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Medical humanities' challenge to medicine

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Abstract

Medicine is predicated on a view of human nature that is highly positivist and atomistic. This is apparent in the way in which its students are taught, clinical consultations are structured and medical evidence is generated. The field of medical humanities originally emerged as a challenge to this overly narrow view, but it has rarely progressed beyond tinkering around the edges of medical education. This is partly because its practitioners have largely been working from within a pervasive medical culture from which it is difficult to break free, and partly because the field has been insufficiently armed with scholarly thinking from the humanities. This is beginning to change and there is a sign that research in medical humanities has the potential to mount a persuasive challenge to medicine's ways of teaching, working and finding out. This article problematizes medicine's narrow viewpoint, grounding its critique in philosophical ideas from phenomenology and pragmatism. I will reflect upon the historical context within which medical humanities has emerged and briefly examine specific examples of how its interdisciplinary approach, involving humanities scholars with clinicians and medical scientists, may develop new research directions in medicine.

Introduction

Medical humanities as a field emerged in the USA in the 1970s as a result of a growing sense that there was something inadequate about medicine's understanding of the human, as demonstrated in its approaches to evidence and practice. This journal has done much to raise the importance of philosophy in critiquing 'moderate-anti-intellectualism' within medicine, and in showing the value of a philosophical approach in revealing underlying unquestioned assumptions within medical policy and practice [1].

There are a number of other humanities and social science disciplines that come within the scope of medical humanities that are also capable of exposing lazy thinking and accepted norms. For example, those interested in the study of literature and medicine challenge modes and processes of clinical practice to reveal their underlying narrative structure [2]. The approach from the humanities has, however, tended to be piecemeal, critiquing particular issues within medicine and health care, such as specific ethical problems, evidence-based medicine, or ways of understanding patients' case histories, without really addressing a core assumption that medical practice makes about the human: that to understand, diagnose and treat patients requires an atomistic view of how human beings work as physically embodied individuals and as persons within their social context. I do not want to suggest that this is a unique or original insight; many philosophers have critiqued medicine for its logical atomism [3]. But what I want to explore in this paper is, first, what is lost by medicine in

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holding that view of human nature, and second, why it is that the humanities (including philosophy) have not managed to lay the 'killer punch' on medicine's atomistic viewpoint. Finally, I will propose some potential contexts where humanities working synergistically with medicine might bring about radical new thinking in public health and in biomedical research.

Medicine's view of the human

Consider these two very different accounts of the side effects of treatment for breast cancer: From the *New England Journal of Medicine* 'Side Effects of Adjuvant Treatment of Breast Cancer': Many women with breast cancer who are receiving adjuvant chemotherapy have fatigue, and about two thirds of them rate the level of fatigue as moderate or severe…. The fatigue appears to resolve after treatment. In a survey of nearly 2000 women with breast cancer who were evaluated three years after adjuvant treatment, the level of fatigue was similar to that of age-matched women [4].

A poem by Julia Darling: 'Chemotherapy' from her book *Sudden Collapses in Public Places*:

I did not imagine being bald
at forty four. I didn't have a plan.
Perhaps a scar or two from growing old,
Hot flushes. I'd sit fluttering a fan.
But I am bald, and hardly ever walk
by day, I'm the invalid of these rooms,
stirring soups, awake in the half dark,
not answering the phone when it rings.
I never thought that life could get this small,
that I would care so much about a cup,
the taste of tea, the texture of a shawl,
and whether or not I should get up.
I'm not unhappy. I have learned to drift
and sip. The smallest things are gifts

[5].

These two pieces of writing illustrate starkly the different perspectives of medical research and the patient in relation to illness. From the medical perspective, it is important to know the side effects of powerful treatments so that an evaluation can be made about risks in relation to longer-term benefits for the patient. Of course, patients are keenly interested in these issues too: they want to know about side effects, how long they will last and how serious they are likely to be. But this information does not *represent* illness for the patient in the way it does for doctors.

