

Scientific Contribution

Medical humanities – arts and humanistic science

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Abstract. The nature and scope of medical humanities are under debate. Some regard this field as consisting of those parts of the humanistic sciences that enhance our understanding of clinical practice and of medicine as historical phenomenon. In this article it is argued that aesthetic experience is as crucial to this project as are humanistic studies. To rightly understand what medicine is about we need to acknowledge the equal importance of two modes of understanding, intertwined and mutually reinforcing: the mode of aesthetic imagination and the mode of analytical reflection.

Key words: aesthetic experience, imagination, intertwining, understanding

Introduction

For several years, there has been an ongoing debate about the scope and the goals of medical humanities. This is often a reliable sign of beginning maturation in a newly established field of study. It is also a sign of health, as such a debate is urgently needed to provide a basis for continuous self-reflection during the further evolution of the field. It may be remembered that it took 10–15 years from the rise of medical ethics in the early 70s to the first substantial signs of a self-critical debate within that area in the mid-80s.

In this article I want to contribute to the exploration of the nature of medical humanities, departing from the assumption that the area involves two related but still different modes of understanding: aesthetic experience, involving emotions and imagination and empathetic identification – and cognitively oriented analysis, involving critical scrutiny, conceptual analysis and historical relativization. It will be argued that however intertwined these modes of understanding often may be, they are nevertheless different in nature and ideally work in a complementary way. It is when we ask ourselves what medicine is about, what its goals are and how they may be reached that these two complementary roads to understanding are needed. Given the all-embracing nature of medicine, penetrating our lives both literally and metaphorically, this is an understanding

that is in no way reserved for health care professionals. Medical humanities may have a particular responsibility in relation to these, but surely the scope of the project is wider than that.

Modes of understanding

First some remarks on terminology. There exists by no means a unanimous view on what the concept humanities ought to mean. I here take humanities to be concerned with the human realm, specifically with a view of human beings as intentional creatures searching for meaning, with their both shared and unique life worlds, reaching out for others, trapped in their history and biology but with some paradoxical margin of personal freedom. It is the task of the humanities to explore these conditions, and in doing this they basically employ hermeneutical approaches. The goal is understanding, rather than explanation (even if Dilthey's classical dichotomy is certainly not as clear-cut as it is sometimes assumed to be¹). It is not unusual to identify humanities with what is otherwise often called the humanistic sciences, that is academic fields of study like history, philosophy, aesthetics, history of literature, history of art, anthropology etc. But the humanities, as I will here view them, involve not only the humanistic sciences but the arts as well (painting, sculpture, dance, novels, poetry, drama, film etc.), to the extent that

these present human beings as acting, choosing and responsible creatures.

What, then, are *the medical humanities*? I propose that medical humanities are those parts of the humanities that are of relevance to the study and practice of medicine. I want to put some stress on the second part of this statement. The goals of medical humanities are indeed both theoretical and practical. Theoretical in that they offer a basis for an analysis and a resulting understanding of what the phenomenon of medicine and health care is about. Practical in that this analysis of course is meant to have, and does already have, consequences for the way health care is practiced, from the very basic laboratory research through the clinical encounter to national health policies. In addition to this, medical humanities have a potential for influencing clinically relevant attitudes, through their capacity to work not only on intellectual capacities and rational reflection but also on emotions and intuitions. It is here we have what I believe to be the most promising and remarkable aspect of medical humanities – the breadth of its invitation and the potentially synergistic characters of the two modes of understanding that constitute their basis.

