Why should physicians read? Understanding clinical judgement and its relation to literary experience

AHLZEN, ROLF

Rolf Ahlzén

Why should physicians read?

Understanding clinical judgement and its relation to literary experience

PhD – thesis University of Durham 2010

Printed by Universitetstryckeriet, Karlstad, Sweden 2010
Bound by bookprinter Olle Myrin, Karlstad, Sweden 2010

Contents

Acknowledgements

Writing a doctoral thesis at a mature age has certain advantages. Probably the most important amongst these is that there has been time enough in life to come to know many persons who have interesting things to say about matters of importance to you. In this sense, I have been immensely privileged. My interest in what is now called "medical humanities" dates back to the late seventies, when I, as a young student of medicine in Gothenburg, found medicine to be deeply intertwined with areas of knowledge that I had just left. During the thirty years since then, I have over and over again been stimulated and challenged in my reflections by colleagues, scholars and friends. I owe them very much.

First and foremost my main supervisor, Professor Martyn Evans, who has also been a friend for over twenty years. I can remember walking on a sunny early summer day in Singleton Park close to University College of Swansea, intensely discussing the necessity to broaden the scope of the by then dominating medical ethics project to involve also the humanities in a larger sense. At that time, I could hardly have guessed that Martyn was, as the first professor of medical humanities in the UK, to be my supervisor in this process. If I ever had any second thoughts about having a friend as supervisor, these were mistaken. Martyn has, with his so characteristic combination of intellectual clarity and generosity, wit, and devotion to the subject, been the ideal supervisor – and though about one thousand kilometers away, still very close and always in reach. Thanks for this, Martyn, and for many years of friendship.

My second supervisor, professor Jane Macnaughton, is not an old friend but I dare say a friend nevertheless. With Jane I share the predicament of being a doctor with an insatiable appetite for humanistic knowledge. Her knowledge of literature and her sharp eye for the elements of clinical judgment have made her comments to my

attempts immensely valuable. The fact that she is also a keen bicyclist in a nation that is not very welcoming to such bears witness to her sound judgment.

I can hardly think of these two main persons in my writing process without also having in mind the rest of the group around the *Medical Humanities Companion* project. With the starting point some years ago in Oxford, this fantastic group has met in Italy, Finland, England – and soon in Sweden – to venture into the rich landscape of medical humanities. The fact that we have had a great time together has hardly made the result of our endeavors less interesting. I thus want to thank Pekka Louhiala, Raimo Puustinen, Iona Heath, Anne Macleod, Carl-Edvard Rudebeck, Jill Gordon and John Saunders for providing me with friendship and scholarly reflections in an unusually fruitful combination.

But so many other persons have been with me in this process. I owe much to colleagues Olle Hellström and Christer Pettersson, who as GP:s have broken new paths in the understanding of the clinical encounter, as well as to Carl Lindgren, who explores the borderlands between clinical medicine and literature. Stig Andersson, retired GP, has been a true intellectual companion over the years, as well as a trusted friend. His generosity, his breadth of knowledge and his devotion to his tasks in my eyes make him the ideal of a physician.

Several times I have enjoyed the hospitality of Department for Medical History and Philosophy at the Radboud Hospital in Nijmegen. The warmth of its atmosphere and the scope of its research have made it an example of a fruitful academic environment. I particularly want to thank Wim Dekkers for his support and friendship over the years. Without him, my understanding of medical hermeneutics would be poorer.

A medical man who ventures into the huge and rich landscape of literature needs good company and guidance. Professor Merete Mazzarella of Helsinki University has

inspired not only me but many, many other clinicians who find literature relevant for medical practice. Professor Anders Palm in Lund has, with his remarkable enthusiasm and receptivity, opened the territory of medical humanities for new groups of clinicians and clinicians-to-be. I can only wish that his wise thoughts on "the values of literature" had reached my eyes somewhat earlier in this process.

What can be more important in the process of writing than good readers? I have been privileged with such. Apart from my supervisors, Cristina Heldner, Fredrik Svenaeus and Staffan Janson have read and constructively commented my text. They have from their respective positions – the linguist, the philosopher and the public health researcher – read my text closely and with, at the same time, critical and sympathetic eyes led me in better directions. Katarina Elam inspired me and commented my book. If I know anything of philosophical aesthetics, it is because of her. Anders Tyrberg, literary historian in Karlstad, set me on the track in my attempts to understand the act of reading. Thanks, Anders, it was heuristic!

Intellectual stimuli of a more disorganized, but no less important, sort have been provided to me by the three other members of what we, with either lack of modesty or perhaps the contrary, call "the gang of four". The encounters with wine, food and wonderfully unfocused talks about high and low – I owe them to my friends Torsten Rönnerstrand, Lennart Jemtelius and Thomas Huss. How much poorer life would be without those evenings!

The University of Karlstad has been my main professional home for now over twenty five years. I have met only generosity and good will here. Thanks to all at the Department for Health and Environment for providing a welcoming and in the best sense tolerant atmosphere – and all others who have shown their interest in my writing.

The university's rector Kerstin Norén took some of her not too generous spare time to read my manuscript – this was both impressive and inspiring.

To my family: Without your trust and support, this would have been a hopeless project from the very start. With great patience you have accepted my eccentric working hours. Thank you for always being there.

Karlstad, June 14th, 2010

Abstract

Is literary experience of any practical relevance to the clinician? This is the overall question addressed by this investigation, which starts by tracing the historical roots of scientific medicine. These are found to be intimately linked to a form of rationality associated with the scientific revolution of the 17th century and with "modernity". Medical practice, however, is dependent also on another form of rationality associated with what Stephen Toulmin calls "the epistemology of the biographical". The very core of clinical medicine is shown to be the clinical encounter, an interpretive meeting where the illness experience is at the centre of attention. The physician can reach the goals of medicine only by developing clinical judgement. Clinical judgement is subjected to close analysis and is assumed to be intimately connected to the form of knowledge Aristotle called phronesis.

In order to explore how literature – drama, novels, poetry – may be related to clinical judgement, a view of literature is presented that emphasizes literature as an invitation to the reader, to be met responsibly and responsively. Literature carries a potential for a widened experience, for a more nuanced perception of reality – and this potential is suggested to be ethically relevant to the practice of medicine. The "narrative rationality" of a literary text constitutes a complement to the rationality pervading scientific medicine.

The final step in my analysis is a closer exploration of the potential of the literary text to contribute to the growth of clinical judgement, in relation to the challenges of everyday clinical work. Some of the conditions that may facilitate such growth

are outlined, but it is also shown that full empirical evidence for the beneficial effects of reading on the clinician reader is beyond reach.

Preface

A short personal back-ground

I started writing this thesis out of curiosity and also out of a sense of growing urgency. My way into medicine was not straightforward. After some years with humanities studies, I began medical studies in Gothenburg in the mid seventies. My strong interest in history, philosophy and literature was far from saturated. But I was increasingly disturbed by what I felt was a lack of direction, of identity and of … yes, I dare call it mission. I was young, idealistic and wanted some sort of mission, something to do that in a visible – and of course also appreciated – way cut into reality and made a difference. Medicine promised this, and was at the same time – I thought – a way of learning both about bodies and persons, about individual life paths and about the struggle for meaning that I so far mostly had met in novels and plays.

The body yielded its secrets through hard studies in the biomedical basic sciences. I was prepared for that, and enjoyed it, but not the absolute absence of anything reminding us students that we were supposed, in some years, to take responsibility for human beings struck by misfortune and suffering. When after almost three years the first living human beings made their entrance into our studies, we had come far in our ability to abstract away from the everyday realities of embodiment and intentionality. We were trained to be physicians through discovering a new language and a particular form of rationality – and by brushing other modes of understanding aside.

I remember vividly one evening during this period at the medical student organisation's *Villa Medici*. The evening went on with singing, eating and drinking. When the atmosphere around the tables had become relaxed and as usual a bit vulgar, one of our invited teachers rose. This experienced psychiatrist raised his voice, looked at us calmly and said: "Dear students, you will read and read until your eyes bleed about dysfunctions, syndromes and psychic and somatic deviances. You will need this knowledge. But do not for one moment forget that in the works of Shakespeare you may get more of the knowledge that you all must have about human beings than in all the medical textbooks you read." Possibly not many of us noticed how extraordinary his words were. I did. I felt they were addressed directly to me and to my increasing unease about the direction my studies had taken. They were to follow me as a question, as a wonder, about myself, my profession and about the task to which I had devoted my professional life. In short, my thoughts centred around the question why sources of knowledge and experience that I considered to be obviously related to the tasks of the physician – healing, ameliorating, consoling – were ignored, non-existent? The sense of an overlooked chance – this is perhaps how this may be described. As if something was there waiting to be taken into use – and we just ignored it.

My sense that there was a challenge not yet realized and addressed has followed me since then. I could have left it to others to explore. I could have given up facing the obvious complexity involved in any attempt to answer it. When I finally decided not to, it was, I assume, also with inspiration from the slow but undeniable rise of general interest in the role of humanities in relation to medicine. I came to see this as an invitation also to myself to make a more sustained effort to investigate the role that literary texts may play for practising

physicians, or for young men and women that were under training to become physicians. The result of my endeavour is this thesis.

Chapter 1

Introduction

> *Nor again does Practical Wisdom consist in a knowledge of general principles only, but it is necessary that one should know also the particular details, because it is apt to act, and action is concerned with details…*
>
> Aristotle [1]

1.1 Medicine and the challenge of human suffering

Medicine is not the only answer to human suffering but it is certainly one of the most important. Medicine is the human endeavour that in an organized and systematic way attempts to prevent, cure and alleviate such suffering that arises due to bodily afflictions. One need not point to human catastrophes, like wars and plagues, to be fully aware that such suffering is part of the basic human condition. And even though medicine has never, and will never, be able to eradicate suffering, its endeavours have been of fundamental importance in regard to this basic human predicament. It has reduced suffering, sometimes very much, sometimes just a little, but just as important has been the fact that medicine symbolizes a collective intent and resolve to come to the aid of the sufferer. As such it is a social force and the expression of a shared moral duty. Embodying this duty is part of the identity of those who practise medicine. Anthropologist Byron Good, whose research will appear several times in this thesis, writes about the "soteriology" of medicine and how this influences the medical students of Harvard Medical School:

> From early on, medical students speak of a kind of "passion" required for doctoring. Not only do they seek a specialty that will maintain their intellectual excitement, but many describe their passionate engagement with the primal forces of sickness and suffering, a passionate struggle on behalf of their patients. It is an attitude for which the students long, although they are ambivalent about its demands. It is an attitude all too often lost in years of training and practice, but it remains present as a dimension of all healing.[2]

The attitude of these students in their early medical training is well in line with the historical roots of the profession they have chosen. Medicine has never explicitly promised salvation from suffering, but it has implicitly promised people that they will be saved from some afflictions, and that there is at least amelioration from the ones that cannot be cured. Possibly, with the successes of modern medicine, this implicit soteriological promise has become even more present. Anyone practising medicine is bound by this combined explicit and implicit commitment. In words that are of uncertain origin, but often ascribed to Hippocrates: "Sometimes cure, often ameliorate and always console."

At the beginning of the 21st century, medicine finds itself in an ambiguous situation. It is more powerful and knows more about the body than ever. It penetrates almost every aspect of human life, from birth to death. It has a major impact on symbolic forms on a cultural level. It uses a considerable amount of our common resources. Yet fear of illnesses has not vanished, rather the contrary, and many human conditions that present themselves as bodily dysfunctions defy medical understanding. Complex ethical issues have appeared accompanying highly technological medical interventions, particularly at the beginning and the end of life. As a consequence, the role of the physician is more complex than

ever: the master of medical science and technology and the priest of a medical soteriology in one.

1.2 Literature and medicine

Byron Good notes that the physician's interest in the personal dimension of medicine is an attitude that is "…all too often lost in years of training and practice." This is a well established fact in several investigations.[3] The rise of medical ethics in the seventies and eighties and the subsequent establishing of departments and research projects in what came to be called "medical humanities" must be seen also against this background.[4]

The relation between medicine, both as a science and as a practical activity, and literature in all its forms is complex, and the word "relation" may obviously mean several different things in this context. The interrelations between these human areas have been vividly explored in the last decades. The appearance of departments for medicine and literature (or vice versa), courses in creative writing for medical students, a journal like *Literature and Medicine* and book titles like *Doctors' Stories: The Narrative Structure of Medical Knowledge*, *On Doctoring*, *Bioethics and Medical Issues in Literature* bear witness to us that this is a booming field of interest. The expectations are sometimes very high. Rita Charon, physician and one of the pioneers for the role of literary acquaintance for physicians, puts it like this:

> As doctors become more and more skilled in narrative capacities, they will improve their ability to develop accurate and comprehensive knowledge about patients, to reach patients, to become their trusted advocates, to

> navigate ethical uncertainty, and to be moved by all that they are privileged to as doctors.[5]

There are at least four major possible connections between literature and medicine. One may, for example, take an interest in how those who practice medicine have also created literature. Writing physicians abound, some of them successful, as for example Anton Chekhov or Alfred Döblin, others mostly unknown. Some of them remained in practice, like William Carlos Williams, while others gave up their medical practice, like Swedish author P C Jersild. Some regularly use their medical knowledge and experiences in their writing, while some don´t. There are several interesting questions in connection to this. Does medical work in some way inspire literary creativity? Are the experiences of physicians such that they "seek an outlet" in writing? How has writing influenced the work of these medical men (they were, of course, almost exclusively men), if they went on practising, or vice versa? Do persons with a specifically intense relation to language and stories more often choose medical tasks than others? While the answer to such questions may be of considerable value to this investigation, they are not my primary targets. They will, however, be touched upon at some occasions, especially in 5.2, when different texts are discussed.

Another approach to the relation between literature and medicine is to attempt to understand how places and conditions of high medical relevance – hospital interiors, disease states, illness experiences, therapeutic interventions, social conditions giving rise to disorders – have been illuminated in literary works, and through such an investigation find out how these texts may help us to reach a more detailed and possibly also more empathetic understanding of clinical

practice. This is a common theme ever since the dawn of literature and the list of works with such themes is almost endless. The reason is obvious: Diseases are part of the human condition and their appearance is often associated with dramatic changes, inner and outer, in people's lives. The very dramaturgy of disease is good stuff for literary narrative, a fact that has been used by numerous authors. Disease may play a rather inconspicuous role in a literary work, like the headache of Marcel in Proust's *In search of lost time*, or be the very core around which the story rotates, like in Mann's *The Magic Mountain* or Albert Camus´ *The Plague.* The setting may be medical, like in Margaret Edson's *Wit* or P C Jersild's *Babels hus,* or non-medical like in Tolstoy's *The Death of Ivan Ilyich* or Lars Gustafsson's *The Death of a Beekeeper.* Not surprisingly, I will in the following now and then return to literary works - drama, novels, short stories, poetry – that in one way or another and more or less prominently have "medical" themes. But my analysis will not specifically deal with literature on medical topics but with literature in general. My attention will not primarily be directed to medical content but to the force of the story, the aesthetical quality and to the depth of the author's intent.

Thirdly, by "medicine and literature" may occasionally be meant the possibility that reading has a therapeutic function. This has sometimes been called "bibliotherapy".[6] Reading would, if this were the case, positively affect the outcome of a disease process, possibly through the healing effects of reflection on fictive persons´ lives and identification with their existential challenges. Narrative as a potential for healing is of course nothing new, and it may well be that there are possibilities here that have not been properly understood and that are still waiting to be employed. I will, however, not deal with this aspect in my

study, except marginally when I analyze the possible cathartic effects of reading on physicians dealing with emotionally difficult human situations.

Even if these three connections between literature and medicine are both interesting and promising, my focus will be on a fourth, related but still different aspect: the potential contribution to clinical skills from the acquaintance with literary texts in general.

1.3 The hypothesis and structure of the thesis

This thesis is devoted to the understanding of clinical medicine, and to the relation of practical medical work to literary experience. While illness and disease have always frequently appeared in literary narrative, it is far less obvious that the experience of literature in general may have anything to do with practical medicine, except giving the readers amusement and relaxation. The link proposed here is the physician, the reading physician. It is the act of reading, of experiencing a literary text and the subsequent reflection on it, which carries the potential for adding professional skills to the physician, who struggles with the challenges of disease and suffering.

My intention is to steer somewhere in between the too far reaching ambitions and the blank denials. I will argue that there is no way to substantiate a claim that literature is the answer to all the challenges and failures of modern scientific medicine. Neither do we have any solid reasons for assuming that literary experience is usually indifferent to clinical judgement. My hypothesis is that the aggregate of practising physicians will, if they keep the company of good literature, learn from this and improve their clinical judgement. However, here

as with the epidemiological paradox[7], this cannot with any certainty be said for each of them. There are so many factors involved in the encounter between reader and text that predictions in specific cases are not possible. This does not mean that one has to abstain from any recommendation to physicians concerning their literary habits, just as we do not avoid some health recommendations even though we know they are not with any certainty valid for each individual. It means that the kind of suggestions one is entitled to make are more general, rather like these: "There is a good chance that you may learn things relevant for your work from this reading, apart from it being relaxing", or "It would not be a bad idea for you as a doctor to read novels now and then….!". And we may, as I will try to show in 5.2, say some reasonably well founded things about the circumstances that may promote a clinically beneficial encounter between the physician and the literary text.

I suggest the notion of *potential* to capture this. This concept is chosen from the rather obvious insight that no one person can guarantee anything about the outcomes of any reading for any person. It should also be seen against the background of the everyday insight that an extensive reading is neither a sufficient nor necessary condition for wisdom or even decency. A potential is something that may be actualised but will not necessarily be so. Potentials are actualised under certain conditions. These conditions may be easy to establish or very complex. The encounter between reader and text is unique and dependent on a very large number of contextual factors. The conditions under which reading becomes a meaningful learning for the clinician are, as a consequence, exceedingly complex and not possible to fully predict.

I am, thus, investigating the threads that bind together the experience of literature *in general* with the tasks of the physician. This fourth aspect of literature and medicine hence means to approach the relation between literary narrative and the performance of the practical tasks of one sector of human life, clinical medicine. One may, of course, argue that this is just one specific instance of the more general question about how reading influences character and how this in turn influences the acts of those human beings that read. This is undoubtedly so, but the analysis here will be specifically related to physicians and to their practical tasks in the care and cure of patients. This is why I will devote a considerable part of the investigation to an understanding of the nature of clinical medicine, and to the question how doctors go about performing their tasks of curing and alleviating – and how they ought to do it. This is also why I will insist on reaching a plausible and for this purpose fruitful conception of literature and literary narrative before starting the attempt to discern the threads connecting the two.

Will literature save the life of medicine, as Stephen Toulmin almost three decades ago playfully suggested that medicine would do with ethics?[8] One may be inclined to think so, given the expectations that accompany some literature programs on medical education. My ambitions are of course far more modest. Literature, *if* it can be shown to be of value, is one of several roads that may lead us to the goal, which in this case is the fulfilment of the ethically defined goals of medicine. It may sometimes be of considerable or even large value, sometimes of very small. It is like a part of a greater web, the web that makes up clinical skills.

The whole of chapter 3 and also parts of 5.1 of my investigation are devoted to an attempt to outline a view of literature and literary experience that is fertile and

useful in connection with an understanding of medical practice. Key notions will be invitation, responsibility, and knowledge. Fiction is an invitation to a widened experience of the world, an offer to see persons and things around us in a richer and fuller way, including those ambiguities and complexities that science often attempts to abstract away from. The reader has the responsibility to answer to this invitation in such a way that he or she learns something, rather insignificant or of decisive importance. But the understanding of literature's contribution to specifically the physician's skills inevitably rests on an understanding of *what it is the physician needs in addition to and intertwined with the biomedical training and forming* that is now so prominent.

Hence, the double focus of this thesis – "Understanding clinical judgement *and*….literary experience" – is motivated by the fact that clinical medicine, in contrast to what still often seems to be assumed, is a "bridging" activity, that relies just as much on personal knowledge as on scientific. To capture this double base of clinical medicine, I have used Stephen Toulmin's idea of the two epistemologies that will be presented in section 2.1.9. To understand this and the challenges of the physician of the 21st century, we must look at how medicine has evolved in western societies, with an emphasis on the birth and growth of scientifically based medicine, which is the task of 2.1. We also need an understanding of what clinical medicine is, the ontological status of medicine, and I will attempt to do this in 2.2. My conclusions will be that clinical medicine is a human interpretive practice, relying on both scientific knowledge and knowledge of persons, with goals that are ethically defined. It is permeated by uncertainty. The physician faces several challenges, outlined in 4.3, which may not all be sufficiently met by bringing in more scientific knowledge (which may be a necessary but far from sufficient condition for handling them). The stock of

relevant scientific knowledge – from the "pure" sciences to Evidence Based Medicine – is enormous and grows rapidly. A reasonable degree of command over certain parts of this wide area, together with a thorough knowledge of and acquaintance with human dispositions and reactions, in health and in disease, make up the basis for *clinical judgement* (4.2 and 4.3). An amalgamation of scientific knowledge, practical skills and practical wisdom thus forms the basis for clinical skills.

The knowledge base of the practicing physician may be formulated more specifically like this:

(1) General understanding of the world and of the life worlds and the living conditions of other humans beings.
(2) Relevant and continuously updated biomedical knowledge.
(3) Memory, analytic skills, capacity for sustained attention and observation.
(4) Emotional maturity and flexibility, self-knowledge, imagination.
(5) Basic ethical beliefs.

My hypothesis implies that at least points (1) and (4) above may under certain circumstances be favourably affected through encounters with literary texts. Possibly, also (3) may to some extent benefit from reading, but I find this far more uncertain. Whether (5), ethical beliefs, are affected by literary experience is an important but very difficult question to answer. I will take the cautious position that basic ethical beliefs, core moral attitudes, are probably not very much affected by reading experiences. The way these are "translated" into action, however, is. The knowledge that literary experience may give the reader carries the potential to facilitate moral action by ways of a more nuanced view of reality, admitting for ambiguity and paradox, and a better understanding of the richness and complexity of human perspectives.

Let us look at the following hypothesis (I): *The reading of literary texts will have as a consequence that the clinician acts in such a way that the goals of medicine are better reached than if he had not read.* It will be made clear that this is an untenable assumption, if it is formulated in this categorical way. Any empirical investigation of, say, the effects of physician A reading novel X would involve thorough going problems of causation and of effect measurements. If this physician performs partly differently in his clinical tasks after reading for some period, and if this was possible to measure in some way, how would anyone know that the experience of the literary narrative is behind this? The same goes for a group of doctors reading for a longer period. The personal and contextual uniqueness of the reading situations means that it is impossible to distinguish them from all other circumstances influencing clinical performance.

The hypothesis may, however, be reformulated like this, in order to take these challenges into consideration (II): *The reading of literary texts carries a potential from which, given certain circumstances, it follows that the physician acts in such a way that the goals of medicine are better reached than if he had not read.* This is what I will argue and attempt to find support for in my analysis.

The conditions of importance for the outcome of a reading experience that will be analyzed in the following are the content and complexity of the story, the literary genre and aesthetic form of the text, the reader's expectations and mode of reading, the extent of reflection on the text, exchange of thoughts on what is read with others and to some extent also the relation of different reading experiences to different clinical tasks. This will mostly be done in chapter 5.2.

Hypothesis II, then, is the more modest assumption that will be developed in this thesis. It points to the demanding tasks of first establishing that this potential actually *does* exist and secondly attempting to outline some of the conditions under which it may be actualized. This is the challenge that I will now take on.

In my investigation, I will, as just noted, look upon the physician's clinical skills as dependent on different modes of knowledge. I will relate these to Aristotle's categories *episteme, techne* and *phronesis.* These concepts will be presented and analysed and specifically *phronesis* will be seen as a crucial, but often ignored, ingredient in what I will point to as the physician's key capacity, *clinical judgement.* Clinical skills are basically a form of practice, an interpretive practice, however strongly dependent it is on theoretical knowledge. *Phronesis* is the major link to literary experience, but also episteme is of relevance in relation to reading experiences.

Finally, I will return several times to Stephen Toulmin's idea of another road to modernity, introduced in 2.1.9. Toulmin looks upon modernity, as we today often conceive of it, as inextricably linked to the rise of modern science. Consequently, arising in the 17th century and closely linked to the emerging sciences and now dominant in many areas are certain modes of understanding and interpretation, including a specific idea of rationality, which constitute the basis for the "new" sciences. This idea of rationality pervades also what I have chosen to call "modern medicine". Other ideas of what may be rational, reasonable, important and relevant, are hence more or less brushed aside. If Toulmin is right it becomes crucially important to attempt to identify the scope and limits of the rationality of the modern sciences, in relation to the *practice* of medicine. We must also ask whether, as he proposes, there may be a

complementary view of rationality and decide the respective roles of these in the task of healing of human illness. These questions are at the centre of this investigation.

1.4 Some notes on method

A possible way to approach my research question had been to conduct a number of empirical investigations on the effects of reading on clinically active physicians and on medical students. I am convinced that there are some important observations to make from such studies and I have outlined one possible design for an empirical investigation in chapter 5.2. However, I consider the difficulties to be huge, and I will develop this further, also in 5.2. This thesis is not empirical. My reflections on the role that literary experience may play for practising physicians have led me to the conclusion that there is a lack of conceptual clarity when claims are made why physicians should read literary texts. I suggest that any understanding of literature's potential contribution to clinical medicine must be based on a thorough analysis of the two phenomena involved: literary texts and practical medicine.

My analysis of practical medicine and of literary texts has inevitable normative elements. I am enquiring into the nature of these phenomena. This is not a value free task. My analysis rests on assumptions about the goals of medicine and about the role that literature plays and could play in our lives. The goals of medicine define, I will argue, what is medical practice, and they are derived from ethical values. Neither is there any value-free "objective" knowledge about the nature and function of literature. As will be seen, the answer to this involves a number of assumptions about the role of literary texts, why we read and what

happens, and ought to happen, when the reader reads. Thus, when I ask what the relation between medicine and literature *is*, I answer both by scrutinizing these practices but also by outlining what I think it *ought* to be, how these human projects ought to be practised. Martyn Evans has made this explicit concerning clinical medicine, in his interpretation of one of my "canonical" voices, Eric Cassell:

> In taking the relief of suffering to be an *internal* goal of medicine , Cassell (1991), for instance, seems committed to the idea that medicine in practice must be both ethical and humane *by definition,* a view whose consequence would be that if we fail to practice medicine humanely or ethically we fail to do medicine at all rather than just doing medicine badly, which seems on the face of it the more natural way of putting the matter.[9]

Cassell's position is also mine in this thesis. This does not mean that there is room for a free floating speculation of a normative kind. The normative foundation of my investigation entails a clear responsibility to carry out a comprehensive analysis based on solid, well-reflected arguments and deep-going knowledge and acquaintance with practice. The basis for this is my own clinical experience, reflection on it and the reading of and interpretation of a number of "canonical" texts in this area, that all have in common that they are in one way or the other related to the question what medicine and literature are and ought to be – as well as their mutual relation. I interpret and reinterpret these texts, and I enter into dialogue with them – all in order to illuminate issues of importance to my hypothesis.

I will insist on calling this thesis an investigation and sometimes also use the concept "essay". I do this in order to emphasize its tentative, exploring and open

nature. An essay is an attempt to understand. My understanding is inspired and facilitated by "a polyphony" of voices, that have in common their intention to understand one or both of the two phenomena I approach: clinical practice and literary texts. These authors have presented ideas which have followed me through many years and my reflection on them has interacted with my clinical practice. Together they have created "a room of understanding" that I find fruitful for this thesis. I am aware that there is an eclectic aspect to this. Being "eclectic" in my case means to be free to search inspiration from many sources, not shallowness or "anything goes". Many voices will talk through my text, but still it is finally me and no one else that is responsible for interpreting them, synthesizing them into a whole that makes up the totality of this essay and its conclusions.

This inevitably means that my investigation rests on inspiration from several disciplines, including different medical subdisciplines, philosophy, history, anthropology, religious studies, and literary theory. This is, I contend, characteristic of many inquiries in medical humanities. Medical humanities is an area of investigation where many disciplines come together to understand different aspects of what is generally called medicine, and which is a huge and very heterogeneous area of human knowledge and activity. Do they inspire and learn from each other but basically retain their methodological commitments to their "home disciplines", making medical humanities a multidisciplinary project? Philosopher and physician William Stempsey in an article asks whether medical humanities is a multidisciplinary rather than an interdisciplinary field, if the latter signifies an activity "…in which the endeavour itself is seen as growing from one comprising several distinct disciplines into a new ´interdisciplinary

discipline´".[10] Does an interdisciplinary field really emerge when medical humanities is searching for its identity?

This thesis, in the words of Evans and Macnaughton, "somehow both straddles the disciplines and falls between them".[11] I analyze a number of concepts that must be understood to approach an answer to my hypothesis. I discern, interpret and reinterpret ideas that illuminate the threads that bind literary experience to clinical skills. I reflect on the conditions that may facilitate certain outcomes of encounters with literary texts.

Stempsey finally, in his article, reaches the conclusion that the fundamental disciplinary belonging of what we now call medical humanities ought to be philosophy. However, he underlines that it is philosophy in a very broad sense that he has in mind, tracing his inspiration back to the roots of philosophy:

> Nonetheless, I am suggesting a return to the roots of philosophy. That view is the one that gave rise to awarding a degree of doctor of philosophy to people who have studied in all sorts of fields, the humanities and the sciences. Thus, philosophy of medicine would offer reflection not only on the traditional philosophical problems inherent in medicine, but also on all of the medical sciences and humanities, and medical practice as well.[12]

Philosophy, it has been said, started in a sense of wonder. So does this investigation.

[1] Aristotle: *Nichomachean Ethics.* Dover Publications: New York, 1998, book VI, 107
[2] Good, Byron J.: *Medicine, Rationality, and Experience: An anthropological perspective.* New York: Cambridge University Press, 1990, 85-86
[3] For a good overview of the research on this, see for example Josephsson, Ulla: *Life View of Medical Students at the Karolinska Institute, Stockholm, Sweden.* Stockholm: Karolinska Institute, 1994, chapter 2.
[4] I have written about the rise of medical ethics in an essay in Swedish, and about the rise and nature of medical humanities in another article. See "Självbestämmandets triumf? ("The triumph of autonomy?)"*?),* in Lantz, Göran/Ahlzén, Rolf./Sverne, Tor./Lutzén, Kim.: *Nedsatt beslutsförmåga. Vem bestämmer för patienten? (Impaired Decision Making Capacity: Who Decides for the Patient* Stockholm: Ersta Vårdetiska Institut, 1998, 9-32, and "Medical humanities – arts and humanistic science" In *Medicine, Health Care and Philosophy (*2007), 10: 385-393.
[5] Charon, Rita: "Reading, Writing and Doctoring: Literature and Medicine" In *The American Journal of Medical Sciences* (2000), 319(5): 285-291
[6] See for example Clarke, Jean M./Bostle, Eileen (eds): *Reading Therapy.* London: Library Association, 1988.
[7] This paradox arises out of the fact that what we can say is true of populations – e.g. that the risk for a certain disease is increased by a certain life style – may not be true for the individual member of the same population.
[8] Toulmin, Stephen: "How medicine saved the life of ethics". *Perspectives in Biology and Medicine,* (1982), 25(4), 736-750
[9] Evans, Martyn: "Medical Humanities – Stranger at the gate or long lost friend?" In *Medicine, Health Care and Philosophy* (2007), 10(4): 363-372
[10] Stempsey, William: "Medical humanities and philosophy: Is the universe expanding or contracting?" In *Medicine, Health Care and Philosophy* (2007), 10(4): 373-383
[11] Evans, Martyn/Macnaughton, Jane: "Should medical humanities be a multidisciplinary or an interdisciplinary study?" In *Medical Humanities* (2004), 30: 1-4
[12] Stempsey, 2007, op cit

Chapter 2

The physician is the person who takes the patient's history.
Stephen Toulmin[1]

Towards an understanding of clinical medicine

Medicine in western culture has come to be synonymous with scientific medicine. The "scientification" of medicine has been going on for at least one and a half centuries. It has radically transformed the practice of medicine and earned medicine a reputation for being highly successful and nearly always in progress towards new brave goals – except, perhaps, for a few blind alleys. Medical diagnosis and treatment are now indeed mostly based on a huge and rapidly growing scientific stock of biomedical knowledge, and in close symbiosis with sciences like biology and chemistry, as well as epidemiology and statistics. The transformation of medical practice has, however, neither been uncomplicated nor totally penetrated the daily work of the physician. By no means all elements of clinical medicine have changed in the direction of scientific method and controlled methodological rigour. This fact is by some observers seen as a serious weakness, while others contend that clinical practice neither ought to nor will ever be fully "scientific".

The question whether medicine is an art or a science or both may be seen as a semantic quagmire or a ground for ideological controversy rather than a

meaningful analysis of the nature of clinical practice. As Alvan Feinstein writes: "So many expostulations, revelations, and platitudes have been written during the traditional art-science debate of clinical medicine that the subject may need burial rather than revival."[2] It is not difficult to agree with Feinstein, but just as he immediately goes on to make some important contributions to this debate, it is impossible also for me to avoid this question. The relation between different forms of knowledge is crucial to our understanding of medical practice, just as it is indispensable for us to delineate the contours of complex phenomena like illness, disease, health, diagnoses and treatment.

If we want to analyze the potential contribution to the medical practitioner's skills of an acquaintance with literary texts, which is my over-all aim here, we will need a solid understanding of clinical practice. We may call this an ontology of clinical practice, or we may call it an outline of medical practice. It is the physician that is at the centre of our interest, not because she is the only medical practitioner, but because this study is about physicians and literature – and also because the physician's work remains, and will remain, the very core of clinical practice, however important the contributions of others are. The physician is not the only person who, as Toulmin observes, "takes the history", but she is the person who amalgamates anamnesis, physical investigation and laboratory or other findings into diagnostic conjectures and therapeutic recommendations. It is this fascinating and highly complex process to which this chapter is devoted. My point of departure will be some historical remarks.

2.1 Some historical remarks

No understanding of what clinical medicine is about can be reached without at least a brief look at the evolution of western medicine. Of course history does not bring answers to all our questions, here as little as in any other area. I will attempt to trace the origins of certain patterns of thought and practice. The nine remarks I will make are all intended to contribute to a more nuanced and fruitful understanding of clinical medicine and its evolution. Their value must be seen in relation to the over all aim: to investigate the potential value of literary experience for practising physicians.

2.1.1 On the Hippocratic tradition

Few observers, if any, resist the temptation to take the Hippocratic tradition as their point of departure for a discussion of modern clinical medicine. There are sound reasons for this. However deeply medicine has been transformed during the almost 2 500 years that have elapsed since the time of Hippocrates , a number of the questions and challenges that faced Greek medicine are still with us. The context is new, but only partly new. "Art is long", as the first sentence in the *Aphorisms* reminds us.[3]

It is commonly stated that Hippocratic medicine turned disease from being a supernatural and metaphysical phenomenon into something that was natural and intelligible. What could this mean? Surely not that we here see a scientific, or

even protoscientific, way of thinking about disease. Neither that disease was not seen as "natural", of nature, before the Coan school, as obviously nature was thought by most Greeks to be permeated by divine powers which were also in control over the body and its ailments and shortcomings. "Individual nature, therefore, since it does not contradict God but is rather his essence, must be apprehended as created by God and as divine in itself."[4]

It is rather the idea of *intelligibility* that is the most fundamental contribution to modernity from Greek philosophy in general, and here specifically from Hippocratic medicine. Wresting disease out of the hands of the priests, the Hippocratic physicians gave an impetus to the development of a secularized medicine whose importance can hardly be overestimated. Disease is looked upon in a way that strikes the contemporary reader as historically new. "The divine influence is still recognized, but it is understood to be only one factor just as is nature, which is a power of its own."[5] There is, for example, in the corpus nothing *exclusively* divine about the holy disease (epilepsy) – at least not if holy means understandable and treatable only within the realms of religious thought and practice.[6] The conviction that diseases can and should be understood as separated from a supernatural context led the Hippocratic physicians to a basically practical and down to earth "will-to-know". They were of course not empirical in the controlled and systematically self-critical way we would today require of anything to be called scientific. Nevertheless, they accumulated evidence from observation, and with a keen and attentive eye watched the disease transform the body and the mind of the ill person.

It can hardly be overstated that medicine in the antique world was a craft. Medicine was to a high degree techne (see below, 2.1.2), the practical knowledge that transforms the world. The Hippocratic physicians were hardly typical of their craft. Edelstein succinctly captures the outlines of a practising physician in general:

> The average physician (…) acquired his skills through apprenticeship with another physician, and when he became a master in his own right, he practised his craft, or art, as crafts and arts are usually practised, that is in accordance with traditional views and usages. He prescribed remedies which had proved helpful before; he took care of wounds and other surgical cases in the ways which previous generations had taken care of them. While learning his trade he was not a "student of medicine"; while carrying on his business he was not a scientist applying theoretical knowledge to the case at hand. On the level of common medical practice, biological and physiological inquiries were neither presupposed, nor were they actually made.[7]

The Hippocratic physician was not well equipped with powerful tools to intervene into the course of the disease. We have this fact to thank for the atmosphere of attentive restraint that pervades the corpus. The physician is an observer, an observer that stands in a healing relationship to the patient, who in turn patiently[8] waits for the disease to take its course. Case stories abound, rich in detailed description, pointing to the meticulously sharp observational capacity of the Hippocratic physician. This casuistry gives the reader the impression of a professional distance that may very well be a prerequisite for healing, but that also points further into the future, to "the medical gaze" of the modern physician.

Intelligibility of course had its limits. If the broad aetiological thinking of the corpus is taken into account, one can hardly avoid the conclusion that most diseases must have been unintelligible to the physician, if intelligible means knowing the specific cause or set of causes. The physician was acting under a veil of ignorance, and must hence take full account of the risk for transgressing *metron,* thereby showing *hybris* and hence creating more harm than good. We are reminded that *primum est non nocere,* and that the right judgement is difficult. This clearly defensive attitude of Hippocratic medicine gives it a considerable interest for the modern physician, who may tend towards bold action and whose technologically driven power over the bodily processes is incomparable to that of his ancient Greek colleague.

The idea of nature as basically, but certainly not easily, intelligible was also a fundamental point of departure for what we have come to see as Greek philosophy. If there were in *cosmos* at large, as in *polis* in the small, a rational order to be detected and described – then this order also comprised a moral order. From this Plato and Aristotle derived a realist moral position. Ethics were about knowing, and moral weakness was equated with ignorance.[9] Hence, when we turn to a second aspect of Hippocratic medicine that has survived the passage of time, the ethical code – the *Codex Hippocraticus* – it was certainly not for the physicians of the ancient days what it would seem to be to a modern observer: an expression of a locally and historically situated subjective view on the morality of treating disease. The code rather was a description of how the moral world was ordered, with special reference to those who had the medical craft.