For patients, illness is encapsulated by what they experience – the effects that it has on their ability to do things, to relate to others, to live as they have before in the world. In this poem, for Darling, the effects of the treatment for her breast cancer challenged her whole idea of herself: it was not in her plan to be 'bald at forty four'. She presents a rather charming (and

we suspect tongue-in-cheek) picture of herself as a delicate middle aged lady gracefully accepting the ageing process and fluttering a fan against menopausal hot flushes. Is this the 'age-matched' woman of the clinical trial? She suffers the side effect of 'fatigue' but in the poem we discover the consequence of this in her life. Her world has contracted. She ignores phone calls, drifts about the house, sleeps and 'sips' (being too tired even to swallow or gulp) soups and tea.

Reading these two accounts of the side effects of illness, it is pretty clear which one draws us as human beings into understanding and sympathy with the patient most effectively. But in presenting these accounts I do not intend to set up a straw dog just so that I can knock it down. I am not criticizing the objectivity of the *NEJM* account, which is evidence-based, valid and essential for doctors to carry out their work. What I am suggesting is that the real experience represented in the poem and the feelings suggested by it – which speak to us as humans in a way the science does not – needs to be taken more seriously in our thinking in medicine.

So far in the medical humanities this kind of calibration of the scientific with the humane has been justified with reference to *understanding* rather than *doing*. Medical humanities has been characterized as a field of study that helps doctors do what they are already doing in a more humane, empathic way: it is to do with making better doctors not with re-envisioning medicine itself. And there are historical and political reasons why the field has taken this path, which I will discuss in the next section [6]. However, current accounts of medical humanities suggest a much bolder intention. One of the major UK centres for medical humanities suggests that:

> Biomedicine has conceptualized illness in ways that have proved profoundly productive from a curative point of view. But it cannot – and it does not pretend to – illuminate the experience of living with it [7].

A further conception is presented by my own Centre at Durham University. While noting that the field has tended to focus its energies on medical education, my colleague, Martyn Evans, characterizes the field as primarily philosophical, drawing upon arts, humanities and social sciences as resources in which the concerns of human beings, including health and illness, are represented, discussed and theorized [8]. This view is summarized on the web site of Durham's Centre for Medical Humanities:

> The Medical Humanities is an emerging field of enquiry in which humanities and social sciences perspectives are brought to bear upon an exploration of the human side of medicine.

These perspectives have a key role to play in analyzing our expectations of medicine, and the relationship between medicine and our broader ideas of health, well-being and flourishing [9]. This implies not a supernumerary role for medical humanities – that we need the humanities only when considering the experiential, leaving scientific medicine untouched – but an integrated function that suggests a fruitful relationship between science and the humanities in exploring the nature of illness and disease within a non-dualistic view of human nature.

The late 19th and early 20th centuries marked a significant turning point in relation to medicine's attitude to the human when the logical atomist philosophy of Bertrand Russell won out over the pragmatism of philosopher/psychologist William James [3]. Russell was a logician and in an era when the methods and successes of science and technology were celebrated, the way of thinking about the world characterized by his philosophy – which depended upon the establishment of logically or empirically derived truths about the world and regarded James' pragmatism as 'a form of subjective madness' – held sway and became rooted in the development of modern scientific biomedicine [10]. That development was important and has led to significant advances in technical medical care. Progress in bioscience has relied upon molecular, indeed sub-molecular, and genetic investigations that have led to new treatments. The testing of those treatments depends upon randomized controlled trials in which individual difference is lost in group similarity. Treatment delivery is by clinicians whose training, even in communication, requires learning a framework within which doctor and patient are assumed to pose particular kinds of questions and respond in anticipated ways [11]. This has been successful in delivering a certain kind of technical medical care, but it may be that holding to the conception of the human on which this progress has so far been based may hamper new directions and further understanding in medicine. Clinicians are encouraged by their scientific perspective to regard patients in certain ways: as biochemical machines that need fixing; as wayward children who need to be led to eat correctly/ stop smoking/exercise; as boxes of molecules to which can be added another molecule that will sort out an imperfect reaction.

