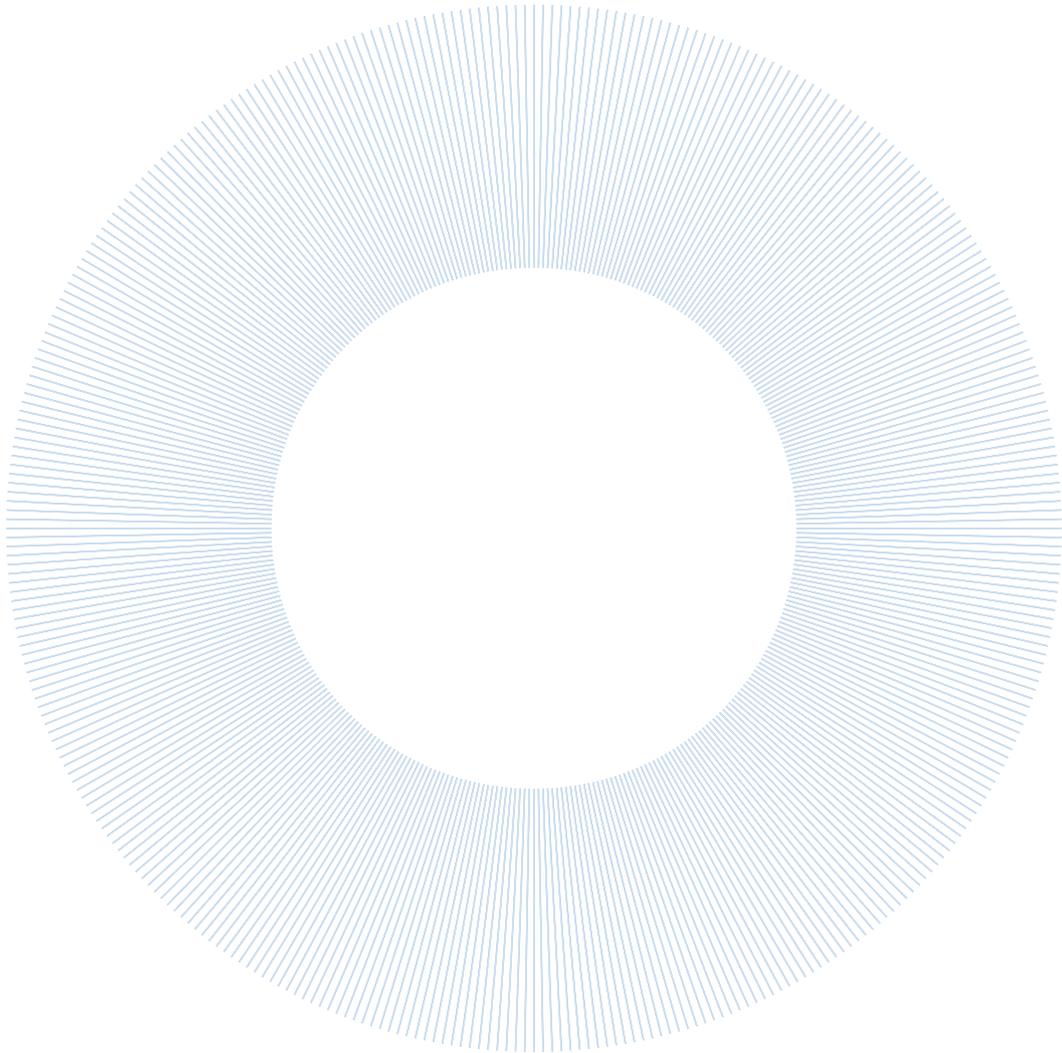


On Being Human in Medicine



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ON BEING HUMAN IN MEDICINE

Once quite common, single case studies are rarely presented in major medical journals. However, individual illness journeys sometimes provide insights that are lost in purely biomedical accounts of disease and treatment. While medical science has made considerable progress within the past century, care that is merely biomedical defeats its own ends because it cannot recognise or deal with the implications of illness and suffering for individuals. It is only our shared understanding of being human that can ensure that science is used to support human flourishing.



