosophy of medicine is the one outlined by Schaffner and Engelhardt (1998). I take this broad view to be closer to what those who see themselves engaged in the philosophy of medicine are actually doing. On this account, philosophy of medicine is defined as ''encompassing those issues in epistemology, axiology, logic, methodology and metaphysics generated by or related to medicine.'' The broadest conception includes medical ethics, although the authors recognize that this has become such a large topic that they do not specifically include it in their article. Elements of the philosophy of medicine that they do discuss include models of medicine, such as the narrow biomedical model or the broader biopsychosocial model of George Engel. Concepts of health and disease have been a ''defining problem'' for contemporary (and classical) philosophy of medicine. Whether these concepts are value-laden or not has been a source of ongoing debate. In addition, recent advances in molecular genetics challenge older views of normality and pathology. Investigations into the logic of diagnosis, prognosis and evaluation of therapies began in the 1950s and were extensively developed in the ensuing decades. Artificial intelligence programs led to computer-assisted diagnosis, and this became a source of rich philosophical discussion. Philosophical discussion has also focused on causation of disease and evaluation of therapies.

In fact, even those who hold a narrower view of the philosophy of medicine would endorse the importance of all the matters included in the broad view of the philosophy of medicine. Pellegrino's own work has touched on causality, logic and the mind-body relationship. These issues are taken to be important only insofar as they lay a foundation for medical practice and medical ethics, however. On the other hand, the broad view takes all these matters, including medical ethics itself, as part of the philosophy of medicine. Philosophy of medicine does contribute importantly to medical practice, but it goes beyond this in trying to understand theory as well.

Situating the discipline

As is the case with trying to understand the structure of the physical universe, the way one sees, or does not see, the philosophy of medicine in the metamedical multiverse depends to a great extent on how one interprets the data. Of course, how one interprets the data also is influenced by the way one sees the situation with regard to philosophy of medicine. The question how the philosophy of medicine is related to other fields was advanced by Arthur Caplan's paper (1992) arguing that the philosophy of medicine does not exist as a field. Even though there has been no diminution, and indeed a significant expansion, of scholarship in what appears to be philosophy of medicine in the nearly 15 years since Caplan's paper was published, the philosophy of medicine still struggles for recognition in the immense shadow being thrown by bioethics. In fact, Caplan has always recognized the importance of the philosophy of medicine, and part of the momentum that drove his paper was the recognition that the philosophy of medicine is sorely needed not only by bioethics, but also by the philosophy of science and by medicine itself.

Vic Velanovich (1994) argued that, even twelve years ago, philosophy of medicine had all the

characteristics of a developing field, even according to Caplan's criteria. The most problematic area, then and now, is the integration of the field into some "cognate areas of inquiry." Velanovich admitted that this was the most underdeveloped area, but drew on John Dewey to argue that the logical forms that govern a field of inquiry are developed as the inquiry itself proceeds (Velanovich, 1994, pp. 78–79). Thus, he admitted that Caplan's assessment of the state of the field may have been right at the time, but that the proper connections may emerge.

Twelve years later, philosophy of medicine activities are as robust as ever, yet as a field, it still seems to wander, not part of philosophy and not part of medicine, yet studied with great interest by members of both disciplines. Indeed, Caplan (2006) has recently argued that bioethics is an insufficient remedy for what ails contemporary medicine. He maintains that medicine needs to know what its methods are for dealing with bias and fraud so that it can resist the pressures put on it by "politics, money, ambition and greed." This is fundamentally an epistemological problem, and Caplan laments the fact that few physicians have any sophisticated knowledge of the philosophy of science or the philosophy of medicine. Philosophy of medicine may still not be a field, but Caplan obviously believes it is essential, at least in the narrow sense that he conceives it.

A related problem in defining philosophy of medicine as a field is figuring out exactly who is doing it. In a response to Caplan, Henrik Wulff (1992, pp. 79–81) distinguished several groups involved in matters pertaining to the philosophy of medicine. There are professional philosophers who have become interested in medical matters, physicians whose main interest has turned to philosophy, professional philosophers who have become very well versed in medicine, medical professionals who are also trained in philosophy, and medical professionals who devote themselves to medical practice. It is this last category, Wulff argues, that plays an important role in formulating problems for the philosophy of medicine. Wulff (1992, pp. 83–85) argues that Caplan fails to see the existence of the philosophy of medicine because he is looking at it from the perspective of a professional philosopher. This seems right, for philosophy has been reluctant to add the philosophy of medicine to its recognized list of sub-fields. However, Wulff (1992, p. 85) claims that philosophy of medicine is a "philosophical activity" that is "closely linked to the main trends of contemporary medical thinking." Because it "serves the same goal as the rest of medicine, philosophy of medicine should be seen as an "emerging (or reemerging) medical discipline." The trouble here is that the practice of medicine, a practical pursuit, is quite different from the practice of metamedicine, by definition a reflective pursuit. It seems much less likely that the medical profession will recognize the philosophy of medicine as a sub-discipline than philosophers will, for philosophy of medicine is much more like philosophy than medicine. To conclude, I would like to suggest a model of metamedicine that holds a broad view of the philosophy of medicine at its center.

Mapping the metamedical multiverse

Philosophy was traditionally regarded as the "queen of the sciences," standing in a unique place to establish foundations of knowledge and ultimate truths. Although those goals may no longer seem realistic, and although professional philosophy itself has sometimes wandered far from them, philosophy still occupies a central position inasmuch as it seeks the assumptions behind and essence of all human endeavors and seeks to integrate them. In this sense, philosophy of medicine might serve as the central metamedical discipline, reflecting upon and integrating the various disciplines that reflect on the science and art of medicine.