A comment may be needed on what is here meant by “mode of understanding”. The point made is the rather trivial fact that the attempt to reach understanding of a phenomenon may focus on different aspects and may hence be reached in different ways. We may, for example, say that we understand something when we know how it came about, or what its purpose is, or the human feelings and intentions involved in it, or the consequences of it, or how it is contextually related to other phenomena. All these aspects of understanding may more or less coexist and we may hence think that the more of them that are illuminated, the better we understand. Distinguishing between different modes of understanding would then mean acknowledging that different faculties of our mental repertoire are differently well suited to do this work for us. To understand a mathematical problem may involve certain capacities, to understand why the First World War broke out another combination and to understand a clinical situation a third. A point of departure for the following analysis will be that the richer our understanding is, the better the chances that we reach our goals – whether these be practical (ameliorating suffering) or theoretical (solving an equation).

A mode of understanding is hence a pattern of mental capacities activated in our attempts to come

to grips with a phenomenon, to understand it. Such capacities are usually combined emotional-cognitive. The mathematician can hardly avoid emotions when facing an intriguing problem to solve, and the artist painting a portrait will find cognitive reflection interacting with emotions. However, in general we may conclude that aesthetic experience usually more immediately and directly involves emotions, bringing in parts of our personality that we often keep outside of intellectual analysis. It is reasonable to assume that I get moved and perhaps even upset by seeing a drama of Chekhov, but far less emotionally involved by reading a philosophical essay on the notion of brain death (though this may of course occasionally be upsetting enough). Possibly, I go on to reflect on Chekhov’s drama when my feelings about it have sunk back and left more of curiosity and wish to verbalize and to bring cognitive reflection into my understanding. In this process of “distancing” myself from the immediate experience, of lifting from the particular to a more general level of understanding, one may experience that something is lost, some aesthetic quality that seems hard to capture into rational discourse. The aesthetic experience is not easily “verbalized”, as we all know, but nevertheless real and plausibly very influential on our way of looking at ourselves and the world.

The evolution of medical humanities

Before presenting this argument in more detail, I want to make a short comment on the evolution of medical humanities as a field of study. The present situation of medical humanities naturally reflects its evolution and some of the challenges involved in the further development of the field ought to be understood in light of the impetus that set this project into motion. When the medical ethics boom lost some of its momentum, one of the remedies proposed was a shift of perspective, taking more areas of human study than moral philosophy into account when interpreting medicine. Barry Hoffmaster wrote, somewhat playfully, about ethnography “saving the life of ethics” (Hoffmaster, 1992). This is not to say that medical ethics, however interpreted, became obsolete, or that there were no medical humanities before the 80s and 90s. The point is that medical humanities were by many expected to offer a broader perspective and a widened frame of understanding – and with this the chance to address more aspects of the complex phenomenon of modern scientific medicine. It was

widely accepted that ethical questions in clinical practice are situated in contexts that may require that several perspectives are adopted in order to reach more fruitful results. It was also asserted that ethical deliberation may involve both feeling and intellectual analysis and that hence the humanities may offer a broader base for stimulating such ethical sensitivity.²

Hence, an increasing number of persons went looking for answers, or good questions, in history, philosophy, theology, anthropology, narratology and so forth. The result was a sometimes bewildering array of different perspectives. Moreover, not only were what I here want to call the humanistic sciences approached. Together with these, the fine arts increasingly came into focus. Literary texts – novels, short stories, drama, poetry – and the figurative arts were used to enlighten medical students or practicing clinicians. Not seldom it was said that reading novels or looking at paintings – preferably with motives borrowed from the world of diseases – would contribute to the development of the empathy of the clinicians or the doctors or nurses to be. The assumption was that health care workers, especially doctors, must have some sort of counterbalancing force to their scientific training, compensating for risks inherent in the medical gaze. An impersonal, cold and distanced physician, unable to go into a dialog with his patient and relying almost exclusively on technological devices was contrasted with an empathetic person-oriented doctor, who not only knew Beauchamp's and Childress's "four principles" but also had the kind of imaginative, yet critically reflective, attitude to her work that would revive the "art of medicine".