At the World Science Festival in New York in 2008, a range of thinkers reflected on the question *What does it mean to be human?* One of the most interesting answers came from the neuroscientist Antonio Damasio.¹ He said:

The critical unique factor is language. Creativity. The religious and scientific impulse. And our social organization, which has developed to a prodigious degree. We have a record of history, moral behavior, economics, political and social institutions. We're probably unique in our ability to investigate the future, imagine outcomes, and display images in our minds.

Damasio's big ideas can be applied to individuals as well as to society. They are, for example, relevant to the medical consultation where language is vital, as is creativity. There are obvious priestly and scientific aspects to the doctor's assigned role, but there are also moral, economic, political and social implications built into the consultation. In medicine, imagining outcomes is the stuff of disease prognosis.

William Blake begins *Auguries of Innocence* by suggesting that it is possible

To see a world in a grain of sand,
And a heaven in a wild flower,
Hold infinity in the palm of your hand,
And eternity in an hour.

So it is that single cases, even single consultations, can say a great deal about being human. The novelist Ian McEwan often incorporates medical themes in his fiction (Macnaughton, 2007); *Saturday* for example, covers a day in the life of a neurosurgeon. *On Chesil Beach* (McEwan, 2007) spans even less than a day and deals with a subject not normally construed as medical, but nevertheless with medical implications. In both novels, eternity truly does seem to be held in an hour. *On Chesil Beach* tells the story of a young couple, Edward and Florence, on their wedding night.

'They were young, educated, and both virgins on this, their wedding night, and they lived in a time when a conversation about sexual difficulties was plainly impossible.' The year to which McEwan refers is 1962 and the sexual difficulties that afflict the young couple are, in Edward's case, a fear concerning his sexual performance on the night and for Florence both fear and repugnance at the thought of her 'sexual duty.'

Clearly this is a novel that deals with an important aspect of human experience, that is our capacity to reflect upon, evaluate and worry about ourselves as sexual beings. Such worries not infrequently find their way into the doctor's consulting room (Read et al., 1997), but

in McEwan's novel neither Edward nor Florence had sought professional help prior to their wedding night. Had either of them done so, their story might never have existed:

This is how the entire course of a life can be changed – by doing nothing. On Chesil Beach [...]. He did not know, or would not have cared to know, that as she ran away from him, certain in her distress that she was about to lose him, she had never loved him more, or more hopelessly, and that the sound of his voice would have been a deliverance, and she would have turned back.

From the outset, we know that Edward and Florence 'lived in a time when a conversation about sexual difficulties was plainly impossible.' In a medical school where I worked in the 1970s, I was responsible for designing a block of study about human sexuality (Gordon et al., 1985). At the time, it was considered highly innovative. There were few computers then, and I would have had difficulty believing that today I would not only have a personal computer, but that I would be relying on something called a junk-mail filter to discard endless advertisements for Viagra and related performance enhancing medications.

Offering biomedical solutions to many of the problems that Freud once categorised as 'ordinary human misery' is controversial (Zola, 1972; Bancroft, 2002; Horwitz and Wakefield, 2007) but demand is high. Today, as doctors dispense biomedical interpretations and remedies, not only for sexual difficulties but for many other troubles – grief, depression, anxiety, obesity, alcohol and drug dependence, and countless other states of being, what impact are we having on the idea of normal human experience?

If it is not clear where the boundaries between 'ordinary human misery' and 'genuine' illness lie, how does one set about the task of identifying the foundational values that underpin the practice of medicine and enable it to define its scope? 2008 was the sixtieth anniversary of the National Health Service in the UK, when the Department of Health launched the 'NHS Constitution'² which summarises NHS values: respect, dignity, compassion and cooperation are among them. There must be, however, values that underlie these values: questions about why respect, dignity and compassion have been selected as core values for the NHS; the competing voices in this discourse are many and vigorous (Mechanic, 1976; Larkin, 1988; DeVito, 2000; Arras, 2001; Zuger, 2004; Checkland et al., 2008). To which voices should we be paying attention?

In the US, George Annas (1995) once suggested that metaphors reveal a great deal about foundational values in medicine. The metaphors that he identified are military, market and ecological metaphors:

The military metaphor has had a pervasive influence on both the practice and the financing of medicine in the United States [...]. Medicine is a battle against death. Diseases attack the body, and physicians intervene. We are almost constantly engaged in wars on various diseases, such as cancer and AIDS (p. 745). [...] In the language of the market [...] health plans and hospitals market products to consumers, who purchase them on the basis of price. Medical care is a business that necessarily involves marketing through advertising and competition among suppliers who are primarily motivated by profit. [...] The role of physicians is radically altered [...] [and] the goal of medicine becomes a healthy bottom line instead of a healthy population' (p. 746).

