

Medicine, philosophy, and the medical humanities

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THE phrase 'medical humanities' has recently begun to find a place in the wider vocabulary of medical and health care, perhaps especially — though not exclusively — within medical education and within academic medicine. Perhaps it is no coincidence that this phrase, and the ideas to which it refers, have come along after the emergence of the phrase 'evidence-based medicine' and the ideas to which *it* refers, for there is something about the idea of a focus on a highly scientific conception of 'evidence' which prompts many people to remind themselves that medicine is above all a science of *the human* and that many kinds of evidence will be important to such a science. Such evidence, it is now being recognised, includes the insights and enquiries made available by the social sciences and the humanities disciplines themselves, as well as those of the natural and life sciences.

In many ways 'medical humanities' is the name for a conscious habit of thought, a willingness to see medicine as being painted upon a very wide canvas — the canvas of human experience in all its complexity, diversity, and unpredictability. As a philosopher, I welcome this attitude and the recognitions that it embodies. It reminds me, too, that the study of philosophy can also benefit from being painted over a wider canvas than the rather narrow concerns with language, which at times dominated academic philosophy in

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parts of the English-speaking world in the 20th century. More specifically, the study of 'medical humanities' invites philosophers to recognise the wide range of philosophical questions to which modern medicine's understanding of the human body inevitably gives rise. Moreover, 'medical humanities' prompts a renewed conversation between medicine and philosophy, since they have as much to talk about now as they ever did; indeed, I believe that medicine and philosophy can be thought of as complementary enquiries into human nature. That is perhaps a rather mysterious-sounding claim, and I will try to say more about it.

One place to begin might be with the idea of medical ethics, which has brought medical matters forcibly to the attention of philosophy and prompted many doctors to notice philosophical questions arising in their clinical practice. However, I will not consider ethical questions as such but, rather, will jump over them to the much larger questions that lie behind them. These are the more 'meaning-of-life' type of puzzles which philosophers call 'metaphysical': questions about the nature of human existence and of our experience of it. Daunting though the name 'metaphysical' sounds, and daunting though 'meaning-of-life' questions undoubtedly are, I do think they claim our attention, especially once we recognise this larger canvas over which both medicine and philosophy clamour to be considered, and the wider conversation between them. As such, the study of medical humanities is an invitation to consider precisely these 'meaning-of-life' questions; however, it is an invitation with some very practical purposes, and not just a diversion from the business of treating patients.

One of the most prominent and central of all metaphysical questions in medicine concerns the relation between our physical state and our conscious experience: in simple terms, the relation between mind and body. (The inescapable importance of this is obvious enough, but strangely overlooked in the rapid development of technological medicine.) People consult their doctors when their states of health intrude into their daily lives and experience. If the problem is an essentially physical one, nevertheless its importance is *experiential* and the patient seeks relief from pain, discomfort, breathlessness or other unpleasant and intrusive symptoms; and if the problem is essentially a psychological one, nevertheless its management may well involve physical interventions, such as relaxation techniques (not to mention the prescription of drugs).

In either case, medicine is asked to intervene in the relation between our embodied state and our experience of that state, either by changing the underlying state itself or by changing our experiential response to it. In one sense this is transparently obvious, and scarcely merits our noticing it. In another sense it is profoundly mysterious. For the truth

about the human condition is that we are made of meat, or more to the point, we *are* meat, quite literally. Medicine is devoted to understanding, explaining, and within limits generally improving the meat or at least supporting it in its frailty. Yet at the same time we are also meat *with a point of view*; meat that *feels* and *knows* that it feels.

This is the astonishing truth about the human condition. Its scientific form is expressed and explored by the biological sciences; its metaphysical form is expressed and explored by the humanities, including philosophy, literature, history, anthropology, theology, and others. Its practical consequences are centrally addressed by clinical medicine. Medicine is, on the account I am suggesting, an organised intervention, not simply in the meat but also in the point of view, the meat's experience of itself. Arguably, the ethical problems that have arisen in medicine in recent years begin by failing to recognise the unity of the 'meat' and its 'point of view'. Thus addressing the ethical problems invites us to take seriously these metaphysical questions, whether or not we use such a daunting term.

More generally, recognising this invites us to consider a still larger re-engagement between the wider discourses of science and the humanities. To clinical medicine belongs the honour of serving notice upon us that this re-engagement is long overdue. It will require us to understand much more clearly what we mean by genuinely interdisciplinary enquiry. Perhaps general practice has a special role in this.