Van Leeuwen and Kimsma (1997, p. 100) rightly point out that medicine is both more than a science and less than a science. It is more than a science because it does not restrict itself to formulation of theories that hold under carefully circumscribed conditions; it is less than a science because it is confronted by the need to act even in the face of an uncertainty that is characteristic of medicine. Physicians bring to bear several different kinds of skills and knowledge on real problems, thus instituting a "medical discursive account of the patient's situation" (Van Leeuwen and Kimsma, 1997, p. 102). I believe that they are right in saying that philosophy, and especially European philosophy, provides crucial insights necessary to understand medical practice. If anything, providing such crucial insights is what makes philosophy of medicine distinctive, and in a sense, confirms Pellegrino's insistence that the clinical encounter is at the heart of the philosophy of medicine.

Specialization is obviously necessary, in metamedicine as well as in medicine, for understanding all

the aspects of such a complex practice is beyond any one individual or discipline. Indeed, Robert Neville (1974) argues that this ideal is impossible because the disciplines inhabit what he calls "different worlds." Each discipline selects elements as either relevant or irrelevant to the model of that particular discipline; the discipline then takes its own explanatory system to apply to the world as a whole and not just part of it. This allows the scientist, for example, to see science as the only discipline worthy of explaining the way the world is, with all other disciplines merely offering subjective opinions not worthy of being called knowledge. Nonetheless, Neville (1974, pp. 63–64) suggests that philosophy, which aims to cultivate the "richest possible experience" of the world, might serve the role of integration of knowledge by translating what those in the various disciplines are saying into an "integrating cosmology." Of course, these cosmologies would be only hypothetical, but they could be judged according to such values as comprehensiveness, ability to specify the terms of the various disciplines, applicability to the whole of experience, and internal consistency and coherence. This approach would be committed not so much to finding truth, but rather to providing a common language for various matters, theoretical and practical, arising from all the disciplines.

Thus, I would like to suggest an alternative model for our metamedical multiverse. The model that sees the medical humanities as a broad family containing the various disciplines is what, at first glance, seems obvious. Within the medical humanities, the various disciplines such as bioethics, philosophy, art, literature, and history of medicine, all inform one another to some extent, but remain worlds of their own, hence retaining their individual identities as disciplines. An alternative model, the bioethics model, tries to incorporate all the various disciplines within it to create a new interdisciplinary discipline called bioethics. The model I am suggesting is one inspired by Cardinal John Henry Newman. Newman (1996, p. 45) argues that all knowledge forms one whole that can be separated only by abstraction. All disciplines have a bearing on one another. For Newman, it belongs to philosophy as the "science of sciences" to comprehend "the bearings of one science on another, and the use of each to each, and the location and limitation and adjustment and due appreciation of them all, one with another." In a sense, it is philosophy in this sense (although not necessarily in the sense of professional philosophy as it is practiced today) that is the genuinely interdisciplinary field.

This model, somewhat analogous to Pellegrino's ecumenical model of bioethics, sees the philosophy of medicine as the core discipline, but not in the sense that bioethics tries to ingest all other disciplines. Rather, philosophy of medicine becomes the common language for all the medical humanities. I believe that taking philosophy of medicine, rather than bioethics, as central will benefit all the medical humanities by providing a broader foundation for analysis of this very complex realm of activity. Making the metaphysical, epistemological and aesthetic aspects of ethical decisions more prominent would provide for a much richer ethical discourse than is currently being fostered by the professionalization of bioethics. Bioethics as a practical endeavor is undoubtedly important, but it could be more.

This necessarily demands that philosophy of medicine be considered very broadly. It cannot just be a subset of the philosophy of science that looks at epistemological, metaphysical and methodological facets of medicine, as suggested by Caplan. Certainly these elements will be part of this broad philosophy of medicine, but they will not constitute the whole of it. Philosophy itself is a broad field – so broad, some might say, that it has ceased being one field. Nonetheless, I am suggesting a return to the roots of philosophy. That view is the one that gave rise to awarding the degree of doctor of philosophy to people who have studied in all sorts of fields, the humanities and the sciences. Thus, philosophy of medicine would offer reflection not only on the traditional philosophical problems inherent in medicine, but also on all of the medical sciences and humanities, and medical practice as well. I am suggesting neither a philosophical imperialism, nor that only professional philosophers will be capable of doing philosophy of medicine. I am only suggesting that philosophical thought about all the medical humanities and sciences offers the best hope at integrating a very broad field of scholarship and enabling at least some communication in a metamedical multiverse that is now characterized either by separate bubble universes that have much trouble seeing into other universes, or worse, by one big bioethical bubble.

Notes

1. This is not to say that bioethics must give a complete account of the moral life. Giving such an account is, however, just what moral philosophy tries to do. Martha Nussbaum (1990, pp. 138–143) has argued that traditional moral philosophy, or ethical theory, lacks the power to express all moral truths, and that literature is important in conveying some of these truths.

She thus distinguishes between ethical theory and moral philosophy, the latter being a more inclusive term, which would include both traditional ethical theory and literature (Nussbaum, 1990, p. 169, n. 2). I do not doubt the power of literature to convey truths in a way that abstract ethical theory cannot. However, it remains a fundamentally philosophical task to judge that what is being conveyed in the literature is indeed a moral truth.

2. It might seem that philosophical reflection on medicine constitutes "second order" reflection. But apparently the point is that in the philosophy *in* medicine model, first order philosophical questions are applied to medicine; it is only in the process of applying the first order questions that the reflection becomes "second order."

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