Annas contrasts the military and market metaphors with the ecological metaphor:

Ecologists use words such as 'integrity,' 'balance,' 'natural,' 'limited (resources),' 'quality (of life),' 'diversity,' 'renewable,' 'sustainable,' 'responsibility (for future generations)' [...]. Unlike the military and market metaphors, which only reinforce our counterproductive American characteristics of wastefulness, obsession with technology,

fear of death, and individualism, the ecologic metaphor can help us confront them (p. 748).

Edward and Florence were living in the age of the military metaphor, an age that had little time for problems that could not be fixed with magic bullets. Today the market metaphor would see them as mere consumers. If the difficulties that confronted them on their wedding night had been soluble with straightforward medical remedies, few of us would want to withhold them. But when certain remedies are discovered or developed, there is always an incentive to create a 'market.' Consider one of my patients, a woman who at 43 is trying to conceive a child for the first time. Live birth rates per cycle for a woman who is 43 or older are probably no better than 2 or 3% (Lintsen et al., 2005) but she has been led to understand that her chances are better than 20%. Ultrasound images in three and even four dimensions are used to 'humanise' what was previously hidden. Consider the information on a fertility specialist's website where a video clip shows a fetus who appears to be yawning:³

The attraction of being able to look at the face and movements of your baby before birth was enthusiastically reported in parenting and health magazines. This is thought to have an important catalytic effect for mothers to bond to their babies before birth.

What are known as 'reassurance scans' and the rather misnamed 'entertainment scans' have quickly become popular.

What should we say about such clinics, staffed by expert gynaecologists whose training costs are, to a large extent, underwritten by society? What will we say, in a few years' time, when new technologies make this and other human desires, especially the desire to delay the ageing process, potentially realizable but at ever increasing cost? (See Deyo et al., 2005.)

Less extreme examples give rise to conflicts of interest that are both more subtle and more manipulable. Medical stories in the popular media can be seriously inaccurate and increasing specialisation makes it more difficult for the lay public to participate in decision making (Gruen et al., 2004). It is little wonder that complementary and alternative medicine, or CAM, has become so widely used (Beyerstein, 2001; Ernst, 2000). The very fact that many CAM remedies have almost no active ingredients (Linde et al., 2001) and no supporting evidence may be part of their appeal (Kirmayer, 2004), raising questions about the place of, for example, placebo treatments in both orthodox and alternative medicine (Evans and Hungin, 2007). But precisely because so many of the treatments used in orthodox medicine are undoubtedly effective from both a biomedical and an experiential point of view, the task of defining medicine's foundational values and limits is all the more important (Fulford, 2008).

The challenges of identifying the values that should guide further developments in medicine lead to another question – what are we to make of the changing nature of the doctor-patient relationship? People are generally clear about what they expect from this relationship – a competent practitioner, who explains the problem and treatment, and who is approachable and trustworthy (Baider et al., 1997). Such a doctor demonstrates what we might best call empathic concern (Matthews et al., 1981; Koestner et al., 1990; Zahn-Waxler and Radke-Yarrow, 2005). Martha Nussbaum describes what this means for her when she says:

Through a position of empathic concern for another person, one can be said to experience, to some extent, another person as a subject, rather than an object. What is wanted, it seems, is a kind of 'twofold attention' in which one both imagines what it is like to be in the sufferer's place and, at the same time, retains securely the awareness that one is not in that place. It is this sort of twofold attention that is most commonly described as 'empathy' in the psychological and psychoanalytic literature (Nussbaum, 2001).

Nussbaum also points out that this 'twofold attention' applies, for example to the experience of viewing an artwork, simultaneously aware of the represented object and of the fact of

representation. This kind of empathic concern implies the experience of another person as subject, combined with the use of expertise on their behalf.

Empathic concern can only occur if the welfare of a person in need matters to the other person (Barson et al., 2007). By remaining secure in the knowledge that one is not the sufferer, it is possible to imagine the effect one's own behaviour might be having on another person. A physician considering such an experience has described the insights he derived from the novel *The Catcher in the Rye* (Schneiderman, 2002).