Hence, medical humanities in educational contexts came to be developed as some sort of additional and compensating activity on top of "the real thing", which was of course training in the biomedical sciences. As a result, and also reinforcing this "additional model", there was a general tendency to look at courses in humanities as preferably elective. The resistance against compulsory teaching of medical humanities often took the form of a rejection of the whole idea of having unmotivated students reading philosophical, historical or literary texts, with the assumption that this would rather make things worse. The fact that much of the teaching in the area of biomedicine is both boring and onerous to many students and other categories of health care professionals, but is done because it is seen as indispensable, was not really considered – or dismissed because the

sciences in some peculiar way are expected to be like that, while the humanities "must" be stimulating and creative. Neither was much said about the tacit signals that this unintended but obvious grading of curricular importance sent to students and professionals.

Medical humanities were of course never developed only for education and never only for health care professionals. There was research in what we now call medical humanities long before it was even named and long before it had come into medical schools. The scope of medical humanities is wider than professional development, however important this may be. It is the understanding of medicine in general that is at stake. Like any dominating socio-cultural force, medicine has to be scrutinized from different perspectives and we have good reasons to assume that society at large will benefit from this.³ If, however, medical humanities as a resource for medical professionals are at the center of interest here, it is because there is still a need to illuminate and bring out more clearly what it is that medical humanities may contribute. If it can be shown that physicians and nurses and other persons involved in the treatment and the care of ill people benefit in different ways from the encounter with medical humanities in the sense here described, this may be of great value in the ongoing reconsideration of what constitutes professional competence in health care.

Additional or integrated?

The idea of humanities as a balancing field of study in relation to biomedicine may also be called *the compensatory model*. Perhaps, it is more meaningful to talk of compensation than of addition, since it highlights the historical fact that the humanities, as were medical ethics, were brought into the study of medicine as a result of an experienced *lack*. Of what? Probably of what is diffusely called "the human dimension" in medicine, of a visible person "behind" the disease, of an attention to the social and cultural aspects more or less strongly influencing medicine. The triumphs of scientific medicine had allegedly pushed the ill person into the background, in favor of a depersonalized search for biophysiological pathology.⁴

But is compensation enough? Will it do the expected work? If we add to the swelling biomedical curricula some "person oriented" human knowledge, some philosophical ethics, a few novels, call it medical humanities and then throw

this into the oven after the biomedical cake is almost baked – will that really affect the ailments of modern medicine? Will that help us reach the proud goals often mentioned in relation to medical humanities – to humanize medicine, to let biomedical progress coexist with a deep commitment for and recognition of the personal needs and predicaments of the ill person? David Greaves does not hesitate about his answer when he writes that “...medicine cannot be adequately understood within the more traditional framework of medicine as science counterbalanced by the arts. What we then need is an *integrated model* of medical humanities.” (Greaves, 2001) Such a model and such a resulting practice seem, however, to be rather far off. Taking a close look at the special issue of *Academic Medicine* from October 2003, where a rich variety of models are presented, it is hard to avoid the impression that medical humanities as educational programs at most places in the US and in Europe are predominantly exactly *compensatory*.⁵ With a considerable simplification the standard model of the medical humanities program at medical schools involves some courses in literature reading, occasionally complemented by a course in creative writing, some philosophical seminars mostly in moral philosophy, courses on death and dying (synthesizing theological, anthropological, psychological and philosophical perspectives), not seldom also a chance to read some medical history (often under themes like “Plagues and peoples” and so forth), more seldom arts courses where visual presentations of illness are in focus. This is often good enough and certainly very ambitious – and, of course, in no way surprising, if we look at the official motivations for developing programs of this sort. That medical humanities would have anything important to say about, and as a result deeply influence, core issues like the disease concept, the diagnostic process, the use of medical technology and other “hard” issues in medicine is not so often acknowledged – or at least only marginally accepted. With a disease concept still heavily relying on biomedical sciences and with a mistaken idea still flourishing that this concept is basically value free, the doctor’s task of diagnosing and treating diseases will result in a medical education and a professional role that looks upon humanities as a sort of “luxury” added, if there is time for it, to the real thing and only externally related to clinical medicine – to compensate for some possible risks that are easily overcome in this way.