The Code is well known to stress the duties of the physician. The physician must be loyal to his teacher and the teacher's family, he must know how to keep things confidential (even things he heard in situations when not working), he must not harm by performing abortion or euthanasia, he must not exploit patients sexually. He must treat his patients respectfully. The interpretation of the code is still under discussion, sometimes intensely, showing how ancient ethical reflection cuts into our own time.[10]

We must, however, take care not to identify the Code with the general position of the Greek physicians at the time. There are reasons to believe that the Code originates from Pythagorean circles and hence partly reflects the somewhat idiosyncratic positions of a rather secluded religious sect. The stress on the purity of the physician and the extraordinary high degree of collegial respect demanded are indications of this. However, whatever its origins, the influence of the Code soon became great and from the second century A.C. it was looked upon as *the* ethical document for physicians.[11]

Are we here, in this heterogeneous corpus, able to identify what would today be called "a clinical method"? Is there anything like "the Hippocratic clinical method", to be identified in this vast mass of writing? Ian McWhinney has reminded us that "the clinical method practised by physicians is always the practical expression of a theory of medicine…".[12] This is true, if we make the important reservation that this theory need neither be very coherent and precise, nor fully conscious. (We will look closer into this below under 2.1.6.) It must also be held in mind that there are strongly divergent views on the Hippocratic physician, as Fredrik Svenaeus has shown by juxtaposing Lain Entralgo's

somewhat idealized picture of the Hippocratic physician with Ludwig Edelstein's clearly more disillusioned.[13]

Let us here initially assume that clinical method means a sum of attitudes and attached practices, more or less well-defined, guiding the physician on how to handle disease professionally. How would the Hippocratic doctor go about with his patient if he were to follow the advices in the corpus? He would no doubt initially consider whether the disease was treatable or not – if not, he would abstain from any attempt to intervene. He would, *if* he decided to treat, closely observe the patient and carefully take his history, but not as the modern physician primarily in order to infer from outer signs to an inner hidden but localized pathogenic reality. The illness narrative would be of crucial importance in the identification of the multifaceted aetiology of the disease, which in turn would lay the foundation to the understanding of the nature of the imbalance that the disease represented. He would attempt to restore the balance in the ill person's body through paternalistic advice on dietetics, involving a lot of factors in the ill person's life - and he would be at great pain to make the right prognosis. Herbal treatment and venesection would be used with constraint, and he could not be expected to use any surgical methods. In dealing with the patient, he would be guided by the rich stock of instructions in the corpus on the right manners and the ideal behaviour towards the ill. He would be friendly but distant, he would (in our eyes) be mildly authoritarian and he would probably desert the patient when she approached death.[14]

To sum up, ancient medicine of the Coan school is basically empirical, concerned with observing the ill person, but certainly not without an underlying theory –

that is, there *is* a rationalistic component to its practice (the four elements, an ideal of a balancing cosmos as a prerequisite for health). Its strength resides in its stress on the unique person, in its will to know and conviction that knowledge can be reached, in its restraint - and in its nominalistic stance, as disease is not viewed as something with an existence of its own but wholly linked to the ill person. "There are no diseases, only persons with diseases", as the well known words go.[15]

2.1.2 On *episteme* and *techne*

In the current debate on medicine it is often referred to clinical medicine as an art – or, at least, aspects of it are suggested to be best captured by the notion of art. The Greek word for this is *techne,* and it appears for example in the just mentioned first sentence of the *Aphorisms*. This "art of healing" is often contrasted with a more scientific and allegedly less humane medicine, which is said to predominate today. I will, in order to be able to later analyse these assumptions, take a brief look at the origins of the term and also at the two other categories of knowledge that were proposed by Aristotle.

Aristotle used the term techne for one of the three basic categories of knowledge – the other two being *episteme* and *phronesis*.[16] Techne is the practical activity of transforming the world – nature and society – and its goal is to produce, to create new forms. Techne is, by and large, associated with the particular. Practical experience of course gives a sort of general capacity to deal with different sorts of

cases but this is not due to knowledge of general regularities but rather to a deep acquaintance with the variability of unique cases.

Epistemic knowledge is knowledge of the invariant regularities of nature – and to some extent for the Greeks also of society. Episteme in classical philosophy often meant looking for *arché,* the very first principle or grounding substance of the cosmos, that is the ontological foundation. This was the task of the philosopher. The practical man dealt with *techne* – building ships, healing wounds, winning new votes on the agora - and there were few reasons for these to meet each other.

It has often been remarked that episteme and techne mostly lived separate lives in the antique world. The relative technological stagnation of the ancient world had, it is also said, one of its reasons in this fact. However, it is clear that the practical knowledge of the Hippocratic physician was often seen as an ideal and that episteme and techne in a way was thought to merge in the practice of medicine – though the emphasis was on techne, on the *practice* of medicine.

The episteme of the ancient doctor was usually the theory of the four elements - earth, air, fire and water. Galen brought this system to unprecedented heights, by introducing its physiological concomitants: black and yellow bile, blood and phlegma, in a rationalistic attempt to create a great and encompassing system for medical thought.[17] Episteme and techne had few chances of coming into close interaction in a world where the need for technology was hampered by the abundant supply of slave labour. Add to this that there was no method of, nor

rationale for, systematically "producing" episteme *with the intention to* transform it into techne – and we see the beginning of a more than two thousand years long separation of hand from brain in the western tradition. Only when the 19th century universities brought basic scientific research into their laboratories and technology was placed close to this research in the form of the new engineers – only then episteme and techne entered into the almost explosively dynamic marriage that has transformed western everyday life.[18]

I will have ample reasons in this study to return to the question of the relation between medicine as theoretical knowledge and medicine as practice. But we may already here note that clinical medicine, unlike for example basic biomedical science, is essentially "knowledge by doing". Clinical medicine is applied science (epistemically informed techne), but it is also accumulated non-scientific experience ("pure" techne) - and it is at the very heart a moral project. This brings us to Aristotle's concept *phronesis.* This basic category of knowledge is often translated as "practical wisdom". I will leave it here and return to it in chapter 4 and 5.

2.1.3 On the scientific revolution

If there are threads connecting modern medicine to Hippocratic medicine , these threads are relatively weak. To note this is not to underestimate the inspiration that has come to modern medicine from the ancient Greek medicine. However, a gap falls between pre-scientific and scientific medicine, as between a pre-scientific and a scientific way of looking upon nature. The cause of this gap is

often referred to as "the scientific revolution", though it of course is no revolution in the ordinary sense of the word. It was rather a series of observations and resulting theories, together with a new ideal of method, that together meant a shift of paradigm in physics, and somewhat later in chemistry and biology – and subsequently also in medicine in the 19th century. Thomas Kuhn called this a revolution, though almost 150 years passed from Copernicus' *De celestium orbi motis* 1543 to Newton's *Principia mathematica* 1687. [19]

In order to understand the way medicine has developed and the idea of clinical judgement, we need to look at some essential features of this alleged revolution of thought, as it has so profoundly influenced our idea of what is science and what is scientific – and rational. Europe entered the Renaissance – here vaguely defined as the period between 1450 and 1600 – under the continuing dominance of the church, albeit considerably weakened by inner tensions, and its world view. The earth was seen as the centre of the universe, which was in turn well delimited and ordered as a system of perfectly circular spheres rotating around the motionless earth. The order of the sublunar world was different from the order of what was above: the moon, the sun, the planets and the stars. Basically, the world was functioning in an orderly teleological manner, as God had wanted it to. Man was created to rule over nature and occupied an intermediary position between God and nature.[20]

When, gradually, the picture emerged of a cosmos (unlimited and with the earth reduced to the role of a small planet circling around a rather small star) governed by a set of relentless laws moving the planets as well as steering the thoughts and movements of human beings as material creatures – then Descartes was perhaps

the most alert observer of the potentially damaging and dangerous implications of this for man's self-understanding. If matter was primary to mind, and mind an epiphenomenon of material forces– what would then be left of our cherished ideas of human free will, responsibility and the immortal soul?

Descartes himself struggled, as Richard Zaner has noted, with the problematic aspects of the dualism that we associate with his name.[21] His suggestion that mind, *res cogitans,* contacts and works upon the body, *res extensa,* within the pineal gland may have seemed more reasonable at the time; now, it can merely be seen as a sort of helplessly inept metaphor in order to find a solution to an overwhelmingly complex problem. It seems pointless to blame Descartes for this, and to talk about his "error" – as does Antonio Damasio[22] – resembles knocking on open doors. Descartes tried to face the overwhelming challenge of his time – that of mind collapsing into deterministic matter – and his answer can hardly be regarded as so strikingly inferior to other suggestions.

Hence, the scientific revolution, with so victorious a description of the world, such powerful predictions of and calculations concerning natural processes, left the European culture with a set of unsolved puzzles: How is matter related to mind, how can experience be understood if we are not to reduce it to electrochemical movements of the brain, how can value be given to a nature that is inert and devoid of any *telos* or meaning in itself? However powerful modern neuroscience may be in its depiction the workings of the brain, however detailed the mapping of ecosystems by the biologists, these questions still haunt us. They can hardly be answered within the realms of science. Clinical medicine is, as far

as these questions are of importance to it, spilling over the boundaries to metaphysics.

Richard Tarnas writes, about the emergence of what he calls "the modern world view":

> In contrast to the Greeks´ emphasis on an integrated multiplicity of cognitive modes, the order of the modern cosmos was now comprehensible in principle by man's rational and empirical faculties alone, while other aspects of human nature – emotional, aesthetic, ethical, volitional, relational, imaginative, epiphanic – were generally regarded as irrelevant or distortional for an objective understanding of the world. Knowledge of the universe was now primarily a matter for sober, impersonal scientific investigation, and when successful resulted not so much in an experience of spiritual liberation (as in Pythagoreanism and Platonism) but in intellectual mastery and material improvement.[23]

Francis Bacon is often associated with the empirical method – his warning against the "idols" that distort our observations of the world[24] seems just as relevant today – while Descartes, though highly open to newly acquired empirical knowledge, landed on the rationalist side, with an emphasis on the independent working of reason. Hence, we may conclude that the two great theorists of science of this era adopted two principally different ways of reaching knowledge. One, the empirical-inductive, places the emphasis on observations and general conclusions *a posteriori* to these. The other, the hypothetical-deductive, rather stresses the importance of *a priori* hypothesis generation with subsequent testing against observations.

2.1.4 **On signs and symptoms in clinical medicine**

The ill person needs to communicate her illness to the doctor and the doctor needs to characterize and give name to what is happening in the patient, what modern medicine would call diagnosis, in order to treat. This process is often referred to as consisting in the naming of of *symptoms* and *signs*. The symptom then, according to this language, is the strictly subjective side of this process. A person experiences something in her body (if we for the moment exclude symptoms of what today is called psychiatric illness) as strange, unexpected and threatening, often also unpleasant. Pain, dizziness and unexpected degrees of fatigue are typical core symptoms.[25] They are first and foremost communicated through language but of course to a variably high degree also through gestures, mimicry, posture.[26] Symptoms may, in a terminology that is today widely spread and that has a certain heuristic value, be said to constitute *illness.* Illness is hence an existential category. It refers to a unique experience of not being the bodily self you are used to being, which also may be expressed as an altered "being-in-the world", that obstructs life plans and decreases life quality. [27]

What, then is a sign? This is not altogether easy to answer. Signs point to the disease process and are often themselves a part of that process. One may find text-book expressions like "The physical sign represents a solid indisputable fact."[28] This will for several reasons not serve our purposes, however. We will first, in order to better see the historical context, take a very brief look at semiotics, and after that – following Swedish medical historian Karin

Johannisson - have a look at how the respective significance of symptoms and signs was transformed when pre-scientific medicine became scientific.

Medicine has often been looked upon as the reading of signs (from the Greek word *semeion,* sign). The art of healing could in the ancient time sometimes be referred to as *techne semeiotike.* Raimo Puustinen has given us a concentrated introduction into the semiotics of medical practice in a paper from 1999.[29] His presentation follows the Russian linguist Mikhail Bakhtin. Puustinen applies this general theory of semiotics to clinical medicine in an interesting way. A sign, in this tradition, is anything that carries meaning. Signs are of course often linguistic, but need not be. Gestures, postures, laboratory data, X-rays and so forth are also to be seen as signs. If these signs belong to a medical reality, if they carry a meaning that is of interest to the clinical encounter, they are medical signs. A symptom is, from this point of view, also a sign. It is, however, a decidedly different sort of sign from a piece of data collected with the help of a technological device. A symptom points to – or should we say: carry meaning concerning? - the inner world of the patient. It "refers to" to the way a response to an unpleasant stimulus, or series of stimuli, has been transformed into linguistically mediated self-reflection. This self-reflection is then communicated through the anamnesis to a physician.

Signs – whether they are communicating an inner mental reality (symptoms) or open to intersubjective control of a physical reality (medical signs) – are always embedded in a social context which gives them their meaning. Medical practice is deeply and inevitably contextualised:

> In the end, the whole route from a response-arousing event, through the experience of it embedded in inner and outer dialogue, to the decision to seek advice, through the process of a DPI (doctor patient interaction, *my comment*), and finally to the diagnosis formulated and the therapeutic act initiated by the physician lies entirely across social territory.[30]

We can see that the advantage of this way of thinking is that it reminds us that both symptoms and medical signs, however different they may be, convey meaning. Semiotics, however, tells us little of the complex and crucial coexistence of these two "main routes" to medical understanding. I will later (under 2.2) return to this question, but will now again turn to history.

In a medicine that is pre-scientific, the semiotic signs that dominate are the patient's words, in combination with inspection of the outer appearance. Before the scientific breakthroughs in medicine, says Swedish medical historian Karin Johannisson, the task for the doctor was to confirm the illness experience and at the same time reach a diagnosis. The medical encounter typically took place in the home of the ill person, often with other persons present.[31] The first and foremost task was to listen. Taking the history was to "…give the experiencing self the privilege of interpretation (*my translation)*."[32] Here, diagnosis was inextricably linked to the personal body and the personal life. This gave an almost endless number of diagnostic possibilities. Reisman concludes:

> To determine the nature of the illness, he relied chiefly on three techniques: the patient's statement in words which described his symptoms; the physician's observation of signs of the illness, his patient's physical appearance and behaviour; and, more rarely, the physician's manual examination of the patient's body. [33]

We will soon see that the relative role of these elements in the diagnostic process will radically change when scientific theories and technological devices step by step transform everyday clinical practice – with consequently new possibilities and new deep going challenges for the physician.

2.1.5 On the birth of modern medicine

Medicine needed a unifying theory. But what, then, is a medical theory? I suggest that it must at least comprise the following elements: A theory of how the body works in health (a physiology), a theory of what happens to it in disease (a pathophysiology and a pathogenesis), a theory of causation (an aetiology) and a theory of remedies (a pharmacology, and so forth).

How did medicine adopt a theory that we are prepared to call "scientific"? One might perhaps expect that medicine became scientific as a rapid consequence of the breakthroughs in physics in the 17th century and in chemistry in the 18th. If the body is best understood as pure nature and if nature during the two centuries after Newton´s *Principia* was explained step by step in scientific terms – then medicine might be expected to have followed quickly after. This was hardly the case. There is a time lag, a latency, between the revolution in physics and chemistry and the appearance of a "new" medicine. How may we understand this?

It must first be noted that it is not the case that no scientific theories and no scientific observations (in Bacon's sense) came into medicine during these centuries. On the contrary, significant breakthroughs took place. We need only remind ourselves of Vesalius' meticulous work on the human anatomy (the result of an enormous "pre-Baconian" empirical endeavour), of Harvey's seminal work on the motion of the heart and the circulation of the blood and of Jenner's elegant combination of induction and deduction in the application of cow pox as protection against smallpox (what we now know as "vaccination"). Behind these outstanding cases we find hundreds or thousands of not so victorious attempts to expose the mysteries of the body and to subsume them under a more comprehensive theory. Often, these theories were the results of empirical efforts, but seldom of what we would call systematic empirical method. Of course, some of these theories *did* affect clinical practice and some were probably rather succesful – but more sporadically and not in a lasting way. Grand theories were indeed constructed, as by Dutch physician Boerhaave, and energetic attempts were made to create large scale taxonomies (see below under 2.1.7). However, when these were brought into clinical practice, they were often found to be either insufficient or directly misleading. The practising doctors of the time were mostly unaffected.[34]

The Swedish physician Carl-Magnus Stolt has looked into the practice of rural doctors in late 18th century Sweden.[35] One of the striking findings in this study is that the practitioners he studies are sceptical about new ideas. The doctors were "…rather uninterested in medical theories *(my translation)*".[36] Therapeutic possibilities were scarce. Some doctors hence tried out their own regimens in a

sort of trial-and-error process. From the material that Stolt examines, a picture emerges of an attitude of everyday empiricism:

> Medicine was, as noted above, usually practised at home during the 17th and 18th centuries. The visit by the doctor was more than just a medical event. His chances to observe the social setting around his patient must have been extraordinary. His tools were limited. Possibly, we may identify the therapeutical poverty of clinical practice and its radical individualization, as major sources of this delayed "scientification". Doctors knew that there was often not much to do. Their equipment was extremely poor. There was no entry to the inside of the body except on the autopsy table. Inspection was fully external. Sympathy, rather than a distanced "medical gaze", was what they had to offer. Even the great clinician Sydenham, perhaps the most influential of his time, though radical in his insistence on combining symptoms into groups, disease entities, still rejected the importance of anatomy and knowledge of the inner world of the body *(my translation)* [37]

The nosographies of the 18th century bear witness to this. *Nosologhia methodica,* the most used of the classifications during the 18th century, mentions 2 400 different diagnoses. By combining symptoms in intricate ways, the possibilities became almost endless.[38] Were there no medical signs, then? Indeed there were, but these were of a characteristically general kind, pointing to general states of the body, not localized (as there was not, as we have just seen, yet a theory of how a localized pathological process could produce general symptoms and signs).

Johannisson reminds us of the signs that the very influential physician Christoph Wilhelm Hufeland pointed to as essential in 1800. These were, (1) a general

characteristic of the sick individual based on an intricate number of signs indicating his "constitution", and (2) areas of signs pointing to the disease: pulse (most important), breath, blood, digestion, excrements, affections of soul and nerve and, last, the facial expression. Within these areas, extensive subcategorization took place. Johannisson stresses the crucial importance that was attached to taking the pulse, and the touch that this meant of the doctor's hand on the patient's arm. However, such touching still was a dangerous area:

> Undoubtedly, the social status of the patient and of the doctor demarcated limits to touching the body. As long as the gaze of the physician was not legitimated and protected by the science's claims on objectivity, trust was dependent on his morals and his respectful attitudes *(my translation)*.[39]

The practitioners hence were often conservative. They largely obeyed what Stolt calls "the law of inertia" – meaning that new ideas were initially received sceptically.[40] Even if they knew their Harvey, even if they had done a number of autopsies, even if they soon accepted Jenner's vaccination – still the doctrine of four elements kept its grip on their thinking, in the form of the theory of catarrhal aetiology for most disorders. Clinical medicine was in a hopeless and disillusioning no mans land between the new ideas and the old. As a result, in the early nineteenth century, the crisis of confidence in established medicine went deep. Magnetism, homeopathy and other alternative schools of medicine consequently thrived.[41]

Around 1800, in spite of the in general dismal state of official medicine, a few "theory driven" doctors still *did* have more than fragments of a physiology of the normal body. A theory of tissues had developed, inspired by Bichat. There were

also emerging theories of pathophysiology, linking disease to the tissues. Autopsy findings were finally systematized and gradually linked to disease entities. In the middle of the century, the German physician Rudolf Virchow firmly localized the pathological process in the cell, in his *Die Cellularpathologie.* Almost at the same time Ignaz Semmelweis, in a piece of elegant empirical work on the hospital ward, proved (or almost proved) puerperal septicaemia to be caused by some noxious agent brought to the women from the autopsies by the students. A few decades later, in the 1880´ties, the relatively sudden breakthrough of a theory of infectious diseases definitely signalled that a new era had come. At that time statistics had definitely begun to be brought into clinical practice. American and European physicians had tried out ether and chloroform as agents of narcosis – and large hospitals had provided "materials" of sick individuals to investigate, to compare and to use as a basis for a general medical theory.[42]

In the midst of all these breakthroughs, it was still the exact localization of the disease that was the crux of the matter. Virchow did not hesitate to identify disease with disturbed cellular processes, resulting in structural abnormalities and tissue or organ dysfunction. The disease *was* in there – and if it really was there, it must be possible to look at, or listen to or identify chemically, both before and after death. This conviction, as we shall soon see, gave an enormous impetus to the development of technological devices designed to visualize and quantify, in one way or other, the disease.

Clinical refers to clinic (from *cline,* bed in Greek). It has been proposed that it is in the hospitals of the early 19th century that the new clinical method is born,

especially the French hospitals. This is during the aftermath of the French revolution. The revolutionary utopianism broke down the French health care system. From this limbo, new forms could grow. New institutional arrangements interacted with new knowledge (for example Claude Bernhard's physiology) and new technical devices (for example Laennec's stethoscope) to create a rich soil for a "modernized" professional approach to diseases to take form. This is at least one of the versions – let us here call it a modified internalist view. Foucault has given another, concentrated on power and control. According to him, forces external to medicine used the clinic as a tool for their purposes – out of a will to control and to create a socially stable order.[43] (Of course, these versions are not mutually exclusive.)

Which, then, were the basic outlines of this new (or partly new) method, this attempt to apply the new scientific theories on the task of treating diseases? An illuminating formulation is given by the just mentioned young French doctor Laennec, in the 1820's:

> The constant goal of my studies and research has been the solution of the following three problems:
>
> 1. To describe the disease in the cadaver according to the altered states of the organs.
> 2. To recognize in the living body definite physical signs, as much as possible independent of the symptom.
> 3. To fight the disease by means which experience has found to be effective:…to place, through the process of diagnosis, internal organic lesions on the same basis as surgical disease.[44]

Several conclusions may be drawn from this quotation. First, the crucial role of the autopsy is underlined. Since medicine in late medieval ages took dissection into its investigative arsenal (not without resistance, which the very gradual acceptance of this practice during the period 1300-1500 witnesses), the dead body came to be seen as the key, the book in which to read the nature of disease. However, this was done basically unsystematically with no accompanying disease theory and no generally accepted nomenclature for the autopsy findings. Still, it was abnormalities of the cadaver that slowly gave the physician his route into the interiors of also the living body.

It is also worth noting the stress that Laennec puts on *signs,* and their "independence" of the symptoms. Johannisson eloquently describes the atmosphere of the French clinic of the early 19th century:

> The medical narrative that starts in the halls of the clinic and autopsy rooms coincides with the most heroic of medicine. The heroes are hungry young doctors who knock, listen and smell, who fold blankets and cover away, cut in dead bodies, separate and observe, dissect into internal organs, blood vessels and nerves just as elegantly as one cleans a fish. It is a sort of hands-on medicine, with triggered senses, the hand's triumph over pure reason. The men of the clinic also loved to draw a self-confident line between the old medicine - "speculations, abstractions and words!"- and the new one, associated with wide open senses and a sharpened eye *(my translation)*.[45]

The goal was to look *into* the body – not in a general unspecific way, but, as the quotation shows, sharply and in detail. The surface of the body is the road to its interior. A Swedish doctor of the time notes that the first precondition of this new practice is to make the ill person's body "transparent".[46] The disease

gradually became more and more identified with the pathological tissue: here was its essence, a real "living" *materia pathologica* that, in its "non-living" state, could be touched and investigated in the corpse but still only very seldom with the patient alive.

It must again be reminded that this was not a sudden break-through of the new clinical method(s). It was, by and large, a creation *by* and, in the beginning, largely also *for* hospital doctors. As emphasized above, the practitioners who worked outside the hospitals were inclined towards another kind of medical rationality – let us call it a conservative empiricism. Only when the new methods gave obvious and superior results did the rural doctors give up their "inertia". This occurred at the very end of the 19th century, when the above mentioned breakthroughs became every day tools for not only a few clinics in the large cities, but for doctors in general.

When disease was firmly placed inside the body, localized and at least in principle describable and quantifiable, the reading of signs acquired a somewhat different meaning. The taking of the history, as noted, was the road to the symptoms. These were the subjective expression of the patient's feelings and experiences. Now the clinician's task was, in a sense, to work backwards from symptoms to the pathological lesion localized somewhere in the body. Signs had the same function as symptoms but did not have the problematically personal character that words have. Signs were objectifiable and, ideally, impersonally pointed to the disease. Signs could reach a high degree of intersubjectivity – one doctor could in principle show another the same sign and discuss and evaluate it together. Signs could, when the camera appeared, often be photographed. Signs

could, when they appeared in the form of laboratory data, be expressed in figures, hence easily turned into statistics. Signs carried with them the hope of making medicine scientifically more solid, less reliable on soft data, more resembling the giant of sciences: physics. We can notice how, from the end of the 19th century on, the rationality that Toulmin (2.1.9) associates with the scientific revolution, with Bacon and Newton, gradually permeates more and more of medical practice.

Of course, the ideal of physics was a huge challenge for scientific medicine. Signs were, however clever the doctors became, unreliable as long as they were almost exclusively dependent on the senses of the physician. If these senses could be refined through technology, the precision would be multiplied. If medical signs could be collected during the illness process, preferably at an early stage, diagnosis would come earlier, be more exact and therapy could be instituted promptly. The search for new devices accelerated. The era of technological medicine hence began.

The stethoscope has already been mentioned. In our eyes, small details like measuring temperature, counting the pulse and respiration, listening through the stethoscope to the heart and lungs, looking into eyes and ears with ophtalmoscope and otoscope respectively …these things may strike us as minor and insignificant. However, they represented crucial breakthroughs in the search for transparency of the ill body.

Of course, physicians had to wait for the more dramatic breakthroughs. During the twenty years before and after the turn of the century 1900 there is an explosive increase in the use of technology in everyday clinical medicine. Bacteriology necessitated the use of the microscope, which can point to the causal agents of infectious diseases like syphilis, tuberculosis and cholera with great precision; Wilhelm Roentgens' discovery and subsequent clinical application of the peculiar X-rays of course created sensation; Eindhoven's practical inferences from the basic physical knowledge of small electric currents on the surface of the body became the ECG and the EEG; and Landsteiner's characterization of the major blood groups made reasonably safe blood transfusions possible.

To conclude, medical signs are "fabricated" in an ever more sophisticated technologically dependent clinical medicine. The rationality behind this is a rationality that is inspired by the world-view of the scientific revolution. The result is an affluence of signs in modern medicine. Symptoms are still often uncertain and vague, highly subjective and still as dependent on the taking of the history as ever before. To this we will return in section 2.2.

2.1.6 **On the triumphs and shortcomings of scientific medicine**

Science slowly and gradually penetrated medical practice via the hospital clinic and through the theory of cellular pathology, through the germ theory of the 1870´ies and 1880´ies, through the introduction of statistics as a method of clinical evaluation and through the deepening mutual exchange between the laboratory (using the advances in physics and chemistry and the new

technological devices) and the clinical practice. This has been linked to a certain rationality, of which the origins are traced by Stephen Toulmin back to the 17th century. The symbiosis between basic medical science – with all its ramifications to different fields of biochemistry, biology and biophysics- and applied technology for medical purposes has been almost explosively successful in certain aspects, but still amazingly helpless in others. In the words of Stanley Reiser:

> As the physician makes greater use of the technology of diagnosis, he perceives his patient more and more indirectly through a screen of machines and specialists; he also relinquishes his control over more and more of the diagnostic process. These circumstances tend to estrange him from his patient and from his own judgement.[47]

It seems that Reiser here takes something for granted – that technology estranges physicians from their patients – that is not at all self-evident. I find this much more ambiguous, and I will approach the question in 2.1.8 and 2.1.9. Before this, I will attempt to show both how successful and helpless this new medicine could be in the 20th century, by describing one successful example of medical practice, based on breakthroughs in medical science, as well as one less reassuring. They both belong to a period of medical development that is usually regarded as a period of great victories. They are, respectively, the characterization of insulin and the subsequent use of pig insulin for treatment of diabetes - and the appearance, at the turn of the century 1900, of an almost epidemic number of cases of chronic fatigue, at the time labelled neurasthenia. A few parallels will be made with today's incidence of chronic fatigue in different forms, and the incapacity of scientific medicine to either understand or handle these cases. I will

then turn to a brief discussion of James Le Fanu's thesis that no breakthroughs of greater importance have been made in scientific medicine since around 1975.

Frederick Banting was a private surgeon in Toronto in the early 20th century. In a difficult period of his life, he came across a scientific article, where a case was described when a stone in the biliary tract had caused an inflammation of the pancreas. What became clear to Banting was that the damage to the pancreas only concerned its exocrine part, that is the secretion of digestive enzymes to the intestine. As only the islets of Langerhans were left, and as the patient did not become diabetic, it seemed reasonable to conclude that something produced in these islets prevented diabetes.[48]

Banting almost instantaneously concluded that he would need experiments on animals to prove his hypothesis. He got the permission, in the summer of 1921, to use dogs and he got the help of a young physician, Charles Best. In the laboratory led by John Mc Leod, the two developed an intense cooperation that – with the sacrifice of the lives of tens of dogs[49] – beyond doubt established the role of insulin in regulating glucose concentration in the blood. Banting of course did not start from zero in his making of hypothesis. There was already knowledge of the pancreas as endocrine gland and a very vague realization that it was crucial in glucose metabolism. Still, his idea must be seen as one of those moments in the history of medicine when a bold hypothesis was tested empirically with a resulting breakthrough. Banting, of course, worked fully inside the paradigm of modern medicine, looking, as he was, for the specific localization of the disease diabetes, hopefully leading to knowledge of the specific aetiology and specific

cure of this dreaded disease. The theory guiding the practical method was, in this case, totally successful.

The discovery of and subsequent therapeutical use of insulin – a rather unclean insulin isolated from pigs – in some respects resemble Jenner's vaccination. It was quickly put into use and saved many people from unnecessary suffering and premature death. In contrast to the vaccination, however, the insulin research was based on much more thorough going knowledge of physiology and biochemistry. Banting could, in contrast to Jenner, tell almost exactly why insulin worked. This is a significant difference as it strongly reinforced the expectations that this was exactly the way to go about it when medicine should progress from helpless guessing to solid knowledge. It is not difficult to understand how fundamental the impact of such a breakthrough must have been – on the medical community and on the public. And as it came rather close in time to other crucial leaps in knowledge – such as the isolation of and therapeutic use of cobolamine, vitamin B 12, and the first antibiotic drug with any substantial effect on some of the more common infectious disorders, the sulphonamides – it became part of a very strong momentum for medicine to reinforce its road towards "scientification".

All was not success, however. The years before and after the turn of the century may even be seen as a period of minor crisis in medicine. The expectations created by the breakthrough of bacteriology were largely unfulfilled. However impressed many were by the X-rays of Roentgen and Landsteiner's blood grouping, as well as the ECG-registration made possible by the biophysical shrewdness of Eindhoven – still, a lot of everyday problems, defined and

understood as "medical", were not possible to alleviate, and major threats to health such as tuberculosis and syphilis remained untreatable (though better understood).

The years around 1900 were a period of unrest and rapid socio-economical transition in Europe. Urbanisation was brisk, cities were brutally transformed, new social patterns emerged as industrialisation shook the foundations of society. In this situation, there appeared a number of "new" ailments, diagnosed by the doctors. Press, magazines and doctors warned in drastic words about the situation. The background was often thought to be the breakdown of traditions, technical modernisation and urbanisation. The tempo of life was described as dangerously high, and social Darwinists talked of a situation of struggle and constant competition. [50]

One of the diagnoses that became common during this period was neurasthenia. Swedish historian Karin Johannisson talks of the rise and fall of neurasthenia, and calls it a "disorder of culture".[51] So deeply entrenched in the patterns of contemporary culture was this diagnosis that it could be used to label an extensive flora of symptoms, ranging from fatigue to diffuse pain, headache, abdominal discomfort, cardiac malaise and so forth. By some it was declared to be a degenerative phenomenon, an integrated part of a whole worried discourse on the decline of western culture, sustained by historians like Oswald Spengler in his *Die Untergang des Abendlandes.* Others strongly contested this and proposed an infectious origin.

The diagnosis of neurasthenia can be traced back to the American physician Charles Beard who in 1880 used it as synonymous with "nervous exhaustion" and included all the above mentioned symptoms. No specific cause was found for neurasthenia. The scientific disease model just didn't fit. In the absence of a localized pathology more or less imaginative explanations were proposed, as mentioned above. The most common suggestion seems to have been a lack of nervous energy, due to exhaustion of what was thought to be a finite amount of energy at the individual's disposal. Others were inclined to see it as an irritative phenomenon, a sort of sensitisation. [52] The lack of tenable etiological and pathophysiological models mirrored an almost complete helplessness on the curative side. If neurasthenia was a disease the modern culture, the remedy would be to attempt to restore the very opposite of the restless and poisonous urban atmosphere. Rural homelike institutions where time was allowed to pass more slowly and where the cruel competition of the emerging society was not allowed to enter – this was what was offered to those that could afford it (and many could, as neurasthenia was predominantly a disorder of the upper classes, at least the diagnosed cases).

Can anything be learnt from these two examples? Do they tell us anything of importance about the strengths and shortcomings of the emerging and victorious modern scientific medicine? The case of diabetes is, of course, a success story where scientific imagination and rigorous method combined to give the clinician tools to reach some fundamental ethical goals of medicine: relief of suffering and prevention of premature death. Diabetes would have continued to be treated in speculative and inefficient ways had it not been for the combination of (1) a disease theory where disease was equalled to a pathophysiological lesion with

resulting disturbed function, (2) a set of ideals in research method, with strict emphasis on hypothesis testing and reproducibility, (3) parallel advancements in basic sciences like biochemistry and physiology, and (4) a disorder that had exactly those characteristics that made it suitable for investigation along these lines.[53] None of these conditions seems to be fulfilled when we look at neurasthenia. The symptoms were vague and floating, no systematic pathology was to be found, hence no remedy or substitution were discovered - and therapeutic efforts remained uncertain and speculative.[54]

This is indeed a striking contrast between impressive therapeutic efficiency on the one hand and helpless ignorance on the other. Are we entitled to infer that scientific medicine is, *by its very nature,* victorious in certain fields and impotent in others? This would be a premature conclusion. It may, of course, be that the understanding of neurasthenia, like that of today's chronic fatigue syndrome and other enigmatic disorders which in many ways resemble it, has just not yet reached its scientific maturation. In that case, something is "in there" waiting to be discovered and defined. If we just look eagerly enough and if we just use technology that is sophisticated enough, we will find it. Hence, there is no principal difference between diabetes and neurasthenia, just a matter of complexity. On the other hand, one may take the opposite position and argue that neurasthenia will never be understood in the same way, nor cured by the same sort of therapy, that diabetes is. For the proponents of the latter position, the appearance of enigmatic syndromes with extremely complex symptoms and unknown aetiology is just one more proof of the limits of today's medicine.

May we, then, conclude that scientific medicine during the whole of the 20th century has been swaying to and fro, caught between sublime success and stubborn failure? There are competing versions also on this. When James Le Fanu's *The Rise and Fall of Modern Medicine*[55] appeared a few years ago, it created a sharp debate on this issue – that is, whether scientific medicine is in a fundamental crisis after the years of success, or whether what we really need is more of the same: more resources to biomedical research, more scientific boldness, new areas explored. Le Fanu points to the thirty-five or forty years from around 1935 until the mid seventies as amazingly successful in medicine. To underpin this, he describes twelve breakthroughs that took place during this period, among them the discovery and practical application of drugs like penicillin, cortisone and the psychotropic drugs - neuroleptics and antidepressants – as well as open heart surgery, hip replacements and transplantations. These were major breakthroughs that appeared at an unprecedented speed and with far reaching consequences. The prestige and impact of modern medicine culminated with these scientific successes.

Why did they come about? Which was the very fertile soil for scientific medicine during these four decades? Le Fanu mentions a number of factors, including post-war optimism and energy, medicine's close cooperation with biochemistry, and simultaneous advances in technology. For our purposes here, however, the crucial importance that Le Fanu places on clinical science is of greater interest. Reading Le Fanu's engaging history around the twelve breakthroughs, it is striking how much their background resembles the method that I have above outlined as essential to the modernisation of medicine in the early nineteenth century. It is the same fascination with localization, with meticulous description,

with function and dysfunction, with the testing of new and bold hypotheses – only that now, this was taking place with incomparably more sophisticated tools and was based on accumulated knowledge that gave it an unprecedented strength. On top of this came a utopian dimension: "If clinical science was to progress it certainly could not put internal constraints on itself but must be capable of pushing at the boundaries of the technically feasible."[56] Le Fanu stresses, in the same manner as we have seen when historians describe the doctors of the 19th century Paris clinics, that this required an attitude of boldness verging on ruthlessness. "In this new world, patients become ´interesting clinical material´ on whom the ambitious young doctor performs his experiments with a view to publication in a prestigious medical journal."[57]

At the end of the seventies, in Le Fanu's version, the period of rapid success is over. Not that there are no more medical innovations and advancements – there are many. But they are not fundamental any more. They are, at best, modifications of already established practices. And, worse in Le Fanu's eyes, the optimism concerning medicine has declined. Doctors are disillusioned, the public is discontented, alternative methods are presented as superior to scientific - and fear and anxiety for disease and disability are all around. Faced with this harsh reality, parts of the medical establishment and the large enterprises reinforce their attempts to induce a superficial scientific optimism that has no sound backing in real progress.

This will not do, according to LeFanu. What is needed is a reconnection to the best elements in the medical tradition. His concluding words are worth quoting at length:

> The time has come to relocate medicine back within that tradition so eloquently evoked by Sir William Osler. The timeless virtues of judgement and good sense might then triumph over the shallow restlessness of the present through a reaffirmation of the personal human relationship between doctor and patient. The personal doctor listens carefully to what he is being told. He (or she) performs the irreducible minimum of investigations required to establish a diagnosis. He confines himself to the matter in hand and does not stray beyond to give impudent or gratuitous advice. He recognizes the intellectual limits of human understanding and the practical limits of what medicine can legitimately be expected to achieve.[58]

I will later show that this is a rationality that owes as much to the heritage of Montaigne, Rabelais and Shakespeare as that of Newton and Descartes.

2.1.7 On hesitations and second thoughts: William Osler

It is no surprise that when Le Fanu wants to reconnect to a tradition in medicine – let us here vaguely call it "humanistic" – that may alleviate some of the shortcomings of today, he mentions "that tradition so eloquently evoked by Sir William Osler".

It has been said that William Osler is perhaps the only physician that qualifies to symbolize, in one person, the rise of modern scientific medicine. Born a couple of years after Semmelweis' struggle against puerperal fever in Vienna and just about a year before Rudolf Virchow published his seminal work *Die Cellularpathologie,* he became the leading figure in American and British medicine for over three decades. Osler was the very essence of a clinician. He was perhaps

the last one to attempt to capture the entire clinical knowledge of his time. In *The Principles and Practice of Medicine* he covered the field of internal medicine, the first and most influential medical textbook of his time. His way of building the reputation of The John Hopkins Hospital, and its school of education, in Baltimore – and his contributions in Montreal and Oxford – in combination with his prodigious writings earned him an enormous respect. Osler was synonymous with American medicine for three to four decades before and after 1900.[59]

Osler exhibits an interesting ambiguity in his views on science and art in clinical medicine. In his concluding speech – "The Old Humanities and the New Science" - in Oxford, just about half a year before his death in November 1919, he strongly emphasizes the necessity of bridging the gap between the new powerful and victorious sciences and the old, at this time somewhat defensive, classical knowledge: "…the so called Humanists have not enough Science, and Science sadly lacks the Humanities".[60] And when the challenge from laboratory based medicine against bed-side medicine was felt urgently in the first years of the 20th century – manifested in the so called Flexner Report, that recommended a turn to more science in the medical educations – Osler, as Francis Peabody, warned

> …against the appointment of medical faculty based on their research accomplishments as opposed to their interests in students and patients. (…) He was not at all opposed to science applied to medicine, but he vigorously resisted a scientific ethos imposing itself between physician and patient.[61]

Osler's firm conviction was that " …to be a good physician *required* that one be broadly read and educated *(author's italics)*".[62] On the other hand – as Karin Johannisson notes - Osler had no idea of giving up the emotional distance that separated the doctor from the ill person. He fully supported the idea, emerging in the late 19th century, that the physician must train himself not to show any sign of emotions in the eyes of the patient.

> The physician that shows the slightest change in his face, expressing worry or anxiety, has not got his nerves under full control and thereby risks losing his head at any moment.[63]

The physician should, true to his scientific base of knowledge, not let feelings intervene with and disturb the diagnostic process. The question that a modern reader would like to ask is, perhaps, whether *any* sign of sympathy and compassion on the side of the clinician was hence forbidden?

The heritage of Osler points in two directions, almost paradigmatic for the evolution of 20th century medicine. One may be illustrated by Osler's disciple Harvey Cushing, who brought neurosurgery to unprecedented levels through new techniques and who was able to reduce mortality to very low levels by the use of almost perfectionist routines. Cushing's rigorous scientific standards presage the coming breakthroughs in surgery, for example transplantation and open heart surgery.[64] We may see this as a process of ever more sophisticated technology, interacting with continuous breakthroughs in the biomedical basic sciences.

The other line from Osler points in another direction. During the whole of the 20th century we may discern an undercurrent, however at times weak and inconspicuous, of worry for the direction of modern medicine. This stream of thought may take the "oslerian" shape of worries for the loss of traditional humanistic knowledge, the lack of "Bildung" among medical professionals. But it has sometimes rather focused more specifically on the interaction between doctor and patient. Like in the quotation from Reisman above (2.1.6) it has been pointed out that if medicine is looked upon as applied biomedical science and nothing else, it will lose contact with a central part of its heritage, with the Aristotelian notions of "techne" and especially "phronesis", what is often referred to as "the art of medicine". Though the successes of scientific medicine have extremely seldom been denied, the hesitations have still been there.

We will now proceed to take a brief look at how this undercurrent of worry about the direction of western medicine grew to become almost a mighty river in the last decades of the 20th century.