Once while trying to persuade an adolescent diabetic patient to attend more carefully to her diet and insulin, I heard my voice echo in a strange chamber of my memory. Not the lecture hall with its erudite revelations of glucose and lipid metabolism, hyperglycemic pathologies, and insulin mechanisms of action, but rather the stunted, plaintive, haunted world of J. D. Salinger. [...] I heard myself endlessly repeating: 'Do you understand me? Tell me what you are thinking. Why are you doing these things to yourself?'

And then the source of the echo came to me: the scene in *The Catcher in the Rye* when Holden Caulfield's English teacher in the most kindly, persistent way tries to understand why his young student is failing.

'Tell the truth, boy,' his teacher implores.

But the teenager is not about to lay truth across the yawning chasm between him and this old man. Rather, he regards his excruciatingly well-intentioned mentor from another world entirely [...].

Dr Schneiderman takes comfort in Salinger's description of the 'aching frustration' of incommunicability. Edward and Florence also experience communication difficulties, but of a slightly different kind:

Their courtship had been a pavane, a stately unfolding, bound by protocols never agreed or voiced, but generally observed. Nothing was discussed – nor did they feel the lack of intimate talk. [...] The language and practice of therapy, the currency of feelings diligently shared, mutually analysed, were not in general circulation (McEwan, 2007, p. 21).

Although Florence has a copy of a sex guide for young women, none of it meets her particular needs, because it presumes that she will have 'normal' feelings. If she had spoken with her doctor, she may well have found that he (and it would likely have been a 'he') would have made the same assumptions. Like Holden Caulfield and his teacher, Florence and her doctor may well have stared across the same chasm of mutual incomprehension.

Far from assuming that humans are naturally equipped with empathic concern, Elaine Scarry has gone so far as to suggest that one of the greatest difficulties we face is actually imagining other persons whose experiences are remote from our own (Scarry, 1998). Not surprisingly, studies in medical settings have found that differences between doctors and patients with respect to social class have an effect on the quality of both technical and interpersonal care (Ross and Duff, 1982; Mülhauser et al., 1998; Blacksher, 2008).

Such are the possible gaps between patients and doctors. How likely was Florence to have found a doctor who understood her wedding night fears? How might such an encounter have changed her life and Edward's?

While reading McEwan's novel, I found myself piecing together my own memory of an Edward and Florence experience. I began to smell the hospital in which I had met them, to see the vague shapes moving in and out through the semi-transparent flaps that served as doors of the Intensive Care Unit; I could hear the monitors bleeping.

I met 'my' Edward and Florence on what might have been a different trajectory for their two lives. When I was 23 – the same age as Edward and a little older than Florence – I began life as a junior doctor in a large teaching hospital. Toward the middle of the year, I was sent on rotation to a peripheral hospital, which was staffed by six junior doctors during the day, but only two at night. After hours I was responsible for the medical wards, an intensive care unit, the obstetrics floor and a small paediatric in-patients' section. My fellow intern covered the surgical wards and the emergency department. Hanging over us was a constant anxiety that something terrible would happen and that we would not be able to manage that terrible something between us. My greatest fear was the maternity ward – that I might be called on to deliver twins, or a baby in breech presentation, or with obstructed shoulders, or to manage a mother with an unstoppable post-partum haemorrhage. I sat up at night poring over the textbooks; I lost sleep and weight, worrying, worrying.

We could seek advice by phone, but the main hospital was a forty-minute drive away. During that term one of the other junior doctors made a serious error which resulted in the death of a healthy, one-week-old baby boy, for no other reason than inadequate supervision. The hospital covered it up.

A key characteristic of being human in medicine is that each individual will, at some time or another, make mistakes (Weingart et al., 2000; Fahrenkopf, 2008). The way that the health care system handles the inevitability of those mistakes tells us a great deal about the humanity as well as the rationality of the system (Leape et al., 1998). Not all fatal errors are medical, of course. In *What Seems to be the Trouble? Stories of Illness and Healthcare*, Trisha Greenhalgh (2006) recalls how a young woman was admitted to an NHS hospital in mid-winter with an ectopic pregnancy – a life-threatening condition. She underwent surgery, recovered and was discharged. The next morning her body was found in the hospital's snow-covered car park – no-one had realised that the young woman was homeless.