The task of medicine

Why, again, may we conjecture that the humanities are at the very core of the understanding and practice of medicine? What would it mean to integrate humanities into medicine, rather than to add them as a compensation for marginal shortcomings of a still predominantly biomedical project? The answer to this will involve a view on what this practice is about, and this question will now be addressed.

Medicine is the activity that aims at the healing or the amelioration of suffering due to disease and at the prevention of such suffering.⁶ Medicine is about bodies and it is about the persons that *are* these bodies. Human individuals suffer, bodies do not. The personal, biographical realm is in this sense prior to the abstracted world of the biomedically “constructed” body.⁷ This is, of course, hardly new to anyone involved in this discussion. Actually, perhaps the most influential of all to propose this is Oliver Sacks (1984) who in his stories shows, rather than theoretically argues for, such a way of understanding what medicine is about.⁸ Another convincing but perhaps not as influential example is John Berger writing about country doctor John Sassall in *A Fortunate Man* (Berger, 1967).

Philosopher Drew Leder has succinctly captured the point of departure for a medicine that takes human beings as biological and cultural creatures into full account:

Just as the lived body is an intertwining of intentionality and materiality, subject and object, so we would arrive at a medicine of the intertwining. That is, our notions of disease and treatment would always involve a chiasmatic blending of biological and existential terms, whereas these terms are not seen as ultimately opposed, but mutually implicatory and involved in intricate ‘logics’ of exchange. (Leder, 1992)

Stephen Toulmin says basically the same thing, though in other words, in an essay on “clinical judgment and historical reconstruction”:

However, even the generalized principles of the medical art could be learned and exercised only as applied to and embodied in the condition of particular human beings. (...) the proper application of general medical knowledge to individual human beings demands an accurate appreciation of their particular needs and conditions; so that the task of medicine – however “scientific” it may become – remains fully *ethical*. (Toulmin, 1993)

This view of medicine leads me to the following conclusions: The practice of medicine integrates – intertwines, amalgamates – knowledge and experience of the human condition in the broadest possible sense, from understanding cellular systems to approaching unique and sometimes strange life-worlds of ill persons, as well as understanding the socio-cultural forces influencing health and disease. The goal of medicine is to restore health, which means alleviating suffering that is due to disease. This may be accomplished in basically three ways, closely related and almost always intertwined but analytically separable: (1) by applying biomedical knowledge in order to explain pathophysiological processes in the body, manipulating these processes in the wanted direction and relying on results from biostatistical methods to evaluate treatment outcomes; (2) through the attempt to approach a degree of common understanding between physician and patient, necessary both for diagnosis and for treatment decisions and also for the ill person's sense of recognition; in Gadamer's words, the partial fusion of meaning horizons in the clinical encounter (Svenaeus, 1999); (3) by the ongoing critical reflection on the theory and practice of medicine, in order for the conduct of professional medicine not to transmute into smugness and conceit. Key words are for (1) *explanation* of disease through scientific theory and *scientifically based control* of pathological processes and treatment outcomes, for (2) *understanding* of the illness experience through imaginative dialog, and for (3) *conceptual, ethical and historical scrutiny* in order to place the practice of medicine in a larger socio-historical context and rightly evaluating it as such.

The importance of *not* thinking about these three aspects of medical work as fully discrete and separable can hardly be overstated. They are meant to be seen as ideal types, in Max Weber's sense (Poggi, 2006). In practice they intertwine just as Leder and Toulmin write. When, for example, the physician faces the patient with a minor stroke she must of course understand as much as possible about the normal and pathological physiology of cerebral vessels and tissue, as well as about ways of diagnosing, treating and preventing new incidents of the same sort. She must, *at the same time*, be able to approach the experience of just this ill person, what he experiences, what he hopes for and fears, what he is prepared to stand and not stand, which his basic motivating forces in life are. But this would not do if she were not prepared and capable of lifting herself, to some extent and at occasions, out of these perspectives, reflect on

other possible ways of understanding and conceptualizing what is happening, if she were not able to relate this unique case to a broader cultural and historical context, letting her cherished assumptions at least marginally and occasionally meet other modes of understanding.