The philosopher Mary Midgley argues against this prevailing scientific vision of the human that forces us into a way of understanding that is at best partial and certainly skewed:

> … the particular vision which has been seen as scientific here centres on an unbalanced fascination with the imagery of atomism – a notion that the only way to understand anything is to break it into its ultimate smallest parts and to conceive these as making up something comparable to a machine.

Because that method succeeded for a time so well in the physical sciences, people have hoped to extend it to the rest of life in two ways. The first and most obvious way is by reducing mind itself to matter and thus to physical particles. This is seen as a way to mend the yawning division which Descartes introduced between mind and body by letting the major partner swallow up the minor one. Thus psychiatrists have sometimes tried to view their patients merely as physical mechanisms and behaviourist psychologists hoped to study human life purely in terms of outward behaviour – of the movement of human bodies – without referring at all to the thoughts and feelings of the people involved. (p. 2) [3] By virtue of their scientific training, clinicians are required to make decisions about treatment and care by atomizing patients (psychologically and physically) while treating them as a type rather than an individual. But at the same time in the clinical consultation doctors are called upon to relate to patients as complete entities, or essences similar to themselves, with feelings, experiences of life, family and work contexts that are essential to their being and that inform how they respond to what they have to face in those consultations. Illness occurs in the context of an individual life filled with imagination, belief, feelings: subjectivities that

shape meaning for that patient. As the novelist Marilyn Robinson suggests in an essay entitled ‘On Human Nature’,

> The thing lost in this kind of thinking [that of logical atomism] … is the self, the solitary, perceiving and interpreting locus of everything that can be called experience [12].

Robinson and Midgley share the view that William James was (as his biographer Richard Richardson suggests), ‘in 2010, a hundred years after his death, very much the prophet’ [13]. James’ book, *The Varieties of Religious Experience*, is subtitled ‘a study in human nature’ [14]. Here he insists on the importance of spiritual or emotional experience as constitutive of human nature in a way that our ability to explain things is not:

> The first thing the intellect does with an object is to class it along with something else. But any object that is infinitely important to us and awakens our devotion feels to us as if it must be sui generis and unique. Probably a crab would be filled with a sense of personal outrage if it could hear us class it without ado or apology as a crustacean, and thus dispose of it. ‘I am no such thing,’ it would say; ‘I am MYSELF, MYSELF alone.’ (p. 9 upper case in the original) [14].

The intellect can explain away the religious experience of others: William’s melancholy about the universe is due to bad digestion – probably his liver is torpid. Eliza’s delight in her church is a symptom of her hysterical constitution. Peter would be less troubled about his soul if he would take more exercise in the open air, etc. (p. 10). James does not deny the truth of such existential explanations – St Paul ‘certainly had once an epileptoid, if not an epileptic seizure’ – but these kinds of accounts do not ‘decide in one way or another upon their spiritual significance’. Such experiences when they come are suffused with significance:

> … when other people criticize our own more exalted soulflights by calling them ‘nothing but’ expressions of our organic disposition, we feel outraged and hurt, for we know that whatever be our organism’s peculiarities, our mental states have their substantive value as revelations of the living truth; and we wish that all this medical materialism could be made to hold its tongue. (p. 13).

So medical materialism is not dismissed by James, but he insists on the centrality of other sort of experiences – emotional, spiritual – which are essential to what it means to be human. His philosophy is now regarded as prophetic because of the way in which he anticipated current thinking in neurophysiology and neurobiology. As Pat Waugh has commented,

> ‘James first showed how rationality rests on feeling’,

and his work is celebrated by current writers on consciousness, such as Antonio Damassio [15]. The central point, however, is a general one: that the way we experience the world is essentially located in our emotional responses to it. These, as well as our rational responses, determine what and how we think about our experiences and mediate their meaning for us. This insight in medicine helps us to understand, for example, the experience of a confirmed smoker who, despite chronic airways disease, may regard her cigarettes as ‘friends’, or the

diabetic who cannot change her diet because ‘what I eat is me’ [16]. If clinicians were to believe the evidence of their own subjective experience, the assumption that the smoking or eating ‘behaviour’ is separate from the patient who demonstrates it, enjoys it and regards it as part of their essential being, would be impossible.