It was in this small peripheral hospital that I saw 'my' Edward in the intensive care unit one Monday morning. On the previous Friday night he had taken an overdose of paracetamol tablets. By the time I saw him, he was almost out of danger. The junior doctor who had been on call that weekend was happy to 'turf' him to me (Caldicott, 2007). He said something like 'Yesterday, I told him that if he wanted to do a proper job of it next time, he should find out the right dose of tablets to take first.'

People who attempt suicide not infrequently find themselves subjected to such ostracism by hospital staff (Tillett, 2003; Wiklander et al., 2003; Pompili et al., 2005) and they report experiencing deep shame (Wiklander et al., 2003). Australian philosopher Robert Ewin suggests that the fear of death is pre-rational, emerging from a complex of emotion, cognition and other aspects of being human that are imbedded in our evolutionary history (Ewin, 2002). It is therefore not so very surprising that a young doctor might stay up all night overseeing the management of a patient who has attempted suicide, only to turn on him in this way a couple of days later.

Inevitably the personal characteristics and experiences of individual doctors influence their practice. Most health care providers are driven by an impulse to help others (Egnew, 2005)

but that impulse sometimes gives way to cynicism and professional burnout (Hojat et al., 2004; Thomas, 2004) when problems prove to be complex and intractable. There is an extensive literature on patients who are perceived as 'difficult' and who are described as 'rubbish,' 'heartsink' or even 'hateful' (Jeffrey, 1979; Ingelfinger, 1980; Barnard, 1985; O'Dowd, 1988; Graver, 2007). Samuel Shem's novel *The House of God* (1978) coined new terms of abuse, the most famous of which is GOMER ('Get out of my Emergency Room!') applied especially to the very old and very poor.

There appears to be a natural history to cynicism and burnout among young doctors, often attributed to long hours of work, excessive workload, poor role models and the peculiar culture of some hospitals (Branch, 2000; Newton et al., 2008). However an additional explanation might be that this burnout period is part of an inevitable transition, since older doctors often return to a more positive state of mind (Testerman et al., 1996). Professional wellbeing, it seems, can be restored if the circumstances are right.

The consultant in this particular instance was himself somewhat 'burnt out.' When our ward round reached the ICU, his shoulders slumped as the nursing staff told him that the overdose in Bed 3 had been precipitated by unspecified 'marriage troubles.' The junior doctor who had turned Edward over to our care had implemented swift treatment to reverse the physiological effects of the overdose; Edward appeared to be recovering well, at least from the perspective of his liver enzymes. The consultant decided to send him to the general ward, monitor his liver function for another couple of days and then send him home.

When he was transferred to the general ward, it was easier for us to talk in private. I found out that Edward had been married for almost three years and the young couple had a baby daughter. It was difficult to imagine what could be terrible enough to make him want to kill himself. It turned out that the marriage troubles listed in the nursing chart were due to problems with the couple's sexual relationship. They had not been physically intimate during the pregnancy or since their daughter's birth twelve months earlier. Edward's suicide attempt had been precipitated by Florence finding him masturbating.

Florence was disgusted by what she saw, and told him angrily that their marriage was over. She had taken their daughter and gone to her parents' house. I was reminded of her when I read McEwan's description of the fictional Florence's reaction to the thought of the wedding night:

Where [Edward] merely suffered conventional first-night nerves, she experienced a visceral dread, a helpless disgust as palpable as seasickness. [...] her stomach tightened dryly, she was nauseous at the back of her throat. [...] Florence suspected there was something profoundly wrong with her, that she had always been different, and that at last she was about to be exposed. Her problem, she thought, was greater, deeper, than straightforward physical disgust; her whole being was in revolt against a prospect of entanglement and flesh; her composure and essential happiness were about to be violated. [...] Sex with Edward could not be the summation of her joy, but was the price she must pay for it (pp. 8–9).