2.1.8 **On the rise of autonomy and of person oriented medicine**

Starting in the 70s and 80s, a number of authors, inside and outside of medicine, articulated their worries about modern medicine. It was often done by on the one hand accepting modern biomedical research and clinical methods, but at the same time appealing to our sense of the person, the individual, of the unique quality of the patient being a subject that has an inviolable right to self-understanding and self-governing. "The rise of autonomy" is a label that has

been used in order to capture this process, when the paternalism of the medical system was challenged and the right to self-determination of patients emphasized.[65] Another, somewhat playful, formulation is "strangers at the bedside", referring to new categories (lawyers, ethicists, representatives of patient organizations) appearing on the hospital wards in the US, increasingly competing with the doctors for influence and power over the fate of the patients.[66]

What happened may perhaps be described by the well known "ketchup-bottle metaphor". First came almost nothing, then came a flood of books and pamphlets on the "human" dimensions of medicine. Paul Ramsey's *The Patient as Person* from 1970[67] may well be seen as an opening signal. During the following two decades, beginning on the American agenda and somewhat later in Western Europe, books, conferences, seminars, departments etc etc were produced and arranged that all had the idea in common that a lost balance had to be redressed in clinical medicine. The terminology could vary, from the four golden principles of bioethics, proposed by Beauchamp&Childress, to a call for a deeper analysis of what clinical medicine is really about. In the latter field appeared clinicians like Eric Cassell and Howard Brody in the US, and the neurologist Oliver Sacks whose attempts to bridge the gap between science and humanities in clinical medicine by way of story telling became popular among a large public. Philosophers with an orientation towards "continental philosophy" – like Kay Toombs and Richard Zaner - took a keen interest in clinical questions. In Europe we saw a revival of interest in half-forgotten medical theory-builders like F.J.J. Buytendijk and George Canguilhem. Michel Foucault and Ivan Illich produced grave and fundamental critique against the role of medicine in modern societies.

Amazingly rapidly, social scientists and humanists turned to medicine and medical systems as areas of study. When some of the momentum went out of the "medical ethics boom", other academic disciplines – like history, philosophy, anthropology, ethnology, sociology - were there to carry on the scrutiny of clinical medicine and its impact on persons and on society.[68] Medical humanities were born.

It is not altogether easy to say which impact this almost explosive outburst of interest in humanistic medicine – or should we rather say: the human dimensions of medicine?[69] – had on the existing medical systems. Certainly there occurred a shift of balance and power in clinical settings, not only from doctors to patients but also from physicians to nurses and other categories involved in caring for and treating ill people. Possibly, this shift coincided with a generally greater interest in the ill person as exactly *person* – that is, in the uniquely biographical aspects of being ill.[70] But parallel to this supposedly keener eye for the personal in clinical medicine, the scientific and technological changes have proceeded at an ever higher pace. We hence face paradoxes, or at least what seem to be paradoxes, like on the one hand the extremely sophisticated and impersonal genetic technology - which in the eyes of its adherents promises to revolutionize clinical treatment – and, on the other, outbreaks of enigmatic syndromes like those described above under names like chronic fatigue syndrome and sick building syndrome. We have primary care doctors advocating a dialogical clinical practice, and performing illuminating research on the philosophical aspects of doctor-patient interaction, with a keen eye on how illness may be an expression of a more general loss of meaning in a person's life[71] - and on the other hand we meet what seems to be an ever increasing pressure on

doctors to "produce" more and quicker. Expectations for health and well-being grow, hand in hand with new medical possibilities; medical focus shifts towards "life style related diseases"; and at the same time, resources to the health care system seem to dwindle in most countries.

As noted in chapter 1, at the turn of the millennium the western medical systems hence find themselves in an ambiguous situation. Never has medical power been greater, in the sense that more processes in the body than ever before may be monitored, quantified, influenced and (when lost) restored. On the other hand, there are uncertainties about the identity, tasks and goals of modern medicine. The huge challenges to public health, inside the rich world but even more so globally, do not quite fit into the medical paradigm as we have described it above. And calls for a "humanization" continue. David Greaves, mentioned in footnote above, talks about "reviving the soul of Western medicine" and notes that "The doctor has personally to manage the two halves of his new persona, the technical and the personal, and he may have serious difficulties in keeping them separate".[72] In what will follow, in part 2.2, I will argue that one of the most crucial insights that a doctor may reach is that he or she should *not* separate these alleged parts, but rather come to see them as two sides of a coin, in a sense making them merge - without at the same time attempting to let the one engulf the other. Clinical medicine is fundamentally based upon the coexistence of two closely related and ideally intertwined modes of understanding man and nature.

2.1.9 On the two epistemologies of practical medicine

Scientific medicine is "modern" in the sense that its growth, as I have attempted to show, occurs parallel to those changes that we associate with the idea of modernity. However, it is in no way obvious what this concept means and where the roots of modernity lie. This question is, however, of considerable importance to my investigation, since the self-understanding and the knowledge base of physicians are linked to ideals of rationality and of knowledge that we think of as exactly "modern". I will hence conclude this historical section by presenting and developing Stephen Toulmin´s ideas of a double source of western modernization, as well as his assumption that clinical medicine relies on two epistemological foundations.

Toulmin traces modernity at least four hundred years back in time. In his book *Comopolis. The Hidden agenda of modernity*[73] he points to the Renaissance as the origin of a number of ideas and attitudes, epistemological as well as ethical, that we would associate with the modern period. Particularly, it is during the decades from around 1580 to 1610 when a number of authors appear who present these ideas : Michel de Montaigne, Erasmus, William Shakespeare, Rabelais, Bacon. These authors represented something that was genuinely new in European thought: an enlightened scepticism, an idea of tolerance, a keen interest in particular and variable human conditions, a tolerance for ambiguity and paradox in human affairs – and for the uncertainty of human knowledge . And this was, according to Toulmin, also a time of relative social openness and tolerance. Until the assassination of French king Henry IV in 1610, the intellectual climate in Western Europe allowed for such openness. But other times were to come.[74]

Let me propose that these assumptions of the Renaissance thinkers concern *the epistemology of the person*. We will soon see that Toulmin assumes that there is a fundamental difference between the modes of understanding of this epistemology and those associated with the new science, the new *epistemology of nature,* that was elaborated during the coming decades. When Shakespeare wrote his most important dramas, Galileo was already launching his experiments in Pisa – and when Montaigne was writing his *Essays* in his tower outside Bordeaux, Tycho Brahe made his observations of the orbits of the planets which such scrutiny that Kepler a few years later could use them for constructing his mathematical picture of the solar system. A fundamental shift in cosmology was about to occur, and Toulmin contends that it coincided with, and even was caused by, a sociopolitical back-lash that drastically put an end to the short period of relative tolerance and intellectual openness in Europe.

One may, of course, doubt whether Toulmin's strongly externalist view of intellectual history is really well founded. But it is striking how the 17th century, so often presented as a period of liberation of the human mind, was in most places oppressive, intolerant and violent. Toulmin's position is that during such hard times, a longing for intellectual certainty and stability, for something secure to hold on to in a world of insecurity, is more likely to be born. So when Galileo, Descartes and Newton presented their mathematically structured cosmology it was in a sense a retreat from the world of ambiguity and contingency that the humanists had been writing about in their works.

As Toulmin notices,

> The scientific blessings of our age (above all, those in medicine) were not widely available before the late 19th century, but these blessings were happy outcomes of scientific inquiries that have made continuous progress ever since Galileo and Descartes, and so were the long term products of the 17th century revolutions undertaken in physics by Galileo, Kepler and Newton and in philosophy by Descartes, Locke, and Leibniz.[75]

There is, hence, no doubt that these discoveries were roads to great progress. However, they tended to brush aside other modes of understanding the world. What Toulmin calls "the shared assumptions about rationality", embedded in the new sciences, spilled over to the human realm, to the epistemology of the person.

Toulmin's basic position is that in order to face the challenges presently facing mankind – and among these I would include the task to "humanize" medicine – we

> ... need to reappropriate the wisdom of the 16th-century humanists, and develop a point of view that combines the abstract rigor and exactitude of the 17th century "new philosophy" with a practical concern for human life in its concrete detail. Only so can we counter the current widespread disillusion with the agenda of Modernity, and salvage what is still important in its projects.[76]

There are obvious consequences for our understanding of clinical medicine if Toulmin's assumptions are right. To spell these out, we need to look at another essay, where he has analysed the epistemological foundation of clinical medicine.[77] Here Toulmin starts by noticing that

> From classical Greece on, indeed, medicine has presented philosophers with a peculiarly rich and close alliance of mind and hand, theory and practice, universal and existential. The art of medicine demonstrates that human reason is practical as well as theoretical, existential as well as universal; that is, reason is concerned not just with abstract, but also with *flesh and blood* issues.

Toulmin traces behind several of the current worries about and controversies concerning contemporary medicine, "differences of opinion about the epistemological nature of medical knowledge itself". He notices, as I will also do later in this investigation, that

> The formal training of physicians seemingly promotes the training of individuals with "split" personalities, having specialized "part selves" for handling technical problems in medicine in isolation from normal personal relations.

The physician can not, if he is to be a true healer, abstract from the humanity of the ill person. But Toulmin is also clear that only by preserving his detachment from his patients may the physician achieve a properly "clinical" view. "Surely", he exclaims, "both attitudes have a place". But how may the physician let them coexist in everyday clinical work? This challenge will be a recurrent theme in my following investigation.

It is hence clear that, as Toulmin puts it,

> ...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.

It follows that "the virtues proper to the physician's modes of life" must include both these epistemological routes:

> Since this vocation is to put the general body of knowledge about health and disease to use for the benefit of particular human beings, it defines also the *Lebensform,* or "way of being in the world", within which the professional physician must do his work.

One may argue that medicine now, in the 21st century, has finally become scientific in the deepest sense of the word. Surely, it makes good sense to train young physicians in the basic sciences and the functions of the body in health and illness? Surely, this is how to proceed towards further medical progress? But if Toulmin is right in noticing that it has, ever since the beginning of western philosophical thought, been clear to those who reflect on medicine that it is a peculiar blend of practical and theoretical, of universal and particular, of knowledge about nature and of knowledge about persons – then, clearly, not only more science will do. All clinical knowledge of unique persons affected by diseases is also historical knowledge:

> The application of general principles to particular individuals in medicine (we remarked) always requires us to understand what exactly it is about the present patient that is peculiar, particular, idiosyncratic – what makes this specific individual the "individual" he is.

This background is crucial to my present investigation. Toulmin makes it very clear that the rationality associated with the sciences, the epistemology that was formed during the 17th century – and indeed has been subject to several challenges over the centuries – will not be sufficient as a basis for clinical rationality.

Are the two epistemologies that Toulmin writes about to be seen as, respectively, that of the sciences and that of the humanities? Yes and no. The methodological complexity of the sciences is, of course, far greater now then was the case in the 17th century – and the humanistic sciences, most of them children of the 19th century, have approached the sciences in order to learn from them and also to gain some of the prestige associated with these. But parts of the humanities are clearly more akin to the arts than to the sciences. And it is, I believe, just as much to the arts as to the humanistic sciences we must look when seeking the sources of the epistemology of the person – and hence also for sources of clinical rationality and what I will later call clinical judgement. I will argue that literary experience is one such source.

Before turning to literature and literary experience I will, however, proceed to deal with a number of questions associated with the notions of health and illness and the clinical encounter. This is the task for section 2.2.

2.2 The clinical encounter

> *Disease occurs, of course, not in the body but in life. Localization of a disorder, at very best, tells little about why it occurs, when or how it does. Disease occurs not only in the body – in the sense of an ontological order in the great chain of being –but in time, in place, in history, and in the context of lived experience and the social world. Its effect is on the body in the world!*
>
> Byron Good[78]

I am in this second chapter occupied with an attempt to understand modern medicine – its origins, its present challenges as well as some of its fundamental preconditions. The present situation for medicine is ambiguous. However interested Osler may have been in the humanities as enlightenment for the scientifically trained doctor, there was for him still no doubt that science was primary and that scientific rigour and scrutiny was *the* road to further success in medicine. This is no longer the case. The doubts about modern medicine are, as just noted, much more present and the calls for a revival of "the art of medicine" or "the healing tradition" are as wide-spread as common-place. Few oppose this, even though the depth of the worries varies considerably. What, to my mind, remains dubious and in a sense the crux of the matter, is how the very interplay between biomedical scientific knowledge ("episteme"), practical skills ("techne") and moral intuitions and feelings and conscious ethical reflection ("phronesis") comes about in the physician's daily work with ill patients. In other words, how may the clinician bring biographical knowledge, empathetic understanding and attentiveness to peculiarities to coexist with scientific medicine's inevitable preference for the impersonal, the general and the repeatable? This may also be

phrased in the words of Toulmin in 2.1.9 – as two epistemologies that must coexist, indeed be intertwined, in medical practice.

I will in this second section of chapter 2 begin with an analysis of some very basic concepts and issues that all contribute to our understanding of the nature of medical practice. There is an extensive literature on these topics, and inevitably my analysis will at times touch on aspects and complications that would well deserve being dealt with more extensively. I will use a number of sources that have inspired me and contributed to my understanding of what clinical practice is. It is my conviction that the following discussion of some central elements of clinical practice will be of value to the overriding aim of this investigation: to approach a better understanding of the possible contribution of literary texts to the clinician's professional skills.

The encounter between the ill person and the doctor is the core situation of clinical medicine. I am in full agreement with Fredrik Svenaeus who writes that

> Clinical medicine (…) is first and foremost a practice and not a science. Medical science must be viewed as an integrated part within the clinical interpretive meeting and not as its true substance; that is, not as the core mode of medical practice, which is here merely 'applied' in contrast to the pure science of the laboratory.[79]

In this thesis, to ask what goes on in the clinical encounter means to ask what *ought* to go on. It is a normative answer I am pursuing, not an empirical, even though such empirical knowledge is indeed crucial to any normative endeavour. It is my conviction that medicine as a practical human activity is defined by its

goals. These goals are derived from shared fundamental human values, which become defined as "medical goals" in an intricate interplay between the professional culture's internal discourse on the one hand - and historical changes on a social and political level on the other. It is through a process of becoming clear about these goals and their implications in everyday practice that we come to learn what clinical medicine is - that is: ought to be. Clinical medicine, thus, is that activity which helps us reach or at least approach the goals of medicine. Before I proceed to analyze this question a bit further something must be said about the most fundamental point of departure for any understanding of medicine: the body.

2.2.1 Dualism and the lived body

Vulnerability is not only one aspect of our basic conditions, it is a point of departure for our entire understanding of the world. A central component of this vulnerability is corporeal. Our existence is fundamentally an existence *as* bodies, rather than *with* or *through* bodies. We learn from the very start that we may, as bodily beings, easily be hurt, that we may experience unpleasant, or even unbearable, sensations in our body – but of course also pleasure and well-being. Even if we in this sense are and live our bodies, they also have a life of their own. Our understanding of our bodies hence becomes peculiarly ambiguous. We know that it is often impossible to say where the "mental" ends and where the "physical" begins. "Feeling well in the body" *is* a mental state, as well as feeling well "in general". How difficult it sometimes is to make this basic experience coexist with our deeply rooted tendency of reifying the body, thinking abut it as an object, is shown in common every day phrases like "I do not feel physically

well" or "his physical well-being was threatened by the injury". Phrases like these reflect our fundamental dependence on a dualistic understanding of the world. Every clinically working physician knows how difficult it may be to overcome, when necessary, this separation between an allegedly physical sphere, the body, and an immaterial realm, the mind, often thought to be in some sort of command of the body.[80] I think we must admit that in scientific contexts, dualism seems hard to do away with, as well as in many aspects of everyday life, and I am indeed not certain that it always is such an important task to overcome it.

This separation of mind and body that I here describe is often referred to as psycho-physical dualism. It operates with different variations on the theme that there is a body that is material and a mind that is non-material. Dualism is often ascribed to René Descartes, though this seems more than acceptably simplified, as dualism is probably age old and can be seen at least as early as Plato in Western philosophy.[81] As mentioned above (2.1.4), the dualistic assumptions were put under increased strain when the new cosmology of the seventeenth century proclaimed a fully mechanistic universe, thereby throwing man into what for many seemed to be a merciless determinism. Descartes' so called dualism is just one of several attempts to respond to this dangerous challenge, albeit perhaps the most well-known. The free will and the eternal life of the soul had to be rescued, and this was done through the postulation of a "substance" – *res cogitans* - which was immaterial, self-reflective and able to work on the body-*res extensa*. This peculiar interaction was according to Descartes supposed to take place in the pineal gland, in the very centre of the brain, where mind contacted body by setting the substance in the nerves in vibrant motion.[82]

Richard Zaner has convincingly shown that Descartes was not at all ignorant of the basic facts of human embodiment. He deals with them in letters and in his *Conversations with Burman.*[83] Hence, to blame Descartes for the inherent challenges that dualism entails is pointless. Dualism, in its modern form, is the heritage of the western world-view, with its (often reluctant) acceptance of scientific materialistic determinism concerning the material world and the resulting collision between scientific "truths" and intuitive assumptions and cherished beliefs about freedom of will and self-reflective intentionality, not seldom also in conflict with philosophical objections to the consequences of this cosmology. It is by no means usually a sophisticated philosophical theory; rather it is an everyday way of conceptualising ourselves in relation to our bodies. It can be discerned in most "sickness-chat" and few would deny that their way of understanding themselves in case of illness tends to be exactly dualistic: a worried mind and an alien body with a disease "in it".

In order to find some ways out of the dilemmas of dualism, inspiration has come from the philosophical tradition of phenomenology. Some of these attempts will be presented in the following. How, then, does phenomenology propose that our everyday understanding of our bodies is structured? To answer this, we may briefly turn our attention to a testimony of a fundamental rupture of a person's "being-in-the-world". In an illuminating passage in his book *A leg to stand on*, neurologist and author Oliver Sacks – who has fallen and hurt his quadriceps tendon – after the operation wakes up in his hospital bed and experiences that his leg (in a cast) is gone, just plainly gone:

> In particular, it no longer seemed a "home". I couldn't conceive it "housing" anything, let alone part of me. I had the feeling that it was either totally solid or empty – but, in either case, that it contained nothing at all. I looked at the rim of toneless flesh above the cast, and then thrust a hand down inside. The experience was inconceivably shocking and uncanny. The day before, when I had put my hand down and palpated the quadriceps, I had found it "horrible" - limp and pulpy, like a sort of soft inanimate jelly or cheese. But the horror was nothing to what I felt now. The day before, touching it, I had at least touched something; whereas today, impossibly, I touched nothing at all. The flesh beneath my fingers no longer seemed like flesh. It no longer seemed like material or matter. It no longer resembled anything. The more I gazed at it, and handled it, the less it was "there", the more it became Nothing – and Nowhere. Unalive, unreal it was no part of me – no part of my body, or anything else. It didn't go anywhere. It had no place in the world.[84]

This passage, albeit describing an extreme situation, gives us clues to an understanding of central aspects of our lives. It is as embodied beings we have met and interacted with the world. The more or less conscious distinction between me and not-me that has suddenly become so frighteningly blurred for Sacks is crucial to our self-understanding. The limits of my body are the limits of *me* – what is outside me is the external world including other embodied beings which have the peculiar characteristic of both being centres of will and intention *and* at the same time pure nature. *Me* is history and memory, is intentional action and the existence of an internal time different from the "outer" physical time. Not-me is either other persons' minds – where my mind's conditions are more or less reflected – or "nature", which may be animate or inanimate.[85]

The task of phenomenology, writes philosopher Kay Toombs, is "…to elucidate and render explicit the taken-for-grantedness of everyday life and, particularly, to bring to the fore one's consciousness-of the world."[86] The way of doing this is according to Toombs, "a systematic neutrality".[87] We ought to "bracket" our theoretical assumptions about the world, indeed much of what we have learnt concerning this world, including our own bodies. By doing this we may reach something that is "pure experience". It may indeed be discussed whether this bracketing of one's own prejudgements of the world is really possible. It is worth noting that Toombs particularly stresses that when adopting the phenomenological position "…one sets aside any theoretical commitments derived from the natural sciences in order to describe what gives itself directly to consciousness."[88] But isn't our way of thinking about the world, including our own bodies, so deeply textured by scientific facts, by the very circumstance that science is permeating our whole culture, that the influence of the scientific description of the world cannot just be pushed aside in an effort to reach the phenomena "as they are"?[89]

Phenomenology again and again reminds us of crucial constituents of our everyday more or less *unreflected* experience of our bodies – and of the relation of this experience to the kind of knowledge that we call scientific. Philosopher Martyn Evans has lucidly outlined this in an essay.[90] Inspired by both Byron Good and Stephen Toulmin, Evans distinguishes, as ideal types, two forms of understanding of our own body: the (more or less) prereflective, as "the lived body" or "the body-as-self" - in contrast to the way biomedical science describes the body: "the medical body" or "the body-as-nature". There are some important insights resulting from his analysis. The lived body is a centre of will and

intention, a source of pleasure and pain. It is characteristically unique and in an important sense indescribable, mysterious and private. The body we know as our own – or rather: the body that we are, that is our very identity – is often understood by us in symbolic forms (the heart, for example, as the source of love and grief) and as bodily creatures we act on the world. The contrast to the medically constructed body could hardly be more striking. Biomedical science conceptualises the body as general, inert, passive, in principal fully intelligible, a source of information and as a complex of different mechanical functions governed by causal regularities.

Evans's aim of contrasting these two modes of understanding is that

> ...it discloses the intensity and power of the medical ´gaze´, and the essentially active nature of practical *perceiving* – that is – perceiving for the purposes of medical explanation and intervention: perceiving and gazing within the categories according to which medical science structures the world.[91]

However, for the purpose of this essay it might have been of interest if Evans had dealt a bit more with the peculiarly ambiguous everyday understanding that most western people have of their bodies. From very early in life they have been taught to think about their own bodies *as nature.* Concrete models of the interior of the body have been presented, touched and thoroughly investigated, from early years in school on to adulthood. News about biomedical science and its progress have thousands of times met them in the form of depersonalized knowledge of causal bodily mechanisms. This mode of understanding is then of course not at all restricted to the biomedical profession – it is lay knowledge , and

coexists in all sorts of hybrid forms with other sources of knowledge of the body's mysterious life. Even in the most commonplace of situations, as for example with a hungry stomach or a full bladder, our understanding of ourselves tends to be a peculiar mixture between the ideal form above described as "the lived body" – and elements of the scientifically constructed "body-as-nature". We are in health unreflectedly our bodily selves but often also – and at almost the same time - suddenly standing "beside" ourselves, looking upon our own bodies as though they were pure nature, or artefacts. We will see below that this fact is of considerable importance in understanding the illness experience as a subjective existential phenomenon, in relation to disease as scientifically described, diagnosed and treated.

One of the central assumptions of phenomenology is that the prescientific understanding of the body precedes the scientific "construction" of the medical body. This may seem a banal fact, as we are born as babies with neither words nor theories about our bodily existence. As Schwartz and Wiggins point out in an important essay, it is still of considerable importance to reflect on the consequences of this, as

> …the pulmonary specialists are able to understand the cellular pathology and radiological findings associated with emphysema because they are already familiar with breathing and breathlessness in everyday life. The technical conception of emphysema, of course, moves far beyond the ordinary understanding of breathlessness. But the scientific notion draws on and always presupposes this prescientific experience.[92]

Science is then, in a sense, raised on the shoulders of non-scientific modes of thinking. Scientific metaphors strikingly often emanate from our non-scientific everyday life, often also from its bodily aspects. Even to understand what counts as symptoms or signs – the hard currency of clinical work – every doctor must have at least some degree of experience of what such symptoms mean.[93] And in clinical medicine, where the physician wants to move from the subjective experience of symptoms to the material reality of the body, the importance of bodily empathy - sharing the predicament of being a vulnerable embodied being - can hardly be overstated. Given the strength of the scientific model of disease, which will be my next topic, it may be a hard challenge for the physician to acknowledge and positively use his bodily empathy.

2.2.2 Models of disease

Doctors treat diseases. This seems to be an uncontroversial statement. Do they also treat illnesses? Would it be more to the point to say that they treat sick people? But sick people *have* diseases, don't they? Then the disease must be the point of attack, mustn't it – the disease thought of and felt as invader and as a foreign disruptive agent? Diseases come and go in a seemingly arbitrary way, they strike sometimes without mercy and they contribute to the basic vulnerability of our lives that we have dealt with above. But do they really exist in themselves? Is my cardiac attack also yours, or are our diseases strictly personal? Shall we put it "My pneumonia is strictly mine" – or rather "My pneumonia is like yours, though with some personal peculiarities"?

Questions like these are core issues in medical philosophy. As such they have been the subjects of much thinking and writing through the centuries. But they also, in a less sophisticated form, cut directly into the daily clinical practice of doctors and hence have consequences that are far ranging. It is almost truistic to conclude that the meeting between the healer – in our case a doctor - and the afflicted person is heavily influenced by that concept of disease that is predominant in the medical professional culture, and of course in the culture as a whole. Eric Cassell notes that

> It is frequently troubling for patients to discover that most doctors are not primarily interested in finding out what is the matter with them, but are concerned instead with discovering what disease is the source of their illness.[94]

If we want to understand why this is so, we must not only look at biomedicine's disease concept, but also shortly attempt to relate it to the dominating world-view permeating the culture where the clinical encounter takes place. The way diseases are understood within an area of knowledge such as biomedicine is often explained by means of the term paradigm, in the sense that Thomas Kuhn used this notion: A set of basic assumptions combined with overt or tacit rules for how knowledge should be gained and delimited from non-knowledge in a certain area.[95] Modern scientific medicine, here called biomedicine, is a somewhat delayed child of the scientific revolution, described above (2.1.4). The concept of disease that to a large extent structures the thoughts and actions of today's clinicians must inevitably basically harmonize with the paradigm of biomedicine. The emergence of this strongly scientifically influenced way of ordering and treating diseases has been dealt with above (2.1.6). I will now very briefly summarize what we may call "the biomedical model of disease".

A basic point of departure for biomedicine is that the human body is the object of interest for medicine and that this body is nothing more or less than a piece of nature. Nothing in the way the body functions, whether in health or in disease, makes it different in principle from any other object in the world. True, the human body is alive but there is nothing mysterious or deviant about that. Life is fully explicable in the general terms of science, through ever more detailed analysis of parts and functions. Human life is in principle similar to all other life on earth. It works according to basic biological laws, which in turn may be derived from the laws of chemistry and physics. It is functionally vulnerable the way all biological life is. This vulnerability in function and structure accounts for the appearance of diseases. Of course there are peculiarities about human biology that distinguish it from other life forms, but in principle it is just one more variation of an evolutionary developed pattern of life on earth.

Hence, biomedicine has progressed by ways of an evermore sophisticated and detailed analysis of the normal functions of the human body and a consequent understanding of disturbed function in disease. The characterization of these deviances from the normal as quantifiable, physicochemical and structurally specific and the connection of these abnormalities to the patient's symptoms is the very core of the biomedical model. This connection is taken to be causal. The biophysical and biochemical deviance causes the patient to experience certain strange and unpleasant things, symptoms – just like a ball hits another ball and sets it in motion. It is important to notice that the sort of bodily perceptions that we call symptoms in order to be caused by the material disease process must be seen as in turn caused by brain processes, in some way registering the localized disease through the nervous system. How brain processes may be related to

mental states is, of course, something that the model doesn't really deal with. In this model of disease and symptom causation, we recognize what Martyn Evans called "the medicalised body". The closer the body is examined through the prism of biomedical science, the more the clinician will "construct" a body that works according to its scientific models.

Of course, this is a very rough and all too brief summary of a model that is more complex in its outlines. It is in no way uncontested. In a book on medical philosophy, Danish authors Henrik Wulff, Stig Pedersen and Raben Rosenberg present an illuminating dialogue on the nature of disease and on the disease concept. This dialogue summarizes the strongest arguments for and against an exclusively biomedically founded concept of disease.[96] It is readily seen that there are good arguments for both positions and that the question is not easily settled.

But let us, for a while, stick to what I here call the biomedical model of disease. It follows from this way of thinking that diseases do exist, in an ontological sense. Their existence is material. The biomedical view of disease is generally viewed as a *realist* position, where diseases have an existence of their own, are detectable by doctors (and occasionally others) and certainly not in any reasonable sense invented – except sometimes erroneously. Wulff, Pedersen and Rosenberg argue that clinical medicine is realism (biomedical science) applied under empirical control (evidence based practice). The contrary view to realism is in the history of philosophy often called *nominalism*, and now often renamed "social constructivism". Nominalists hold that diseases are "invented" – or in today's fashionable language "socially constructed" - by science and the medical profession in order to be possible to handle, and hence have no independent

existence of their own. The disease concept then becomes totally relative to culture and to historical period.

There is a certain terminological mess here. Oswald Temkin preferred the terms *ontological* respectively *physiological* for these positions concerning the metaphysics of disease.[97] This difference has been suggested as a dividing line in the history of medicine, with, broadly speaking, *dogmatists* taking the realist position and *empiricists* on the nominalist line.[98] But regardless of whether we prefer a nominalist or a realist attitude to disease, or a position in between, any doctor is in urgent need of diagnostic units in order to speak and write about the patient's ailment, and for treatment and prognosis. Furthermore, as will be discussed below (2.2.5), patients often urgently ask for diagnosis.

The biomedical view has obvious advantages. Schwartz and Wiggins notice two. First, "…the biomedical model imparts systematic unity and rigorous coherence to medical practice. A high degree of clarity and intersubjectivity results." Secondly, in contrast to many other modes of knowledge (like art or social sciences or intuitive knowledge), "…the natural sciences possess a marvellous exactitude and precision in conceptualisation." The precision is related to the assumption that bodily function can be subsumed under natural laws. The knowledge and mastery of these result in a high degree of predictive power.

> When compared with the almost complete absence of predictability in the social sciences, formulations derived from the natural sciences prove attractive indeed to the physician who must intervene in the patient's life with some certainty of the possible outcome.[99]

To this must, I believe, be added a less instrumental but no less important factor. The central assumptions about the world that are built into the biomedical model are indeed congenial to the dominance in contemporary western society of a world view shaped under the strong influence of science. We may here call it materialistic monism, a world view where everything that exists is basically of material nature with mechanical forces governing it, leaving no room for any other dimension of reality.[100] This more or less conscious way of conceptualising the world paves the way for has been called "the fallacy of misplaced concreteness", the tacit assumption that what is most real is what is quantifiable and what can be thought of in the terms of science and mathematics. The brain is hence more real than the thoughts that in some way are related to it; the peptic ulcer is more real than the abdominal pain it gives rise to; the remedy of a pharmacological agent is more real than the remedy resulting from hope and trust alone.

There are growing misgivings about this model of disease. A well known challenge came already from Engel in an article in Science in 1977.[101] Engel writes about "the need for a new medical model" as "a challenge for biomedicine". In an attempt to avoid the primacy that the biomedical model – in line with post-Newtonian science – puts on physical causation, Engel constructs a model where a human being should be studied and understood by ways of a hierarchy of "natural systems". These systems reach from the physical to the spiritual. The understanding of a human being, in health as well as in illness, must necessarily involve knowledge from several of these levels. Hence, social sciences may well be brought into the picture as well as humanistic studies of man as creator of meaning. However – and this is criticized by Schwartz and Wiggins – Engel says

nothing about what causes what, what is primary to what, in his hierarchy. The biomedical model frankly declares tissue damage to cause symptoms such as pain. What does Engel's model say about this? Nothing it seems. It invites us to understand tissue damage mainly on a couple of levels, and pain and suffering possibly on one or two other levels of the system. But the interrelatedness of these levels is left out. The model, in the words of Schwartz and Wiggins, allows for almost every aspect of human and non-human life to be incorporated, but says nothing about how to choose among and how to delimit and relate the almost endless number of possible perspectives. It is an important step towards a broader perspective on, for example, the ill person – but it gives little practical help to the physician's basic attitude to her patient.

William Stempsey, philosopher and physician, steers a middle way between the extremes. For him, disease is a conceptual apparatus that

> … allows us to talk about, classify and have some control over the constellations of signs and symptoms that we observe in sick people. It is, however, a conceptual apparatus that is necessarily bound to fact. That is, there are facts about people who experience illness, and these facts are the raw material from which we build our conceptual diseases. Furthermore, empirical observations tell us that certain clusters of phenomena, which we have some to call diseases, have a relatively constant occurrence.[102]

As we build these conceptions of disease from the manifestations of disease, and as these manifestations are certainly both of a material (biochemical and biophysical abnormalities) and mental (threatening and/or unpleasant bodily perceptions) nature, Stempsey is able to show that a narrow biomedical model

will not do. I will return to Stempsey's concept of a "value dependent realism" below under 2.2.6.

The biomedical disease model may serve us well in certain aspects but may also lead us to an unfortunately narrow understanding of diseases. As noted, there are attempts to widen the concept so that it may include elements from the illness experience. Departing from a "hard medical fact", the well-known and feared disease entity *myocardial infarction,* commonly called heart attack, David Greaves has written an interesting essay, "What are heart attacks? Rethinking some aspects of medical knowledge".[103] The syndrome got its name and was characterised as a consequence of the emergence of modern scientific medicine. The disease is localised in the heart - or more precisely, it has its background in the state of the coronary arteries, depending on whether blood may flow freely or at least sufficiently freely through these vessels or if it is gradually obstructed by the process of atherosclerosis in one or several of these vessels. In case of total obstruction a part of the myocardium (the heart muscle) is damaged and replaced by connective tissue. This process is described in pathophysiological detail and can be shown in different ways using modern medical technology, often in order to intervene before a thrombosis has occurred or to dissolve an already established one.

This may seem clear enough. But Greaves asks interesting questions about heart attacks in the western world. Why were they hardly recognized until in the twenties? Did they not "exist" before this date? Two answers have been given to this. The first says that the disease of course *was* there before, but that the technology to diagnose and the level of scientific explanation of this disease

process hadn't advanced far enough for it to be recognized on a broad level. As Greaves notes: "This whole process is then seen to be one of discovery, through a gradual uncovering of evidence."[104] But the appearance of myocardial infarction as a major diagnostic category may be explained in another way, either alternative or complementary. Epidemiologists have talked about a "transition" in the West in the early 20th century. The rapidly changing conditions of living turned degenerative disorders – of which myocardial infarction is one – into the major threats to health while infectious diseases, earlier in total dominance, were gradually pushed into the background. The suggestion here is that "heart attacks" were much more uncommon among the population before the advent of the 20th century.

These are both "realist" theories, assuming that myocardial infarction exists as a disease ready to be detected and characterized by biomedical science, however in a frequency that depends on social conditions. Now, as we have already seen, there is a strikingly different way of thinking about this, the nominalist or physiological or however we want to name it. Here diseases like this one appear "through a process of social negotiation and construction".[105] They "are there" only as a result of our socially and historically embedded project of detecting diseases, characterising them in a certain way and treating them in line with the world view of modern science.

Greave's position is that both "scientific" and "social" theories have something interesting to say about the appearance of myocardial infarction as disease diagnosis. However, they both have some inherent weaknesses (which we must leave out here) and more importantly, they are too limited to capture another

crucial aspect of this disease: its relation to human experience. Taking this dimension seriously we may, writes Greaves, "transcend the division" between realist and nominalist theories of disease.[106] This means finding a way to overcome the seemingly hopeless division in clinical medicine between subjective ("illness") and objective ("disease"). This project is only very briefly sketched by Greaves. Suffice it to say here that Greaves finishes his essay wishing for a dissolution of the dichotomy between the objective and the subjective aspects of clinical medicine by looking upon them as two sides of the same coin, or as two fists where the fingers intertwine with each other. He rightly remarks that all too often is Engel's biopsychosocial model as described above seen as a tool of reversing the causation from physical-social to social-physical. Very little is won by that. Greaves borrows the words of philosopher Drew Leder, proposing that

> 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.[107]

Greaves concludes that the "epidemic" of heart attacks arose from a complex set of interrelated circumstances of both scientific, social and cultural nature. His analysis helps us to see possible ways of adapting the notion of disease to a more comprehensive understanding of what happens when a person is afflicted. This requires a double focus. Clues to this, I have so far tried to show, are the phenomenologically informed understanding of human embodiment and the

idea of a complementary rationality originating in the Renaissance. (I will in chapter 4 link this further to phronesis and clinical judgement.)

Most doctors, in their clinical practice, transcend the biomedical disease model in the sense that they necessarily must involve, to some degree, the illness experience of the afflicted person in their understanding and handling of clinical situations. It must be stressed, though, that doctors still are deeply formed by the strictly biomedical thinking about disease - and of course, not only they are. It has, as noted in connection with Evans's article on the lived and the medically constructed body, grown deeply inside most people of our culture (and perhaps increasingly also non-western cultures). This is not surprising as it has been the basis of therapeutic success and it still promises to give more of the same. The biomedical perspective is supported by strong institutional interests, like medical academies and pharmaceutical industries. Medical education still, too a large extent, forms students to adopt this notion of disease as a foundation for their work. As a third year medical student at Harvard Medical School in the late eighties says to anthropologist Byron Good:

> You are not there just to talk with people and learn about their lives and nurture them. You're not there for that. You're a professional and you're trained in interpreting phenomenological descriptions of behaviour into physiologic and pathophysiologic processes.[108]

This student has not misunderstood the message. He sees himself as a scientist who uses ordinary language mainly as a clue to get to the real hard facts of the body, those that really matter, those that cause the patient's symptoms. But he will sooner or later realize, perhaps painfully, that his idea of the doctor's task as

being an interpreter from the (less real) world of the lived body to that of the (more real) medicalised body is insufficient to help him reach the goals of his profession. What is missing is exactly the lived body as subjectively experienced, and with it the rupture of the life world commonly associated to disease. This is the topic for my next section.

2.2.3 The illness experience

When Oliver Sacks, in the above cited book about his leg injury, is visited by the surgeon on the ward and when this surgeon almost totally brushes his strange and frightening experience of having "lost" a leg aside, he is left in a state of disappointment verging on despair.[109] He is well aware that the surgeon probably has done a good job in a narrow technical sense. Nevertheless, he is not acting as a healer. Without recognition there is no confirmation. And without confirmation not only is the person not respected; moreover, the disease is not treated properly.

This last assertion may seem peculiar to some. Aren't we entitled to say that a doctor may be clever at treating diseases but lousy in his handling of human beings? If the biomedical model of disease is fully accepted, a repair of some part of the body can be performed by a surgeon – or some other doctor - irrespective of how the patient is treated as a human being. This would count as a successful treatment of a disease. I will show that this way of talking about disease and disease treatment is deeply inappropriate. To do this we must take a closer look at the notion of illness as an individually unique experience.

The notion of illness is a way of talking about the experience of being ill. What is then "being ill"? One way of answering would be to say that being ill is "to have symptoms". We then push the question ahead of us. What is it, in that case, to have symptoms? I propose that symptoms are perceptions of the body that are in some way alien, unusual, unexpected, most often unpleasant, sometimes threatening. Symptoms may be unpleasant – or even unbearable – in themselves, like pain or nausea or itching, or rather for what they point to, an imminent or more distant threat, like strange lines before the eyes or mild fatigue - or most often perhaps a combination of such vague perceptions, that are not in themselves really so troublesome. Strange perceptions from the body that only very transiently come and then go away without leaving any trace behind hardly count as symptoms. There must be at least some degree of severity and/or permanence for bodily perceptions to be called symptoms. Understood in such a way, symptoms make us feel that we are not really ourselves any more – whether it is deeply and permanently or more superficially and relatively transiently.[110]

I will in the following rely on a terminology that has already been partly introduced – that of phenomenology. I have already suggested that phenomenology in relation to scientific medicine may provide that complementary form of rationality that I see as urgently needed. It is philosophers like Kay Toombs, Richard Zaner and Fredrik Svenaeus that have inspired my thoughts on illness and the illness experience, as well as my own clinical experience – and not least, my personal experience of having been ill in different ways.

> …illness strikes at the fundamental features of embodiment. Consequently, at the level of immediate experience (prior to any reflective objectification of body) illness manifests itself essentially as a disruption of the lived body. [111]

writes Kay Toombs in her long essay *The Meaning of Illness.* She goes on to notice that illness is disability, that is the inability to relate to and engage with the world in habitual ways. All sorts of acts – like reading, walking, talking, eating – which are in health performed without our conscious attention may now become effortful, problematic to perform and in need of strong attention. The gestures and the spatial orientation of the body may change. The upright position – so crucial to our experience of being autonomous subjects – may not be possible to uphold. Concentration may be diffuse and as a result the self-evident intentionality of everyday life is not there any more. The experience of time may change when the future takes on a threatening and uncertain character and the past is seen more or less as the background to my present predicament.