It is with the two latter tasks that medical humanities are involved. It is not difficult, I think, to see that there might be a tension here. Approaching a person's illness experience, taking some steps towards a shared life world, involves a degree of identification, although very conditional. This seems to be a significantly different challenge from the distancing that the critical analysis involves, however closely intertwined these modes of understanding may sometimes be. Imagination and empathetic openness and involvement are capacities that would be of value in the former task. If the physician constantly keeps relativizing and critically examining the words of his patient, he would lose the crucial personal contact and seem distant and indifferent. If, on the other hand, he does not keep a critical eye on his engagement with the patient, if he lacks both the will and tools to analyze crucial elements of the encounter from a somewhat distanced position, his good intention may be transformed from being beneficial to being dangerous and harmful for his patient. May we perhaps look upon this as a sort of wavering movement, a process of amalgamation, where imaginative participation, involving emotional and aesthetic aspects, intimately interacts with distanced analysis, involving applying abstract concepts and logical deliberation (of course as crucial in the successful accomplishment of diagnosis and therapy). It is when these two modes of understanding coexist and are brought to interact with profound biomedical experience and skill that the full human potential of scientific medical knowledge is actualized.

The role of the arts

Philosophy and history may facilitate conceptual analysis and stringency of thought and provide inspiring perspectives on medical reality. But are the arts – poetry, novels, paintings, drama, film – really of any value to clinical medicine? Are they not rather a sort of pleasant “turning-away-from” reality? Do the arts really give us knowledge of the world; do they really say anything about the essence of clinical work? David Greaves has suggested that medical arts, as he formulates it,

are basically ornamental to the practice of medicine, while medical humanities proper (and I take it that he here means philosophy, history and other humanistic sciences) are at the core of medical practice and hence crucial to the integrated view of medical humanities (Greaves, p. 22). Greaves does not deny that the arts⁹ may be beneficial to practitioners but fears that these will go on working with an unchallenged idea of medicine as exclusively biomedical in its nature. I disagree with his position – if I understand it rightly. Acquaintance with the arts in forms appropriate for increasing medical understanding will, I contend, in the long run lead those involved in clinical medicine to question the simplified model of medicine – medicine as exclusively the application of biomedical knowledge – that Greaves so strongly laments. I would even go as far as to say that medical humanities without medical arts may be sterile and unable to influence more deeply our attitudes, just as philosophy without literature loses something of its potential to change our views of the world. This position is the result of my association of aesthetic experience with emotions, and with combined emotive-cognitive reflection – that is with aspects of our personalities that are crucial for our moral position, our apprehension of complex contexts and of ambiguous and paradoxical aspects of reality.

In contrast to Greaves I regard arts in medicine, used as roads to a more nuanced and complex understanding of human conditions and to what illness is, to be at the very core of the project of developing medical humanities. As such, the arts stand in a complicated but fruitful tension to the humanistic sciences. Most of what we do in clinical practice involves – or ought to involve – the two modes of understanding that characterize these areas of knowledge, blended into an intriguing mixture of conceptual analysis, historical relativization, literary imagination, visual perception, ethical reflection, narrative understanding, emotional participation, intellectual distancing...