Whether thinking of sexual union or the act of masturbation, both Florences had difficulty dealing with 'entanglement and flesh.' Masturbation has additional connotations. It was elevated to the position of a disease in 1710, with the publication of *Onania; or, the Heinous Sin of Self-Pollution and, All its Frightful Consequences, in Both Sexes, Considered* (Rosenberg et al., 1974). This pamphlet was written to promote the anonymous author's panacea for the ghastly consequences of masturbation. Onania went through sixteen editions,

so he can be said to have enjoyed some success. It has been suggested that the speciality of paediatrics, which came into existence in the mid nineteenth century, was made possible by the identification of two supposedly deviant but related childhood behaviours, thumb-sucking and masturbation (Gillis, 1996).

A Hungarian paediatrician, Dr S Lindner, introduced the idea of an association between the two. His writings were cited by Sigmund Freud, who considered thumb sucking a manifestation of infant sexuality, and both thumb sucking and masturbation were viewed as habits potentially harmful to future neurological development. Gillis points out that these ideas were formed 'against a background of a medical and societal interest in child behaviour and its implications for specifically hereditary degeneration, but also for a possible general societal degeneration manifested by poverty, declining industries, and, in the United Kingdom, poor performance in the Boer War at the end of the 19th century' (Gillis, 1996). From the Boer War to a young man in a small hospital in Australia ... the world in a grain of sand.

Edward was soon well enough to be discharged from the hospital; the consultant was not very interested (Silverman, 2006) and left any plans for ongoing management up to me. Uncertain of what to do, I asked Edward if he would like to talk to a psychiatrist about his difficulties. He refused. He could see little point in recounting the shameful story to yet another stranger; he was not sure what he would do next, but he said that he could not face the thought of losing his wife and daughter.

We talked for a while and I did my awkward best to reassure him, not only that masturbation was normal but that it was in his situation particularly unsurprising. He seemed relieved. Would I be willing, he asked me, to speak to his wife?

When she came to visit him in hospital Florence agreed to speak to me. She was shocked to know that Edward had actually told me what had happened, but even more shocked when I suggested to her that masturbation itself was not harmful. She looked at me with that same 'visceral dread' and 'helpless disgust' with which she must have confronted Edward.

As we kept on talking, all I could hope was that she might gradually come around to the idea that there could be other points of view. Edward was discharged the next day.

I do not know what happened after that. I do not know if Edward followed my colleague's advice and tried again with an increased dose of paracetamol. I do not know if that little family stayed together or if their baby daughter grew up without him. I do not know if either Edward or Florence ever look back on that time and wonder at their lives' strange unfolding, just as the fictional Edward does at the end of *On Chesil Beach*.

It seems that the disappearance of other sources of authority, notably religious authority, in the period following Edward and Florence's wedding (Schenker and Rabenou, 1993) has left doctors holding responsibilities that might be perceived as only peripherally related to health and medicine. But medicine as a purely scientific pursuit is a recent conception. The history of medicine has always been intertwined with mystery and shamanism (Selzer, 1981; Ross, 1994; Helman, 2006). Evidence-based decision making⁴ (Sackett et al., 2000) has been a relatively recent phenomenon and biomedical research has only lately questioned the basis of religious and other forms of authority.

Consider the social changes that have accompanied improved understanding of human sexuality as an example. Not that the path has been a smooth one, as the American

Psychiatric Association's Diagnostic and Statistical Manual, or DSM, makes clear in the case of homosexuality. In 1952 the DSM listed homosexuality as a sociopathic personality disorder. In 1968 the next version of the DSM reclassified it as an example of sexual deviancy. In 1973, in DSM IV, it vanishes. The history of homosexuality and medicine requires a re-examination of some very basic questions. What is a disease? What is an illness? And, importantly, what is neither? A tongue in cheek summary of the roles and views of priests and of different kinds of doctors might look something like this:

Questions	A priestly perspective	A technical, biomedical perspective	A comprehensive medical perspective
Who am I?	A child of God	A complex machine	A poor bare, forked animal
How should I live?	With God's guidance	However you decide	I can share with you the best available evidence on what promotes human flourishing
Why am I here?	To find your way to God	You are a product of evolution	We both discover and create the answers that meet our needs
Am I understood?	You are fully understood by God	Our understanding changes as science advances	No one is fully understood by the other, but I have a personal and professional responsibility to do the best I can
Where does it end?	In the hereafter	In death	Wherever your own beliefs decree
How can you help me?	I can help you connect with God	I use the best available evidence to cure disease, relieve pain and postpone death; when there is no hope of cure, I am of no further use to you	I can use the best available evidence to cure disease, relieve pain, interpret illness and I value you as a whole person in your life's context. I can remain with you as long as you need my help.