Toombs admits that

> …under normal circumstances, the body appears as an object both in the experience of being an object for another and in certain 'limit situations' in which the body is apprehended as a material, physical entity".[112]

She believes illness to be such a "limit situation", but may underestimate the extent to which we place ourselves in such a distanced position to our bodies in our daily living . But no doubt it is often the case in illness that the body becomes alien, "not-me", a piece of inert nature – yet at the same time peculiarly *mine.* The ill person, writes Toombs, "… objectifies the body not only as a physiological organism but as a *malfunctioning* physiological organism."[113] But objectification

can only be partial and conditional. The lost leg is still Sack's leg, it is his and still not his – and this combination of being me and not-me sometimes seems to be the most frightening aspect of serious illness. It is a common experience for physicians that their patients often talk about the defective parts of their bodies in a neutral way, as "the leg" or "the breast" instead of the usual "my leg" and "my breast". We may perhaps see this as a defensive strategy as much as an alienation. Being ill, I protect myself by expelling the part of me (of my body) that is out of order, that threatens my integrity.

Toombs makes an interesting remark on illness in relation to disease. She notices that the ill person ("the patient") may very well "…come to view his or her 'suffered illness' as 'disease'…".[114] This is an understatement. As a matter of fact it seems as if this is an almost constant occurrence. The ill person more or less objectifies the state of illness into something that has vague similarities to what we above called "the biomedical model of disease". Of course, this is done in a far less sophisticated way than what the trained medical eye would do, and of course it is an ambiguous experience where a wish to understand the disease as "a thing", as something with an independent existence somewhere in the body, like an invader or intruder – where this often coincides with a likewise diffuse feeling of being in a transformed state, of being permeated and enigmatically transformed by an invisible and unlocalized force.

With a combination of theoretical stringency and narrative presence, Richard Zaner has in a number of books approached the same reality, the experience of being ill. As a recurrent theme in his texts, we encounter the ill person's wish to know: "First, sick people want to know what's wrong with them; second, they want to know that the people taking care of them really care."[115] One is inclined

to add that they also want to know that the people who are supposed to help are able to more than care in a general sense, that they also know reasonably much about what to do, but Zaner does seem to consider this as built into the kind of "therapeutic dyad" that comes out of the first two aspects.

Zaner also stresses vulnerability and dependence:

> To experience affliction in its various forms is to find oneself critically and uniquely singled out as vulnerable. Our bodily abilities compromised (not being able, for instance, to choose those with whom to associate), our need to be preoccupied with the pains and suffering that befall us – in short, illness affects our own vital sense of ourselves, to one degree or another.[116]

Zaner here touches an aspect that strikes me as curiously seldom noticed by those who try to describe the nature of illness. Being ill has a tendency of capturing the attention of the ill person and directing it towards the body. It is as if the mind starts searching for symptoms instead of, as we assume is the situation in health, only somewhat reluctantly registering them when they really knock hard on the door of our consciousness. This of course has to do with the fact that the body is no longer a safe place to be for the ill person, as is often noted by phenomenologists, but also the extent to which the ill person's mind "searches for" bodily perceptions is of crucial importance for the healer to understand. [117]

The vulnerability of the ill person calls for trust: "Impaired in some way or other in the ability to do for himself or herself, the afflicted person unavoidably enters a complex network of trust relationships…".[118] Trust is a prerequisite for asking

for help. It must, however, be kept in mind that this is not a qualitative break with the situation in health. Trust relationships make our existence possible. It is rather a question of the scope of the required trust. As we shall soon see, the encounters with significant others that follow after the onset of symptoms will to a large extent determine the amount of trust that the ill person is able to mobilize – as also of course do personal factors of a psychological character.

Symptoms are more or less easy to communicate. If signs – like pallor, sweating, a lump or a swollen ankle - are there to "support" the existence of the "inner" mental state, many patients feel relieved, as if their reality were real only if it could be observed by others. Carl-Edvard Rudebeck calls this crucial aspect of illness "symptom presentation". The symptom presentation is the attempt to communicate an illness experience to persons close or to professionals who may be expected to know what to do. It is naturally textured by numerous contextual factors, of which we will subsequently look into some. Rudebeck very strongly stresses that "the fact that a symptom is an expression of the-body-as-self means that its hidden significance is directed outwards, towards the patient's life context".[119] It is the healer's task to search for this hidden significance, while at the same time not losing the biomedical aspects out of sight.

2.2.4 The pursuit of health as the goal of medicine

If persons in general in our culture were asked to give an answer to the question "What is the task of medicine?", a large majority of the answers would probably be of basically the following sort: "Medicine diagnoses, treats and cures

diseases." My point here is simply that the common view of what doctors do and should do is strongly disease oriented. This is of course perfectly reasonable. In our everyday life, diseases do behave like entities that invade and harm people and sometimes prematurely end their lives, and it is rightly thought to be the task of doctors to try to fight these vicious forces. (A few persons would probably also remind us that doctors ought to prevent diseases.)

The idea – an intuitively reasonable one – is that diseases should be the focus of medical activity. This gives doctors the role of warriors against visible or hidden dangers in the form or biomedically definable disease. There are some good arguments supporting this position. Such a way of thinking about medicine's goals delimits the realms of medicine better than many other suggestions, and hence the responsibility of the health care system will not spill over its limits. Other definitions of the goals of medicine, like for example those based on promotion of health, may seem to involve a risk of facing an almost insurmountable amount of tasks, as many definitions of health are extremely wide and include almost all aspects of life. This, some would say, paves the way for medicalisation. Another argument in favour of disease orientation is that, just as we noted above, it is a common intuition that medicine is about diseases, and this may be a reason in itself for defining its goals in such a way as to commit doctors primarily to handling diseases. Thirdly, it is an undisputable fact that diseases are often the cause of symptoms and when they are successfully treated, the symptoms go away. As we have seen in section 2.1, this has been a formula for great success for at least a century and a half. If so, why not define the fight against disease as medicine's primary task?

But identifying the goals of medicine with the struggle against disease is a project involving considerable problems. What if a person who comes to the doctor is just not feeling well and has peculiar and unpleasant symptoms - but no disease is found? In line with our terminology above, this is a case of illness without disease. A considerable amount of those who seek medical advice in western societies either do not have diseases in the biomedical sense, or at least they do not have diseases that in any reasonable way can explain their symptoms – or they do have disease processes going on in their bodies which present medical knowledge is not capable of detecting.[120] Whichever of these alternative groups we deal with individuals in such situations are liable to present diffuse complaints that are seldom found to be accompanied by those biochemical and biophysical deviances that modern medicine so eagerly looks for. Should these patients then be deserted by doctors, be defined as non-patients?[121] And what about patients with lethal diseases that can´t be cured, or can be relieved only temporarily? Will palliative medicine really find a place within a medical practice exclusively oriented to disease treatment, as palliation per definition means that treatment has left place for care and symptom amelioration? Furthermore, in the treatment of "ordinary" well-defined diseases that fully correspond to the biomedical model, everyone knows that a person may be treated and cured from his ailment in a way that leaves him highly unsatisfied, in spite of a normalization of biomedical parameters, feeling ill and incapable of functioning the way he is used to. The disease is cured but the problem is still there.

Putting heavy stress on the treatment of disease hence may be a risky strategy, in case we want medicine to respond to the moral challenge of suffering due to

illness. It also seems theoretically dubious. There can hardly be a reason to treat disease *as such,* at least not if "disease" means what we have called the strictly biomedical model of disease. There can be no reason to treat pathophysiological deviance as long as it doesn't interfere with the life of the person, or threaten to do so in the future (except perhaps out of pure curiosity, and that would seem like a game with high stakes). If we treat diseases it must surely be because they *do* something to people? What, then, do they do? Or put another way: Is it perhaps not *illness* rather than disease that moves us to act, to come to the rescue, to enter into a clinical relationship with a patient? If we look upon illness as a loss of health, would it not then seem reasonable to propose the pursuit of health as the over all goal of medicine? This does of course not mean that no secondary goals present themselves, but the point here is that they in some way may be supposed to relate to the restoration of the patient's health.

The writings on this topic are of course extensive. I have no intention of surveying this literature. My wish is to relate health to our understanding of illness and hence judge whether the pursuit of health is a feasible and morally acceptable candidate for being the overriding goal of medicine. If so, it will have decisive consequences for our further analysis of the clinical encounter, and hence also for how literary texts may contribute to clinical skills.

Health is an elusive concept. Much warranted critique has been directed towards the health definition of the WHO as being far too demanding and blatantly impossible to handle in practice.[122] Furthermore, the notion of health is to a problematic degree incorporated both into the everyday language and the terminology of social medicine, like "health care system", "health care centre",

"department of health", "healthy food" and so forth. Such an extensive use tends to blur the connotation into the hopeless. It is hard to avoid the conclusion that health is a sort of catch word for almost everything that is good and nice and a mantra for the "feel-good" culture that has got such a strong hold of contemporary life. But dealing with health in such a way has its problematic consequences. As Hans Georg Gadamer points out

> Health is not a condition that one introspectively feels in oneself. Rather it is a condition of being there (Da-Sein), of being in the world (In-der-Welt-Sein), of being together with other people (Mit-den-Menschen-Sein), of being taken in by an active and rewarding engagement with the things that matter in life…..[123]

It follows from such a way of thinking about health that exactly the attempts to make people aware of just how healthy or unhealthy they are in order to make them better "care for their health" are dubious indeed, and may even be counterproductive as they tend to interrupt that flow of engagement in and with the world that characterizes health.

If the restoration of health is to be seen as a candidate for being a goal of medicine, we need an understanding that is reasonably well defined and that really captures the essence of what health is. The quotation from Gadamer points in a direction that has been followed by Fredrik Svenaeus, in his already cited work *The Hermeneutics of Medicine and the Phenomenology of Health.* Svenaeus' analysis proceeds in three major steps. First, he gives an account of and some comments on Lennart Nordenfelt's theory of health. The second step is an introduction to the basic outlines of Martin Heidegger´s philosophy, in so far as

it is of interest for our attempts to understand health and illness. Although Heidegger seldom wrote about health and about illness, Svenaeus considers his way of understanding basic human conditions – his fundamental ontology – very valuable for our efforts to understand what health is. Thirdly, he turns to Hans-Georg Gadamer as a thinker that explicitly brings human dialogue into his philosophy and who's hermeneutics are seen by Svenaeus as offering a fruitful point of departure for our understanding of the clinical encounter. Svenaeus is stably situated inside the phenomenological tradition that I briefly sketched in 2.2.1. His work may be seen as an attempt to further develop a number of interesting themes, in order to approach a philosophy of practical medicine.

In this context, an attempt to present first Nordenfeldt's and then Svenaeus´ analysis risks being simplified and missing the richness of their argumentation. I restrict myself to present their assumptions only in very short, while hopefully still capturing the essential elements in their argumentation. I will give a very brief summary of their positions, following Svenaeus´ presentation in parts 2 and 3 of his book. I will finally point to the importance this has for my analysis of the goals of clinical medicine.

Disease, according to Lennart Nordenfelt, is a process that interferes with our possibilities to achieve our vital goals in life. What then are vital goals? It is those goals that are "necessary and jointly sufficient for a minimal degree of happiness". But I may have goals for my life –e.g. becoming the richest person in Sweden – that are so unrealistic that the poor outcome of my efforts makes me continuously unhappy. Am I then unhealthy? This would amount to calling all unhappiness, however reasonable it is given the unrealistic aspirations, a

deviance from health, a strongly counterintuitive and probably dangerous thought. Nordenfelt hence qualifies his theory by saying that the vital goals he is talking about are those that could be reached "given standard circumstances". But is anything really "standard" when we deal with human preconditions to act in certain ways and reach certain goals? Nordenfelt uses "standard circumstances" as an evaluative concept meaning that the conditions under which I act are not extreme, that they are reasonably ordinary. This will vary from person to person according to time, place and culture. He is also reluctant to identify vital goals exclusively with what we ourselves define as our goals in life, leaving open the possibility that we may have vital goals of which we are not (fully) aware – and the other way around, thinking we have goals that are not really vital (as in the dream of enormous richness). Finally it must be reminded that Nordenfelt's notion of happiness, somewhat in contrast to everyday language, is not primarily a *feeling*, but rather a cognitive state. This leads Nordenfelt to separate subjective from objective health. When you are subjectively healthy you experience the happiness of being able to realize the minimal goals for your happiness. When you are objectively healthy you may feel indifferent to your life, but are still able to reach those basic goals.[124]

It seems to follow from this that if I am healthy and fall ill, for example with a chronic joint disorder, I will be unhealthy and ill as long as I am not able to adjust the goals that define my "minimal level of happiness" so that they "fit" the new situation. When I do, I return to health but may again be threatened by aggravation of this disorder, once again obstructing my "minimal goals". Obviously the disease is there all the time – biomedically defined as inflammation and destruction of the tissues in several joints – but illness, defined

as loss of health, is not. Or may we stay free from such perhaps counterintuitive language if we say that there still may be illness accompanying the disease, but that it is considerably reduced due to adaptation and modification of aspirations and goals in life. On the other hand, we don't want persons' health to be a question exclusively dependent on how they reduce or even minimize their expectations for what to achieve in their everyday life. The person who is able to consider fewer and fewer things in life as vital to her may either be on a sound track of need reduction, or in a self-denigrating trap where the sphere of life is finally reduced to that of a prison. Nordenfeldt's notion of vital goals that are not conscious offers us a way to avoid calling the latter alternative healthy.

How do we, then, live our lives when we are in health? What characterizes the state of being healthy? One might today often expect psychologically or sociologically oriented answers to such questions, stressing for example certain feelings or certain individual or collective life forms.[125] Svenaeus rejects such an understanding. His understanding of health is based on Heidegger´s philosophy, which in turn is based on an ontology of being, of *Dasein*, an often untranslated category that captures the seemingly simple fact that we are, that we exist.[126] If we look at *Dasein* we find that it is a being-in-the-world, a being that is related to the world and interacts with the world (objects and persons). We are "thrown" into this mode of existence, as nobody came here through a wish of his own and also as the major circumstances deciding who we become are out of our control.

We have seen that Nordenfelt proposes that health is a state in which we may reach our vital goals, with certain necessary qualifications. Svenaeus' suggestion is rather close to this, but he avoids wish-fullfillment as criterion for a healthy

state. Rather, he thinks, we must look for a "being-in-the-world" that we are prepared to call healthy. This can hardly be biostatistical, based on the acquisition of a certain number of statistically normal bodily functions. Neither can it be equated to absence of disease, as this certainly doesn't say more than a minimum about a person's "being-in-the-world". Svenaeus instead chooses to focus on Heidegger´s notion "attunement".

> To be delivered to the world of intersubjective meaning – language, culture, history, etc – is to *find* oneself in the world (*sich befinden),* and this finding oneself appears in the form of an attuned understanding, in the form of finding oneself in a mood. Our attunement colours and determines our understanding of the world.[127]

Most of the time we understand the world, including our own bodies, as familiar, reasonably benevolent and foreseeable – at least comprehensible not threatening. Our understanding of ourselves is "home-like". However, we may due to different reasons lose this "homelikeness". The terminology here may of course cause problems to some. Why use such an awkward notion as "unhomelike being-in-the-world"? Does this metaphor, if it is such, help us the grasp the phenomena of health and illness in a better way? Svenaeus analysis has obvious advantages. One such is that he is able to associate health – and loss of health - to an existential condition, not to a feeling, a set of feelings or some cognitive experiences alone. The understanding of health that comes out of this is, as I see it, more comprehensive and covers more aspects than what we are used to when discussing this notion. Loosing health doesn't, and we all know this, strike us just in one dimension of our lives while everything goes on as usual in all other respects. The loss of health affects us as full and whole persons in our being. This is what Svenaeus' analysis lucidly brings out and I think it

proves to be of great value for the understanding of the clinical encounter, to which I will soon proceed.[128]

Before this, however, just some concluding words on health and illness and the goals of medicine. We have reached a point where we may conclude that loss of health is the same as illness. There is then no necessary connection between this state and the state of ”having a disease”. Of course, in most cases of illness there is a disease “behind”. However, the point here is that illness in a sense is the primary concept, in the way that it is illness, loss of health, symptoms, which bring a person to seek help. We are used to thinking, through the strong influence of the biomedical disease model, that there is an almost necessary connection between symptoms and disease, but this analysis makes it possible to loosen this connection.

We have now firmly embedded illness in the life world of the ill person. I have noticed that moral commitments arise out of this life world, as an answer to a call from the afflicted person in a state of unhomelike being. The moral commitment of medicine is to restore health in ill persons. But why should that be an overriding goal? Is it because a person suffers in illness? If we think so, we are in line with physician Eric Cassell, who declares that “suffering can be defined as the state of severe distress associated with events that threaten the intactness of the person”, and proposes that it is the task of medicine to reduce suffering.[129] However, it is not unproblematic to link illness to suffering, as most people would object to the idea that all illness amounts to suffering. It may just be a word with too strong connotations. If we instead say that illness threatens the well-being of persons, we may deduce the moral commitment out of a general

social ethos to increase the well-being of all individuals in a society. Finally, and this is what is favoured here, we may say that whenever a person is in distress due to illness there arises a moral commitment to do whatever is possible to help them return to health. Medicine is the institutionalised and professionalised historical project that is committed to this end. To restore health, physicians must understand illness and to do this they must approach the life world of their patients.

2.2.5 The clinical dialogue and the hermeneutics of medicine

It need hardly be said, that the encounter between the healer and the afflicted person – in our case between the doctor and the patient - is a complex event. It is necessarily deeply embedded in all those cultural and historical circumstances that account for the enormous diversity of medical reality. In the first section of this chapter we saw how the encounter was transformed as medicine became scientific, or rather: as practical medicine became more open to scientific influences, in late 18th and early 19th century. The continuous introduction of new technological devices has added new "layers" to the encounter, new "texts" to be read by the doctor. It is, for example, often pointed out that the introduction of the stethoscope was symbolic in this sense. When Laennec in early 19th century Paris discovered that sound could be led by ways of a wooden tube from the chest of the patient to the ear of the physician, the necessity for the clinician to press the ear against the chest wall in order to catch the sounds from heart or lungs was no longer there.[130] Bacteriologically sound as the distancing might have been, it literally created a distance between physician and patient that in some respects may have grown.

In contemporary medicine, the meeting between the ill person and the physician is often divided into two parts: the "taking" of the anamnesis and the physical examination. The crucial role of anamnesis has already been stressed. The anamnesis is the patient´s story of her symptoms, recalled and presented in her own words. It develops in the dialogue between doctor and patient that almost always constitutes the first phase of the encounter (if the patient is awake). We have seen that the formulation is that the anamnesis is "taken".[131] It must be remembered, however, that anamnesis is not necessarily a well delimited part of the encounter that ends when the physical examination starts. The taking of the history may very well have started somewhat earlier through the doctor's words with some of the close relatives prior to the encounter, or with an advance message from the ill person to the physician. The dialogue with the ill person often goes on during the examination and is resumed afterwards in the light of what has come out of it. The doctor asks the patient questions about symptoms but also background questions that help her to get some idea of what kind of person this is, what her life situation may be like, how she experiences herself and her body. But the patient of course also asks the doctor about things important to her – if the physician does not silence her through subtle signals that forbid questions - and these questions are often of great importance for a degree of mutual understanding to develop. A clinical encounter characterised by instrumental distance, where questions are sharply focused towards certain possible diagnoses may sometimes be successful in bringing about a rapid diagnosis, but risks missing valuable information – hence of giving a false diagnostic suspicion - and also leaving the patient with a feeling of being interesting mainly as a diseased body.

Broadly speaking, anamnesis is about symptoms and physical examination concerns signs. Symptoms are said to be subjective, while signs on the other hand are "objective". Symptoms are necessarily communicated by words, though signs can indicate, or occasionally question, their existence. Cardinal symptoms may be nausea, fatigue, dizziness, itching, different sorts of pain. In a sense, symptoms are signs to the patient. Signs, as the term is usually employed in medical literature, are things like pallor, a rash, a lump, unusual eye movements or fingers shaking (tremor), a cardiac murmur, a red ear drum. However, in addition to these signs that belong to the physical examination, and are observed by the physician without sophisticated instruments - with the help of "bed side technology" - there are all sorts of signs that may come as a result of technological investigations like blood chemical analysis, X-rays, ECGs, endoscopies, CT-scans, MR-exams etc etc. The variety of both symptoms and signs are of course enormous, and the basic reason why anamnesis and physical investigation are such complex procedures.

The awakened interest in the role of understanding in the clinical encounter has, not surprisingly, prompted several attempts during the last decades to relate medical practice to hermeneutics. Hermeneutics was originally, in the early 19th century, developed as a discipline within humanistic studies oriented towards the interpretation of texts.[132] In a broader sense and in a language that has now become common, hermeneutics is the study of interpretation in general and how interpretations generate meaning. If hermeneutics is defined this way, many human activities, if not all, become hermeneutical. Human beings attempt to order the world, make sense of it, by way of interpretations. If the clinical encounter then is seen as one instance of this general interpretive activity of our

every day living, what is so special about it? What may be said to characterize clinical hermeneutics?

The ill person has attempted to make sense of his symptoms from their very onset. These interpretations have relied on his own earlier experiences of illness, also of course on what he has heard and read. Possibly he asks persons around him for advice and even turns to the computer to search on internet for information that may shed light on what is going on in his body and what to do about it. It may take a long or a short time to get to the doctor.[133] Here the interpretive efforts continue, in a way that is structured by the character of the encounter. The doctor interprets words from but also signs of the ill person, while the ill person interprets her own symptoms as answers to the doctor's questions - and of course also asks herself "What does she think that this is?". The questions, the taking of the anamnesis, the answers to the questions…all this of course to a smaller or larger extent influence the patient's and the doctor's interpretations, in a mutual and circular way, so that it may be tempting to look at the clinical encounter as one instance of what has been called the hermeneutical circle. The dialogical situation where "he thinks that she thinks that he thinks……" will appear here as elsewhere when humans meet.

The most influential and controversial text on medical hermeneutics is probably Drew Leder´s article from 1990, "Clinical Interpretation: The Hermeneutics of Medicine".[134] This article has inspired a number of responses, both favourable and critical. At the time when it appeared, the idea of medicine as "a hermeneutical enterprise" was, if not shocking, still unexpected and even a bit

provocative. This is no longer the case. Hermeneutics and clinical practice no longer seem to be two totally unrelated entities.

Drew Leder's article is to a remarkable extent relying on the concept of text. He defines a text as "…any set of elements which constitutes a whole and takes on meaning through interpretation." (We will soon see that it is at this point that the heaviest criticism has been raised against Leder´s article.) The first and most primary text of the clinical encounter hence is "the person-as-ill". The elements of the encounter – "experiences, physical changes, life-goals" – are seen against the background of the person "as ill", that is of having perceptions of a sort that he and often people around him look upon as indicative of disease. Perhaps we may say that this primary text of a person being ill totally textures and situates the encounter and decides its limits and its potentials. Departing from this text, Leder discerns four "secondary texts": the "experiential", "narrative", "physical" and "instrumental".

We can see that Leder proceeds in three steps in his analysis. The first is to underline the interpretive nature of human existence, second to define hermeneutics as concerned with the interpretation of texts and finally to define a text in such a way as to include medicine, or rather: practical medicine. His analysis gets much of its force from exactly this identification of different elements of the clinical process with the interpretation of texts.[135] But is it reasonable to think about the dialogue between physician and patient as a text? Svenaeus has raised severe critique against Leder's textual metaphor.[136] I share much of his critique and will present my objections in short, while still acknowledging the value of Leder's analysis.

The use of the metaphor of text to capture the hermeneutical elements of the clinical encounter has serious draw-backs. As noticed, when doctor and patient interpret each other they establish something that is very similar to what is often called "the hermeneutical circle". It is, however, a hermeneutics of dialogue, not the traditional hermeneutics that arises between reader and text. A text does not respond to the reader, can not in turn interpret what the reader interprets. A text is a "frozen" semantic structure. The interpretation of the clinical dialogue is an ongoing, changing, open-ended attempt to make two horizons of understanding partly fuse. How is this possible, given the different worlds of physician and patient (as, for example, Kay Toombs has so eloquently analyzed them)? I think that a clue to this is the fact that the physician is also vulnerable as a human being, has also experienced periods of unhomelikeness in her life, and moreover has a capacity to imagine situations of unhomelikeness due to the fact that she has seen and read and heard about them as existential realities. This experience is as crucial for the physician as is the knowledge of diseases (which is in fact, as we already have noted, constructed on the pre-existing knowledge of the life world). It is hence an experience that may be direct in the form of the doctor's own immediate experiences of her own unhomelike being-in-the world, but it is also a question of indirect imaginative understanding, a complex inference of combined emotional and cognitive character from real and fictive afflictions and challenges to different persons´ bodily and psychological integrity in a wide variety of contexts. A central assumption of this dissertation is that literary imagination may here play a considerable role. Acquaintance with "fictive" experience in the form of literary texts may, I will later argue, be as formative as familiarity with "real" cases. Such literary imagination constitutes a knowledge that may be of crucial importance in the search for diagnosis and treatment.

2.2.6 The role of diagnosis

We have described illness as a state of being in an alien and sometimes threatening landscape. In the early phase of illness, the symptoms are utterly meaningless (if the affliction is not familiar to the person). There is yet no context to which they belong, where they would acquire some meaning. Hence, the questions arise that we have already returned to several times: "What is this?", "What can I do?", "Who could help me?", "Will it go away? ", "Will I be able to stand this?".

Diagnosis is one answer to this. The clinical dialogue and the physical examination, including whatever complementary information that may be needed through technical devices – in Leder's words: the reading of the different texts – are more or less oriented to diagnosis. In effect, in most countries, every visit to a doctor and hence every clinical encounter should lead to the registration of a diagnosis.[137] This, of course, reinforces the assumption that for every illness that brings a patient to a doctor there must be a corresponding disease. If the clinical process is structured in the way we commonly think about it - and this is the way it is taught in medical schools: symptom-anamnesis-physical investigation-diagnosis-treatment-prognosis - all difficulties in finding diagnoses will be looked upon as anomalies, as challenges not only to the doctor but to the system as a whole.

I will soon return to the need for the doctor to reach a diagnosis. For the ill person, to get a label is to get the situation under some sort of control, to achieve

at least a minimal distance by conceptualising what was at first nameless and vague. As John Berger notices:

> This is why patients are inordinately relieved when doctors give their complaint a name. The name may mean very little to them; they may understand nothing of what it signifies. But because it has a name, it has an independent existence from them. They can now struggle and complain *against* it. To have a complaint recognized, that is to say defined, limited and depersonalized, is to be made stronger.[138]

It is worth noting that this process of depersonalisation of the disease, of reifying it, of thinking about it as a "thing", usually to some extent has occurred already with the advent of the symptoms – but then as a nameless and hence also uncontrollable and diffusely threatening challenge. This is hence not the result of the naming, the giving of diagnoses, but the other way around: naming becomes necessary due to this rift in the experience of the lived body as a whole. The naming of the disease for the patient also makes it "common", not so unique, recognizable, communicable. There is now an answer to the questions "What is the matter with you?", "What illness do you have?". With this come increasing possibilities to handle and, at least hopefully, to treat: "Others are where I am". This does of course not exclude that the ill person is more or less ambivalent about getting a diagnosis. This ambivalent wish to know and not to know will be dealt with below (2.2.10).

[139]

The need for diagnosis binds doctor and patient together. Berger continues:

> The whole process, as it includes doctor and patient, is a dialectical one. The doctor in order to recognize the illness fully - I say fully because the recognition must be

> so as to indicate the specific treatment - must first recognize the patient as a person: but for the patient – provided that he trusts the doctor and that trust finally depends on the efficacy of his treatment – the doctor's recognition of his illness is a help because it separates and depersonalizes the illness.[140]

Once again we see the theme of personal knowledge and biomedical diagnosis recurring. Diagnosis is mostly impossible without personal biographical knowledge. It is possible, writes Berger, that computers may be clever diagnosticians in the future (or perhaps already are) but they would still very often have to be presented comprehensive "information" about the patient in a way that fully relies on a close knowledge of the ill person's life whole situation.

Diagnosis hence serves a crucial function for the ill person. We have briefly outlined the beneficial aspect of this. There are darker sides. There is no lack of knowledge about the dangers that the force of diagnosis also entails. We have a huge literature on this aspect of "the diagnostic culture", which will not be covered in this context, from Foucault to the recent critique of the diagnostic excesses of American psychiatry. It is, so it seems, the very essence of the diagnosis to have this double individual and social function as liberating and as potentially oppressive. We need not think beyond recurrent diagnoses such as chronic fatigue syndrome, multiple chemical sensitivity, electricity hypersensitivity and fibromyalgia to see how ambiguous diagnosing may be: freeing ill persons from guilt and giving them legitimacy in their role as afflicted, but at the same time reinforcing a disease-thinking about their predicaments that may just not be appropriate to understand and handle them.

At the same time, it must be repeated that diagnosis is an indispensable tool for the physician to reach an understanding of what goes on and what may be done about it. As we have already stated, if every case were totally unique the doctor would be helpless. Similarities between disease states are the basis for treatment recommendations and the underlying assumption is that basically the same processes are at work in patients with the same disease. Diagnoses thus presuppose that the individual is subsumed under the general. Disease in relation to the individual is unique, but disease as a general concept applies to a group of persons who share some characteristics in symptoms and signs. It is of great weight to realize this. It is not difficult to see this challenge to the physician's knowledge: combining a sense for the unique in every patient's condition with the inevitability to see exactly this condition as a "case" in line with other cases and to give a name to it that is the same name as other ill persons may have received for their afflictions.

But again, there are reasons to think that a too heavy stress on disease orientation, on biomedical diagnoses, from the physician's side may be an obstacle to a successful clinical encounter. For the physician to keep her mind open, to listen in as many directions as possible, not to jump on diagnostic conclusions, not to focus too early on a certain path of thought – this is a tough diagnostic challenge. This may be likened to a sort of cognitive and emotional flexibility – the art of not jumping to conclusions even when the temptation and the expectations for it are great. If this imagination and combined emotional/cognitive freedom is not there at least two things are lost: first, the too early reached diagnostic conclusion prevents the clinician from seeing other possible biomedical explanations for the symptoms brought out by the

anamnesis and the signs revealed by the physical examination. Secondly, and closely related, the ill person may then tend to be brushed aside by the strength of the diagnosis, with its obvious action orientation and with its foundation in tissue damage and pathophysiological malfunction. The disease – or rather: the suspected disease – may then brush aside the experiences of the ill person.[141]

Diagnosis may in some cases be seen as a sort of negotiation between patient and doctor. Where no clear cut diagnostic option quickly presents itself, there may appear a situation where the need to find a name for the illness experience leads the doctor tentatively to propose some sort of diagnostic category to the patient, even though the biomedical rationale for this diagnosis may not be overwhelming. The doctor does this when she feels reasonably convinced that there is no serious disease that might be treated that fits the patient's symptoms and signs. Still, a name is needed for consolation, for legitimization, for hope, for practicalities. The diagnosis may have a potential for placebo healing, that is the tentative diagnosis presented offers the doctor a chance to heal by hope and trust and relatively innocent drugs, instead of by hard hitting biophysical interventions. Possibly, this is not so far from the almost archetypical situation in the history of human illness where a healer proposes a potentially healing "myth" to the afflicted person. This is hardly in accordance with principles of evidence based medicine, but nevertheless seems hard to condemn. As we soon turn to investigate the meaning of the expression "the art of medicine", this use of "healing myths" may be kept in mind.

Finally, I must again stress the value laden character of disease and diagnosis. William Stempsey eloquently shows how in all steps of inventing and using diagnoses, values of different sorts appear:

> All our facts are value-laden, and our diagnostic facts are value-laden in a peculiarly complex way. In the search for medical facts, there is an art of value discovery and an expression of values that goes beyond what some claim to be a value-free scientific method.[142]

In chapter 4, the presence of values in everyday clinical medicine will be linked to the notion of clinical judgement and in chapter 5, it will be shown that the acquaintance with literature offers a potential for realising and handling this fact.

2.2.7 "… why be a physician at all?"

I have in this section, 2.2, presented an understanding of key concepts like health, illness and disease, based on a phenomenological understanding of what it is to be human. In the light of this understanding, I have shown the clinical encounter to be an interpretive meeting where two horizons of understanding – that of the physician and that of the ill person – must be brought to coexist in a way that makes diagnosis and treatment possible. This presupposes that the physician is not exclusively oriented towards the biomedically defined disease process but is prepared to and capable of orienting himself towards the illness experience.

Another related theme has been the peculiarly divided character of modern medicine. I have traced its roots in the emergence of modern science-based medicine in the early 19th century, which in turn is a child of the scientific revolution of the 17th century. I have also repeatedly pointed to the prevalence of non-scientific elements of medical practice, elements that are often referred to as "art". Whether these may be called scientific, in any meaningful sense of this word, is as we have also seen a controversial question.

If medicine, as has been proposed, is basically a hermeneutic project aiming at medical understanding in order to promote health and relieve suffering, then the physician will have to work in a field of tension between the two epistemologies that Toulmin so eloquently describes. The medicalized body has come to stay. There is no return to a view of the body as consisting of four undefinable elements or as being the seat of magical powers threatening its integrity. We will face an ongoing process of evermore detailed description of bodily structures and functions. We will see numerous new ways of imaging and controlling these functions. And we will certainly see continuously increasing expectations on the results of medicine, in terms of fighting diseases and increasing life expectancy.

But this is not the whole story, of course. The "patient as a person" has also come to stay. The paternalistic physician, as Godlike in his knowledge as in his behaviour, will never return. The ethical implications of new technologies will not, as they largely were in the 19th and early 20th century, be ignored. The interaction between socioeconomic factors and health problems is common knowledge and will be at the centre of interest. The

emergence of strange and – at least for a time – unexplained syndromes will not halt. The physician will continue to be, perhaps even increasingly so, a mediator between the knowledge, values and presuppositions (and prejudices) of the life world of ill persons – and the specialized and for most people impenetrable scientific knowledge of biomedicine. Fantasy, intuition and sensitivity will continue to be tools as indispensable as scientific rigor, logical stringency and instrumental rationality.

I see no reason to wish for a full reconciliation of these different but complementary sources of knowledge in medical practice. The doctor will remain in a precarious act of balance between the epistemology of modern science and the epistemology of personal history. But if we take Toulmin's analysis of the roots of modern science seriously, we may hope for a reconnection to that tradition of modernity and rationality that is built *not only* on respect for quantitative abstract laws of nature and experimentally founded knowledge, but *also* on the acknowledgement of ambiguity, particularity and contextuality. I will later suggest that literature offers one way of doing this.

We must, I believe, also face Toulmin's perhaps most pressing question, formulated at the end of his essay:

> (…) if one does not wish to accept some real psychic involvement with sick people and is not really willing to involve one's whole personality in that interaction – and it is not just a case of the physician treating the patient as a "whole man", but rather one of the physician himself, as a

> "whole man", dealing with the patient as a "whole man" – then, I would ask, *why be a physician at all?*[143] (*author's italics*)

The next chapter of this thesis will be devoted to an area of human knowledge that may promise to be of value when bridging the gap between particular and universal, between the lived body and the medicalized, between feeling and thought.

---

[1] Toulmin, Stephen: "Knowledge and art in the practice of medicine: Clinical judgement and historical reconstruction". In Delkeskamp-Hayes, Corinna & Gardell Cutter, Mary Ann: *Science, technology, and the Art of Medicine* .Dordrecht: Kluwer Academic Publications, 1993, 231-249
[2] Feinstein, Alvan: *Clinical Judgment.* Baltimore: The Williams&Wilkins Company, 1967, 291
[3] Hippocrates: *The Aphorisms.The Internet Classics Archive* (translation Francis Adams). The full first paragraph reads: "Life is short, and Art long; the crisis fleeting; experience perilous, and decision difficult. The physician must not only be prepared to do what is right himself, but also to make the patient, the attendants, and externals cooperate."
[4] Edelstein, Ludwig: *Ancient Medicine: Selected Papers of Ludwig Edelstein.* Baltimore: The John Hopkins Press, 1967, 213
[5] Ibid, 215
[6] Hudson, Robert P.: *Disease and Its Control: The Shaping of Modern Thought.* Westport and London: Greenwood Press, 1983, 78
[7] Edelstein, op cit, 350-351
[8] It is worth noting the close etymological relation between patient and patience – the former is someone who patiently waits and the doctor, according to the Hippocratic corpus, must just as patiently share the patient's waiting.
[9] Tarnas, Richard: *The Passion of the Western Mind.* London: Pimlico, 1996, 69-72
[10] Sundström, Per:. *Det hippokratiska arvet: Den medicinska etikens historia tecknad utifrån källtexterna. (The Hippocratic Heritage: The History of Medical Ethics Based on the Texts).* Nora: Nya Doxa, 2001, 32-49
[11] Ibid, 36.
[12] McWhinney, Ian: "Focusing on lived experience: The evolution of clinical method in western medicine". Toombs, S. Kay (ed): *Handbook of Phenomenology and Medicine.* Dordrecht: Kluwer Academic Publishers, 2001, 331-350
[13] Svenaeus, Fredrik: *The Hermeneutics of Medicine and the Phenomenology of Health: Steps towards a Philosophy of Medical Practice* .Linköping: Linköping Studies in Arts and Science, 1999, 31
[14] Sundström, op cit, 72-76
[15] This aphorism might originate from Hippocrates but it can not be found in the Corpus. (Personal communication Raimo Puustinen.)