The question must once again be raised concerning the nature of the two modes of understanding described above. Art is often associated with empathy and imagination. Now, to this one may object that imaginative empathy is far from the only attitude that may characterize our encounter with a work of art. Some novels, for example, rather seem to constantly sabotage the reader's attempts to read for identification. Dependent upon the kind of work and upon the attitude of the person varying degrees of distanced

reflection may accompany the primarily identificatory reading or looking. We may, thus, distinguish between prereflective and reflective elements in the experience of art. On the whole, the prereflective experience is more emotionally dominated while intellectual analysis has a greater chance to get into the reflective phase of art experience. Somewhat simplified, we may conjecture that art evokes emotions that we then, to a greater or lesser degree, reflect on, problematize, scrutinize. Many works of art seem to sabotage a non-reflective approach, like the dramas of Brecht with their capacity for *Verfremdung* – that is, sabotaging attempts to identify with the events and persons of the drama. If this element in, for example, a novel becomes too predominant it will lose its capacity to move the reader, to evoke those emotions that so stimulate and encourage reflection.¹⁰ Or, similarly, if the reader adopts an attitude, a way of reading, that is “hyperactive”, he will risk escaping this rewarding interplay of prereflective identification and reflective analysis.¹¹

Of course there are considerable aesthetic elements involved also in the sciences, both humanistic and natural. A degree of empathetic imagination is often part of scientific work.¹² However, the encounter with works of art in most cases predominantly involves identification and imagination, usually directed towards particulars, and only in a second phase reflection on those images and emotions; whereas humanistic sciences primarily involves conceptual abstraction, distanced reflection – admittedly often emotionally textured – and usually also a more universal ambition. My partition is hence by no means clear-cut and the borders between aesthetic imagination and scientific reflection may be less sharp than often assumed, but I insist that it is still valid as an over-all characterization.

The reading experience

The imaginative immediacy and the strongly emotive texture of the experience of a work of art may hence be transformed into a more or less distanced analysis when we reflect upon, for example, a literary text – especially if this is done in a more or less systematic way. If students of medicine read Lars Gustafsson's (1990) *The Death of a Beekeeper* and then discuss it in groups, perhaps under supervision, the two modes of understanding that characterize medical humanities will potentially unite: imaginative involvement with the

beekeeper's predicament and his problematic life history, his more and more intractable pain, his actions and their consequences in terms of close relations to persons – together with theory-inspired analysis of his motivating forces in psychological and existential terms, of the ethical standard of his important choices in life and his responsibilities to himself and others, of historical factors influencing his social position and hence also his repertoire of choices. This would probably in most cases not be sufficiently reached through the reading experience as such, neither through exclusively historical analysis or philosophical reflection. It is when two modes of understanding unite – the mode of prereflective aesthetic participation during the act of reading and the mode of hermeneutically inspired, distanced intellectual analysis in the following analysis – that a work of art offers its richest contributions to clinical medicine.

Why not “real life” then, why art? Is not the interplay with persons around us, the stories encountered when meeting and listening to living individuals, a road to human understanding far superior to fictive stories? One would easily guess so and of course there is much good to be said for a broad life experience and a keen attention to the stories around us. But returning to Gustafsson's book, the experience of reading about the beekeeper is prone to be richer in complexity and in detail and also in a sense easier to get adequately moved by exactly because it is fictive. Imagine meeting this man at a party. What would he say? What would we learn of him? Or encountering him on a train and having a long conversation with him? What would we learn? Would dislike prevent us from seeing him? Or would, on the contrary, strong positive emotions also prevent a more nuanced understanding? And would the kind of associative reflection on his life, his chances, his dilemmas that the novel inspires really occur?

Martha Nussbaum has perhaps more eloquently than any other philosopher pledged for an alliance between moral philosophy and literature, that is: between critical scrutiny and aesthetic experience. In several of her books she develops the thoughts presented here in much more detail. Her experiences from teaching law students in Chicago led to her to write the book *Poetic Justice*. Among several passages worth quoting at length we find this:

Another way of putting this is that good literature is disturbing in a way that history and social science writing frequently are not. Because it summons powerful emotions, it disconcerts and puzzles. It inspires distrust of conventional pieties

and exacts a frequently painful confrontation with one's own thoughts and intentions. One may be told many things about people in one's own society and yet keep that knowledge at a distance. Literary works that promote identification and emotional reaction cut through those self-protective stratagems, requiring us to see and to respond to many things that may be difficult to confront – and they make this process palatable by giving us pleasure in the very act of confrontation. (Nussbaum, 1995, pp. 5–6)