This is not to undervalue the technical proficiency of biomedical care. Countless hours of painstaking research go into each significant biomedical advance; Edward may not have survived the paracetamol overdose without such advances. Biomedical research elucidated the structure of paracetamol and how N-acetylcysteine can be used to prevent it from destroying the liver. What biomedicine cannot do is contribute to questions about values, and these questions are of critical importance if we are to maintain a health care system that is responsive, accessible and affordable.

As much as we claim to value comprehensive medical care, it is increasingly broken up into a series of brief consultations with highly specialised services, and the trend is towards less and less personal care, in keeping with a market model. These changes may not matter a great deal when the illness is trivial, temporary or merely annoying, but the doctor-patient relationship takes on much greater significance when the illness is chronic or life-threatening.

Without a close, understanding relationship, it is difficult to know how a particular set of circumstances is affecting another individual. Is the patient who has just announced to the doctor that she is pregnant full of joy or seeking a termination? Is the middle-aged man with low back pain concerned or secretly relieved to be found unfit for work? Beyond these everyday impediments to communication there is, at the very heart of any relationship, an ultimate incommunicability when it comes to individual experience.

A study to evaluate how well patients were prepared for autologous stem cell transplantation in the treatment of recurrent lymphoma illustrates the difficulty (Little et al., 2008). The aims of this study were to compare patients' expressed satisfaction with pre-treatment information with their satisfaction with the pre-treatment information when viewed from the other side of the transplant experience. Patients can expect to experience nausea, vomiting, diarrhoea, mouth sores, skin rash and hair loss. High-dose chemotherapy leaves patients susceptible to infection, anaemia and bleeding. Recovery usually takes about three months, but can take up to a year. All of this was carefully explained, and patients and carers expressed high satisfaction with the information given by individual clinicians and by speakers at a formal information day. After transplantation, however, the ordeal dominated the narratives and retrospective dissatisfaction with information was common. The research concluded that 'information about treatment theories and protocols can be satisfactorily communicated, but personal experience of suffering defies communication.' How then is it possible to speak of something as basic as informed consent, in the face of experience that is essentially incommunicable?

The doctor-patient relationship in extreme situations brings together major aspects of being human – the incommunicability of experience and therefore our sense of ultimate personal isolation (Yalom, 1990), the difficulty of making choices that can accommodate all of our different and conflicting needs, the confrontation with the very meaning and purpose of our lives and, finally, awareness of mortality. These experiences have been described by writers such as Arthur Kleinman (1988), Kay Toombs (1992) and Arthur Frank (1991, 1993, 1995). Kay Toombs expresses it this way:

The patient does not simply 'possess' this body. He IS this body. Consequently the patient does not so much 'have' a bodily illness as he 'exists' his illness. [...] A dysfunction in biological body represents a concurrent disruption of the patient's being-in-the-world (pp. 220–1).

Tymieniecka and Agazzi take up the same idea:

So much of the illness experience lies within, and is accessible only to, the patient. Fundamental features of embodiment (bodily intentionality, primary meaning, contextual organization, body image, gestural display, lived spatiality and temporality) are all disrupted in illness (Tymieniecka and Agazzi, 2001).

The incommunicability of experience works both ways, of course, and there is in the experience of medical education and training a process of professional socialisation that has, among its many effects, the effect of making it possible to disregard the suffering of the other in order to do things to another person's body that would otherwise be unthinkable. Arthur Kleinman

begins his book *The Illness Narratives*, (Kleinman, 1988) by describing an early experience as a medical student, during which he sat daily with a little girl undergoing horribly painful treatment for severe burns. No one would choose to inflict such pain without knowing that it was essential to minimise scarring and contractures, and even then, the terrible task of debridement is hard for everyone to bear. 'Rational cognition has one critical limit which is its inability to cope with suffering.'

Rates of depression, anxiety and burnout are high among doctors (Agius et al., 1996; Willcock et al., 2004; Woodside et al., 2008). Despite improvements in medical education and training, a recent Australian survey showed that 2/3 of the junior doctors surveyed believed that they were working unsafe hours, almost half of them reported getting less than six hours of sleep per night in the preceding month and 17% regretted their choice of medicine as a career (AMA, 2008).