James’ emphasis on the centrality of emotion as determining the meaning of experience also enables us to challenge medicine’s reliance on sameness. It is not possible to purge variety from subjective experience. As Marilyn Robinson writes:

> It may have been perverse of destiny to array perception across billions of subjectivities, but the fact is central to human life and language and culture, and no philosophy or cognitive science should be allowed to forget it [12].

Acknowledging this, the essential, exciting and challenging task of medical humanities is, as Robinson suggests,

> … to open the archives of all that humankind has thought and done, to see how the mind describes itself, to weigh the kind of evidence science tacitly disallows.

And where is this archive located? I would suggest that we should look no further than the arts and humanities, where the work of human imagination and creativity can take us into the world of individual subjectivities and feelings, and beyond the understanding that is solely located in testable facts. Medicine has tried, but there really are no objective tests to measure imagination, no scales to represent emotion. The humanities, by contrast, collectively allow us access to the depth and range of these integral aspects of human experience.

The core *raison d’etre* for the medical humanities is that medicine has got human nature wrongly – or at least incompletely – conceptualized. It is a huge responsibility as well as a heady challenge to correct this imbalance. So far the field has singularly failed to grasp this challenge. Critics such as Rafael Campo, therefore, seem entirely correct in complaining that,

> Despite some public exposure in such divergent forums as Academic Medicine and the New York Times Magazine, no conception of ‘the medical humanities’ compels, caught somewhere between manifesto, mushiness, and marketing lingo [17].

Medical humanities has a compelling vision of human nature, informed by philosophy, illustrated and explored in literature and the other creative arts, assumed by the empirical ethnographic and qualitative methods of social science. What the field has failed to do, however, is to take it forward into collaborative discussion with those at the forefront of policy and research in medicine so that it can inform the basis of decision making about how medicine is practiced. Medicine at the cutting edge is about *doing*, so medical humanities’ contributions to *understanding* need to demonstrate that they can go on to inform action and have the potential to change things for the better.

Medical humanities: failing to grasp the nettle

It is helpful to examine why it is that, despite its encouraging beginnings, medical humanities has become identified as making a contribution only through medical education. The early development of the field can be traced to the Society for Health and Human Values in the USA in the late 1960's. This Society developed from an earlier group of theologians and clinicians who had set up a consultation on the nature of ministry at medical schools. This group identified 'depersonalization', the 'centrality of molecular biology' and the 'teaching of mechanistic medicine' as the focus of their critique of medicine [6]. The group agreed on what was wrong, but not on the best way to solve it. The physicians decided that the way to reform medicine was by changing medical education; the clerics favoured dialogue and persuasion at all levels of the profession and from different perspectives in society (such as their own). According to the historian, Daniel Fox, the strategy to bring about fundamental change through 'demonstration programs' was one that was fashionable at that time [6]. The problem was, as Fox suggests, 'demonstration programs rarely achieve their goals'. Medical humanities emerged at this point with a challenging critique of medicine for its 'depersonalization' and 'molecular reductionism', but immediately attempted to make its mark from within the profession by trying to reform medical education, thus becoming mired in discussions about justifying curricular time and funding and recruiting academic teachers with humanities qualifications. From the outset, the radical focus of the field inevitably became dissipated and its focus confined within pre-existing medical assumptions and structures that were supporting the very problems that the new field needed to challenge.