[16] More precisely, Aristotle in his *Nichomachean Ethics* discerned five forms of knowledge – Art, Knowledge, Practical Wisdom, Science, Intuition - of which then has been made three major categories. Op cit, 100
[17] Nilsson, Ingemar&Pettersson, Hans-Inge: *Medicinens idéhistoria (The History of Medical Ideas).* Stockholm: SNS Förlag, 1998, 58-59
[18] Sundin, Bo: *Den kupade handen: Människan och tekniken.(The Cupped Hand: Man and Techniques).* Stockholm: Carlssons, 1991, chapter 10
[19] According to Thomas S. Kuhn, in his *The Structure of Scientific Revolutions.* (Chicago: University of Chicago Press, 1970), paradigms break down and are replaced during a protracted period of unstable science where observations that do not fit into the old paradigm, "anomalies", accumulate. The emerging paradigm is, in Kuhn´s view, wholly incommensurable to the old one. They can in no way be compared or even exchange points of view due to a radical change of fundamental concepts and assumptions.
[20] Tarnas, op cit, 224-232
[21] Zaner, Richard: *The Ethics of the Clinical Encounter.* Engelwood Cliffs, New Jersy: Prentice Hall, 1988, chapter 5.
[22] Damasio, A.:*Descartes´ Error: Emotion, Reason and the Human Brain.* New York: G.P. Putnam, 1994.
[23] Tarnas, op cit, 287
[24] These idols were the idols of the tribe, springing out of certain characteristics of human nature; of the cave, with their back-ground in upbringing and cultural imprints; of the square, originating in the traps of language and ordinary human interaction; and finally the theatre, where delusions about the world stem from false theories, religions and scientific ideals. Nordin, Svante: *Filosofins historia*. (*The History of Philosophy*) Lund: Studentlitteratur, 1995, 269-270
[25] Actually any significant deviance from what a person is used to think about as normal in her bodily experience may count as a symptom, but it is of course an intriguing and complex question as to more exactly what it is that makes a symptom a question for medical handling.
[26] It is worth noting that in bodily expressions of emotions, symptoms in a way seem to merge with what we will below call signs - that is, facts that are observed by the doctor, pointing to the disease. But does a gesture of hopelessness qualify as a sign, pointing to a disease? Yes, if disease is seen as generalized, no if it is seen as a well defined local process in the body. Maybe the gesture is a sign of the existence of disease but not the nature of the disease?
[27] These are notions that we are later, in 2.2, going to scrutinize and employ.
[28] *Harrison's Textbook of Medicine.* New York: McGrawHill, 7th edition, 1974, p 4
[29] Puustinen, Raimo: "Bakhtin's philosophy and medical practice – Toward a semiotic theory of doctor patient interaction" In *Medicine, Health Care and Philosophy* (1999), 2**:** 275-281
[30] ibid, p 277
[31] There were, of course, hospitals before the 19th century but we do not have reasons to believe that their medical practice in any fundamental way differed from that outside the hospitals.
[32] Johannisson, Karin: *Tecknen: Läkaren och konsten att läsa kroppar.(The Signs: The Physician and the Art of Reading Bodies.)* Stockholm: Norstedts, 2004, 19
[33] Reiser, Stanley: *Medicine and the Reign of Technology.* Cambridge: Cambridge University Press, 1978, 1
[34] Nilsson&Peterson, op cit, 90-135
[35] Stolt, Carl-Magnus: *Den beprövade erfarenheten: Medicinsk idéhistoria och läkekonst i Boråsbygden 1780-1900. (Tried Experience: The History of Medical Ideas and the Art of Healing in Boråsbygden 1780-1900.)* Borås: Norma, 1994.
[36] Ibid, 87
[37] Ibid, 10
[38] Johannisson, 2004, 22-25
[39] ibid, 27
[40] Stolt, op cit, 223-226. Stolt points out that this alleged rule is tacit rather than overt, working half- or subconsciously in the mind of the practitioner. It may be seen as a sound form of scepticism, preventing humbug and quackery from entering into practice. Or, less encouraging, it may be seen as a continuous obstacle to the renewal of clinical medicine.
[41] Hudson, op cit, chapter 3.
[42] Ibid, chapters 6-8

[43] Foucault, Michel: *The Birth of the Clinic: An Archaeology of Medical Perception.* New York: Vintage Books, 1994.
[44] Faber, K.: *Nosography in Modern Internal Medicine.* New York: Paul B. Hoeber, 1923, 122
[45] Johannisson, 2004, 51
[46] ibid, 51
[47] Reiser, op cit, 230
[48] Stolt, C-M: *Medicinen och det mänskliga: Vårdkonst och vardagsetik. Humanism och humaniora.(Medicine and the Human: The Art of Care and the Ethics of Everyday Life.).* Stockholm: Natur&Kultur, 2003, 222-223
[49] It is dubious indeed whether the experiments of Banting and Best had been approved of by a committee on research ethics today, given the amount of suffering that must have been caused for the animals.
[50] Johannisson, Karin: *Medicinens öga: Sjukdom, medicin, samhälle – historiska erfarenheter. (The Eye of Medicine: Disease, Medicine, Society – Historical Experience.)* Stockholm: Norstedts, 1990, 106-109
[51] Ibid, 112
[52] We can see in the early works of Freud the same figure of thought, resting on the idea of the presence of some sort of innate psychic energy that can be reduced or increased, transformed and channelized.
[53] If it is obvious that diabetes has a specific pathophysiology and specific treatment, it is far less clear that the etiology may be seen as such. The etiology of diabetes is multifactorial and still not fully known.
[54] Using our terminology spelled out above, we may conclude that there wasn, in neurasthenia, an abundance of symptoms contrasting to a striking lack of signs.
[55] Le Fanu, James: *The Rise and Fall of Modern Medicine.* London: Abacus, 2000.
[56] ibid, 202
[57] Ibid. It may be noted that almost all the medical research that Le Fanu describes as preceding the twelve breakthroughs occurs before the adoption of the Helsinki declaration in 1964. It is indeed dubious whether some crucial elements in this research would have been accepted had they been subject to the research ethical scrutiny that is now routine.
[58] Ibid, 408
[59] Bliss, Michael: *William Osler: A Life in Medicine.* New York: Oxford University Press, 1999, 493-504
[60] Ibid, 461
[61] Tauber, Alfred I.: *Confessions of a Medicine Man: An Essay in Popular Philosophy.* London & Cambridge, Massachusetts: The MIT Press, 1999, 12
[62] Cassell, Eric: *The Place of the Humanities in Medicine.* The Hastings Center, 1984, 9
[63] Johannisson, 2004, 87-88
[64] Stolt, Carl-Magnus: *Kaos och kunskap: Medicinens historia till år 2000. (Chaos and Knowledge. The History of Medicine to Year 2000.)* Lund: Studentlitteratur, 1997, 209
[65] Ahlzén, 1998
[66] Rothmann, David: *Strangers at the Bedside: A History of how Law and Bioethics Transformed Medical Decision Making.* Cambridge: Cambridge University Press, 1991.
[67] Ramsey, Paul: *The Patient as Person: Explorations in Medical Ethics.* New Haven: Yale University Press, 1970.
[68] Hoffmaster, Barry: "Can ethnography save the life of medical ethics?" *Social Science and Medicine* (1992), 35(12): 1421-1431
[69] The notion of *humanistic medicine* is misleading in the sense that it may be taken to imply that there is a non-humanistic medicine that is strictly "biomedical". All medicine is humanistic in the sense that its basic goals are to restore human well-being and to support the integrity of individuals facing the threat of disease.
[70] David Greaves amusingly and somewhat sadly captures this in his short narrative of how a physician resident on a hospital ward related to his patient in the sixties as compared to the nineties. The doctor seems to divide himself into two. One is the science driven physician searching for the real causes of disease. The other is the listening and caring doctor who realizes that he must take at least a minimum of interest in the ill person, but that this really has nothing to do with his *real* task. See *The Healing Tradition: Reviving the Soul of Western Medicine.* Oxford: Radcliff Publishing, 2004, 2-3
[71] Hellström, Olle. *Patienten som person: Om mening och dialog i allmänmedicinsk praktik.(The Patient as Person: On Meaning and Dialogue in General Practice.)* Umeå: Umeå University Press, 1999
[72] Greaves, op cit, 3
[73] Toulmin, Stephen: *Cosmopolis: The Hidden Agenda of Modernity.* New York: The Free Press, 1990.

[74] Ibid, chapter 1
[75] Ibid, 9
[76] Ibid preface, xi
[77] Toulmin, 1993
[78] Good, op cit, 133
[79] Svenaeus, 2000, 28
[80] Jennifer Bullington, as one among many in the phenomenological tradition, has underlined that dualism runs against some of our everyday experiences as embodied beings, see *The Mysterious Life of the Body: A New Approach to Psychosomatics*. Linköping: Linköping University Press, 1999. It is indeed hard to see how anybody would accept to be seen as a peculiar combination of a material body and some ghost running the machinery.
[81] Tarnas, op cit, 275
[82] ibid
[83] Zaner, op cit, 106-116
[84] Sacks, Oliver: *A Leg to Stand on.* New York: Summit Books, 1984, 73
[85] In our understanding of others as nature *and* mind we do, I believe, often reproduce a dualism that we are ill at ease with when it is applied to ourselves. The kind of split that dualism introduces in our understanding of others seems to result from the overwhelming presence of their materiality (we can touch and feel and be hit by bodies), described by modern science in detail - and the simultaneous enigmatic evidence of an acting, feeling and experiencing self that *is* (permeates?) this body.
[86] Toombs, Kay: *The Meaning of Illness*: *A Phenomenological Account of the Different Perspectives of Physician and Patient.* Dordrecht: Kluwer Academic, 1993, p xii
[87] ibid
[88] ibid
[89] And of course, this "things-as-they-really-are"- terminology is philosophically problematic after Kant. Kant's categories structure our experience and "das Ding an Sich" will remain a phantom. It doesn't really help much to say that what we are after are "phenomena-as-they-really-are-to-our-experience", as it is not plausible that this act of experiencing can ever be lifted out of its historical and biographical context (perhaps except for during the short, short moment of perception when things may look new and mysteriously open). Possibly, however, phenomenologists mean something less demanding, amounting more modestly to inspire us to brush aside at least some of our ingrained ways of thinking in order to take a fresh new look at the world.
[90] Evans, Martyn: "The ´medical body´ as philosophy´s arena". *Theoretical Medicine* (2001), 22:17-32
[91] ibid
[92] Schwartz, Michael&Wiggins, Osborne: "Science, humanism, and the nature of medical practice: a phenomenological view." *Perspectives in Biology and Medicine* (1985), 28(3): 331-366
[93] One may wonder whether a physician who has never experienced the slightest degree of nausea, and just had it reported in factual experiential terms, would really be able to treat a patient with nausea at all? On the other hand, interestingly enough no doctor has ever experienced more than a miniscule part of all possible ailments. It is as if some core symptoms must necessarily be familiar in some way to the person who is taking the healer's role – and from this familiarity with very *basic* conditions in health and illness a bodily empathy becomes possible, extending to disorders far beyond the experiential horizon.
[94] Cassell: Eric: *The Nature of Suffering and the Goals of Medicine*. New York & Oxford: Oxford University Press, 1991, 95
[95] Thomas Kuhn actually described this process and is probably more useful as an historical analysis of a profound scientific change than as a general model for how scientific work is conducted and how sciences change their basic positions.
[96] Wulf, Henrik & Pedersen, Stig & Rosenberg, Raben: *Medicinens filosofi. (Philosophy of Medicine.)* Göteborg: Daidalos, 1992, 67-83
[97] Temkin, Owsei: "The scientific approach to disease". Crombie, A.C. (ed): *Scientific Change.* New York,, 1963, 628-647. These are also the terms used by Rudolf Virchow when he, after having been on the physiological track for long, in 1895 completely turned to the ontological position: "In my view a disease entity is an altered part of the body (…) that disease is a living entity that leads a parasitic existence."
[98] Coulter, Harris:*A Divided Legacy: A History of the Schism in Medical Thought.* Washington D.C.: Wehawken, 1973-77.

[99] Schwartz/Wiggins, op cit
[100] Of course, it follows from such a way of thinking that science must ultimately be the source of answers to all questions about our existence, and this is perhaps not far from what seems to be a widespread intuition.
[101] Engel, G.L.: "The need for a new medical model: A challenge for biomedicine." *Science (*1977), 196(4286):129-36
[102] Stempsey, William: *Disease and Diagnosis: Value Dependent Realism*. Dordrecht: Kluwer Academic, 1999, 114
[103] Greaves, op cit, 41-53
[104] ibid, 43
[105] ibid, 44
[106] ibid 47
[107] Leder, Drew: "A tale of two bodies". Leder, Drew (ed): *The Body in Medical Thought and Practice.* Dordrecht: Kluwer Academic Publishers, 1992, 28. The attentive reader perhaps notices how close this position of Leder's comes to Stephen Toulmin's conclusion, that clinical medicine ought to be seen as a bridge between two epistemologies.
[108] Good, op cit, 78
[109] Sacks, op cit, 104
[110] See also Ahlzén, Rolf: "Giving meaning to symptoms". *The Radcliff Companion to Medical Humanities*, Volume 1: *Symptom* Oxford, 2008, 115-129
[111] Toombs, op cit, 62
[112] ibid, 70
[113] Ibid, 71
[114] ibid, 76
[115] Zaner, op cit, 62
[116] ibid, 67-68
[117] This is, admittedly, a very dualistic way of putting it, but it seems as if dualistic formulations are more apt for the situation where a rupture has taken place in the lived body.
[118] Zaner, op cit, 69
[119] Rudebeck, Carl-Edvard: *General Practice and the Dialogue of Clinical Practice: On Symptom, Symptom Presentation and Bodily Empathy.* Sc J of Primary Health Care, suppl 1/1992, 30-39
[120] From time to time there are estimations of just how large this portion of help seeking patients is, but these are bound to be notoriously uncertain, not least since physicians generally are obliged to ascribe more or less well-defined biomedically founded diagnoses to each patient seeking their help. See also below under 2.2.6.
[121] A possible and common answer to this is to say that these patients certainly ought to get help but not within the limits of the health care system and most certainly not by doctors, as these are educated to treat diseases and nothing else. However, with striking regularity these patients pop up again and again on the surgeries and on the emergency units, in spite of our efforts to define them out of the system. The reason is that they communicate in the semiotics of disease and are as such initially indistinguishable from those who have "real" diseases.
[122] Health is defined as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity".
[123] Hans-Georg Gadamer' s book *Uber die Verborgenheit der Gesundheit (The Enigma of Health),* Frankfurt am Main: Suhrkampf Verlag, 1993, quoted in Svenaeus, op cit, 136
[124] Svenaeus, op cit, 117-128
[125] We have an enormous literature today on health mainly based on popular psychology and a sort of lay understanding of biology. This flood of literature may, as noted earlier, rather be an obstacle than an asset if we wish to approach an understanding of health – and illness.
[126] Going back to the presocratic philosophers, Heidegger argued that this question is philosophy's *first* question, though deplorably ignored during long periods of its history.
[127] Ibid, 155-156
[128] There is one set of objections to Svenaeus analysis that I will not go deeper into but that deserves mentioning here. If loss of health, illness, is to be seen as "unhomelike being in the world", do we not then face the imminent danger of creating a concept of illness that is far too wide? Surely, not only what we

usually think of as illness (neither somatically nor psychiatrically) may bring about this "unhomelike being-in-the world"? If I loose my job and at the same time my wife leaves me, I risk loosing foothold and sink into such an alien state. Is this illness? Are all sorts of ailments that we may think of as unhomelike really equal to loss of health? Svenaeus does comment on this, for example by saying that for a person to be called ill it must be more than a very temporary and very partial loss of homelike being. He resists saying that it is those states of unhomelike being that are associated to disease that we should count as illness. This would bring him back to the task of defining also disease in a way that suits his ontological project, and this seems to be exactly what he wants to avoid. However, it seems to me as if this leaves the delimitations of medical responsibility problematically wide.

[129] Cassell, op cit, 33

[130] Reiser, op cit, 30

[131] One may reflect a bit on the use of the word "take" here. Does it imply more of unilateral control over the dialogue than we would wish there to be? Do we not want the encounter to be characterised by a mutual dialogue, where no one takes anything from the other? And it may be objected that there is nothing there, within the ill person, ready to be "taken". I believe that we may still defend the use of the word, realising to which extent it still is the doctor who is setting the conditions of the dialogue and how much it is her wish for knowledge that determines how it envelops (this does not exclude a great amount of attentive listening on her part and does definitely not mean that the dialogue is reduced to a snap shot interview), also aware that what comes out in the clinical dialogue is shaped during the encounter.

[132] Nordin, op cit, 415-417

[133] Ahlzén , 2008, op cit

[134] Leder, Drew: "Clinical Interpretation: The Hermeneutics of Medicine" *Theoretical Medicine* (1990),11:9-24

[135] Dekkers follows Leder in an article about a patient with lower back pain, see Dekkers, Wim: "Hermeneutics and Experiences of the Body. The Case of Low Back Pain". *Theoretical Medicine and Bioethics* (1998), 19: 277-293.

[136] Svenaeus, Fredrik: "Hermeneutics of Clinical Practice: The Question of Textuality" *Theoretical Medicine and Bioethics* (2000), 21:171-189

[137] Without being able to prove my assumption, I am prepared to say from long experience of my own and colleagues that this leads to a considerable amount of "diagnosis fabrication". However, this takes place in a way as to minimize the possible negative consequences of setting diagnoses that are not fully validated.

[138] Berger, John: *A Fortunate Man: The Story of a Country Doctor*.London: Penguin Press, 1967, 74

[140] ibid

[141] Schwartz and Wiggins would probably say that the reason for this is the fallacy of misplaced concreteness, dealt with above. The physician consciously or subconsciously regards the material reality as more real than the mental state of his patient, reflecting both his professional training but primary to this also a general cultural bias. See Schwartz/Wiggins, op cit

[142] Stempsey, op cit, 2

[143] Toulmin, 1993, op cit

Chapter 3

The experience of literature

> *A novel that does not discover a hitherto unknown segment of existence is immoral. Knowledge is the novel's only morality.*
>
> Milan Kundera [1]

In my attempts to capture the basic elements of practical medicine I have so far repeatedly stressed the importance of imagination, of a broad experience, of empathetic capacity and of a sort of flexibility of thought and emotion. It is now time to turn to an area that is often assumed to give nourishment for such virtues. It is this encounter between literary text and reader, with the author enigmatically involved, which will be the focus of my interest. This understanding will then, in chapter 5, be brought into my analysis of the way literary texts may influence clinical work.

The first part of this chapter will hence be devoted to an understanding of literature and literary experience. Thereafter, I will turn to the relation between ethics and literature. Here, the importance of hermeneutic understanding in relation to aesthetic experience will be explored, and will be found to be of crucial value to ethical judgment. The central role of emotions in this process will be outlined and more specifically the interplay between the cognitive and the emotional aspects of our understanding. Finally, I will take a look at the role of ambiguity in literature and the notion of catharsis will appear once again.

The reader will find that there is in this chapter a strong emphasis on literature as knowledge of the world. This knowledge is here understood as inseparably emotive-cognitive in nature. Literature is, in my view, basically a way of relating to the world. Any theory that looks upon literature as mainly self-referential will be rejected. During the last decades, this has not been an uncontested way of looking upon literature. Hence, I will in what follows argue for the relevance of literature for understanding the world.

3.1 Understanding literature

Literature is a peculiar phenomenon. Many, though certainly not all, would testify to the importance it has for their basic orientation in life. Many would point to literature as a source of entertainment, of relaxation, of reflection, of company. A few would go as far as saying that a life without literature would not be worth living.[2] Given this importance for a presumably large number of people, it is a bit strange that if the same persons were asked to define what literature is one may expect the answers to differ considerably. There would hardly be any controversy about including the works of Charles Dickens, of Albert Camus, of Margaret Atwood or Margeruite Yorcenar into the concept of literature. But what about the Bible? What about *Das Kapital*? What about cartoons like *Superman*? What about popular scientific texts or biographies?

It hence seems as if the concept of literature is elusive. It may be that the wisest solution to this is to pragmatically confess that the search for a sharp delimitation is a hopeless project. In fact, and as Stanley Fish proposes, we should perhaps

call that literature which is considered to be literature.[3] Of course, this suggestion in turn raises numerous questions such as: By whom? By how many? At which time and on which grounds? Fish's point is still clear enough. There is no essentialist definition of what literature is, nothing invariably defining a literary text. We may quarrel about certain cases, we may realize that whether something is allowed to be seen as literature or not may influence its status and we may agree that not any text will do. Still, we continue to lack the clear cut criteria for inclusion and exclusion

Literature is a certain sort of text. What, then, is a text? The concept of text seems to be as tricky as that of literature. There is an almost overwhelming number of different texts, with different purposes, structure, style, length. Even if we combine our concepts here, literature and text, and talk of "literary texts", we will as just noticed face challenging tasks defining what this "literary" means, and to choose the kind of literary texts that we are interested in here. Again we may encounter a wide array of different literary texts. What is characteristic of these different texts? Texts may fall in a shady borderland between the documentary and the fictive, they may be very short like aphorisms, they may be synopses for films. Obviously, these are very different sorts of literary texts and this fact of course increases the challenge of finding something that is common for them all.

3.1.1 Literature and the world

The discussion concerning the relation between literature (fiction, written narrative) and the world has been going on as long as there has been philosophical reflection. As Kevin Vanhoozer writes, "the interpretation of texts lies at the center of western history and culture".[4] Hermeneutics as a study in its own right was born in the early 19th century. It was the interpretation of texts that was then in focus, and texts then meant predominantly Biblical texts. Friedrich Schleiermacher is associated with the first attempts to give a structure to the reading of texts. There is for Schleiermacher no doubt that it is the author's intention that decides the meaning of the text. When this intention is recovered, we know what the text means. Interpretation hence, in a way, at least partly collapses into psychology.[5]

Not surprisingly, the critique against such a position has been strong. Still, the referentiality of the text – the assumption that the text is related to the world around us – was never seriously questioned until at the middle of the 20th century. When the so called New Criticism appeared in the late 40´ties and the 50´ties, the structure and the formal aspects of the text came into the foreground. This shift of focus paralleled a turn in philosophy towards language, sometimes called "the linguistic turn". Structuralism looked upon the literary text as a sort of machine governed by laws of semiotics. The interest turned to what the text *is*, rather than what it is *about*. Gradually, the idea that the literary text referred in some way to "outer" realities faded into the background, to vanish even more with the advent of deconstructivist philosophy in the 70´ties and 80´ties.[6]

Kevin Vanhoozer somewhat maliciously calls the deconstructivists Undoers. The very essence of an Undoer is for him Jacques Derrida. What Derrida does, according to Vanhoozer, is to "undo" meaning. The assumption, so widespread and almost intuitive, that there is a meaning in the text, and that this meaning is somehow related to the author's intention and related to the world which surrounds us[7] – this set of assumptions is questioned, or at least made far more complex, by deconstructivists. The text, according to them, is basically referring to nothing but itself. If this is the predominant deconstructivist position, it may be called an extreme epistemological relativism. There is no favoured view of reality, no authorizing perspective, no privileged position. What remains is an endless number of perspectives, all dependent on historical and socioeconomic perspective – the one no better, more true, than the other. The author vanishes, the meaning of the text becomes elusive, and the role of the reader is to be involved with the text as a sort of playful trying out of textual possibilities, all referring to other texts or to the text itself.

The reaction against Derrida was strong, and it is possible that he was, and is, often misunderstood in the debate between defenders of deconstructivism and those who held on to ideas of texts as referential. Appropriately enough, then, Derrida's work has given rise to a sharp conflict between conservative and radical, right-wing and left-wing interpretations, writes Vanhoozer. According to him, Derrida "undoes" not only the meaning and referentiality of the text but also large parts of the western philosophical tradition. And he does this in a language that is often more poetically obscure than lucid, more literary than philosophical. Nevertheless, Vanhoozer concedes that he has also had and has supporters who look upon his contribution as seminal and upon him as a deeply

serious philosopher – and who deny that Derrida has ever rejected the idea that literature is indeed referential.[8] Hence, whatever we call the ideas of Derrida – postmodern, poststructuralist, deconstructivist, non-realist – they have no doubt elicited responses and philosophical exchange that has been of value to the debate about literary meaning and experience. One possible response to Derrida's (and others´) challenge is an increased humility concerning the power of reason and an increased scepticism against too naïve ideas about the relationship between the text and the world.

The momentum that gave so called "postmodern ideas" such a strong position among many social scientists, as well as among quite a few literary critics and some philosophers , seems to have weakened considerably around the start of the new millennium. Swedish literary theorist Torsten Rönnerstrand points to a number of factors that may have contributed to this[9]: the disclosures in 1987 about the leading "new critic" Paul de Man and his sympathies for Nazism during the forties; the acceptance and publication in *Social text* of an article by American physicist Sokal that ridiculed the jargon of some postmodern writings[10]; the rediscovery and renewed influence of the canonical work of literary theory and history by Erich Auerbach, *Mimesis* – and most likely also the accumulated weight of all responses of philosophical nature to the postmodernists. The result of the waning of postmodernism is that there is now talk all around about "the ethical turn" and about the relevance of literature for the understanding of and coming to terms with the realities under which we live our lives. However, this does of course not mean that all the intricate questions about *in which way and to which extent* literature relates to the world have become superfluous. On the contrary, there seems to be a renewed interest in

philosophical aesthetics and in the philosophy of literature, and we witness how novels, poetry, short stories and drama are now often looked upon as potential tools for a richer understanding of certain aspects of reality. But before proceeding in this direction, it will be of value to take a look at some basic elements of literary theory.

3.1.2 The concept of text

The most basic phenomenon to approach is exactly the text. What is it in fact? We have earlier seen that the concept of text may be used in an extended way, so as to include what would in ordinary language not be called "text". I will soon return to this. Let us first look at narratologist Mieke Bal's attempt to define what a text is:

> … a text is a finite, structured whole composed of language signs. The finite ensemble of signs does not mean that the text itself is finite, for its meanings, effect, functions and background are not. It only means that there is a first and a last word to be identified; a first and a last image of a film; a frame of a painting, even if those boundaries, as we will see, are not watertight.[11]

The strange thing about this quotation is, of course, that it starts out with the perfectly intelligible assumption that a text consists of language signs and ends by bringing in paintings and films. I will maintain that a film is not a text, though there may be a text behind what is spoken in a film and the dialogue may be written down as a text. And a painting is definitely not a text, as it is not linguistic at all. It may be spoken of, described and analyzed by means of words but it is not a text. A literary text, then, will be "a finite whole of

language signs" ordered in such a way as to create semantic meaning and to conform to the conventions of what is called "literary".

It seems likely that the everyday understanding of text, and what a text "does", is much like what Swedish literary theorist Anders Pettersson calls "the transportation metaphor", or "the container metaphor".[12] We tend, Pettersson maintains, to think about texts as somehow "containing" a message or a meaning, peculiarly hidden in the physical object – most often a white paper page with black letters on it. This meaning is "put" there by the author – or more general: the originator of the textual message - and is "transported" to the reader. This transport may take place by ways of a book, a newspaper, a small piece of paper, a stone – or even sand on a shore. As Pettersson notices, this is plain nonsense if it were to be taken literally. There can be no such thing as a meaning in some way residing "inside" a book on a shelf, except exactly in a metaphorical sense. Still we tend to think so and there have been numerous attempts to rescue this common sense understanding of a text.[13] How deeply ingrained this metaphorical language still remains is shown by common expressions like "I found such interesting things in that text!", or "This is a text full of joy and sorrow!". Most of us would probably be inclined to look upon such expressions as an innocent and practical way of speaking about a somewhat enigmatic phenomenon. Where else would these "things" be if not "inside" the text? Pettersson, however, does not share that assumption. He thinks that the idea that something is hidden inside the text, even if taken metaphorically, is systematically misleading, and of course at closer look counter-intuitive, in a way that makes it useless for a deeper understanding of what a text is – and for the

further and related question about what literature is. I will now take a look at some of his arguments.

A poem may be said to exist as the author's words written with ink on a piece of paper and is subsequently printed and copied within a book, perhaps in many identical copies. Which of these physical artefacts, then, is the text? Is it only the ink on the paper? Or ink plus paper? Do all copies of the book contain the text? Or must we speak of the "true" text and the "imitating" copies? Perhaps such hopeless questions may be avoided, Pettersson hopes. The text written down may then be seen as a linguistic sign sequence created with an intention. The intention is crucial. Without the communicated intention it would be impossible to understand within which framework of reference it should be understood. There are all sorts of signals to the reader which kind of sign sequence this is (i.e. a linguistic sign sequence). If the reader is acquainted with those rules and conventions and if he reads according to them, the communicated content will be retrieved, though hardly *exactly* the way the author intended it. Hence, the meaning has never been "inside the text" in any meaningful sense, argues Pettersson:

> …the author communicates with his audience by producing a *physical object* – for instance a page of handwriting which can be made available to interested readers. The paper exhibits physical traces – for instance patterns left by a ballpoint pen. These traces represent a *sign-sequence* – for instance, a sequence of English words and punctuation marks arranged into lines and stanzas. Author and reader expect the physical object to make it possible for the reader to reconstruct the sign-sequence and, in the next step, the *intended meaning* that the author wished to convey to her (and then use this intended meaning to initiate a literary experience).[14]

If we look upon novels, poems or short stories in our bookshelves – and upon instruction sheets, signposts, advertisements etc - as "communicative objects", does a pragmatic approach like the one presented provide the kind of understanding that helps us to see the fundamentally mutual nature of a text? Once again, in the words of Pettersson:

> What we really do in reading, I maintained, is reconstruct and react to an intended meaning, starting from the physical traces on the paper and from our own knowledge and experience. In that connection we might indeed be said, in a sense, to encounter a genuine, external object. At least we form an idea of such an object: the author´s intended meaning.[15]

We may perhaps stop to ask ourselves if Pettersson´s notion of a text goes beyond Bal's definition, to approach the definition that Drew Leder used in his article on medical hermeneutics? As we saw in 2.2.5, Leder proposes that a text is "…any set of elements which constitutes a whole and takes on meaning through interpretation.". I believe that the reply to Leder, if we follow Pettersson, would be that indeed not any set of elements is a text but only those sets of elements that we conventionally think about as texts, indeed in much the same way as Bal talks of a "a structured whole composed of language signs". Texts are such sign sequences that are made up of letters ordered in a way as to be intelligible through linguistic understanding. The literary work will here be regarded, not as an autonomous language machine referring to itself and other texts, but as an invitation from one person (the author) to other persons (the readers) to take part in a common act of creation – the creation of literary meaning.

Umberto Eco has called the text "… a machine conceived in order to elicit interpretations".[16] It is worth noting that texts were from the beginning usually read aloud for others. A text that is listened to while read is different from a text that one reads quietly with the freedom of interpretation that this gives. This freedom of reading is the theme of Albert Manguel's *A History of Reading*.[17] He notes that the power of the written makes it tempting to try to control it. The power over reading became the power over the mind. Quiet reading is a late phenomenon. It gives reading a freedom from outer rule, and almost at once gave birth to censorship and index. We will soon see that this freedom of the quiet reader is not an uninhibited freedom but rather a freedom under responsibility.

This is close to the question concerning the possible differences between oral and written semantic communication. Very much has, of course, already been said about this, from the very birth of *logos* in the Greek world of *mythos*.[18] It has for example been pointed out that the text "freezes" the communicative content, that the reader may meet it over and over again and that it may consequently be the subject of repeated interpretation. Texts live during long periods, they work over time. Oral communication is less long-lived. It can only be transmitted by being remembered and retold (if it is not read text) - and is hence usually also slightly transformed in every passage from narrator to listener who becomes the new narrator. One may remind that Plato was generally suspicious of poetry and of art, for several reasons. In his dialogue *Phaedro* the dangers of reading are discussed. Plato lets Socrates warn Faidros against writing things down. [19] Such writing will be prone to create misunderstanding, the reader becomes uncritical

and slave under the text, or he becomes hypercritical and maltreats the text. To this topic I will return below in connection to the role of narratives.

3.1.3 Author and reader

The question of meaning in a literary text is exceedingly complex. It is, however, so closely related to my fundamental question about the moral significance and the combined cognitive-emotional relevance of literary texts that it cannot be ignored. Before addressing it, I will take one more look at the interplay between author, text and reader. In this, I will be inspired by Swedish literary theorist Anders Tyrberg who has proposed a way of looking at literature that I find very attractive in general, and particularly in relation to my purposes here.

The literary text is not transparent, Tyrberg argues. The act of reading must be seen as the answer to an appeal, as a reaction to a *request,* to an *address.* If the literary text, as we have seen, may be regarded as presentational communication, Tyrberg wants to stress the etymological links between communication and *communis,* community, also containing the Latin word *munus*, meaning gift and duty. He asks us to see this pair of words as a clue to our understanding of literature. The text is munus and communis and "mediates" between author (intention) and reader (application or reconstruction). The text creates a common ground where reader and author meet. This goes on by means of "a contractually governed interplay between written and reading":

> But this interplay isn't always harmonic and free from problems. The *request* and the *address* of the author may cause objection and the reader may for different reasons offer resistance *(my translation)*.[20]

What kind of "contract" is this then? Of course there are no explicit rules written at the start of the reading. But it is just as obvious that there are a number of prerequisites for the act of reading to be meaningful:

> A necessary condition for communication even to come into being is of course an attainable mutual semantic code, but such a system of signs constitutes only a minimum of common text from which the activity of interpretation may depart. Had it been possible for us to stay content with only linguistic conventions, communication would be free from problems. It is, however, made more difficult by the fact that author and reader come into the language game from different positions in space and time, with different pre-understandings, intentions and expectations.*(my translation)*[21]

The important thing here is how Tyrberg at the same time stresses the vulnerability of literary communication, how easily it may go wrong, and its enormous potential. If a strong emphasis is placed on its communicative aspects, it follows that it would be almost absurd to think of the text as if there were no intention behind its creation, as if there were not something that someone wanted to say with it:

> At the same time it is almost self-evident that such an intention must be assumed if we are to allow ourselves to be involved in the risk-taking that serious communication means *(my translation)*.[22]

Address and appeal are the key notions here – and *answer and responsibility*. To think about literature in this way means that literature is seen as ethically relevant and reading as a moral act. The ethical appeal arises out of the shared predicaments of being human and vulnerable and part of a community tied

together by mutual rights and obligations, and also out of the fact that what happens to the fictive characters could – mutatis mutandis – happen to me and my closest. The literary text is potentially meaningful, not "full of" meaning, by being able to give rise to meaningful experiences. How then does a text acquire meaning, and what do we mean by saying so? Why is it "meaningful" in a way that can make us laugh, cry, long, hope or fear – and increase our knowledge of the world, even though it is exactly presentational, with no ambition to be factually correct?

3.1.4 Interpretation, meaning and understanding

I have already several times employed the concepts meaning and meaningful. It is not without some hesitation that I do this. Few concepts are more tricky – and disputed. The same goes for the related notions interpretation and understanding. We seem to use them without thinking much of their complexity and lack of exact connotation. Possibly, it is precisely this vague and open character that makes them so useful for communicative purposes. They have wide denotation and connotation, a fact that makes them suitable for many different purposes.

This has been the subject of innumerable philosophical digressions and I would perhaps do well to stay outside of this challenging controversy. But I will still attempt to find a way of using these concepts that helps my further analysis. The reason is that it would be unsatisfactory to avoid all the time these notions, as they are so crucial for our chances to talk about what goes on when we read and

also when physician meets patient – and, as we have seen in chapter 2.2 and will analyze further in chapter 4, when persons get ill.

Let us start from the assumption that interpretation is a search for understanding. A successful interpretation, then, results in understanding. If I do not understand what I read, my attempt to interpret may be said to have failed. Understanding seems to be related to meaning – at least if we thus link meaning and interpretation. Most of us would, I believe, agree that meaning is something that appears when we understand. Understanding, so understood, is the discovery of meaning.[23] Something, like for example a text, "makes sense" when we understand. We see a structure, pattern, a point made, a coherent content, perhaps an intent. We find ourselves making associations, experiencing emotions, drawing conclusions, making conjectures. It is tempting to think that if we are puzzled and bewildered, if we "don't get it" – then there is no meaning in the text. Or is there perhaps a meaning to be discovered that we are just not able to get at – to "discover" or maybe to "construct"? Perhaps the bewilderment and the restless search for understanding may be said to be a sort of meaning. Could, perhaps, the understanding of a text appear without interpretation, a sort of momentary fit between me and the text? Like looking up from the page, exclaiming "Yes this is how it is! Heureka!" (Metaphors could perhaps work in this way when they fit perfectly into the reader's experience.) If not, is interpretation associated with a conscious effort to think about meaning – whereas if I do not strive for meaning at all and it appears just "by itself", I do not have to interpret?

It may be claimed that meaning is an exclusively subjective phenomenon and that it is "constructed" by the reader during the act of reading. The reader sovereignly "constructs" the meaning in the reading process. There is nothing more or less than that. The intended meaning of the author is then totally irrelevant. The meaning of a literary text would hence be a wholly subjective category, totally relative to reader and in turn to the time and place of the act of reading. Any meaning and hence any interpretation is then legitimate. The reader is free and should exert her full freedom without second thoughts on what the writer may have intended (something that will moreover never be known, sometimes not even to the author herself). This may seem tempting but I will soon try to show that this position has serious draw-backs and ought to be abandoned.

I must return to the idea of literature as invitation, as call, as an act of communication and what it may imply for the question of knowledge through literature. If the author invites the reader to interpret the text in order to understand, where does meaning come in? We may of course conjecture that the reader through interpretation is led to an understanding, and that meaning is closely connected to understanding. But are we helped by this? It seems that meaning will then be hopelessly linked to the use of two other complex and highly vague notions, which doesn't really clarify much. And moreover, as just noted, it seems questionable whether it is really the case that interpretation necessarily preceeds understanding. Michael Wood rightly asks:

> How is it possible to see an object according to an interpretation?′ Literature doesn't answer this riddle but enacts it constantly, offering what seem to be

> direct perceptions intricately intertwined with often elaborate interpretations.[24]

Wood goes on to cite Paul Fry's argument about "the suspension of knowledge in literature", and describes this as moments of "ostention, in which people and things are held in their non-signifying opacity". I think that what Wood is saying is that the literary experience is a peculiar combination of immediate, "pre-reflective" elements and more or less elaborate reflection on what has been read. This need not be in temporal sequence (though it may often be). We can "sense" a text at the same time as we ask ourselves what it is about, and the sensing may strike us as just as much a part of the understanding, of the "literary meaning", as the reflection. If this is true, it is certainly problematic to apply any schematic "interpretation-understanding-meaning" model on the literary experience.

If, however, we stick to meaning as an essential element in the act of reading, is then this meaning something residing "in the text" or is it something in the head of the reader, or the author, or is it maybe both? Following Vanhoozer and Tyrberg we may avoid the either-or dichotomy, the hopeless stalemate between the constructivist position and the realist. Literary understanding and meaning, as noted above, result from the combined efforts of author and reader, and the text is best seen as a physical object that is taken as an invitation to certain desired experiences. These experiences consist of thoughts on what is read but there are also emotions inseparably accompanying the thoughts.

It has just been noted that the concepts of meaning and interpretation are closely linked. The reader interprets what she reads. I suggest that we see this as a reaction to mental representations conveyed during the act of reading. The reader "processes" the mental representations evoked in the act of reading: associate, compare, conclude, object, react, sympathize, dislike, worry. I have described this process as emotive-cognitive. It is usually pleasurable but not necessarily. Its material is fictive yet it is about the world and through it, knowledge is gained. How is that possible?

3.1.5 **Literature as knowledge**

As noted above, Michael Wood calls a collection of his essays from 2005 *Literature and the taste of knowledge.* There, he frankly declares that he has given up his earlier belief that "…literature doesn't know anything and can't know anything". Wood "…no longer wants to disentangle literature from other human affairs."[25] But how, then is literature "entangled" with the world?

Wood's essays are an attractive attempt to answer to this question. I think his own words in the introduction constitute a good enough summary:

> Literature, I wanted to say, isn't like this, it's the place where doubt never ends. But this isn't right. In fact, it's dangerously wrong. The entertainment of possibilities in literature – and literature, in one crucial aspect, just is the entertainment of possibilities – resembles doubting, and is probably a good school for informed doubt. But it is not doubt, precisely because, in literature, alternatives are in play but not in contention. We are interested not in the choices we are going to make but in the choices we could make, and we can always go back on our

> interpretative decisions. Indeed, we shall be better readers if we do go back on them, and there is no equivalent in practical life for the sheer disinterested attraction of this multiplicity of chances.[26]

I have cited Wood at length because there is a lot here to reflect on. What seems particularly relevant in the present context is how strongly Wood stresses the openness of literature, its intimate connection to potentialities, to the "could-be" and "would be" of our lives. Salman Rushdie in the same vein has talked about literature as a room of possibilities in a large noisy house, a little room to enter where many sorts of life, many life worlds if we want, exist and are tried out.[27]

But this isn't really *knowledge*, is it? If literature invites us to know the world better, what do we then mean by knowing in this context? To know may of course mean several things: to establish an empirical fact, to be familiar with something or someone, to have deep personal knowledge about a person or a phenomenon, to possess a capacity to handle and perform a certain procedure or set of procedures. To know medicine, for example, seems to be an instance of several of these connotations. I know medicine if I know a lot about bodies in health and in disease but I surely also need to know how medicine works in general, be used to and able to handle medical devices and routines of many sorts - and also be deeply familiar with the experience of being ill.

Literature knows, and it does something to us when we read. I lift the book and start reading. The black letters come alive, or if one prefers: the black letters set my thoughts and emotions in motion and in doing this give rise to emotional and cognitive responses. These responses are the possibilities that Wood talks about.

These responses are not exclusively about the literary universe that the text conveys, they are in an important sense just as much about "the world". They bring with them a kind of knowledge, or perhaps better, in Wood's somewhat cautious formulation: a taste of knowledge. It is a knowledge that is akin to what we are used to calling knowledge but has distinct features. I will attempt to outline some of these.

Literature, says Anders Pettersson, conveys representations of the world. Because these representations are not closed, not definite, they are open to modification and reactions of doubt, affirmation, indignation, rejection, joy. Fictional statements about the world, as in what has above been called presentational discourse, are exactly possibilities inviting us to compare their content with, associate to, try against, and modify our view of persons and events.

It follows from this that literature is not innocent. If it were, there would be no "taste of knowledge". Literature can seduce. Literature can take such a strong hold on our assumptions as to distort our understanding of the world. Literature hence seems to have a potential for deepening our understanding and making our way of looking upon ourselves and others richer and more complex. With this, as its darker follower, goes the potential for distortion and simplification. This is one of the inevitable challenges of this investigation that will be further dealt with in chapter 5.2.

3.1.6 The responsibility of the reader

The view of reading that has emerged from this analysis is one that looks at the reader as free to read according to his or her own interest, background and preferences, but not unrestrictedly free. The reader exerts freedom under responsibility. The responsibility grows out of the fact that the reader is invited by the author to receive the literary text and to handle it in a way that shows respect to the author's intent, but also to the reader's own interpretive capacity. The author cannot bind the reader, cannot dictate which interpretation is appropriate and which is not. This does not mean that any interpretation is as good as any other. There is an authorial intent, and built into the text there are norms of interpretation, there are genre conventions and other indications from the author to the reader. And the semantic structure of the text is itself restricting the reader's freedom, even when it may be very open to different interpretations. Of course, these are subject to cultural and historical variation, but this fact does not render them unimportant or totally arbitrary – because they were the very preconditions for the communicative act to come into being at all. The example of Camus´ La Peste was earlier given. It would be preposterous and indeed offensive to Camus to say that what this book shows is that the strongest should win and that we ought to succumb to oppressive power. If I flatly say "Well that's how I wish to read it and interpret it", I ought to be corrected on the ground that I am just plainly mistaken.