If Nussbaum is right, and I believe she is, we need to focus on the process of moving on from this emotional confrontation that meeting good literature (or a painting) may give us, and that of course from the beginning involves some cognitive activity, to a personal reflective involvement that opens up possibilities for a widened experience, for moral growth and for a more nuanced knowledge of the world. We need of course also to face a number of intriguing, but certainly not unsolvable, questions about which works of art and which areas of humanistic study ought to be included in medical humanities.

Concluding remarks

What then, with the integrated view of medical humanities? With such a view and practice of medical humanities, in theory and in practice, it is acknowledged that disease and illness are two aspects of the same coin and that applying the one without the other in our understanding of medicine is meaningless and will prevent medicine from reaching its goals. Integrated medical humanities are then not brought in when the hard sciences have already done most of the work; they are with us all the time as the Siamese twin of biomedical sciences. Integrated medical humanities are ideally taught in close connection to the teaching of biomedicine. The medical intern instructing the students in the art of doing a sternal puncture will, when medical humanities are thus integrated, find it just as natural and inevitable to direct their attention to the anatomy of sternum and underlying structures, to the histology of healthy and diseased bone marrow and potential pathological findings – as to the experiences of the ill person undergoing such a procedure, to ethical aspects of consent to medical interventions, to the history of blood analysis and treatment, to stories of persons living with and dying from hematological diseases.

This is how integrated medical humanities will work. Integration will mean that medical humanities take as their task to contribute to an intertwining of the experiential aspect of “not being well”, often called illness, with the scientifically constructed disease concept, expressed through the language and concepts of biomedical science. This intertwining of the epistemology of science and that of personal biography will not take place if the two modes of understanding described above as central to medical humanities are not accepted as crucial to all clinical work, as well as to the understanding of medicine as a cultural and historical project.

Notes

1. Dilthey proposed the goal of science to be the explanation of natural phenomena by ways of universal causal forces, such as natural laws. The humanistic sciences, on the other hand, were involved in the understanding of human actions by means of intentions and motivations. This has led certain observers to infer that the sciences are not aiming at understanding – a suggestion that seems blatantly mistaken, as understanding is crucial to all scientific work.
2. The influence of Aristotle was clearly seen in this context, presented for example by Martha Nussbaum in her influential *Love's Knowledge* in 1992.
3. And medicine has been lucky, in this sense, to have been the subject of intelligent and provocative critique, contributing to a thoroughgoing debate about its nature and goals. Excellent examples are Ivan Illich's (1976) *Medical Nemesis*, Susan Sontag's (1979) *Illness as Metaphor* and, lately, James LeFanu's (1999) *The Rise and Fall of Medicine*.
4. This theme is recurrent in medical humanities literature since Paul Ramsey's (1970) *The Patient as a Person*.
5. *Academic Medicine*, October 2003: “The Humanities and Medicine: Reports of 41 U.S., Canadian and International Programs”.
6. We have recently seen a vast and often illuminating literature on this subject. Among the contributions presenting thoughts most worthwhile to pursue are Eric Cassell (1991) and Fredrik Svenaeus (1999).
7. We are reminded for example by Martyn Evans (2001) about the degree of abstraction from our

ordinary experience of a lived body involved in the medically perceived and treated body.