One reason for saying this is that the role of experience in our understanding of health states (and of our need for medicine's responses) is especially apparent in general practice, where patients' experiences have a threefold importance. First, as we've noted, the patient's experiences of illness or disability prompt them to consult the GP at all. Second, it is the GP's consultation that, in many ways, sets the tone for their experience and their expectation of the management of their condition. Although a technically successful intervention is always the aim (where possible), the way in which care is delivered remains long in the patient's memory, and can become all too prominent in their experience of their health state and, if things go badly wrong, in their experience and esteem of themselves as individuals. Third, the ways in which patients fall ill and the manner and extent to which they will become well again, are importantly influenced by the wider circumstances and events in their lives. At least in theory, GPs have a princely opportunity to understand this and to act upon it, based on their traditionally longitudinal contact with patients and their families. This is — or it ought to be — the soul of clinical medicine. An important recent recognition has been of the role of 'narrative' in understanding how patients fall ill and how they might recover. Although the term can be misused, it points to the need to restore the unity of the human body and the unfolding story of its wider experience; the unity of the 'meat' and its 'point of view'. To do this is to take the medical humanities seriously; what's more, the longitudinal framework of traditional primary care is a central arena for doing so.

General practice medicine has an unmatched encounter with the undiagnosed patient as a whole. It is the pre-eminent place in clinical medicine where a doctor may see someone in the undiagnosed state — even if only for a few

moments before the first provisional diagnosis begins to form in the doctor's mind. (Appreciating what this encounter represents might help to guard against diagnostic assumptions that are too rapid or premature.) In this sense, the GP performs the first act of medical 'reduction' upon the patient. By contrast, the hospital specialist receives patients already diagnosed and already to that extent reduced. The truly general medical practitioner, in the primary care setting, is thus the first and finest defence against an exclusively reductionist version of medicine. This role and its opportunities are precious; they are also at risk if the GP's role is changed to becoming a specialist general physician, seeing patients who have been screened instead by someone else: in other words, if the GP is replaced as the effective frontline of patient contact, and if the traditional 'gatekeeper' of the NHS is in turn 'gate-kept' by someone else — a generic non-medical practitioner. Saying this is emphatically not to impugn other clinical roles; however, it *is* to say that the extinction of the truly general medical practitioner leaves the field of medicine still less able to avoid reducing the patient to collections of medical categories, in which the patient's individual humanity is all too liable to be obscured.

Only the GP routinely has an operational, working medical encounter with the undiagnosed human being as a whole. Unlike specialist medicine, medical general practice can, as standard, begin with the understanding of illness in the context of patients' lives; it can routinely construct biological diagnoses in a biographical context, a context which of course includes the challenging but essential variety of other roles which the GP plays in his or her patients' lives. The loss of these roles would be the loss, not of optional extras, but of part of medicine's core 'mission' to understand and respond to human suffering. As things stand, of all doctors the GP is best placed to appreciate what is particular and individual about particular individual patients. This appreciation is part of what it is to put the 'medical humanities' into operation, and as such it is the embodiment of 'humanistic medicine'. (The role of personal physician strikes me as being in this sense the most privileged of all medical roles, but it is one that is in danger of being relegated to a heroic past.)

Now, not only in general practice but throughout clinical medicine, medical education and research, there is an awareness that the human side of medicine matters essentially and, perhaps to a lesser extent, a recognition that its exploration draws upon the social sciences and the humanities. Sceptics, however, may reasonably ask for concrete evidence for the effectiveness of such resources in promoting humanistic medicine. From an examination of, for instance, the Nuffield Trust's published initiatives in medical humanities, three areas of research suggest themselves; in each case, clinical general practice might offer a prime arena for pursuing them.

First, it would be good to be able to gauge the effectiveness of personal and professional development strands in medical education (to which structured engagement with the medical humanities might naturally belong), in terms of graduating doctors' subsequent career satisfaction, their avoidance of 'burnout', and their personal resources in meeting the challenges of clinical life. The sheer number of

GPs and the sheer variety of the professional and clinical challenges they face make them obvious subjects for such studies.

Second, it would be good to be able to assess whether an engagement with the narrative and representational arts can help doctors understand and interpret their patients' stories, to their mutual benefit. It seems reasonable to suppose that the context of longitudinal care offers a promising opportunity to develop, and assess, the habits of making sense of stories which themselves unfold over time in the lives of patients. It is in this context, perhaps, that we can best explore whether or not this 'making sense' can support a richer and more sensitive diagnosis and management of illness and disability, particularly those of a chronic nature.

Third, it would be good to be able to evaluate whether community-based arts projects, or a more humane attention to the built environment (whether inside or outside organised healthcare), or other means of collective expression and identification, can make a positive impact on the health indicators within a community and upon the health-seeking behaviour which its members exhibit. This is pre-eminently an enquiry in which GPs could play a starring role, since they are already 'on the ground' to see at first hand (and even at times to instigate) such community developments, and their own primary care services are those where any resultant impact would first be felt.

Taken together, these three enquiries would constitute a working testbench for the practical importance of the 'medical humanities'. Undertaken in the primary care arena, they would attest to the centrality of general medical practice and to its unparalleled engagement with the biographical as well as the biological, with the 'point of view' as well as the 'meat'. This engagement invites another — between the GP and the philosopher — in terms of their complementary enquiries into embodied human nature. Of course it might be objected that, unlike philosophers or historians or poets, GPs are not paid to undertake metaphysical enquiries. I hope I have said enough about the metaphysically astonishing relation between our embodied being and our experiences of health, illness, and disability to suggest why I think the objection would not be wholly true.