George Steiner has in a few words captured an essential aspect of a work of art, as for example a novel or a poem or a drama:

> I take it to be a moral and pragmatic fact that the poem, the painting, the sonata are prior to the act of reception, of commentary, of evaluation.[28]

What does this mean, then, for the reader? If the reader does not create the work, if the reader meets the work when it is already there, there must be a responsibility to be truthful and honest to its character, to what it is – in the case of a literary text a communicative act with an intention that may be recovered. In Vanhoozer's words:

> *My thesis is that in reading we encounter an other that calls us to respond.* With Steiner, I view this as the moment of transcendence in interpretation (…) (*author's italics)*[29]

What, then, does responsible reading mean? To read attentively, one may suggest, means to be in an important respect open-minded, as far as possible to let go of preconceived judgements about the text, to allow for the text to "work on" oneself. Earnest reading is similar to what Kevin Vanhoozer calls *proactive* reading. Here, the reader responsibly acknowledges the invitation from the author, and sets out with a serious intent to meet the text on its own premises, so to speak. The objection that this is impossible, that there is no neutral, unfiltered and "clean" reading is largely beside the point. The important thing is the reader's will to understand, to be moved and maybe even shaken by what is read, to let the text "spin", as Wood so eloquently puts it.[30] This will not happen if the reading is *hyperactive*, and the reader incessantly interprets, reflects, infers and concludes – and is hence never able to perform the above mentioned "ostention of judgement"; neither will it if the reader is *inactive*, does not respond, reads disinterestedly and resists the invitation to be touched; finally, a *reactive* reading is one where the reader is struggling against the text, fighting it, and also in this case the *munus* that Tyrberg writes about will not appear.

The responsible reader, in Vanhoozer's words, is an *answerer.* The encounter with the text is an encounter with the work and with the "face" of the author – a face to which the reader must respond through a work with which he must grapple. There is a sort of humility involved in this responsible reading – a wish to understand that coexists with a realization of the limits of understanding and a sense of the text "escaping" from full decoding. The text is not fully deconstructable and this fact emanates from its communicative character. The author's call is always in a way larger than the reader's reconstruction of it. Interpretation never exhausts the possibilities of a literary work. There still remains, after all interpretive efforts, meaning to discover.

Of course, these ways of reading are ideal types in Weber's sense. They seldom exist in pure form and they coexist in bewildering mixtures in most people´s reading. However, there is an argument to be made for comments between readers of the same novel, like: "You didn't really give it a chance, did you?" or "You misunderstood it because you didn't really want to understand". If deconstructivist critics were right, such utterances would be totally meaningless and beside the point. It is my conviction that they are not, and that, however misused comments like these at times might be, they play an important role in our development of aesthetic, in this case literary, experience and judgement. To state this does not imply a return to fixed and rigid interpretive schemes, on the contrary. But it means that interpretation goes on within limits set by what is reasonable, but that are still often relatively wide. Not any interpretation will do. And if there is conflict in interpretation – which there is bound to be – this is not because there exists no meaning but because, as Vanhoozer notices, "literary knowledge, like all knowledge, is provisional

and open to correction".[31] The open, hypothetical, unfinished character of literature - its knowledge of indeterminacy, ambiguity and paradox - is a wonderful invitation to the reader to partake in an enrichment of the world. Or, as Wayne Booth expresses this:

> Each narrative, fictional or historical, provides an alternative story set in a created "world" that is itself a fresh alternative to the "world" or "worlds" previously serving as boundaries of the reader's imagination.[32]

Different literary texts invite to different sorts of reading. There are numerous more or less subtle signs with which the author directs the reader towards certain ways of approaching the text. The notion of *genre* is of course crucial here. Indications of genre may deliberately be misleading. Authors may play a little with the reader by sending false or ambiguous messages about how the text ought to be received. Or the author may suddenly shift genre, permanently or temporarily. Genres have built in rules. Genres create expectations and when expectations are let down or remain uncertain, readers may discover unexpected aspects of a text. Author and reader become involved in an intricate play of expectations and surprises. It is exactly because the reader is earnest and responsible that this playful "game" may go on. Responsible reading involves an attempt to respect the author's indications of genre. If there were exclusively distrust or indifference, if the reader did not take some things for granted, what ground would there be for surprise?

A number of questions could be asked about the preconditions and circumstances for responsible reading. Is there anything that could be said

about this in general? This question must be postponed until later in my investigation, when I discuss further the role of dialogue on reading experiences. Having now taken the first steps to establish how reading may be seen as a fundamentally ethical activity, it is time for me to turn my attention to literature's potential for influencing our moral reflection and providing readers with experiences that may prove to be of importance for their orientation in life.

3.2 Narrative, imagination and the ethical dimension

> *The ability to understand and sympathize with others reflects the multiple nature of the human being, his potentialities for many more selves and kinds of experience than any one being could express.*
> Louise Rosenblatt[33]

The last decade has seen an explosion of interest in stories, in narrative as a basis for understanding the world. It has become almost trivial to assert that narratives are crucial for creating meaning and structure in life. So intense has this interest been that it may be debated whether the notion of narrative has now been exploited beyond reasonable limits. However that may be, I will make an attempt to look into it before moving on to some introductory reflections on ethics and literature.

3.2.1 **Man the story-teller**

It has been said that stories are as important for human beings as are food or water. Why, then, are stories so important? Why this wish to organize them into texts? If a number of events were collected together and described with no intelligible relation to each other and with totally uncertain temporal ordering, this would hardly qualify as a story. Stories are a way to create intelligible, or at least potentially intelligible, patterns. Events in our lives are understood through causal and/or intentional relations, and most often in temporal sequences. Things happen in some sort of order and for different reasons (though these may of course be difficult or impossible to discern). Together these sequences of events may be ordered to form a pattern, the story. The same events could obviously have been ordered in another way and hence made up another story.

A chaotic reality will lack coherent patterns and hence prompt a search for meaning through the construction of a story that orders the seemingly meaningless events into patterns that "go together", "make sense". But this should not be taken as if we first experience reality as chaotic and then by an act of intention start to organize into "stories". The patterns usually come to us immediately, they are "seen" by our structuring perception, our "ordering eye". It is when this automatic ordering of the world doesn't work that the active search for coherence and structure appears. New and unexpected events, as for example the onset of illness, may initiate a search for meaning by ways of a story, or a set of stories, more or less comprehensive. The already "ongoing" stories must then be more or less remade, restructured, adapted so as to fit with the new events that have occurred. Unexpected events thus challenge the preexisting understanding of our lives, often expressed in stories, and call for a reorientation.

The ways they are ordered largely decide how they will be valued. The meaning-creating story is the basis for our attitudes towards things, persons and events.

Events are ordered into stories in a linguistic form, the narrative, oral or written. Anyone who has tried to write down what was on their mind during a day in life – or for that matter an important memory - will experience that the ever changing nature of our inner world, where images live side by side with diffuse moods, elaborated lines of thought in verbal form with non-linguistic sensations, often defy linguistic formulation. The text written down will inevitably only "freeze" some aspect of this rich and often ambiguous mental content. There hence seems to be a sometimes painful discrepancy between our inner mental states and our attempts to capture these into words, however far modern literature may have taken this endeavor. It is interesting that impressive attempts to overcome this gap, like James Joyce's novel *Ulysses*, have to stretch the rules of the language game, in order to approach something like the flow of "inner" language. Perhaps we may say that there is a somewhat tragic aspect to our craving for stories, that these stories will go on and on, be remade and restructured, partly because they will never fully succeed in capturing either the inner world or the outer. The world is always richer, more enigmatic, more complex and ambiguous then we will be able to describe in words.[34]

Let us hence look upon narratives as expressions of the deeply human urge to structure, to create meaning, to grapple, to come to terms with and to understand. This doesn't mean that stories are always serving an explicit purpose. We may rather think of them as a mode of being-in-the-world, an expression of a deeply human urge to orient and to structure. As for literary

stories, we may think of them as imposed purposefully upon the events of life, a mastering of a chaotic reality from a sovereign position, the author's. The author, as any story teller, is bound by our intersubjective understanding of the world. Even when stories push the limits of the reasonable into the fantastic and "unreal", they will still depend on exactly the shared interpretive norms of communities.

Stories are also told to control, to master, to offend, to dominate, to oppress. There is, of course, nothing necessarily nice and innocent about stories. They may be liberating, they may be amusing, they may be indifferent, they may be dangerous. This goes for fictive stories, made up narratives, as well as for stories based on "facts" – that is: for informational as well as for presentational discourse. Stories may be grand stories, like religious myths, ideologies or major scientific hypotheses, or they may be inconspicuous every day stories of minor things happening to us. The grand stories, the "Stories", have moved people to heroism, to cruelty, to mercy, to hope and to fear – the world religions, the great ideologies of the 18th and the 19th century exemplify this. Postmodernism has been suspicious of these "master stories" and see them as having a Janus face - one liberating and one seductive. But there seems to be no reason to assume that grand stories are always dangerous – they may or they may not be.

Literature is mostly stories, "invented" stories, "imaginary" stories. If we think about the dividing line between the imaginary and the real as clear cut and sharp we are mistaken. Any ordering of events into a story followed by the writing down as a text is necessarily subjective. It involves the exclusion of some elements, the inclusion of others, the stress on certain events and actors and the

relative dismissal of others. This is the very essence of ordering and of structuring into patterns. What is, however, obvious is that the fictive story has *another* relation to the world, different from the factual. The latter may be and should often be checked, fact by fact, against what was the case and what is the case – the degree of intersubjectivity becomes potentially high. We may all agree that it seems reasonably well founded to assert that Churchill took such and such decisions in the autumn of 1940, if the historical evidence for this is sound; whereas Molly Bloom can't be "checked" against anything at all, as she hasn't existed in the sense that Churchill existed. Molly Bloom is "made up" – but Joyce's story is a story that moves us (more or less, admittedly), that evokes our fantasy, stimulates our judgment, sets our associations in motion, thrills us and possibly provokes us. In this sense, by ways of the thoughts and emotions the novel gives rise to, Molly Bloom in a certain sense becomes a real person, her story lives, she is there with us for a while and she may linger on in our minds for a long time after the book is finally closed. Or better: she is at the same time a "real" person, existing like you and me, and an invented person, just a figure in a novel. This peculiar double status of a fictive person and of fictive events accounts, I believe, for many of the possibilities that are inherent in literary narrative.[35]

Having delivered these preliminary reflections on the role of narrative in general I now wish to proceed to a set of questions concerning narrative and morality, or in other words on the relation between literary narrative and ethics. An ideal point of departure for this is presented by Wayne Booth who already in 1990 predated what is now often called "the ethical turn" in literary science and criticism. I will now turn to a short presentation of Booth's thoughts.

3.2.2 Narrative and character

I have so far assumed and argued that we are affected by literary narratives. If so in which way and to which extent? The answer, of course, depends on who the reader is and of course also what and when she reads. This is largely the theme of chapter 5, but I want to make some preliminary remarks already at this stage.

A widespread assumption is probably that the reading of literary texts may thrill, may stimulate and amuse, may even worry – but it hardly leaves any deeper or more persisting impressions on us. It is fashionable, for example, to assert that it is better that young people read, whatever they read, than not having them read at all. This may of course be backed by an argument about "bad literature" as a road to qualified reading. Such a hypothesis is in principle empirically testable and may prove to be right or wrong. More often, it seems, the argument relies on an assumption, tacit or overt, that literature is really morally inert, that all warnings of bad influence from stories are just old styled nonsense and a heritage from authoritarian times, when parents supervised their children's reading as closely as their hands under the blanket. There is, if we follow this line of thought, really no better or worse reading and what the reader, young or old, enjoys and values is good "for him" or "for her".

It is my firm belief that this position must be rejected. I believe that one of the most important reasons for this rejection is based on an understanding of what *character* is, how it is formed and reformed and the role of stories in this process. In this analysis I am inspired by Wayne Booth who in turn relies on philosophers Charles Taylor and Alasdair McIntyre – and, perhaps more important, on an

understanding of how literary narratives have actually proved to influence and even transform people's lives for as long as we have had them with us. Booth takes on this task with caution and humility, and his conclusions are well founded and of great importance for anyone who wants to understand how deeply narratives, and in this case literary narratives, cut into our lives, into our very selves. "In one sense", writes Booth, "anyone who has read with intense engagement 'knows' that narratives do influence behavior."[36] Booth says more than that. He maintains that they form our character in a subtle but decisive way. In a sense, the common phrase "you are the food you eat" is paraphrased by Booth into "you are the stories you read" (and those you hear, we may add).

The concept of character has until very recently been important when describing people, their qualities, "who they are":

> Until quite recently in history, everyone who talked about character would have assumed (…) both that one could make distinctions among bad and good characters – whether in literature or life – and that the ultimate point in talking about character was to improve it, to save one's soul.[37]

Character in this broader sense meant the sum total of a person's capacities, "personal qualities". It is, writes Booth, most suitably to *the habits of conduct* that character refers – and, I would add, also to the inclinations to conduct. Etymologically the word comes from the Greek word for "stamp" or "mark" and we may, as Booth notices, think of it as if character stands for traits, "marks", which are stamped into us as persons. However, these marks, the character, are not finally given or unchangeable. Greek thought is insistent on the perfectibility

of character, on the responsibility of everyone to cultivate it. Anne Hunsaker Hawkins develops this in an article on "the idea of character":

> Character (*ethos*) in the Greek drama is a specifically moral concept. The Greeks made a distinction between a person's inborn nature, which they called *physis*, and his or her character, or *ethos*. *Physis* is a more or less static concept; it is those qualities and capacities that we are born with. *Ethos,* though, is capable of development; it is conformed, strengthened and defined through the choices that we make, for better or worse.[38]

It is exactly for this reason that Plato fears literature – because it tempts the reader away to an imaginary reality instead of striving to the real world of ideal forms, in connection with which the true perfection of character resides.

The ancient view of character has, writes Booth, at least since the 18th century been challenged by the thought that character grows out of something residing "inside" us, our "real self", a sort of personality core. This centre of authenticity is reached through cutting down through layers of insincerity, through alien influences that have been stored upon us through our life experiences. Booth calls this "rampant individualism" and associates it with the romantic movement, though I believe we find traces of it also in the enlightenment's stress on the individual's supreme rights and capacity to develop his and her own life project, undisturbed by outer restrictions. The *Bildungsroman,* from young Werther to Stephen Dedalus, may be seen as an influential expression of this idea, where the young hero in opposition against an inauthentic world finds his deeper vocation and follows his true desires.

Against this Booth places the idea of a social self. Man is no island. We are

> …constituted in a kind of counterpoint of inherited "languages", a multiplicity of voices only the ensemble of which can in any meaningful sense be called "my own".[39]

This will obviously have consequences for the way we think about ourselves:

> If I think of myself not as an atomic unit bumping other atoms but as a character – as someone doing my best to enact the various roles "assigned" me – I discover there are no clear boundaries between the others that are somehow both outside and inside me and the "me" that the others are "in".[40]

When we encounter others, they in a sense move into and out of us. We carry them with us, we have inner conversations with them, even when they are not really there. In this sense, they become part of our stories. We may forget them or we may remember them. It is obvious that this goes for real persons that we have actually met, just like those we have heard of but not met – as well as fictive persons in narratives. These latter may stand before us as real enough, but, as noted above, "real" in another sense than are those persons that are or have been alive.

This is the force of narrative. If encounters with other people are the very source of our moral growth, how could our characters possibly remain unaffected by these encounters, by this "company we keep"? Admittedly, the encounters with fictive characters are different, fiction is not life and a fictionalized narrative is not a narrative of persons needing our help, our compassion, our pity in a

concrete and immediately urging way, the way "real" persons may do. They are hence less morally imperative, may be reflected on in a more relaxed way, permitting a combination of distance and engagement. There is a sort of hypothetical question underlying a literary narrative, and the "as-if" of fiction does not fully go away however involving and capturing the narrative may be. Hence involvement with fictive persons is engaging and initiates emotions and thoughts, but at the same time leaves the reader with an amount of "freedom" in her emotional and cognitive response, a freedom that may often not be there with the challenges that the predicaments of life present. Still, the options, the possibilities, the "roles" here offered, the moral challenges involved in them, cut deeply into our desires, our inclinations, and most fundamental orientations. They interact with them, challenge them, modify or reinforce them. Fictive encounters, like the encounters of real life, present us with the presence of other persons, a presence to be immediately felt and often also reflected on. It is this combination of immediate and unreflected presence of fictive persons and the reflection on what they mean to us that is ethical by its very nature and, as a consequence of this, offers a potential for ethical growth. (I will return to and develop this theme further in chapter 5.1)

To be in good literary company is a wise thing, then, and also to try to make the best of this company. Booth, just like Vanhoozer and Tyrberg, emphasizes the reader's co-responsibility. The reader does not use either deduction or induction, but rather what Booth calls *coduction* to reach judgments about literary texts.[41] Coduction is a process whereby the reader compares, associates and draws conclusions from her literary experience and from her general experience. Coduction is neither exclusively aesthetic nor normative; it is rather a combined

ethical and aesthetical approach, whereby a kind of overall position towards the read is reached. When reading, for example, Conrad's *Heart of Darkness,* the reader will compare it to what else he has read that he may associate to, and also to those personal experiences and circumstances of historical and contemporary nature that he finds relevant. He will appreciate both form and content and he will not separate these two because they cannot be separated. Aesthetics mix with ethics in this process.

By "good company" Booth does not mean the company of stories telling us in a moralistic way what to do and how to live. Good company is company that takes us seriously as reflecting creatures. Good company poses the questions in an earnest manner, rich in detail and complication, and leaves us to search for answers. When, for example, discussing a number of novels that describe middle aged male university teachers going to bed with their young female students, Booth notices that just a few of them – like Coetzee's *Disgrace* –really presents the reader with this as a moral dilemma and invites the reader to think both once and twice about it. If a novel is capable of doing this, it is according to Booth better literature than if it is not.[42]

A result of coduction is also, and this is important for me here, that the reader is invited to reflect on his preferences and desires, in order to develop what Booth calls "second order desires". When I read, I have a chance to discover, Booth suggests, my desires through my reactions to the text and I then reflect on them and develop desires concerning my desires – in order to get rid of them, or to reinforce them, or to modify them and so forth. This is one way to build

character and it is one of the things that could, under certain circumstances which I later approach, come out of the reading experience.

3.2.3 Nussbaum on literature and moral philosophy

Booth's analysis in some respects comes close to Martha Nussbaum's. Nussbaum is probably the most influential voice to speak of literature and ethics during the last decade. My analysis here is based exclusively on her possibly most influential book on these matters, *Love's Knowledge (*LK).

Nussbaum gives, in the first chapter of LK, a short account of the background to her intense interest in the role of literature. She was, she writes, a rather lonesome child, much disposed to reading and obviously a somewhat premature reader. During her school time, she thought and wrote about several problems that she would later think of as "philosophical", but at that time mostly in the form of literary examples and analysis. It was figures in literature, their conduct and their plans, their love, courage and hate that provided the "raw material" for her reflections. It seemed, she writes, "…best to discuss issues in connection with a text that displayed concrete lives and told a story."[43] Later, when starting studying philosophy at university, she understood that the very same issues that she had thought of as concrete and particular questions of fictive persons´ lives were there "lifted" to a general level, an abstract level of universal knowledge, presented in a language totally different from the literary. What had happened to them during that process?

Ethics has been and is still widely regarded as the domain of philosophy, of what is generally called moral philosophy. But, asks Nussbaum, what if

> …there may be some views of the world and how one should live in it (…) that cannot be fully and adequately stated in the language of conventional philosophical prose, a style remarkably flat and lacking in wonder – but only in a language and in forms themselves more complex, more allusive, more attentive to particulars.[44]

Form and content are then, as just noted, deeply connected. Nussbaum maintains that there are forms of expression – in our case and in hers: literary expression – that are especially well suited for certain thoughts and ideas. Some of these thoughts and ideas are those that have preoccupied Western philosophy since its very birth. They are all questions that follow from the very basic wonder of philosophy: "How should a human being live?".

What does "well suited" in this case mean? Nussbaum seems to mean that the subtlety and richness of life's events – and with them the moral predicaments that accompany it - come out better, more accurately, in the literary form. If we are to understand ethics we must, asserts Nussbaum, attempt to get as rich and comprehensive a view as possible of the role that moral perceptions and judgments play in our everyday life. Her position is based on the idea that complexity of thought and a nuanced perception is something valuable because life as we live it is complex, ambiguous and sometimes also tragic. To trace the origin of this assumption, one has to look for Nussbaum's inspiration in ethical thought – which is indeed a philosopher who never wrote a poem or a novel or a

drama. It is Aristotle's thoughts on ethics, presented first and foremost in his *Nichomachean Ethics,* that inspire her. Aristotle, in the "ancient quarrel" with Plato, sided for an ethics that was founded on the conviction that there are indeed "absolute values" but these are many and they are incommensurable, that is they cannot be changed, so to speak, into each other by some sort of moral currency. The existence of these incompatible values neither can nor should be suppressed. This fact makes moral choices "unclean" in a certain sense. In an ethical dilemma, even if our choice may be the best one possible, something of great importance will be lost. There is, moreover, no easy way of discerning which among conflicting values must take precedence over the other. Neither is there, like in some forms of utilitarianism, one single value – well- being or happiness – that outweighs all the others.

The fact that values conflict and the fact that the events of life all the time present us with unexpected but morally important surprises are crucial in Aristotle's thinking. Nussbaum calls this latter fact "the moral significance of unexpected events". Life in this sense is greater than our understanding of it; it surprises us, takes us aback, crosses our plans, crushes our desires or provides us with happiness on occasions when we least expect it. One does not have to be a very ambitious reader of novels to see how predominant this theme is in the "Western literary canon". We may call it chance, we may call it fate, we may call it the overwhelming complexity of causality – whatever the label it is a feature of life that is of the greatest ethical significance, according to Aristotle.

Another important point of departure is the moral significance of emotions. Western philosophy has not always looked upon these with a benevolent eye,

especially not when ethical judgment is involved. Nussbaum takes the Aristotelian position - and has developed it further in a later book[45] - that we are moved by *appetite.* We come to understand and act on a phenomenon of ethical importance through being moved by our emotions and then, at least sometimes, reflecting on them. No answer to an ethical question may be found if emotions are excluded – indeed the very moral dimension of an event will not be perceived if emotions are brushed aside.

Nussbaum's aim, then, is

> ..to establish that certain literary texts (or texts similar to these in relevant ways) are indispensable to a philosophical inquiry in the ethical sphere: not by any means sufficient, but sources of insight without which the enquiry cannot be complete.[46]

To support her argument and to bring out its genealogy, Nussbaum gives her version of the just mentioned "ancient quarrel" between – roughly speaking – Plato's sceptical view of the tragedy and of poetry in general, and Aristotle's defence of tragedy as perhaps the most important way to refine one's moral judgment and come to a richer understanding of life. What the citizens of Athens went to the theatre to see were not aesthetically seductive fantasies with no connection to their pressing personal and social problems, but a drama that cut right into their most urgent needs and convictions. This is where her interest started and this is, as she writes in LK, where her own almost spontaneous conviction about the close interconnection between certain philosophical questions and literature found its nourishment.

Now, may one not suspect that Nussbaum's position is unbearably didactic, that it looks upon literature as a form of moral education and refinement? If so, isn't this an impoverished and superficial way of looking at literary narratives, and indeed also dangerous, at it seems to invite to censorship and protective measures on behalf of those who might be threatened by "subversive" texts? This is an important objection that cannot easily be brushed aside. I must again remind that if Nussbaum – and for that matter Booth – is right about the potentials of literature, if it has the force I have tried to outline above, then it may of course be dangerous. If novels can change their readers, they can do it for bad or for worse. But from this it does not follow that literature pinpointing alleged moral truths or moralistic education is something to strive for. As Nussbaum reminds us,

> Again, far from insisting that literature must play some single, simple role in human life, the best ethical criticism, ancient and modern, has insisted on the complexity and variety revealed to us in literature, appealing to that complexity to cast doubt on reductive theories.[47]

Nussbaum's point strikes me as important, if, as she says, the starting point of philosophical enquiry is "How should one live?" The answer to this question can hardly avoid the factual question "How does one actually live?", meaning how do people actually live their lives. How does a person's life look from "inside"? Can things be seen with another person's, albeit fictive, eyes? What kind of perspective on life may I find if I for a while with the help of Marguerite Yourcenar share my time with King Hadrian, or allow myself to be taken by Ian McEwan to London in 2003 to see a day's events with the eyes of a neurosurgeon? The expansion of experience this brings and the possibilities of a

more complex and nuanced understanding of other persons´ lives – and the world filtered through their eyes - could hardly be unimportant to our capacity for moral discernment and judgment. (Again, this will be further developed in 5.1.1)

We see Booth's and Nussbaum's thoughts converging here. If I keep the company of these literary figures and if I am helped to see the world to some extent with their eyes, my experience of reality will be broadened. I will be invited to take part in the possibly most difficult but most important act of human life – taking a step out of my own world, my own prejudices, my own cherished assumptions and inclinations – to face another reality that is not mine, be it rather similar to it or very very different. If, but only if, I meet a literary text where content and form are able to capture some of the richness of any one person's perceptions of the world, I will find a rich soil for my coductions, my evaluations, of what a good life is, which acts are acceptable, unacceptable, detestable or heroic. I will deepen my insights as to how passions move people to act in certain ways, or how reflection on action may reinforce or arrest their immediate impulses. I will understand – and this understanding will involve emotions as well as cognitive reflection – how tragic choices may appear in our lives and how "unclean" and ambiguous moral reality often is. I will, potentially, be less prone to hasty moral condemnation and more inclined to search for a deeper understanding of peoples´ motives, their weaknesses, and prejudices, their courage and their good will.

I have been writing about ethics and ethical aspects on literature and narrative as if by this could be meant something reasonably precise and delimited. This is of

course not the case. The controversy about how to understand the very nature of ethical values and how they ought to be interpreted and handled is a recurrent theme in Western thought. Any account of it is far beyond the scope of my present investigation. However, the question(s) cannot be ignored altogether since the importance we ascribe to literary narrative will depend largely on how we look upon the role of ethical values in our lives. As we have just seen, Nussbaum – who is so deeply familiar with Greek moral thought and who has perhaps more than any other writer contributed to the wave of interest in Aristotle's ethics - repeatedly stresses that it is the shortcomings of moral philosophy to illuminate, give full justice to, our moral intuitions and our moral deliberations that make literature so important. The finely tuned nuances of the novel help us see how complex moral reality is. As our perceptions become finer and richer, our ethical judgments will follow. As, with the help of among other things literary narratives, we grow in our understanding of the ambiguities and the paradoxes of life we increase our capacity for moral judgment. This is far from the somewhat mechanical application of ethical principles - be they deontological or utilitarian - that has by some been proposed as the essence of ethical deliberation and ethically relevant choice.[48]

However, neither Booth nor Nussbaum have escaped critique. One eloquent and erudite example is Adam Zachary Newton, who – albeit basically favourable towards Booth's and Nussbaum's contributions – in his *Narrative ethics* presents some modest objections to their positions. Zachary Newton sides with French philosopher Lyotard in regarding Nussbaum's analysis of Henry James´ novels as "aristocratic":

> Nevertheless, Lyotard need not even be invoked in order to point out that the models for such perceptual discernment in Nussbaum's account – the Ververs in Henry James´ *The Golden Bowl* – display an assured, aristocratic quality of their judgments which in its very taken-for-grantedness can seem remote and too easy. (…) Clearly, articulacy is the whole point here, since the capacity to say things in a certain *juste* way demarks more finely tuned judgments from those blunter and more crude.[49]

Newton continues by talking of "a kind of chill perfectionism" in Nussbaum's formulations of the virtues of literary texts, as if she means that there was "one single chance of 'getting it right'". He counters by presenting what he calls "an ethics of inarticulacy", or "a-not-so-always ´lucid bewilderment´". But it remains unclear why what Nussbaum presents as an ideal for moral deliberation – to be nuanced and to understand the complexities of moral choice – would be a threat to a somewhat more disillusioned way of looking at our moral capacities. If we are, as Newton seems to be saying, often inarticulate and far from perfect as moral creatures, what would the problem be with striving for more articulacy and more nuances in our ethical deliberations? Exactly those novels which show humans as fallible, as prone to prejudice and self-denigration and mockery – such as, to take just one example, Dostoyevsky's *Notes from underground* – may seem especially promising in offering a chance for moral growth, in the sense of a deeper and richer understanding of human shortcomings – and, just as important, a humility in the face of human weakness, including one's own. Or is it, perhaps, the allegedly moralistic undertones in expressions like "moral growth" that provokes Newton? Nussbaum, however, lends little support to one who would consider her too exclusive in her literary taste – that is, as too limited

in her view of which form would be appropriate for which content. Nussbaum may borrow her examples from Henry James, Marcel Proust and Fyodor Dostoyevsky – but brings in Charles Dickens as well, and there is no reason to think that she could not also have chosen Margaret Atwood, Toni Morrison, Orhan Pamuk or Alexander McCall Smith. There are of course some qualifications to Nussbaum's choice – and to these I will return – but it seems clear to me that she is not advocating an extreme exclusivity of literary expression.

Newton rebuts Booth as well by objecting to the above presented idea of "second order valuings". Newton's objections are those to be expected from someone who at least partly accepts the narratological premise that there is no author behind the text from the reader's point of view, only an "implied author" within the text. This implied author is, then, what the reader thinks is the author, or rather: what the story makes the reader think is the author's voice.[50] He continues:

> This is why for Booth reading a text can be thought of in terms of friendship; for ultimately, it is the author – whether free-standing or represented by his text – who will turn out to be a better or worse friend for us.[51]

The reminder that things happen "inside" fictional texts and that "…we must be a party to these before we construe literary texts as messages sent from authors to readers" may be wise enough. But this is not really, I think, a point of much relevance to Booth's analysis. Far from being "a narratological lacuna" in Booth's thinking, his insistence on the literary text as a form of company is in line with the above outlined ideas of literature as invitation, as call, as

communication. Of course, the company we keep when reading is not the company of the author. We are in the company of those persons who inhabit the stories and we are indeed "a party to these". My point, and I believe also Booth's, is that while we are moved by their thoughts, feelings and actions, we *at the same time* think of them as the author's invitation to us to participate, to engage, to be morally involved. To ignore this authorial intention seems just as pointless as regarding it as all there is to it. The persons of a novel live their lives regardless of any author's wishes – and *at the same time,* the reader knows that they are in the hands of the author. Hence, many readers´ stubborn insistence on talking of what, for example, Jane Austen wants to say by this or that passage in *Sense and Sensitivity* far from being a naïve misunderstanding reveals the fundamentally ethical nature of literary narrative.

3.2.4 Emotions, literature and morality

In 3.1.6, emotions have been defined as affective states which are directed to towards persons or things. The word feeling, by contrast, is a more general concept, including also mood and sensations (bodily feelings). Sadness and joy are moods. Certainly we often conjecture about causal factors behind these moods, but they are not obviously and directly linked to objects or persons as emotions are. Emotions are intentional. They are sometimes almost impossible to disentangle from their object. Fear, love, sympathy, dislike, longing and so forth are emotions with a clear direction and a clear object. I fear *something* and I long for *someone.* I also suggest that we think of moods as very basic, somewhat diffuse feelings, only differing from these in that they are even less easy to identify and understand. The expression "to be in a strange mood" captures this

well. Moods colour and texture our experiencing as do emotions, but perhaps in an even subtler way.[52]

How are we, then, to look at feelings and emotions in relation to literature? To start with, one may, as does Susan Feagin, declare that to respond to a book, whether negatively or positively, necessarily involves a strongly emotional component:

> To appreciate a work is not merely to recognize *that* a work has certain properties, aesthetic qualities, or artistic virtues, nor merely to be able to recognize what it is about a work that gives it these qualities or its value. To appreciate a work is, in part, to get the value out of it, and getting the value out of it involves being affectively or emotionally moved. It is to experience the work in certain ways; it involves "reading with feeling".[53]

I agree with Feagin that "getting the value out of" a literary text will inevitably involve feelings: These will be directed towards the persons of the novel and the things they experience and do. I will here stress that how we understand and value will depend on an intricate interplay between thoughts ("mental representations") conveyed by the text and the feelings, and to some extent emotions, elicited by these, and which in turn will color the cognitive content of the reading process. We may say that cognitively transmitted words give rise to feelings, which in turn color the words and partly change their cognitive content.[54] It seems wise here to speak of a whole complex of cognitive/emotive contents where the images, moods, representations, reflections, associations are intricately linked. Thoughts, mental representations that touch on matters very close to us, close to our deepest values, will generally evoke stronger feelings,

and thoughts of a more general nature, more distanced and impersonal, will be easier to deal with in a predominantly intellectual way. To propose, as Solomon did in his *The Passions* thirty years ago, that the feelings are really what are what our lives are about seems pointless. If feelings are evoked by thoughts, if they are mixed up with each other, if they are mutually interdependent – why would we need to propose the primacy of either of them?

The immediate thoughts and feelings that result from reading – let us call these the prereflective judgement – give us a first appreciation of a narrative. We get absorbed, bewildered, fascinated, moved – or disgusted or bored. These preflective reactions will then, more or less depending on situation and kind of reading, be reflected on. I may ask myself why I feel such sympathy for a fictive character or why I remain indifferent to a series of events in the plot. As noticed above, different literary narratives will be more or less inviting to reflective evaluation. To the degree that such evaluation takes place, and I will later in 5.2 argue that talking with others about literature may be one way of stimulating such activity, there might be reflection both on what the fictive characters and events may tell us of the world we live in and also on my own reactions towards these.

We can assume that some texts will be prone to evoke responses where the emotional content is more prominent (romantic novels for example, at least if they work), while others will rather elicit intellectual reflection. As earlier stated, however, there is no reason to believe that any reading of a literary text may be exclusively emotive or cognitive in nature. Feelings and emotions carry cognitive content. Facts set our fantasy in motion. The characters evoke our

responses and these are bound to be "emocognitive". Appreciation - or if we like: evaluation – will result from a complex mental interplay, characteristically involving human faculties that are necessary for moral judgment in general: primary response, reflection on this, intuitive associations, desires, scepticism, objections, reinforcement, scrutiny – and again and again reflection on these. It is in this way that meeting a literary text has the potential for increased self-understanding, facilitating what in chapter 4 will be developed as phronesis, the practical wisdom that Aristotle saw as the very foundation of moral judgment.

But how do feelings and emotions "get into" texts? Is it even appropriate to talk of them, as we often do, as "inside" the text? I have above rejected "the transportation metaphor" and proposed instead that we look at literary texts as acts of communication whereby an author invites a reader to share a fictive reality, with all the cognitive-emotive responses that follow from this invitation. In a sense, then, the author communicates emotions. Or rather, in line with what was proposed above, the author communicates thoughts that give rise to emotions in the reader's "processing" of them. Some of these emotions are instant, that is they appear continuously as the reading goes on, and others will appear when the reader reflects, more or less systematically, on what was read. There really doesn't seem to be anything strange about this everyday phenomenon which in a sense has its very beginning when parents read or tell their children stories, and the children listen with their eyes wide. But still, it *is* enigmatic how strong emotions in relation to fictive persons may be. How is that possible? We may look upon this as due to identification, because we put ourselves in the fictive persons´ place. Or we may see it as a consequence of sympathy for the other, sympathy that does not really include any "living with"

but still reaches out towards the destiny of another (fictive but potential) human being. The feelings evoked are related exactly to the potentiality of fictive persons – that they *could have been* and that hence *things could have been* as they were described in the narrative. Is it exactly the "as-if", the hidden possibilities shown by the text, that opens up a margin, a gleam of freedom, and hence sets our emotions in motion?

Does the emotive strength of literary texts have any relevance for their capacity to illuminate ethical aspects of human affairs? No, if we believe that a precondition for sound ethical judgment is to push feelings and emotions into the background in order for our ethical deliberation to be as unemotional and detached as possible. Yes if we believe that evaluation usually starts in our emotive reactions and proceeds by an analysis of these in the light of critical reflection and intellectual scrutiny. We have already seen that this is the position of Martha Nussbaum, who is again inspired by Aristotle.

Unemotional deliberation has long been seen as the hallmark of rationality. The bias for such a position in Western philosophy is strong, Nussbaum writes. Emotions and imagination were from Plato on generally thought to corrupt judgment by making it victim to selfish passions and to the irrational forces of human desire. But Aristotle does not share this position. For him imagination (*phantasia)* is a necessary faculty for ethical deliberation. Imagination may capture particulars and particulars are crucial to judgment. Moreover, in order to be rich, nuanced and aware, perception is dependent on the combined emotive and cognitive attentiveness to situations. Following Aristotle, Nussbaum writes: "The emotions are themselves modes of vision, or

recognition. Their responses are part of what knowing, that is truly recognizing or acknowledging, *consists in"* (*author's italics)*[55]

I am in agreement with Nussbaum on this crucial point. I believe, as she does, that we may be threatened from two directions as moral creatures. The one direction, over and over again pointed out to us in the Western philosophical tradition, is when we are overwhelmed by our "passions" and these lead us in a direction that deviates from the morally acceptable. This is a traditional conception of the age old *akrasia* dilemma, acting against one's moral beliefs, and it is usually answered by an appeal to more rationality, i.e. the pushing of emotions out of reach to let the intellect have its chance to pursue the good. There is the opposite risk, too. Nussbaum captures it in the following words:

> Frequently a reliance on the powers of the intellect can actually become an impediment to true ethical perception, by impeding or undermining these responses. It frequently happens that theoretical people, proud of their intellectual abilities and confident of their possession of techniques for the solution of practical problems, are led by their theoretical commitments to become inattentive to the concrete responses of emotion and imagination that would be essential constituents of correct perception.[56]

Somewhat less heavily expressed, we may conclude that bringing imagination and emotion into our perception of a situation helps us see it in a richer way. This does certainly not mean that overwhelming and unreflected emotions help us much, neither that free floating fantasy is of any value in moral judgment. It means that I invite my emotions to illuminate my intellectual analysis and I bring in critical reflection to cast light on my feeling/emotions – in an ongoing, intimate interplay. In so doing, Nussbaum believes that we will get a richer

understanding of moral reality, acknowledging the plurality and incommensurability of valuable things, the ethical weight of unexpected events, the primacy of the particular and the relevance of emotions in moral deliberation. None of this excludes intellectual clarity, interest in and even some reliance on general ethical principles, or some ordering of valuable things. Nussbaum just calls for an adjusted balance that we have, at least sometimes and in certain contexts, lost sight of and to which she thinks we ought to reconnect. Nussbum, as does Toulmin in *Cosmopolis,* urges us to balance the rationality that emerged during the breakthrough years of the new sciences, and that deeply affected also philosophy, with the rationality of Aristotle and the Renaissance writers.

3.2.5 Ambivalence, ambiguity, tragedy, catharsis

Our apprehension of events and their contexts may, as noticed above, be more or less imprecise, vague and uncertain. (This is indeed one of the things that good literature shows us.) The cognitively recognizable features of a situation may seem to point in different directions, and it may be hard to fit pieces of information together. Our affective reactions to things happening may lead to responses where it is hard or impossible to discern the "authentic" feeling or emotion in relation to a set of facts or events or in relation to a person. I may ask myself, "What do I really feel for her?" and come to the answer that I really don't know. I seem to feel many contradicting things at the same time. I experience a hopeless uncertainty. And as these (sometimes contradictory) feelings and emotions will largely form what I assume about the person, how I interpret her actions and words, and as my emotions in relation to her in turn will be strongly influenced by what I assume, my attitude might be locked up

in a self-reinforcing circular movement of thought and emotion, a process that is hard to discover and handle once it starts rolling. We may call this ambivalence, or uncertainty, or just plain human weakness and fallibility. The more correct and nuanced and sensitive our knowledge of persons and events is, the more well-founded our moral judgments will be. The more nuanced and sensitive and well-reflected our moral judgments are, the more appropriate, "true", our knowledge will be.