Commenting recently at the opening of one of the UK's major new centres for medical humanities, Howard Brody outlined three conceptions or 'personalities' of medical humanities that he has identified from his reading of its history [18]. The first relates to the idea of the liberally educated person and the role of the humanities, broadly represented, in that education. Medical humanities, therefore, is conceived as a programme of education that would allow doctors to participate in informed ways in broader conversations about life outside medicine's narrow concerns. The problem with this, he suggests, is that the idea of this 'grand conversation' has frayed and dissipated as universities have become more discipline specific. The humanities' offer to medicine now takes the form of multiple programmes from a series of disciplines allowing no shared conception of what they collectively represent. In this conception, medical humanities represents a list of disciplines, a potpourri of stimulating courses, which might be of interest to medical students or doctors but can never fundamentally challenge their view of the world.

Brody's second conception refers to the idea that the humanities, and especially the classics, are important for developing humane judgement. This idea has been quite pervasive in medical humanities, where humanities have tended to be conflated with the notion of 'humanism' in medicine, particularly in the USA. A strong rationale for this view of medical humanities is that humane clinical judgement is a constant in the face of continually changing clinical evidence. The argument has been made that the humanities could help develop that attribute [19]. But its accomplishment cannot be left to uncritical engagement with the resources of the arts and humanities alone. As has often been remarked, Hitler had

humanistic interests: he was an artist and writer and was keen on the music of Richard Wagner.

The third personality proposed by Brody presents medical humanities as ‘supportive friend’. In suggesting this he appeals to an Oslerian idea that literature, music, art, etc. are a solace after a hard day at the clinical coal face; not a mushy distracting solace, but one that helps to make sense of the suffering and pain that the doctor must necessarily deal with. Brody again finds this third conception wanting as it

> … fails on its own to explain the *critical and reflective* function we believe that the medical humanities can serve. As a rule, we seek comfort and solace in our bedtime reading, not acute intellectual challenge [18].

The field of medical humanities inhabits all of these personalities depending on its content, function and circumstances, but in sum they represent a fundamental lack of ambition. Each of these conceptions is rooted in an assumption that the role of the humanities in medicine is confined to influencing practice via the education of future doctors, and not through intellectual co-engagement with policy makers and clinical researchers. In view of the critique that the humanities correctly make of medicine’s view of human nature, this is a serious failure, but one that is beginning to be redeemed.

The personalities so far revealed by Brody are, therefore, characterized by their instrumentality in serving the larger purposes of medical education and practice. But the personality I propose is, appropriately for a fledgling field, that of ‘disruptive teenager’. The emergence of this personality is part of a new phase of deeper engagement between medicine and bioscience and the disciplinary perspectives of the humanities and social sciences. It is also a return to the origins of the field: that initial sense that stimulated its development back in the 1970’s, that the disciplines of bioscience and even bioethics were insufficient to explain or explore the concerns of medicine contextualized within the lived experience of humanity.

Medical humanities as ‘disruptive teenager’

This radical new phase in medical humanities has as its base the intellectual rationale I have discussed, but this is being given urgency, in the UK at least, by political contingency. In 2011 humanities scholars in UK Universities face two challenges. Unlike in the USA, UK funding for teaching and research in the humanities has relied largely on government funding. However, this funding base no longer exists. From October 2011, The English Higher Education Funding Council (HEFCE) will provide funding support only for teaching in so-called STEM subjects (science, technology, engineering and mathematics). Furthermore, government funding for research in the humanities will depend upon the ability to demonstrate ‘impact’ in terms of ‘social, economic, cultural, environmental, health and quality of life benefits’ [20]. These policy changes, whether we agree with them or not, are encouraging humanities scholars to engage in interdisciplinary collaborations; and medical humanities, which has struggled to interest the best minds in its ideas, is now benefiting.

The practical fruits of this deeper intellectual engagement between humanities and medicine are not yet ready to be picked, but I wish to illustrate its potential with reference to two examples relating in turn to public health policy and neuroscientific research.