Stress comes in many forms. A study of psychiatrists in Scotland, found that almost 70% had experienced the loss of a patient through suicide. Fifteen percent considered taking early retirement as a direct result of that experience. Maintaining a position of empathic concern without becoming burnt out is clearly difficult. Hodges and Biswas-Diener (2007) have suggested that there may be an optimal level of empathic concern beyond which mechanisms to regulate emotional responsiveness (suppression, distancing and controlling exposure) come into play. I believe it was this mechanism that accounted for the comment made by the junior doctor who 'turfed' Edward on that Monday morning.

From the two Edwards and the two Florences it is possible to see how medicine and lived experience are entwined, how impressive are the life-saving achievements of biomedical research, but how clinical medicine bears responsibility for constructing as well as identifying disease, how untenable is the idea that science can answer questions about values, how important is the idea that the arts and humanities can and must help to address the problems created by a reductionist conception of science (Midgley, 2001).

In 2008 the Wellcome Trust made a grant of over £1.8 million to Durham University to establish a multidisciplinary Centre for Medical Humanities. The Centre has undertaken to explore the relationship between scientific and experiential accounts of human nature, health and flourishing, and the effects that the divergence between these two accounts has on clinical health care and health policy. In doing so, the Centre will look at ways that clinical health care might be reconceptualised so that medicine can benefit from the contribution of the human sciences (Macnaughton et al., 2005) while the arts, humanities and social sciences can simultaneously benefit from the contributions of the biomedical sciences (Evans, 2005). One of the ultimate goals of the project is a radical re-conceptualisation of clinical health care that acknowledges the foundational place of the humanities within it.

The research team comprises Martyn Evans, Professor of Humanities in Medicine in the School of Medicine and Health, Dr Jane Macnaughton, also in the School of Medicine and Health, Professor Corinne Saunders from the Department of English Studies and Dr Sarah Atkinson, Reader in the Department of Geography. Additional team members will add even further diversity to the core team.

The 2008/9 IAS theme 'Being Human' has encompassed philosophical, political, historical, literary and even photographic conceptions of the human condition. An underlying question has been: what exactly do we mean when we speak of 'human nature'? IAS scholars have examined observable human behaviours such as engagement in conflict and revenge,

manifestations of xenophobia and other forms of prejudice, agonistic politics and manifest stupidity. Are these behaviours part of human nature? How have they come about? In cultures, societies and historical periods when they have been or are being observed, are they fixed or mutable? The exploration being undertaken in the Centre for Medical Humanities takes as a given the possibility of improving the quality and safety of health care. The value that we place on being human in medicine is central to that exploration.

The moral philosopher, Raimond Gaita, in *A Common Humanity: Thinking about Love and Truth and Justice* (Gaita, 2000) says

I feel ... a little embarrassed talking ... about the preciousness of each individual human being, not least because it can sound precious, or sentimental or soft-headed ... Talking of the preciousness of human beings has however the advantage that it directs our attention to a feature of the person and to our response to the person. ...Were it not for the many ways human beings genuinely love one another – from sexual love to the impartial love of saints – I do not believe we would have a sense of the sacredness of individuals or of their inalienable rights or dignity (p. 5).

Our sense of the preciousness of other people is connected with their power to affect us in ways we cannot fathom and in ways against which we can protect ourselves only at the cost of becoming shallow. ... it is partly what yields to us that sense of human individuality which we express when we say that human beings are unique and irreplaceable. Such attachments, and the joy and the grief which they may cause, condition our sense of the preciousness of human beings (p. 27).

So, was Edward's attempted suicide a fit matter for medical concern, after the danger to his liver had passed? Gaita suggests that our uniqueness, whether represented in a novel or in the course of everyday life, makes a purely biomedical orientation to health deeply deficient, if not damaging – security and certainty bought 'at the cost of becoming shallow.' It suggests also that within his conception of our common humanity lie many of the answers to the challenges of being and remaining human in medicine.



Notes

¹www.worldsciencefestival.com/speakers/antonio-damasio

²www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085814

³Obstetric Ultrasound: a Comprehensive Guide, at www.ob-ultrasound.net

⁴See for example, the Centre for Evidence Based Medicine website at www.cebm.net/index.aspx?o=1014

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Insights

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