In our everyday language we would, I believe, be inclined to see the "unclean" affective and cognitive situations of most ordinary contexts as instances of ambiguity. Ambiguity would then mean "pointing in many directions at the same time", or "consisting of different aspects that do not go together" or "appearing hopelessly vague and messy", or something like that. So understood, it means that a sign or a number of signs (in the semiotic sense) carries several relevant and valid meanings. In Wikipedia, ambiguity is described as

> Ambiguity is the property of being ambiguous, where a word, term, notation, sign, symbol, phrase, sentence, or any other form used for communication, is called ambiguous if it can be interpreted in more than one way. Ambiguity is different from vagueness, which arises when the boundaries of meaning are indistinct. [57]

William Empson has in his by now classic study *Seven types of ambiguity* dug deeper than most into this question and given us some important clues on intentional literary ambiguity. There is no need to present all seven of

Empson's types of ambiguity. Let us, however, have a look at how he defines literary ambiguity. It is, he writes,

> …any verbal nuance, however slight, which gives room for alternative reactions to the same piece of language.[58]

Again looking at Wikipedia's definitions, linguistic forms of ambiguity are subdivided into *lexical ambiguity*, which consists in "a word or phrase having more than one meaning in the language to which the word belongs"; *syntactic ambiguity,* where "a complex phrase or a sentence can be parsed in more than one way"; and finally *semantic ambiguity,* meaning that "a word or a concept has an inherently diffuse meaning based on wide-spread or informal use".[59] These are instances of ambiguity that arise in literary texts, as well as often in clinical situations.

For the purpose of this investigation, I will use the concept both in its general sense as defined in Wikipedia, and in its linguistic sense. I will also at times refer to ambiguity as inherent in contexts, situations, whether linguistically formulated or not, that are open to different interpretations which all seem valid but from different perspectives. If we, for example, say that the existential condition of human beings is ambiguous, we would by this mean that persons may be understood and interpreted both as biological creatures as well as cultural and – some would say – also as spiritual. Seeing a phenomenon in different dimensions that all seem relevant is a way of making our understanding richer and more ambiguous.

Ambiguity is, naturally, highly dependent on situation and on frames of reference, and may not be there at all for someone with a different understanding of a certain context. Metaphor is often seen to be the very essence of ambiguity, though if we follow Empson it is just one type of literary ambiguity and perhaps not even the most common. Metaphors are sometimes ambiguous, but certainly not always. If I say "My love, you are like a rose", does such an expression really qualify to be called ambiguous in the sense Empson suggests? Hardly, because it doesn't really leave any room for different meanings, at least not *clearly* different. A person can't be a rose and hence it must be the *qualities* of the rose that I am pointing to, and these don't seem very ambiguous (though we may, of course, have slightly different opinions about what is attractive about a rose). But if I write "We walk from cold rooms to warm/and from warm to cold again" (as Lars Gustafsson does in a poem), the lines are bound to be ambiguous, stubbornly resisting interpretation along one line, keeping their secret in spite of the reader's efforts. Ambiguity may be hence be deliberate and function as a tool in poetry and other literary genres. Ambiguity here, as Empson convincingly argues, creates aesthetic responses and fruitful tensions in the reader, most often with thought and emotion in interplay. The reader "suddenly" sees something in a different light - as richer, more complex, "fuller" – or is invited to play with several possible interpretations of which no one may be seen as necessarily superior to the other. In this sense, ambiguity working well expands our understanding of reality and it does so with semantic means.[60]

Finally, I want to introduce a question to which I will return in chapter 5. If feelings and emotions are an essential part of the reading experience and if

pleasure (or satisfaction) is what readers are after, at least mostly – how is it then that reading about dark things, creating unpleasant associations and evoking painful memories still may be enjoyable? One may of course argue that reading about death and cruelty and injustice is a chance to approach forbidden things, to get a thrill of cruel satisfaction at the misfortunes of others. As I am not allowed to take overt pleasure in other persons´ suffering, my hidden dark impulses may here find their outflow. Literature – as well as film and some music - would then, as it were, offer a valve of security for a society that represses the darker sides of human existence and individual character.

I would not deny that this is sometimes the case. I do not deny, either, that we sometimes do not read for satisfaction or pleasure at all, but to learn, to be enlightened. I do not, however, think that this can be the general answer to the question. A more plausible way of looking at what Anders Pettersson calls "the problem of tragic pleasure" originates in Aristotle, and it attempts to combine knowledge and pleasure. I cite Pettersson:

> The paradox emerges for the first time in Western aesthetics as early as in Aristotle's poetics where Aristotle says of the tragedian that "the poet should create the pleasure which comes from pity and fear through mimesis". That such pleasure does not seem paradoxical to Aristotle himself may perhaps be explained by his conviction that well-made imitations afford knowledge, and hence satisfaction, even when they represent objects that it would have been painful to observe in real life.[61]

Pettersson notices that the paradox appears only *if* we assume that we read for pleasure, at least to a large extent. If one, alternatively, thinks that the predominantly cognitive aspect of literature is what we are mainly after, then

knowledge of tough realities would seem to be as tempting as anything else, even if the accompanying feelings might hurt. But let us stick with Aristotle's assumption that we, in general and by and large, read for satisfaction and pleasure. How, then may we understand the tragedy and tragic elements in novels, poems and dramas?

A first thing to notice is that pleasure may mean different things here. Pleasure may result from being amused and entertained, or from being taken away for a while from the harsh realities of one's own life. Pleasure may of course also come out of meeting a fictive reality that is benevolent and encouraging. We then see life in a more positive light. We (re)gain hope. But certainly we experience that pleasure also results from getting a deeper understanding of those hard aspects of life we know are there, though we usually avoid thinking about them: cruelty, human fallibility, pressing moral predicaments, hopeless longing, love without response. No human being can deny – but certainly repress - the reality of these aspects of life and nobody can entirely avoid them in their own life. The more diffuse and unknown and beyond words and expression they are, the more threatening they become. When the author offers us a chance to approach them as fictive realities, gives them faces and names, the result is a paradoxical relief. We look straight into the dark, we face it and we are *able to* face it exactly because it is "as-if", fictive. This encounter with tragic fiction discharges something of the strength of our hidden fears by making them visible. Catharsis is then the relief of becoming conscious of what was earlier dangerously repressed – or more neutrally: pushed aside - into the corners of our mind.[62]

I believe that tragic aspects of texts would generally not induce cathartic feelings if they were not a part of a whole where other elements work in a different way, are more "immediately" pleasurable. These may be aesthetic elements, more encouraging aspects of reality or hopeful passages in a darker whole. Tragic elements are then integrated into a whole of light and dark. Obvious examples of this are found in the Greek tragedies. How this is interpreted is, of course, bound to be highly personal. What one reader may find to be hopelessly dark and uninspiring, another may experience as an important source of relief, though the great tragedians must have known very well how to elicit cathartic experiences in most spectators.

But why is fiction superior to "reality" in this sense? Why not go to "life itself"? We must again underline the "as-if" character of fiction. Fiction is, in a sense, a play with possibilities. To face the arbitrariness and injustice of life's events tends to overwhelm our capacity for sympathy and "Einfuhlung", "living-with". It is hard to stand the face of, for example, children suffering or persons step by step destroying their own lives without actually knowing what they are doing. We shy away from this, we steer away from facing such realities which, if we are still forced to face them, may leave us either so overwhelmed by pain and sorrow, or numbed of any compassion, that no meaningful reflection is possible. On the contrary, fictive realities leave a door open for our reflection, permitting a complex combination of distanced reflection and intimate emotional involvement. Tragic elements in fiction enable us to involve ourselves strongly without getting emotionally lost, offer us images for things otherwise outside the reach of imagination, things encountered in "real life" but often overwhelming, confusing, unbearable – such fiction leads us

steadfastly but cautiously through a landscape of light and darkness, to a cathartic sense of relief. (Again, see section 5.1.2)

.

If a text doesn't work in this way, it may partly be because it doesn't induce the playfulness that is a part of reading fiction. Play is also a game of "as-if". Pettersson interestingly cites psychologist Winnicott who proposes that playing is essentially pleasant "even if it leads to a high degree of anxiety". Playing often includes difficult and even painful elements, and the border with the unbearable is not always easy to recognize and respect. But everyone also knows that playing doesn't always work and that what was a totally absorbing game for one person might be boring and meaningless - or even unbearable - for another.[63] So is, I believe, often the case with tragedy. *Elektra* or *Medea* might induce cathartic relief in many of the visitors to the theatre while a few – perhaps those who do not stand the amount of sorrow and misfortune – will just find it hopeless and numb.

Are we hence allowed to conclude that literature, at least some literature, may help us to face and handle the dark realities of life: its contingency, arbitrariness, injustices, shortness? It might be wise to seek literature that brings us right into life's dreadful realities, in order to be stronger and more able to live our lives boldly facing their mess of light and dark, of contingency and lack of meaning. In short, should we read for catharsis? These are some of the questions of chapter 5. Of course we ought to read for many reasons, and reading for a certain desirable result is a dangerous business that could go wrong. But we may so far conclude that catharsis is at least a possibility, something that might result from reading or from watching the theatre (or

film). We may also conclude that literature may capture ambiguity, which is here judged to be an essential feature of moral choice. Finally, we are justified in thinking that the emotional charge of literary texts is important for their capacity to stimulate reflection, both on the events of the fiction but as a result of this also on our own reactions to these events (and our reactions to our reactions, and so forth). Emotions are, in themselves, a mode of understanding, as Katarina Elam has convincingly argued in her *Emotions as a Mode of Understanding*.[64] When Kundera, as we saw in the very start of this chapter, asserts that it is literature's task to "discover hitherto unknown segments of reality", we may in the light of the analysis above conclude that those segments of reality are the things, persons and events of the world around us but also our own character, our "inner world". Literature helps us to look out from ourselves, but also into ourselves.

---

[1] Kundera, Milan: *The Art of the Novel*. New York: Grove Press, 1988, 5-6

[2] The philosophically well read person may be inclined to wonder whether what is meant by this is the same thing that Socrates meant when he declared that the "unexamined life" is not worth living?

[3] Fish, Stanley*: Is there a Text in this Class?* Cambridge, Mass.: Harvard University Press, 1980.

[4] Vanhoozer, Kevin: *Is there a Meaning in this Text?: The Bible, the Reader and the Morality of Literary Knowledge.* Grand Rapids: Zondervan, 1998, 38

[5] Ibid, 24

[6] Ibid, 19-22. One might think that post-structuralism saved the text from being judged by the morality of its intention and instead opened the eyes for its aesthetic values. This was hardly the case. As we will soon see, the aesthetic qualities of a literary text can not be separated from reflection on what the text is about, what it tells us about the world. See below under 3.2.4

[7] Vanhoozer eloquently states that this assumption is based on "a metaphysics of meaning", where the author is "…the sovereign subject of the sign, the one who rules over meaning, assigning names to things, using words to express thoughts and represent the world." Ibid, 48

[8] ibid, 211-214

[9] Rönnerstrand, Torsten: "Referenten är död. Leve referenten! ("The referent is dead. Long live the referent!")" I *Tidskrift för Litteraturvetenskap* (2000), 2/3, 41-51

[10] The title of Alan Sokal´s article speaks for itself: "Transgressing the Boundaries: Toward a Transformative Hermeneutic of Quantum Gravity", published in *Social Text* in 1996. The fact that this deliberate nonsense was accepted and published seemed for some to be the ultimate proof of the non-sensical character of most postmodern writing. Sokal followed this up by publishing a book together with a French physicist, Jean Bricmont, called *Intellectual impostures: Postmodern philosophers´ abuse of science* (London: Profile, 1998), where they systematically attacked a number of the presuppositions of postmodern (or poststructuralist) thinking.

[11] Bal, Mieke: *Narratology: Introduction to the Theory of Narrative.*Toronto&Buffalo&London: University of Toronto Press, 1997 (second edition), 5

[12] Pettersson, Anders: *Verbal Art: A Philosophy of Literature and Literary Experience.* Montreal&Kingston, London, Ithaca: McGill-Queens University Press, 2000, chapter 4

[13] Among these is what Pettersson calls "the amalgamation theory". According to it, the text is a peculiar blend, amalgamation, between a physical object and a content with meaning. The text is neither of these, but both. This is more in line with how we usually speak, but I agree with Pettersson that it would have seriously negative consequences for the subsequent questions of meaning and intention in literary works.

[14] Ibid, 93

[15] Ibid, 101

[16] Eco, Umberto: *Interpretation and Overinterpretation.* Cambridge: Cambridge University Press, 1992, 85

[17] Manguel, Alberto: *A History of Reading.* London: Flaminco, 1997

[18] See for example Ong, Walter: *Orality and Literacy: The Technologization of the World.* London: Methuen, 1992.

[19] Plato: *Phaedrus.* Oxford: Oxford University Press, 1992. It is a striking historical paradox that if Plato had not written down what he thought was the essence of Socrates numerous conversations, they would have been altogether lost for humanity and Socrates would probably have been less than a footnote in philosophical textbooks.

[20] Tyrberg, Anders: *Anrop och ansvar. Berättarkonst och etik hos Lars Ahlin, Göran Tunström, Birgitta Trotzig och Torgny Lindgren. (Call and Responsibility: Narrative Art and Ethics in the Writings of Lars Ahlin, Göran Tunström, Birgitta Trotzig and Torgny Lindgren.)* Stockholm: Carlssons förlag, 2002, 18

[21] Ibid, 19

[22] Ibid, 20

[23] But this close linking of understanding and meaning seems to lead us to the threatening conclusion that the concepts are synonymous. If I need to understand in order to find meaning, and if, when meaning is found, there is also understanding, what´s the use of having two different concepts?

[24] Wood, Michael: *Literature and the Taste of Knowledge.* Cambridge: Cambridge University Press, 2005, 6

[25] ibid 4

[26] Ibid, 4-5

[27] Salmon Rushdie in *Dagens Nyheter*, 2001 11 07

[28] Steiner, George: *Real Presences.* Chicago: University of Chicago Press, 1989, 149-150

[29] Vanhoozer, op cit, 368

[30] Wood, op cit, 41

[31] Vanhoozer, op cit, 300

[32] Booth, Wayne: *The Company We Keep: An Ethics of Fiction.* Berkeley, Los Angeles, London: University of California Press, 1988, 17

[33] Rosenblatt, Louise M.: *Literature as Exploration.* New York: The Modern Language Association of America, 1995 (orig publ 1938), 40

[34] I deliberately leave aside the fascinating philosophical question what it really means to attempt to talk of a world outside of language that we try to describe through language. One might object and say that the limits of language are the limits of our world and that the world is not there "before" language but comes into being with language.

[35] I think this "double status" is exactly the reason why people want to go to "literary places" like Ystad (Kurt Wallander), or Botswana (Ma Ramotswe), explaining it in words like "I want to see where Kurt Wallander chased his murderer", or "I want to feel the atmosphere of Ma Ramotswe's "Number One Ladies' Detective Bureau".

[36] Booth, op cit, 227. Booth notes that Cervantes opens *Don Quixote* by telling the reader that the tragic hero destroyed his reason through so much reading and so little sleep that he finally lost sight of the demarcation line between real and fictitious. Did, asks Booth, really anyone think that Cervantes wrote this as irony or metaphor?
[37] Ibid, 230
[38] Hunsaker Hawkins, Anne: "The Idea of Character" Charon, Rita & Montello, Martha (eds): *Stories Matter: The Role of Narrative in Medical Ethics.* New York, London: Routledge, 2002, 69-76
[39] Booth, op cit, 238
[40] ibid, 239
[41] Ibid, 70-77
[42] Booth, Wayne: "The Ethics of Medicine, as Revealed in Literature" In Charon & Montello, op cit, 10-20
[43] Nussbaum, Martha: *Love´s Knowledge: Essays on Philosophy and Literature.* New York, Oxford: Oxford University Press, 1990, 12
[44] Ibid, 3
[45] Nussbaum, Martha: *Upheavals of Thought: The Intelligence of Emotions.* Cambridge: Cambridge University Press, 2001.
[46] Nussbaum, 1990, 23-24
[47] Ibid, 22
[48] I have touched upon this above in 2.2.8, noting that certain principles of biomedical ethics were for some time by many thought to be the clue to medical ethics.
[49] Zachary Newton, Adam: *Narrative Ethics.* Cambridge, Massachusetts: Harvard University Press, 1995, 62
[50] How tricky this is might be underlined by the fact that this sentence could be reformulated like this: "…what the author makes the story make the reader think is the author´s voice".
[51] Zachary Newton, op cit, 65
[52] This vocabulary is common in contemporary discourse on emotions, but nevertheless may create some tensions with ordinary language. Hence, when we ask people how they feel, we usually ask them for their emotions and we ask them for their mood, we ask for their feelings or mood.
[53] Feagin, Susan L.: *Reading with Feeling: The Aesthetics of Appreciation.* Ithaca and London: Cornell University Press, 1996, 1.
[54] I hesitate to talk of words even primarily as strictly cognitive. It is of course true that our linguistic abilities are dependent on certain cognitive capacities – we are sadly reminded of this for example when parts of the cerebral cortex are damaged and some form of aphasia results – but from this doesn´t really follow that words are exclusively cognitive and only secondarily emotive. If we take, for example, three common words – say: book, water, child – I can hardly imagine any person who can understand them in a purely cognitive way, that is without any feeling arising simultaneously with the cognitive realization what the word stands for, what it "represents". I will, however, not pursue this matter further, as it would bring us into the very heart of language philosophy.
[55] Nussbaum, 1990, 79
[56] Ibid, 81
[57] Wikipedia, 091031. In clinical practice, ambiguity understood like this is exceedingly common. An everyday example could be when a physician asks her patient: "Tell me how you feel!", and the patient answers "It is so difficult, doctor….." There are several different potential meanings in this answer and the attentive physician must find out which of these are relevant in this context.
[58] Empson, W: *Seven types of ambiguity.* London: Penguin Books, 1995 (orig publ 1930), 19. In his preface to the second edition from 1947, Empson acknowledges, and cites at length, the critique he received after his book was published. One important line in this critique, which he comments, is that his notion of literary ambiguity was far too wide for the purpose, and basically very vague and imprecise. In fact, Empson's way of using the concept ambiguity is close to mine in this thesis. Ibid, 7-16.
[59] Wikipedia, 091031
[60] I will in section 5.2.4.1 develop this argument using the concept of *defamiliarization.*
[61] Pettersson, op cit, 200
[62] Freud borrowed this connotation of the concept catharsis and used it to denote the sudden relief appearing during psychoanalysis when the person under analysis with the help of "free associations" is able to reach and verbalize those repressed memories that were the origin of the neurotic symptoms.

[63] Pettersson, op cit, 206
[64] Elam, Katarina: *Emotions as a Mode of Understanding: An Essay in Philosophical Aesthetics.* Uppsala: Uppsala University Press, 2001.

Chapter 4

Clinical judgement

…doctors will begin to understand that, qua doctors, they are distinct from their tools and their science.
Eric Cassell[1]

Chapter 2 has provided a ground for understanding what medicine is about. Chapter 3 outlined the experience of literature. Before these two areas are brought together it is necessary to look a bit closer at the clinical situation, at what goes on in everyday medical encounters. In order to do this, I will now go on to present a case story in two versions. The story is from primary care and concerns a middle aged woman who experiences peculiar and distressing symptoms. The story is fictive but based on my own clinical experiences. The two versions are intended to describe two rather different scenarios, both common in medical practice. They will provide a possibility to illuminate some central aspects of clinical judgement, which is the main purpose of this chapter. They will also give me a chance to look closer at the concept of phronesis in the context of clinical reasoning and decision-making. Specifically, I will be identifying a number of challenges facing the clinician, in general and as exemplified in these two hypothetical chains of events. The purpose of bringing in the stories and of understanding the physician's challenges in their context is to make it easier to see which elements in the reading experience may be connected to such challenges. If we are able to identify such elements, we will also be able to proceed towards a better understanding of more precisely what in literature may be valuable and how we may capture it. The chapter is concluded

by some remarks on the idea of clinical rationality in the light of Stephen Toulmin's ideas of modernity, as presented above in chapter 2.1.9.

4.1 Two stories of Lisa

"Mummy, do we have to have such boring food", the 9-year old exclaims when he comes rushing in through the kitchen door from his football training. Lisa feels the blood rushing up to her head. She is tired. The exhaustion doesn't make her patience greater. The complaints can drive her crazy. And nothing gets better by the fact that she is dizzy. She doesn't know what it means. She has been dizzy now and then before, surely, but now this feeling of instability, of falling or sinking, of walking "on cushions", is with her most of the time. It wears her out, her thoughts hook on to it like the tongue to a little wound in the mouth. A burden has come over her daily life. How much do the children notice, she thinks – how much does her husband Erik notice?

It has been going on for almost six weeks now – came insidiously, almost without notice. Yesterday she had a sort of pouring feeling, tingling and pricking, on the outside of her right leg. However much she rubbed the feeling stayed on for several hours. It must be the exhaustion, she thinks, the fatigue that has been with her ever since the second child was born several years ago. As if she never really recovered. And the ever increasing pressure at work… For how long will she be able to stand the sad expressions in the faces of the old when she has to rush to the next room or flat, without really sitting down for a chat?

The other day she read in the paper about burn-out syndromes. Somebody had called it "brain-stress". She recognized some parts of the description. If my brain is stressed, the whole of me must be, Lisa thinks. But I like my work, I love my family, my life is a good life. Why this dizziness that won't go away? The questions keep going around and around: Should I talk to someone, Erik surely notices that something is wrong, should I really put this burden on him, he's got his own challenges at work, is there any doctor who cares about this and who listens and

understands and can tell me what it is? At the health centre there are almost only doctors on temporary posts, a friend told her after a disappointed return from a consultation….

We may stop here for a while to think about Lisa's situation. The way we have come to understand illness, we must conclude that she is ill. If she also has a disease we do not yet know. Her being-in-the world is increasingly unhomelike. It is essential to notice that even if she has earlier been tired, this is something definitely new. Her symptoms may not be overwhelming, rather they are annoying and above all threatening, and she experiences insecurity and grave distress. It is, we may assume, the lack of understanding of what goes on in her body, the fundamental and also ominous changes in her lived embodied reality, which is most worrying for Lisa. We may infer from her situation that the most common of all the questions in this early phase of illness is "What is going on?", entailing deep uncertainty about what "it " is, what "it" will lead to, why "it" has appeared and what may be done about "it".[2]

Had the strange sensations suddenly vanished and left no trace, Lisa would probably not have gone for help. She would have thought about it now and then, puzzled. But it would have sunk away, becoming a thin thread of memory. Neither would she have gone to the doctor if she had got a satisfactory and soothing explanation from someone that she trusted, even though this may not be a medically trained person. Also, if Lisa's distrust of the medical system had been deep – maybe due to earlier strongly negative experiences – she would have waited or even abstained from going. But in our story she is now urged by her

husband and this helps her overcome her hesitance, and so she phones and gets an appointment.

Lisa fidgets about on the chair. She fights a sudden impulse to rush out. When after a short wait she is fetched by an upper middle aged, female physician dressed in white, her legs feel unstable. She is filled by irritation towards herself. "This can't be anything to be so frightened of!"

The meeting with the doctor becomes longer than Lisa had expected. The physician listens attentively, occasionally asks a question, seems genuinely interested in her story, however incoherent and vague it may seem – yes, she has the feeling that it takes shape and structure during the dialogue. Lisa relaxes. What was she worried about? The subsequent examination in a bare and rather chilly room in some way becomes an extension of and deepening of the talk –Lisa thinks that now it is her body that tells what she herself was not able to say.

When they part, the inevitable question is on Lisa's lips but the doctor anticipates her. "I notice that you do not feel well at all and that something is wrong with you. I cannot yet tell you what it is, but I expect us to reach an answer rather soon. We will now take a number of blood samples and I will also order a magnetic resonance investigation. The symptoms you have may point to a neurological disorder but there are also several other possible explanations. I will phone you as soon as the results are ready and you will get a new appointment within two weeks. Of course, you may phone me earlier if there is anything you want to talk about. Don't hesitate to do that!

"The physician is the person who takes the patient's history", in the words of Toulmin that starts chapter 2. Taking a story is to invite someone to remember.[3] Anamnesis means to remember. At first we would think that it is only the patient who is invited to remember. But if we think about our doctor here, listening to Lisa's story about her symptoms and gently guiding the dialogue in those directions that may prove to be illuminating for understanding what she feels

and explaining why it may be that she feels like this, she is of course involved in a memory process of her own. Scientific facts, other medical "cases", of course – but also something that tends to be forgotten: vague, perhaps subconscious memories of afflictions that she has had herself, situations where she experienced an "unhomelikeness" that at least to some extent bears a resemblance to what Lisa experiences. Taking the story is hence a mutual act of remembering and it is also a mutual act of construction, a fact to which we will return below.

A crucial aspect of this encounter between Lisa and her GP is the way the dialogue develops. The doctor is indeed steering the dialogue in directions judged by her professional experience to be of importance in a case like this (and in doing this, differential diagnoses[4] will already be gathering in her head), but if she is too dominant, too clear in her signals of what may be said and what may not be said, it will negatively affect the dialogue. Lisa will then quickly realize that this is an encounter totally dominated by the scientifically defined interests of the doctor, while her lived experience of illness - so hard for her to capture into words – is brushed aside. Partly, of course, whether this happens or not is dependent on what the doctor asks about – but surely also on what she does *not* ask about, on her silences, on her facial expressions of tolerance, interest and recognition. In our case, Lisa feels trust. Trust is the result of experienced, interested and attentive questioning, answering, listening and observing. The doctor notices how Lisa gradually relaxes and as she does this, her story develops more easily, she finds her words in more nuanced ways, she allows herself to hesitate to search for words now and then without feeling that she should not - or that she is in an extreme hurry. Her impression of the doctor's attitude is that of a calm and waiting centre of concentrated interest, signalling:

"I am here with you now, and it is you who are the focus of attention in this encounter, it is what you feel and think that is our most basic point of departure in this process of finding out."

Lisa's doctor, while staying attentive to her story, and while remaining true to her lived experience, is already partly relying on another kind of knowledge, the epistemology of biomedical science – thinking about Lisa as what we have already called a medicalised body. We must notice that this goes on at exactly the same time as she confirms Lisa's account of how the symptoms developed, how they affected her and what Lisa herself thinks about them. This double aspect of attention and reflection is of crucial importance. If the doctor stayed exclusively inside Lisa's world, as far as she would be able to reach into it, she would be able to do no more (which is of course not always so little) than confirming by listening and recognizing her story. If, on the other hand, she brushed Lisa's illness experience aside, if Lisa's troubled "being-in-the-world" was uninteresting to her, not only would she fail to recognize and confirm the nature of Lisa's suffering, but also fail in diagnostic sharpness, as many of the clues to diagnosis reside exactly in the experiential data given by Lisa, in her illness experience. So what we call symptoms have an intertwined double interest for the doctor, as clues to Lisa's life world and as indicators of what might be going on in her body. Hence, as the dialogue unfolds and as the ensuing physical examination takes place, the diagnostic activity of the doctor becomes more and more focused on one disease or a group of diseases, while she is still relating – *at the very same time* - to Lisa on the level of lived experience. This means that she is able to anticipate Lisa's question "What may this be?" and to formulate a very

cautious initial hypothesis ("something neurological") in a way that doesn't eradicate all Lisa's hope of finding a way home from the alien land she is now in.

Lisa is once again at the health centre. It is easier this time. During the weeks that have passed she has felt a little calmer. The symptoms are still there, but a faint gleam of hope and confidence has opened. She is not so alone with all this any more, and she will very soon know. The investigation at the hospital made her think a lot about strange deviances of her brain – her fantasies and worries overwhelmed her. But now it is done and only the doctor knows what goes on in her brain. Anything rather than this gnawing uncertainty, she thinks. I am prepared for the worst.

She has to wait longer this time. When the doctor comes she looks tired. When they sit down in her room and the usual questions about how she feels and how her weeks have been are answered, Lisa knows that this is something very serious. "I've had the results from the MR-exam that was made a week ago. It shows that there are changes in your brain that may explain the symptoms you have. The picture is the one we see with the disease multiple sclerosis in an early stage….." The physician becomes silent and looks steadily, even somewhat sadly, at her patient. Lisa's head becomes empty, totally empty. I knew it, she thinks, I knew it. Good God, what am I to do? What's going to happen to me and the family?

She is only able to pose a few questions. In a calm voice the doctor tells her some essential things about the disease. She stresses the new therapeutic options coming up. She does not play down the ominous meaning of the diagnosis and the unpredictable course of the disease. Still, she gives realistic hope in a moment of shock. And they part with a promise from the doctor to see her again within a few days.

The result of this second encounter with the doctor is a diagnosis, in this case a diagnosis which has a number of worrying or even frightening connotations.

Lisa is relieved to know, but she is at the same time shocked by the truth about her state. The encounter is this time directed exclusively to the giving and taking of a serious diagnosis. Honesty and clarity in this situation are of crucial importance. Any attempt on the side of the doctor to play down the meaning of this diagnosis, to attempt to soothe by selecting less worrying facts, would have been deeply misguided. Lisa would have taken that as an insult. The trust has to be mutual – from patient to doctor, but in this sense also from doctor to patient. The doctor must trust Lisa to be able to handle the truth about her state. She knows, of course, that after the shock, all sorts of questions will fill Lisa's head. Therefore she will see her soon again. She is at this stage above all the person who *recognizes*, both Lisa's grief and perhaps also anger, but also at the very same time what is going on in her body, what will probably happen in the future and what can be done about it. John Berger's notion of recognition, as presented in 2.2.6, here acquires its full meaning. The recognition is biographical (based on understanding of unique human experiences) and it is scientific (based on scientific explanation from the biomedical sciences). In a healing clinical encounter, these two aspects merge. If either of these two modes of understanding are lost, the clinician will not act as a healer.

Multiple sclerosis is a medically well-defined disease. There are lesions in the brain and often also the spinal cord that may be examined through sophisticated techniques. Even if symptoms are diffuse and unspecific and diagnosis hence often delayed, there nevertheless exists a standard procedure for diagnosis. Curative treatment is lacking but in an increasing number of cases there are now possibilities to slow down the progress of the disease through medication. Prognosis is dubious and varies a lot. The course of the disease is unforeseeable

and usually means exacerbations interspersed with quiet periods. This raises serious challenges for the ill person to find a way to live with a situation of great existential uncertainty. Using the language spelled out above, it may be extraordinarily hard for the ill person to return to a degree of homelike being, because the disease is so unpredictable.

We may reflect a bit further on the story about Lisa and we may imagine another course of events. What if no pathological lesions had been discovered on the MR? What if no sophisticated technological investigation had shown any biomedically defined deviance(s) from the normal, nothing that could explain her symptoms? It is not hard to see that her and her family's challenges in finding a meaning in her symptoms and situation would then have been greater, as would the risks that the health care system would have deserted her.

We will now look at the second story, that presents an alternative set of events from the second encounter on, and hence also other challenges for Lisa and her physician:

Lisa is back to see the doctor. She is not as tense this time. She knows the doctor and she trusts her. They have been talking on the phone a week ago and Lisa felt relieved to understand that she really cared, was treated like a person of her own, that she was not just one case out of an anonymous mass of diseases.

When the physician comes to the waiting room, Lisa looks into her face. Does it show? Could she read the answer there? Inside the office, after only a few questions about the

days gone, the doctor says: "Well, Lisa, you've been to the MR and there was nothing there that could explain the way you feel. It was a perfectly normal investigation." She pauses and looks at Lisa. "I understand that this is a relief for you but also something of a disappointment, since we still do not know why you feel the way you do. But we will find out." Inside Lisa conflicting emotions struggle. She really is relieved. But still: What is it then? What's going on? Why isn't she the way she is used to be? What will happen now?

Lisa's worst fears did not come true: No MS, no tumour……But the distressing symptoms are not gone. They remain unexplained and without diagnosis it seems as if the doctor is searching the dark. This is a difficult moment for both physician and patient. The former must handle both the disappointment and uncertainty of the patient, while at the same time finding a strategy to go on in other directions. The search for a diagnosis must involve the patient, give reasonable hope and proceed in a way that starts with the more likely and continues to the less likely. It is a moment of genuine uncertainty and it is the first serious test of the stability of the relation built up between doctor and patient.

"There are many things that may be behind such symptoms as you have", the doctor proceeds after a moment of silence. "The MR excludes the most serious alternatives. We must look in more directions. A few more blood samples need to be taken, to exclude some more unusual diseases. But the reason that you do not feel well may not be a disease in the body. Dizziness and fatigue may sometimes be seen as expressions of "stress"- such stress that comes from not really getting one's life to fit with one's inner resources, from – so to speak – burning the candle from both ends. Symptoms like yours also at times have to do with a depressive state, that may arise even if one has a good life situation and

even if nothing is really wrong in life. I think we ought to look in all these directions. And after that, we need to talk now and then, and I will also ask you to fill in a questionnaire that may be used in these situations. What do you think about this?"

Lisa is silent. She doesn't know what to answer. She feels that it is just too much at one time. She likes the doctor but she doesn't understand where they are heading. She can't see how her strange sensations could be "stress". Stress makes people agitated or exhausted, "burnt-out" or whatever it's called. That's not how she feels. But she somewhat reluctantly admits to see the doctor in a week for a longer consultation. She knows there is really no alternative and her trust is still there.

There is no real fit here of symptoms into diagnosis. If the new blood tests, too, prove to be normal, the search for a well defined somatic deviance behind Lisa's symptoms seems to have run into a blind alley. To avoid such a situation's becoming too sudden and threatening for her patient, the doctor has already cautiously introduced some other alternative possibilities, however vague they may have sounded in Lisa's ears.

In this scenario, the outcome may well to a large extent depend on how well this physician is able to handle the sensitive balancing between certainty and uncertainty, between hope and despair, between scientific rigor and empathetic imagination. To approach some degree of understanding of Lisa's situation, it seems that the physician not only needs scientific knowledge and clinical experience in the form of similar cases, but also bodily empathy, in the sense that Carl-Edvard Rudebeck describes this.[5] Without a combined emotive-cognitive

flexibility and imagination, our doctor would hardly be able to proceed towards a diagnosis, while still keeping a trustful relation to Lisa. But are there dangerous feelings and emotions inside herself that might be awakened by a more dialogical relationship to Lisa? If so, is handling this a matter of personality? Or of training, of personal and professional experiences, brought into practice in a fruitful way?

Two months have passed. Lisa is on her sixth visit to the doctor. This seems to be the last for at least some time. It was strange, at first, to sit in front of a doctor who mainly wanted her to talk. She was so used to doctors being busy, active, dominating and very practical. Here was one that really wanted to find out both about her body and her mind. The same feeling of being at the centre of attention lingers on, but this time it is not as much the body as her thoughts and feelings that are in focus.

At first talking about herself was difficult. She was not used to it. Her needs and her feelings had been secondary to the needs of the family. But now she experiences a sort of relief when talking even of difficult things. She wonders how that may be. The dizziness is still there but it is not as threatening, not as obstructing for her. She has started to feel a little hope. She will come back, but perhaps not exactly to what she left when she fell ill. Her reluctance towards the temporary medication with an anti-depressant is also gone. After the first tough days, when the doctor phoned her several times, she has had no side effects. Now she thinks about it as just some sort of supplement: - Some persons need vitamins for a period and I need this to become myself again.

In three days she will be back at work on full time again. It both worries and pleases her. Her ambivalence is not gone but it is more under control. She is not ruled by some strange power inside her any more. She is slowly, very slowly, becoming the ruler of her own life.

I will now proceed to some general reflections on the tasks and challenges of the clinician, while at the same time reconnecting to the stories of Lisa. These reflections will then end up in a discussion about clinical rationality and clinical judgement towards the end of the chapter.

4.2 Clinical challenges

In this short story with two alternative outcomes, some central aspects of the patient-physician-relationship are illuminated. Which are these aspects, these crucial challenges that the clinically working physician must handle in order to reach the goals of her profession? I do not, of course, believe I may cover all dimensions of the complex patient-doctor-interaction, but my analysis will prove to be of value when I soon turn to literature and the role literary experiences may have in relation to the practice of medicine.

Acting in a situation of asymmetrical power

The physician is, by the very nature of the clinical encounter, very often acting in a situation of asymmetrical power. Pellegrino notices:

> Unless the person wishes to ignore his illness, or to rely on his own healing power, he must seek the help of another. The ill person is condemned to a

> relationship of inequality with the professed healer, for the healer professes to possess precisely what the patient lacks – the knowledge and power to heal. [6]

Extraordinary power is at times given to the medical expert, as for example in situations of compulsory psychiatric care or withdrawal of life sustaining treatment. But in most everyday situations, too, the physician is in a radically different situation as compared to the patient. We see this clearly in our stories. The doctor is healthy, she is the one who possesses the professional knowledge and she is familiar with the context in which the clinical encounter takes place. Very often her social position differs from her patient's and very often so does her age. On the whole, one may well think that it is amazing how in fact any degree of shared understanding may arise in a situation with so much asymmetry and so many chances for misunderstanding and collisions of perspective. The reluctance that Lisa feels from the beginning is, from this perspective, fully understandable – but it is overcome by the physician's ability to create trust.

It has earlier been noted that the doctor shares certain common existential predicaments with her patient, like being vulnerable and prone to falling ill, as well as being in need of recognition and support, of trust and mutuality. The recognition of this common human condition may create a platform for shared understanding in spite of sometimes striking differences in actual life circumstances. Imagination and a combination of emotional and cognitive flexibility are likely to be of great value in this process of approaching another individual's life-world that may be very different from one's own. When imaginative (though necessarily limited) identification, often called empathy,

interacts with the internalized professional ethical norms, also including an amount of self-critical distanced reflection, what Sören Holm calls "protective responsibility", a notion that I will soon return to, will characterize the physician's relation to the patient.[7]

The power to heal is also a power to harm and hurt. This is intensely felt by most physicians, not as a constant uncertainty and pressure but as built into the very daily routines that to a large extent govern their work. If, still, at occasions technology tempts doctors to push the limits of their work, if they sometimes aggressively pursue technologically defined goals, this will make it more difficult for the them to handle their tools with temperance and use power only insofar as it is in the best interest of their patients, that is: protecting them from any harm beyond what is absolutely necessary for their recovery. Possibly, as noted earlier, the speed of technological innovation in medicine and the pressure of knowledge of new therapeutic and diagnostic methods threaten this attitude of constraint. Temperance presupposes a combination of personal and scientific knowledge, and it presupposes a degree of personal maturity in the face of suffering and death.

Between two languages

Ordinary language may be understood as a discourse that works in everyday situations and is understood by most persons belonging to the same language community. Semiotic theory tells us that language is one set of signs used to convey meaning. Despite the fact that there are related and closely interacting systems of signs that are of crucial importance to convey this meaning, it still

seems reasonable to conclude that the words uttered by patient and physician are the most essential elements of the clinical encounter.[8]

General practitioner Olle Hellström has in an article described his effort to come to an understanding of a patient, Victor. Hellström suggests that in order to "understand the significance" of Victor's experiences, the physician might "relate to him as a reader to a text". Hellström's point is that the reader has to be open for a meaning that gradually emerges during the reading of the text and must hence be open minded and resist a personal temptation to have one's own needs confirmed in the narrative. This sounds like Drew Leder's idea of the patient as a text (see 2.2.3) but Hellström's intention is not really this. He stresses, like Fredrik Svenaeus in his critique of Leder, that the clinical dialogue is a subject-to-subject relationship, a mutual exchange of meaning, and in this sense different from the reading of a literary text. Hellström writes:

> The ambition of dialogue medicine is to apply biomedical knowledge with judgement in order to make room for the patient to dare and find it meaningful and worthwhile to cooperate in revealing his present image of himself.[9]

The discourse going on in a clinical encounter may be analysed. John Nessa has provided such an analysis in his *Talk as Medical Work.* Starting from a solid basis of semiotic theory and speech act theory, Nessa records, transcribes and analyses semantic exchange in some encounters between doctor and patient in clinical practice. He concludes that

> Formally and logically speaking, the doctor and patient, in cooperation, choose between many possible worlds and decide how the world actually is and how they would like it to be. They are creating a medical reality. This is

> a linguistic reality, with symbols and distinctions from the language, constructed through interaction.[10]

This becomes obvious in the second story about Lisa. The story is totally open, perhaps even dangerously open, as long as there is no diagnosis. Dialogue then may be seen as the instrument to "choose a world", though the choice is of course not arbitrary but governed by the results of the investigation. Even if we admit that the physician has to establish a shared semantic ground, and even if we accept the vital importance of searching for mutual trust and understanding, it remains crucial for her to search for diagnosis with the help of concepts and constructs that are very different from those of common language. How may these two "language games" be accommodated, and reach a reasonable degree of "fit"? A reality best captured in the concepts of science meets a reality that is expressed in the words of everyday language and by metaphors and symbols. No wonder that a degree of common understanding may be difficult to reach. If understanding wholly fails, the risks increase that the physician gets too little or irrelevant information from his patient and takes the wrong course of action. The patient is then liable to feel deserted and misunderstood.