Being and becoming a smoker

Legislation banning smoking in public places in the UK has contributed to a decline in smoking rates [21]. However, smoking prevalence, while falling, is still around 26% in the UK overall [22]. Most research on smoking is carried out in the context of public health and with a focus on getting people to stop. This approach, whether qualitative or quantitative in method, tends to limit the researchers' vision about how to understand the experience of smoking and its importance in people's lives. The public health approach may elicit a characteristic respondent response to enquiries about their smoking based on guilt, defensiveness and a litany of reasons why they have not stopped. Research within interdisciplinary medical humanities conceives of a different approach, one that accepts the possibility of aesthetic pleasure and gain, and is interested in the extent to which smoking is part of the individual's sense of themselves. This approach, which has led to the establishment of a new research group at our Centre for Medical Humanities at Durham University, has been stimulated by anthropological research in which smokers have described cigarettes as 'keeping them company' and as 'friends'; and by literary accounts of the physical pleasure of smoking: of the body being 'caressed' by smoke, of descriptions of the embodied experience of holding a cigarette in a certain habitual way [23,24]. In order to develop new ways of working with smokers for whom the habit has become part of their sense of themselves, anthropological theories of 'being' and 'becoming', may prove useful [25]. We need also to recruit ideas from phenomenology, which will help make sense of the relationship between smoking and personhood; and to explore what it might mean to have a 'relationship' with an object – a cigarette – via the sociologist Bruno Latour's actor network theory [26,27].

This understanding is intrinsically important, but also offers a critique of the kind of language that pervades many public health documents – language that implies a fractured human nature in which behaviours can be separated from selves and are easily manipulated. A recent article on the concept of 'nudging', for example, asks, 'Nudging can certainly trigger behaviours that worsen our health, but can it also be used to cue behaviours that improve it?' [28] This critique will be taken seriously if the resulting research involves public health in the collaborative development of interventions to help people and communities towards healthier lifestyles.

Understanding auditory verbal hallucinations

My second example concerns the exploration of auditory verbal hallucinations or AVHs. We are developing a collaboration at Durham between experimental psychologists, literary scholars, philosophers, theologians, clinicians and neuroscientists to re-examine the understanding of hallucinatory voice-hearing. Conceptualized in biomedical terms AVHs are usually associated with schizophrenia and other psychiatric disorders. However, voice-hearing is not necessarily a sign of mental illness. Many voice-hearers do not seek

psychiatric help, and research has shown that it is a reasonably common experience across the healthy population [29,30].

The focus on a biomedical approach has meant that the subjective experiences of people who hear voices have been largely ignored. Assumptions about the homogeneity of the experience have obscured important phenomenological differences between voice-hearing experiences, which in turn have implications for neuroscientific and therapeutic interpretations [31]. Voice-hearing is rich in cultural meaning and therefore particularly well suited to medical humanities inquiry that can take a long historical and cultural view, integrating subjective accounts, ranging from those of the medieval mystics to contemporary voice-hearers, with current scientific understanding [32]. The guiding principle of our developing research at Durham University is that any scientific study of human experience requires as comprehensive a description of that experience as possible, and that scientific accounts of voice-hearing will not progress unless the subjective experiences of voice-hearers are integrated more comprehensively into scientific theory-building. Thus a central aspect of our work will be to enable the findings of our phenomenological and literary/cultural research to inform the neuroscience, starting with a re-conception of the way in which functional magnetic resonance imaging (fMRI) scanning is undertaken with voice-hearers.

We believe that this collaboration has the potential to lead our field into a new era of work within clinical science, in which interdisciplinary medical humanities can change ways of thinking in even the most esoteric of fields.

Conclusion

Engagement between medicine and the humanities, broadly conceived, is crucial if medicine is to recognize a more complete conception of human nature. So far the field of medical humanities has failed to challenge accepted and comfortable medical norms and assumptions. There is great potential now given the kudos of interdisciplinary research in the academy, and as humanities scholars rise to the challenge of funding cuts in some higher education settings.

Medical humanities has a crucial part to play in the re-evaluation of medical and health-care practice, policy and research. By fostering a real interdisciplinary engagement between humanities and science the field has the potential to change from medical education, as the kind of intellectual collaboration required will not arise in that context. However, the policy developments and research generated should in turn inform curriculum change so that we develop doctors in the future informed by a more nuanced vision of their patients, and armed with more appropriate tools to help them.

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