8. I consider his *A Leg to Stand On* to be the outstanding example of his capacity to capture the reality of falling ill.
9. I do not here talk of medical arts in their *therapeutic* use – that is, literature, drama, poetry, visual art as therapy for ill persons. It is better not to include these in what we regard as medical humanities, but rather in the field of medical therapeutics.
10. For an extensive discussion of the role of emotions when understanding the world through works of art, see Katarina Elam's *Emotions as a Mode of Understanding*, particularly part III (Elam, 2001).
11. Kevin Vanhoozer distinguishes four basic reader attitudes: “reactive”, with a reader in both cognitive and emotional clinch with the text; “hyperactive”, where the reader escapes the pre-reflective stage of reception to get stuck in a quagmire of analytic interpretation; “inactive”, with an inactive, indifferent reader not responding to the text; and finally the most hopeful attitude, “proactive”, where the reader gives justice to the combined emotional-cognitive content of the text, acting responsibly in relation to the fictional content and “gives the text the best possible chance”. See Vanhoozer (1998, pp. 395–398).
12. The idea of an emotion-free science, distanced and unengaged, may in many instances be misguided, even in the so-called hard sciences. See for example Evelyn Fox Keller's book (1983) about Barbara McClintock.

References

- Academic Medicine*, October 2003: ‘The Humanities and Medicine: Reports of 41 U.S., Canadian and International Programs’.
- Berger, J.: 1967, *A Fortunate Man: The Story of a Country Doctor*. New York: Pantheon Books.
- Cassell, E.: 1991, *The Nature of Suffering and the Goals of Medicine*. New York and Oxford: Oxford University Press.
- Elam, K.: 2001, *Emotions as a Mode of Understanding*. Uppsala: Uppsala University Press.
- Evans, M.: 2001, ‘The Medical Body as Philosophy's Arena’, *Theoretical Medicine and Bioethics* 22, 17–32.
- Fox Keller, E.: 1983, *The Life and Work of Barbara McClintock*. New York: W.H. Freeman.

- Greaves, D.: 2001, 'The Nature and Role of Medical Humanities', in: M. Evans and I. Finlay (eds.), *Medical Humanities*. BMJ Books: London, pp. 13–22.
- Gustafsson, L.: 1990, *The Death of a Beekeeper*. London: Collins Harvill.
- Hoffmaster, B.: 1992, 'Can Ethnography Save the Life of Ethics?', *Social Science and Medicine* 35, 1421–1431.
- Illich, I.: 1976, *Medical Nemesis: The Expropriation of Health*. London: M. Boyars.
- Leder, D., 1992, 'A Tale of Two Bodies: The Cartesian Corpse and the Lived Body', in: D. Leder (ed.), *The Body in Medical Thought and Practice*. Kluwer Academic Publishers: Dordrecht, pp. 17–35.
- LeFanu, J.: 1999, *The Rise and Fall of Modern Medicine*. London: Little Brown.
- Nussbaum, M.: 1992, *Love's Knowledge: Essays on Philosophy and Literature*. New York and Oxford: Oxford University Press.
- Nussbaum, M.: 1995, *Poetic Justice: The Literary Imagination and Public Life*. Boston: Beacon Press.
- Poggi, G.: 2006, *Weber: A Short Introduction*. Cambridge: Polity.
- Ramsey, P.: 1970, *The Patient as Person*. New Haven: Yale University Press.
- Sacks, O.: 1984, *A Leg to Stand On*. New York: Summit Books.
- Sontag, S.: 1979, *Illness as Metaphor*. London: Allen Lane.
- Svenaeus, F.: 1999, *The Hermeneutics of Medicine and the Phenomenology of Health: Steps towards a Philosophy of Medical Practice*. Linköping: Linköping Studies in Arts and Sciences.
- Toulmin, S.: 1993, 'Knowledge and Art in the Practice of Medicine: Clinical Judgment and Historical Reconstruction', in: C. Delkeskamp-Hayes and M.A. Gardell (eds.), *Science, Technology and the Art of Medicine*. Kluwer Academic Publishers: Dordrecht, pp. 231–249.
- Vanhoozer, K.: 1998, *Is There a Meaning in this Text? The Bible, the Reader and the Morality of Literary Knowledge*. Grand Rapids, Michigan: Zondervan.