Göran Lantz attempts to analyse the differences between these discourses in an essay, *De två språken (The two languages)*.[11] Lantz in his essay comes close to Evans's distinction between the two bodies, the lived body and the medically constructed body. We may say that the two languages answer to the needs of those two ways of apprehending the body. Lantz´s somewhat surprising conclusion is that the alleged differences may not be so great after all. The two languages tend to be mixed in different societal contexts, as a spill over from the

prestige of medical modes of explanation. This is also a consequence of the fact that patients are now more well-read in medicine and that medical or quasi-medical advice is all around. Nevertheless, there are substantial differences that make it reasonable to talk about two distinct, though often blurred, discourses.

A scientific language for medical diagnosis and treatment is of course indispensable. It is worth noting that this specialised language relies on exactly the kind of abstraction involved in the construction of a medicalised body. This language is very precise in certain areas, where biomedical sciences provide a framework for description and analysis. As soon as it turns its attention to symptomatology, to the expressions of the life world of the patient, it becomes notoriously vague and ambiguous. Core symptoms like nausea, fatigue, dizziness, pain in all its forms etc may mean radically different things for different individuals. This very fundamental vagueness may certainly be reduced during a dialogue of mutual clarification, and this dialogue usually works well enough, and through the observation of accompanying signs – but a substantial degree of uncertainty in their interpretation will sometimes remain. One may perhaps say that this cluster of very central, yet very vague, verbal symptom reports are the very place where the two discourses of the clinical encounter have to fit into each other reasonably well - in order to make a successful outcome possible.

Handling uncertainty

Numerous students of medicine have had the harsh experience that what they were taught during their training to think of as the crown of sciences, detailed

and comprehensive and ever more sophisticated, was transformed into a hopeless quagmire of uncertainty and unclear delimitations when they started practising. The idealized picture of medicine as a hard science providing us with truths about diseases and cures is of course not altogether untrue. As shown in chapter 2, progress has been immense and there is a massive amount of medical facts that are of relevance to the clinician. Stressing clinical uncertainty should not be taken to imply that this knowledge is in any way dispensable for the clinician.

But uncertainty remains. We see this amply illustrated in the second story, where Lisa suffers from "something" that neither she nor the physician may fit into either everyday understanding or diagnostic models. Uncertainty permeates the discourse between Lisa and the physician. Uncertainty is related to time, in the sense that it is usually reduced with the help of further information that comes with time. In our first scenario, one uncertainty is replaced by another. The diagnosis of MS is reasonably certain, but the course of the disease is uncertain, the outcome of therapy is uncertain and the consequences for Lisa are very uncertain.

The physician must handle this. She must show her patient that she knows, that she is familiar with it, that there is indeed accumulated knowledge about this disease – but at the same time be confident enough to let Lisa know that knowledge is still limited and that no medical science in the world may give her full reassurance about the course of the disease and the outcome of therapy. This is, for the physician, of course not only a question of scientific uncertainty. She equally faces a deep personal uncertainty, a conflict of expectations, indeed to

some degree an existential ambivalence both from within (her own internalised longing for medical omnipotence vs her awareness of the relative lack of power in relation to this disease) and from without (the patient's "magical" expectations on the physician as an almighty saviour vs the realistic insight that she is only too human and that no doctor can cure every disease).

Hence also when dealing with well known and well described diseases crucial moments of uncertainty are bound to appear. Eric Cassell writes:

> Diagnostic and therapeutic power in clinicians is directly proportionate to their ability to tolerate uncertainty. Uncertainty is intrinsic to the nature of diagnosis and therapy.[12]

How does uncertainty affect clinical practice? It may make doctors prone to safeguarding themselves against therapeutic mistakes, with the resulting difficulties of handling all the technological options open to the clinician. It may make them over-compensate their sense of insecurity in an attempt to appear as flawless technical experts, radiating a security that is ill-founded and counter-productive. It may tempt them to give up the idea of scientific rigour in clinical practice altogether. Or it may spill over to the patient as a vague feeling that what he or she experiences is not recognized by the physician – neither medically nor humanly - and that there is hence no hope for amelioration or cure. It may, finally, help the doctor develop a sense of humility and support her in a medical "style" that is more temperate than it is bold. It is, I am convinced, this last attitude that has the largest chances to contribute to the doctor's professional skills in relation to the goals of medicine, as medical foolhardiness seldom permits the kind of attentiveness and well reflected observation that I have

suggested as central elements in good clinical practice. I will soon also argue that a sense of the tragic aspects of human existence could be of value for the clinician in order to handle uncertainty in such a way, and of course also make therapeutic failures easier to handle.

Most doctors learn with increasing experience to handle uncertainty . However, this ability to handle uncertainty in practice does not eradicate it. Uncertainty is an element that is crucial to the understanding of medicine. It involves uncertainty of diagnoses and of therapy – and perhaps most important, it involves uncertainty in the interpretation of the life world of the ill person, the illness experience. Admitting this uncertainty is also a way of acknowledging the irreducible "otherness" of the ill person and the limits of empathy. As such it is an indispensable safe-guard against a kind of emotional imperialism that may be involved in clinical encounters where the physician is benevolent and humane, but where temperance and moderation is lacking. (I will return to this in 5.1.5)

Acting under time pressure while handling large amounts of information

A widespread impression of doctors is probably that they are always in a hurry. This is of course not altogether untrue. Physicians are in certain situations in extreme hurry, facing the challenge to act briskly and decisively in acute situations. But doctors do not seem hurried only on the emergency ward. In general practice, most physicians in most countries have a very short time for each patient. This is far from the ideal situation. As has been repeatedly stressed, taking the history and making a thorough physical investigation is fundamental to good medical practice. Even for relatively well defined and uncomplicated

ailments, it seems obvious that those few minutes will not always suffice to make contact and establish the kind of dialogue that is necessary for accurate diagnosis and for the establishment of a mutual trustful contact. A patient that is more worried and uncertain than the average, the existence of co-morbidity[13], and the fact that what seems at first to be a relatively well-defined and not too complex aliment may sometimes at closer scrutiny turn out to be the opposite – these and other circumstances combine to make short encounters potentially counter-productive. It is also hard to avoid the conclusion that physicians in a hurry will strongly tend to favour decisions that are time-saving, and consequently often more instrumental and to a lesser degree involving the patient's own resources and knowledge.

Seen in this perspective, one may ask whether our stories about Lisa are not in fact very far from the harsh realities of most health care systems. This may indeed be so. With a doctor in a great hurry Lisa would certainly be worse off. It is not difficult to imagine that, in the first story, she would still get the diagnosis and she would formally have undergone the same medical procedures. But may we not assume that she would have been less secure, more alone, that despair would be closer? And in our second version of the story, the risks grow. Here, not only would Lisa have risked being deserted when no clear cut somatic diagnosis was reached. We may conjecture that crucial information in this complex process of reaching diagnosis would have been lost, as this information is not likely to be brought out without a dialogue that searches for an understanding of Lisa's situation.

Of course, with professional experience comes an increasing capacity to take in relevant information and handle it in short time. One may talk about a sort of sensitivity that the experienced clinician employs in his daily encounters with patients. This intuitive capacity to sense when a situation contains elements that are not ordinary, that call for a different sort of attention and approach, may largely compensate for the briskness of the clinical encounter. The experienced clinician knows, or senses, when to break up the rigid time schedule and offer a patient more time. He knows when unexpected aspects must be brought in. He knows when it is necessary to deepen the anamnesis and extend the physical investigation – if only rigid routines and pressures for medical "productivity" do not undermine such sound clinical judgment.

Still, handling much information in little time is tricky and sometimes not quite possible. In general practice, for example, patients often present with at least two or three major diagnoses and for these diseases they may be treated with at least four or five drugs. Needless to say, the chances to get a reasonably comprehensive understanding of such an ill person's situation, both biomedically and personally, on ten to fifteen minutes, are small. GPs know this and have all sorts of tricks to compensate for the worst problems that this dilemma entails. One way is to split the patient's problems into several compartments and take one after the other on separate occasions. This is, however, not uncomplicated, as the diagnoses may not be easily separated in the biomedical sense, and such a strategy may also leave the patient with an unwanted feeling of being treated as a collection of organ systems, and not as one whole being. Another "trick" is to rely heavily on what is already done, not questioning treatment strategies that may have become obsolete. (Every clinician

knows that it takes much more time to get a patient to stop taking a medicine than to accept a new one or to go on as before.) It is often quicker to comply with a request for some further investigation – like MR or CT – than to undertake a time consuming discussion in order to explain the futility of such a step. The result is likely to be patients who have more drugs than are really needed or who are prescribed drugs that they don't take, self perpetuating circles of sophisticated investigations, lost chances of personal growth in the face of disease, discontented patients and relatives who know too little about their diseases and find themselves not really seen by the doctor. Finally, one way of shortening clinical encounters is to send tacit though obvious signals to the patient that the visit is over after a few minutes. The patient will comply.

Rapidly growing medical knowledge and new treatment options interact with increaseing expectations from the public and with cultural factors like weakening social cohesion and conflicting value systems to create complicated tensions in the physician's work. How may a GP at the same time handle the role of biomedical expert, processing vast amounts of information that are continuously revised, and at the same time function as a combination of priest and therapist – and all this on booking tables that allow only for a minimum of contact with the patient?[14] It is not surprising that there may be a temptation to retreat into the secure land of biomedical facts and what we have earlier called "the medicalised body". But then the doctor is no longer "the person who takes the history" – and the mutual dialogue that I have stressed in chapter 2.2 and earlier in this chapter as so crucial to diagnosis and treatment is not established. This may then instead be done by nurses or more than willing paramedics, leaving physicians with the

dismal task of being nothing more or less than smart biological engineers, masters of an ever more sophisticated biomedical science and technology.

Some, perhaps most, clinicians will nevertheless find a way of balancing these seemingly contradictory obligations, driven by a combination of curiosity and a will to heal. If this is so, John Berger words about country GP John Sassall may provide some understanding of how this is not only possible but also rewarding:

> Every week now he reads in considerable detail the three main medical journals, and from time to time goes on a refresher course at some hospital. He sees to it that he stays well informed. But his satisfaction comes mainly from those cases where he faces forces which no previous explanation will exactly fit, because they depend on the history of a patient's particular personality. He tries to keep that personality company in its loneliness. [15]

Acting in a network of ethical obligations

In the self-understanding of physicians, ethical obligations constitute an absolutely integral part. More obviously than perhaps any other professionals, they rule over life and death and take decisions that penetrate - literally and metaphorically – deep into individuals' lives. In chapter 2.1 the changing face of medical authority has been outlined. The physician's authority remains, though far more questioned now than it was fifty or one hundred years ago. From Ivan Illich on, medicine is the subject of a more or less fierce criticism from different perspectives.[16] On the other hand, as the influence of medicine and medically influenced modes of thought spread continuously, medical authority spills over to new areas. Both tendencies have contributed to an increasing emphasis on ethical consciousness among practitioners. Medical ethics is still "booming

business". No medical student may today pass his or her education without being invited to do a considerable amount of reflection on what is generally called "medical ethics". Programmes in medical ethics are all around.[17]

Why does Lisa's doctor not desert her in the second version? What makes her go on, venture into this unknown landscape that is Lisa's inner world? Certainly because she has reasons to believe that she can help her by doing this. But also curiosity? A sense of responsibility for a human being that is extremely vulnerable and that it is hard to see where else she could be helped? Obviously, the physician needs no medical ethical principles to do this. What she needs is courage, knowledge, temperance and imagination.

The Hippocratic Oath is still intensely discussed in medical magazines. Declarations like the Geneva Declaration, The Helsinki declaration, The Madrid declaration and professional codes of ethics for national medical associations are very much alive and function as broad guidelines of professional conduct and ethos, inviting reflection and discussion. As ethical declarations abound, doctors find themselves struggling with the every day practical implications of the abstract and very general formulations. Respecting patient autonomy may mean totally different things in different clinical contexts, as may doing good and not harming ill persons. Ethical principles offer no easy escape from difficult interpretations, or from developing a sort of context sensitivity. Probably, no doctor ever went around with the "Georgetown mantra", the four principles suggested by Beauchamp and Childress, in their pocket as a quick fix for ethically complicated situations – and if they did, they were bound to be

disappointed, when they found how difficult it was to "translate" abstract principles into unique clinical situations.[18]

The balancing move during the last ten to fifteen years in the understanding of medical ethics has meant an increasing interest in context, in emotions, in imagination and in virtue as basis for clinical decisions. Broadly speaking, character has come more into focus while intellectual analysis on the basis of ethical models like utilitarianism and rule ethics has somewhat been pushed into the background. Of course, this interest in virtue ethics in no way excludes either ethical theory or ethical principles. It is, however, widely recognized that the element of interpretation in any ethical theory is substantial and this interpretation is dependent on deliberations and interpretations which transcend the theory itself. As an example, we need only mention how extraordinarily difficult is any utilitarian calculus of the amounts of happiness or well-being resulting from different action alternatives in medical contexts is. Virtues like imagination, temperance, discernment, flexibility and so forth are proposed to be of value in such situations.

Danish physician and philosopher Sören Holm has given us some clues to how ethical obligations might be experienced by doctors and by nurses. In his rich study in descriptive ethics from 1996, *Ethical Problems in Clinical Practice – A Study of the Ethical Reasoning of Health Care Professionals*, he interviews a number of Danish physicians and nurses about their experience of some ethically challenging situations recently involving them. Holm summarizes his findings by a model involving the key notion of *protective responsibility* (with inspiration from German philosopher Hans Jonas). This idea should not be confused with

the kind of paternalistic responsibility that one would more commonly find expressed in medical practice half a century ago. In Holm's words:

> The analysis of protective responsibility showed that health care professionals do primarily feel responsible for protecting the patient from evil (the bad effects caused by disease etc), and that they thereby see their responsibility as restricted in scope at any given time (i.e they are not responsible for making the patient happy).[19]

Protective responsibility springs out of a realization of the vulnerability of the ill person, and the power of the health care professional to affect this person. It is, however, important to underline the clear limits to this responsibility. Protective responsibility is hence an attitude where doing good is tempered by respect for the patient's autonomy and integrity. This inevitably means potential value conflicts, as what is judged by the doctor to be in the obvious interest of the ill person will now and then collide with this patient's own desires and wishes. And even when it doesn't, the responsibility includes protecting from harm, not paving the way for a person's struggle with challenges in her life. This delicate balancing of basic values as an expression of responsibility is one core element of the clinician's task.

Balancing distance and closeness

Howard Brody in an essay reflects in an interesting way on the repeated warnings to young physicians not to get too close to their patients. "If the truly prevalent problem is in not getting close enough to hear empathetically and to construct mutually a healing narrative, why the ritual advice against getting too close?" Brody recommends "the synthesis of power and humility" that depends

on the physician's capacity to realize his own vulnerability. The balancing of distance with closeness means being

> …close enough (…) to feel an emotional identification and to experience, not just know about, what is happening, and at the same time be just far enough away so as to be able to reflect on that experience with some degree of critical detachment.[20]

I will later argue that emotional identification with their patients is not something that could or should be expected from physicians. Also, it is probable that Brody's diagnosis – too little closeness being the major problem – does not really hold today, at least not in a number of cases. While acknowledging exaggerated distance as a risk in patient-physician relation, we should perhaps be open to a risk that has earlier seemed small but that may gradually increase: that "person-oriented medicine" (or whatever we want to call it) may pose a risk to the integrity of our patients. Let us assume that physicians, of whom at least some will certainly lack the necessary degree of sound judgement, are on a broad scale taught to go looking for "the person behind the symptoms". May we not conclude, then, that this may be done clumsily, insensitively and in a way that makes things worse rather than better? Hence the necessary stress on temperance as a crucial medical virtue.

It can hardly be sufficiently emphasized that physicians´ access to their patients´ private sphere must be handled with great restraint and temperance. Even when there are good reasons to believe that knowledge about the ill person's private life might be of value to diagnosis and therapy, it does not follow from this that the physician should always seek such access. The physician hence treads on a

thin line, balancing between knowing too little and too much. There are other reasons than purely medical to abstain from knowing.

Making theory and praxis coexist

The amount of theory that doctors are expected to command seems to grow without any end in sight. However ambitious the physician is he is bound to know less than he ought to. However, professional clinical knowledge is only partly theoretical. To put it another way, practical knowledge largely relies on "learning-by-doing", and this does not necessarily involve thorough knowledge of the mechanisms involved in the course of disease. Rather often, in clinical medicine, these are not even known. This has been called "black-box situations". The organism, the "black box", is manipulated in some way and out comes a favourable response – known by the physician through classical trial and error knowledge, often called "tried experience". If such situations may be reduced or even eliminated, in favour of biomedically well defined interventions, is open to controversy.

Doctors´ professional understanding is, as already noticed several times, action oriented. The theory they employ and find worth while knowing is largely "theory-in-practice". It is a theory that, interpreted and applied in concrete situations, help them reach certain goals. We may probably conclude that most practising doctors, not least through the sheer force of their everyday tasks, tend towards a sort of "trial-and-error"-empirical position. What works is OK, whether it be solidly founded in scientific investigations (like EBM), backed by some encompassing theory of the organism and its diseases, or whether it has

"just" through reasonably solid experience proved to be of value.[21] To this I will return soon when analysing the concept clinical judgment.

Harbouring sorrow and suffering – the need for catharsis

The tension in medical work is to some extent a tension that has always been there. Doctors are, to put it bluntly, situated in a complicated no man's land between the ideal and the possible. This predicament has not been radically changed by the advent of modern medicine. There is a strongly pragmatic stance to many physicians´ self understanding. When facing disease processes which are stronger than our attempts to curb them and when standing face to face with human fallibility and vulnerability, doctors may develop a tendency towards pessimism verging on cynicism.[22] If full recovery is seen as the goal, physicians have to face therapeutic failure more often than therapeutic success – and sooner or later we will all die, however much the grandiose medical project of preventing death attempts to postpone death.

It is from this relative powerlessness in the face of suffering that the need for catharsis arises. If physicians are trained to fight disease and if success in this project is only sometimes possible, then there is a need for reconciliation, for coming to terms with the resulting guilt and feelings of insufficiency. This need persists even when we extend the task of physicians from cure to alleviation and palliation. The physician may fall into despair facing the brutal arbitrariness of disease and suffering. Eric Cassell points to this as a reason for the physician's retreat into the secure landscape of technical facts:

> Every physician has the same fear – becoming closer to suffering patients, many of whom will die, surely promises pain, sorrow, and loss. Why would we not want to hold back, cover our feelings with a white coat, and hide behind incomprehensible technical language?[23]

If this is not to happen, physicians, as other health care professionals, are in urgent need of a way to handle their despair, their sense of powerlessness, their fear. Catharsis was the Greek notion used to capture the paradoxical experience of relief when the citizen of Athens left the theatre after having witnessed the often bloody and cruel story of a tragedy. As noted above in 3.2.5, Aristotle thought that this paradoxical sense of liberation, "tragic pleasure", was a result of facing the world as it is, of looking into the most shameful corners of human existence, of getting a structure for the unstructured darkness. The tragedy dealt with some of the most merciless aspects of human existence, but it did so in a fictive form, hence permitting for a participation on conditional grounds. Catharsis was and is the paradoxical experience of relief that came out of an act of imagination – what in the next chapter I will consider to be central to much of literary experience.

We will hence return at length to the drama and to the concept of catharsis in chapter 5. In connection to the nature of the clinician's work, let it just be noted that practitioners of modern medicine are no less than their predecessors in need of a comprehensive and intelligible fictive presentation of the dark forces of human existence. Looking right into the darkness in fictive stories will prove to be one clue to meeting the challenges of clinical practice.

The last words will once again be those of John Berger who, in his sensitive attempt to understand the work and the motivation of a British country doctor, manages to capture the essence of the physician's task:

> He had exchanged an obvious and youthful form of extremism for a more complex and mature one: the life-and-death emergency for the intimation that the patient should be treated as a total personality, that illness is frequently a form of expression rather than a surrender to natural hazards. This is dangerous ground, for it is easy to get lost among countless intangibles and to forget or neglect all the precise skills and information which have brought medicine to the point where there is the time and opportunity to pursue such intimations. The quack is either a charlatan or he is a healer which refuses to relate his own few insights to the general body of medical knowledge.[24]

4.3 Clinical judgement and phronesis

It is sometimes asserted that the best way to understand the "non-scientific" elements of clinical medicine is to describe them as "the art of healing". This "art" may then be seen as some sort of additive to the real, scientific medicine. Admittedly, this view of medicine as ideally a branch of the natural sciences is becoming more contested, as the triumphs of medicine become less obvious (see above, 2..1.7). Still, it lingers on and exerts a considerable influence of the attitudes of medical professionals.

The art of healing is often contrasted with scientific medicine. If so, one may be tempted to think that there is really such a thing as a "healing art" that is separable from the scientific elements of medicine, working on conditions of its

own and in clear opposition towards elements of modern medicine that rely on biomedical sciences. We have already seen (2.1.2) that "art" in the history of medicine has been associated with "techne", which means craft or practical knowledge rather than what we would think of as art. The art of healing, if there is such a thing, would then probably have to include elements of both episteme, techne and, not least, phronesis.

Carl Magnus Stolt writes that

> The art of healing may from an overriding perspective be seen as the art that is practised when the physician individually tailors a strictly scientific therapy according to an individual. (*my translation)* [25]

This idea seems to involve a sort of leap from scientific rationality to another kind of rationality, founded in what Toulmin calls "the epistemology of the person", the characteristics of which I have outlined in 2.1.9. Stolt, however, stresses the intimate interplay between science and art. Only by loooking at them as deeply intertwined may we understand how clinicians practice.

David Greaves, the fierce critic of some aspects of Western medicine, in his essay *Reflections on a new medical cosmology* suggests that there is indeed "an inescapable element of indeterminacy and uncertainty, or a mysterious quality" in medical knowledge. He points to the peculiar blend of particular and universal knowledge that has already been mentioned. There are several valid perspectives on the clinical situation, he contends, and hence there is no privileged gaze. Greaves wants to rescue the notion of healing from its

connotations of obscurantism, while stressing the "…spiritual and mysterious quality which transcends scientific rationalism….".[26]

One of the most articulated defenders of one unified notion of rationality in medical practice is Alvan Feinstein. When his *Clinical Judgment* appeared in 1967, it was in a situation where bedside diagnostics and clinical judgement were, in the eyes of many, threatened by the enormous expansion of technology dependent diagnosis and therapy. Feinstein's aim was to restore the solid basis for clinical judgment by stressing that the process of diagnosis and therapy is indeed possible to describe, understand and - most importantly – to conduct in a scientifically sound manner, while not losing human qualities out of sight. I will briefly take a look at Feinstein's arguments.

Feinstein's central notion, hence, is "clinical judgment":

> All good clinicians use a distinctly clinical type of reasoning, called clinical judgment, for making decisions about therapy and prognosis for their patients. We often refer to a physician's judgment as being good or bad according to the wisdom with which he makes those decisions. (…) Clinical judgment depends not on knowledge of causes, mechanisms or names for disease, but on a knowledge of patients. The background of clinical judgment is clinical experience: The things that clinicians have learned at the bedside in the care of sick people. In acquiring this experience every clinician has to use some intellectual mechanism for organizing and remembering his observations.[27]

One must not misunderstand Feinstein here. He is not talking about some mysterious quality of practical medicine that is incomprehensible by

intellectual means. Feinstein distinguishes three different kinds of data that the clinician has to use to make sound judgements. The first is data about disease, scientific data of a purely biomedical nature. The second type of data describes the host in which the disease occurs, that is data about age, sex, heredity, earlier diseases and the physical background etc of exactly this patient. The third kind of data Feinstein calls "environmental". These are data about the illness consisting of symptoms and to some degree of signs. Feinstein over and over again emphasises that these three forms of data are interdependent and that one form is virtually useless without the existence of the others.

Clinical judgement may well be scientific, argues Feinstein, as long as we don't restrict this word too much. Being "scientific" in this sense means systematically learning from experience and doing this while respecting certain rather basic methodological rules. Every clinical encounter, in this sense, is an experiment. Feinstein devotes his book to showing this, with a rich number of examples. It follows that the whole idea of a separation between medicine as an art and medicine as a science is flawed from his perspective. There are "scientific" elements in art as there are "artistic" elements in science. There exists no sharp boundary and in clinical decision making this distinction is very much blurred. All aspects of clinical work may be said to be scientific but they are so in different ways. There is no escape for clinicians from being systematic and critical in their work just as there is no escape from using fantasy, intuition and aesthetic judgement.[28] Hence, Feinstein includes in his notion of "science" also large parts of what Toulmin would call "the epistemology of the biographical".

Feinstein's view of clinical medicine may be encouraging in a time when advocates of evidence based medicine sometimes describe their project as the elimination of personal judgement from practical medicine, at the same time as those who oppose EBM are unable to understand the necessity for creating a sound empirical basis for treatment decisions. One may ask why Feinstein so explicitly excludes diagnosis from what he calls clinical judgement – restricting this concept for only therapy and prognosis - and why he separates some biographical data from experiential, but these question marks are of minor importance. In Feinstein's view, profound biomedical knowledge and a sharp and distinct diagnostic gaze and language must coexist with a sensitive openness and respect for the unique elements of personal experience.

There is a difference of emphasis but, I believe, not of kind, between Alvan Feinstein and Katherine Montgomery. The latter, in her rich analysis *How doctors think,* devotes considerable space to a polemic against what she thinks is an impoverished idea of what clinical medicine is. What she calls medical science is not what Feinstein would use this label for. Feinstein's clinical judgement, that he considers to be scientific, is in Montgomery's eyes rather a different kind of rationality. Her analysis deserves close attention in this study, and it will hence consequently be presented at length.

A fundamental point of departure for Montgomery's analysis is that there is a discrepancy in the way many doctors theoretically conceive of their work and how they actually go on to practise it. In the former case, a rationality characteristic of the natural sciences is favoured; in the latter, it is rather what

Montgomery prefers to call a "narrative rationality", or "practical reasoning", that is employed. Medicine as a practice is "unclean", it is characterized by an awareness of both biological variation and the unpredictability of human intention that ultimately defy statistical generalization and scientific law making. No doubt, basic pathophysiology and epidemiological statistics are of great importance for the clinician – and, as we have seen in chapter 2.1, they provided the basis for the success of modern medicine in many areas. However, there are numerous situations in which the clinician's task - to "work backwards" from the symptoms and signs of the patient to a reasonable aetiological hypothesis and from this forwards to a diagnosis and treatment – may just not be subsumed under general scientific generalizations. The second story about Lisa illustrates this. Furthermore, there are numerous medical considerations which do not deal at all with what Toulmin would call "the epistemology of nature", but rather with "the epistemology of biography", that is with the personal realm of human intention. In such situations, which are abundant in clinical practice and which we see illustrated in the narrative of Lisa, the physician employs what Montgomery calls *practical reasoning* or, relying on Aristotle, *phronesis.* The crucial source of this complementary and with scientific modes of thought intertwined method of practical reasoning is the case story. Through this, a narrative rationality is established as a decisive element of clinical work, amalgamating with scientific knowledge into clinical judgment.

The concept of phronesis, as presented in Aristotle´s *Nichomachean Ethics,* has been shortly mentioned above in connection to the two other forms of knowledge that Aristotle mentions, episteme and techne (see 2.1.2), and with which it usually merges with different emphasis. Phronesis has become a popular concept since the interest in Aristotle's philosophy has increased

considerably. Translations, however, differ. Most often, one encounters *practical wisdom* as a synonym.[29] The notion of wisdom may create very different associations and for some probably has the connotation of something mystic and intangible. Perhaps *practical reasoning* is a better attempt, but this strips it of the clear link to morality that the former translation contains. Whatever we use as translation, phronesis is by Aristotle used for the capacity to *see and do* what is right in unique situations. It is important to note that this is a theoretical as well as a practical capacity and that it is a certain kind of *knowledge.* This means that what is right, the good, should not only be identified but also actualized, brought into being. The fact that it is seen as knowledge is connected to the value ontology of Plato and Aristotle, according to which morality is linked to knowledge, and the person who knows the good also does the good.

Aristotle's position is not altogether easy to understand today. I doubt whether most persons would accept the idea that my evil acts are due to ignorance, and that when ignorance goes away and I see clearly, I will do the good. Evil results may of course be due to good will in combination with bad judgement, that is a poor understanding of the conditions under which I may bring about a result that I rightly judge to be valuable. But that evil intention is equal to ignorance seems harder to accept. So when phronesis is today used to capture the capacity to do the right thing in the right moment in a particular context, it often avoids the question about *how* the right thing is first identified and motivated. The answer that I see what is good when I have adequate knowledge of the situation does not seem very satisfactory. This is a common critique against so called virtue ethics and I find it relevant. I will, however, not go further into these intricate questions in moral philosophy at the moment.

Montgomery particularly stresses the narrative character of phronesis. Narrativity here means the presence of a chain of events developing in a time sequence and the presence of elements that are usually seen with suspicion in scientific contexts: contingency, unexpected events, paradox, ambiguity – and, notably, human intentionality:

> Complexity and uncertainty are built into the physician's effort to understand the particular in light of general rules. If physicians could be scientists, they surely would be. The obstacle they encounter is the radical uncertainty of the clinical practice: not just the incompleteness of medical knowledge but, more important the imprecision of the application of even the most solid seeming fact to a particular patient.[30]

Montgomery captures the process of clinical reasoning and decision making well. It is, indeed, a combination of hypothetic-deductive method and something rather different from that: a reasoning that is "practical", "interpretive" or "narrative", and, as she rightly stresses, "it is the latter that makes them clinicians".[31]

We can see this in our narratives about Lisa. In neither of the two stories, the physician's considerations, actions and decisions may be described as the result of a purely scientific rationality. This means that they could not be deduced or inferred from the knowledge of scientific facts, laws or patterns alone. In the first story, the physician in an orderly and seemingly logical way diagnoses a serious and well described disease, multiple sclerosis. However straightforward the road to this diagnosis may seem, there are several occasions on which the doctor employs other ways of knowing and sensing, more related to a mode of understanding associated to our understanding of narratives and aesthetic works. This is the case for many of the aspects of the first encounter with Lisa:

the way of listening and relating to her, the way the anamnesis is "taken", the proceeding investigation and the following report to Lisa about what to do and what to expect – all this of course requires large amounts of scientifically based knowledge both from pathophysiology and from epidemiology. But it would be far from enough for the doctor to rely exclusively on this. It is easy to see that practical wisdom in a decisive way enters into all of these sequences of the diagnostic and therapeutic process.

Even more of complexity may, however, be found in our second story, where the diagnostic process is less "deducible" from textbook medical knowledge, the considerations more complex and the relation to Lisa clearly more sensitive and risky. In this case, the physician will compare the symptomatology of Lisa to a number of standard cases, representing a number of differential diagnoses. However, it will soon become obvious that this is not a straightforward case; it is rather one of those encounters with an ill person where aetiology, diagnoses and treatment remain obscure and where time is used to reach a reasonable degree of certainty, enough to act from in ways that offer hope for the patient and increases the chances to reach certainty.

Both versions, but especially the second story, offer us good examples of what Montgomery calls "narrative rationality". I want to cite her at length here, because what she writes is highly relevant to this investigation:

> Physicians share this narrative rationality with lawyers, moral reasoners and detectives, all of whom must negotiate the fit between the organizing principles of their professional worldview and specific problematic situations. In each field, such a set of circumstances is called

> a "case". The rational procedure that determines what any particular case is a case *of*, is neither induction nor deduction but a third thing: the logic that the pragmatist C.S. Peirce described as "abduction" or "retroduction". Reasoners start from a particular phenomenon and, using preliminary evidence, hypothesize its possible causes; those hypotheses are tested against details revealed by closer examination. This circular, interpretive procedure moves between generalities in the taxonomy of disease and particular signs and symptoms of the individual case until a workable conclusion is reached. Far from barring rules and generalities, narrative rationality – Peirce's "abduction" – puts them to interpretive work.[32]

This quotation captures the practical reasoning of our clinician in both stories, and it may be seen that this capacity to "abduct" is more crucial in the second case. It is also obvious from this case that the abduction is a protracted process; it does not reach a well determined end and the interpretive task of the physician is much akin with what is called "the hermeneutic spiral" – one interpretation is matched against new clues from anamnesis and investigation. In the light of time passing, the interpretations change as the assembled evidence from anamnesis and investigations change – and are once again matched against new evidence, until the case is settled, that is: a diagnosis and resulting therapy of sufficient clarity, predictive certainty and therapeutic success are reached. Or, alternatively, no diagnosis is found and it becomes reasonably clear that Lisa's problems has to be understood and in a different way than a medical diagnosis and a "medically" treatable disorder.

The picture Montgomery paints of how doctors actually think, in line with their alleged ideals from their training, about medicine in relation to science strikes me

as much more relevant to a clinic on a university hospital then to a primary care unit or, for that sake, a small countryside hospital. The primary care physician is likely to think of substantial parts of basic scientific medicine somewhat as the cook thinks of physics and its laws: they both take advantage of it all the time, but without really knowing how it works. It is dubious whether most physicians really hail the ideals that probably to a large extent permeated their education, those of the "pure sciences". A wealth of studies and analyses, written by experienced clinicians, have disproved the naïve idea from the late 19th and early 20th century of medicine as the straight scientific road from specific aetiology to specific diagnosis and treatment. For example, the emerging stock of knowledge on "the consultation" bears ample witness to this. At least after some years of practice, most doctors know this also on a theoretical level – but often lack a language for it.

Montgomery's emphasis on case reasoning as essential for medical learning, on the other hand, seems well founded and of particular interest to this investigation. It is through the case that the complexity of clinical judgment becomes visible, yes almost tangible. Physicians do indeed often think in cases. Cases develop over time. They are told to make justice to the complex and uncertain character of clinical judgment. The assimilation of numerous complex case stories is a true mark of the experienced clinician and fruitfully they interact with the generalized knowledge of biomedicine and epidemiology. Case stories cannot be replaced by "pure" medical facts assembled to illustrate a patient's disease. These would lack the specifically dynamic, unfolding, provisional and tentative character of much of clinical reasoning.

The recognition and handling of particularity is crucial to clinical skill. The case is particular. Knowledge of unique cases has to coexist with the generalisable knowledge of large studies and disease "materials" in medicine. As Montgomery eloquently puts it:

> Understanding the particulars, despite the inexact relevance of biological science and statistical epidemiology to the circumstances of one person's illness, is medicine's chief moral and intellectual task.[33]

Though this may strike one as perhaps somewhat exaggerated I believe that Montgomery is on very solid ground here. The physician in our two stories grapples with this challenge all the time. Lisa's symptoms are indeed such as *generally* will be found among patients in early stages of multiple sclerosis, but they are also found, in more or less vague combinations and appearances, in patients with a large number of other afflictions – or perhaps no identifiable disease at all. There are group resemblances between these illnesses, but each case will present its characteristic and partly unique combination. Our experienced physician knows this without even thinking about it. The diagnostic process is very far from being a mechanic subsuming of a cluster of symptoms and signs under some group heading ("syndrome" or "disease"). The search for diagnosis is more like an open search in different directions, a sort of sensing by intellectual as well as emotional means, using language, senses and biophysical observations intertwined, a fitting together and adaptation of evidence to model. This complex process largely takes place in language, it requires imagination and flexibility of thought, it needs to be tempered by restraint and sound scepticism and it must all the time be communicated in a delicate and dignified way to the person for whom the diagnostic endeavour is undertaken. This is the very core

of clinical judgement and it is in certain important ways more like the rationality of literature then that of the pure sciences, because it is based on "narrative rationality" as described by Hunter.

4.4 Clinical rationality, literary experience and Toulmin's complementary epistemologies

It is time to conclude this chapter and, in doing this, to reconnect to chapter 2. Clinical medicine both should be and usually is practiced rationally. The physician's rationality is, however, not the same as the physicist's or the chemist's – to which it is in considerable debt. Clinical judgement, which is the concept here used for the physician's skill, owes just as much to the modes of understanding of the social sciences, the humanities and the arts.[34] Practical reasoning, or *phronesis,* involves a complex set of capacities and hence necessarily depends on virtues of character. Character is, of course, formed through a wide range of influences on our lives. In chapter 3, it has been argued that encounters with literature do, in fact, shape character. This character-dependent rationality is not a rationality that can be attained by exclusively intellectual means. It seems to borrow just as much inspiration from what Toulmin called the "modernity" of Erasmus, of Montaigne and of Shakespeare as from that of Newton or Descartes (see 2.1.9). It is a rationality that does not deny contingency, that remains open to paradox and ambiguity, that – while fully acknowledging the value of general scientific laws and principles – recognizes the tension-filled coexistence of chance and necessity, between the general and the particular, between the predictable and the unforeseeable. This is a rationality that fits in with clinical realities, that gives full justice to them.

Shakespeare's genius, his deep rationality if one likes, consists in the capacity to show, in an intellectually as well as emotionally convincing way, the limits of human rationality.[35] I believe that this is the rationality that Toulmin associates with the Renaissance and which he contends was partly lost with the scientific revolution of the 17th century and its aftermath. And if Kathryn Montgomery is right, it is from this heritage from the sciences born in the 17th and 18th centuries, that the idea arose, so powerfully successful in modern history, that medicine in both its theoretical and its practical aspects should mimic the methods of the sciences. I have attempted to show that this is a wise recommendation, only if one uses the concept "scientific" in the way that Feinstein does: as combining systematic observation and logical reasoning with narrative imagination and an acceptance of complexity and paradox and vagueness in clinical situations.

I have stressed the challenge that clinicians face when they move from the illness experience to the facts of pathophysiology and back again. Literature is an important source of knowledge of the life world of humans. The novel or the poem or the drama have a remarkable capacity to capture and help us sense – with awe and wonder, with joy and gratitude, with disgust and revulsion - "the ways of the world". It may be argued that music and visual art work just as well in this respect, or that the social and humanistic sciences are most apt to help us. It is unnecessary to play these roads to knowledge against each other. They may all be of importance, but the present investigation is directed to literary texts and their potential for the practising physician. In chapter 5 this theme will be further explored

[1] Cassell, Eric: *The Place of the Humanities in Medicine.* The Hastings Centre, 1984, 25

[2] I feel obliged to use quotation marks here, exactly for the reason we have been dealing with earlier, that is the "reification" of a state of illness to being something existing somewhere in the body. The longing for diagnosis is, we will soon see, to some extent a result of this. If there is an "it", well then there must be a name for it. See also Ahlzén, 2008.
[3] Raimo Puustinen has warned of talking of the "taking" of an anamnesis. There is no such thing to "take". An anamnesis develops gradually and unforeseeably during the clinical dialogue. Puustinen, personal communication.
[4] A differential diagnosis is one of those diagnoses that from the evidence at hand must be taken into consideration. Usually, the more evidence, the fewer differential diagnoses.
[5] Rudebeck, op cit, 40-47. Bodily empathy in this context means the capacity to understand, to some extent, the patient as embodied being in the situation when she is ill.
[6] Pellegrino, Edmund D.: "Being Ill and Being Healed: Some Reflections on the Grounds of Medical Morality" In Kestenbaum, V (ed).: *The Humanity of the Ill: Phenomenological Perspectives.* Knoxvill: Univ of Tennessee Press, 1982, 157-166
[7] Holm, Sören: *Ethical Problems in Clinical Practice – A Study of the Ethical Reasoning of Health Care Professionals.* University of Copenhagen, 1996, chapter 4. Holm develops this concept after an analysis of interviews with doctors and nurses in Denmark concerning a clinical experience that they found ethically problematic.
[8] There are of course numerous exceptions to this, appearing in all situations where the ill person is not able to enter into a verbal dialogue with the physician. Obvious examples are very small children, seriously mentally ill persons and, of course, unconscious or deeply somnolent individuals unable to express verbally what they think, feel and need.
[9] Hellström, Olle: "A phenomenological analysis of doctor-patient interaction: a case study". Article IV in Hellström, 1999, op cit
[10] Nessa, John: *Talk as Medical Work: Discourse Analysis of Patient-Doctor Communication in General Practice.* Universitas Bergensis: Bergen, 1999, paper IV
[11] Lantz, Göran: "De två språken" ("The two languages"). *Det öppna rummet: Festskrift till Merete Mazzarella. (The Open Room: In Celebration of Merete Mazzarella.)* Helsingfors: Söderströms, 2005, 321-330
[12] Cassell, 2004, 235
[13] Co-morbidity is the existence in one and the same person of more than one disease.
[14] Arguably, this role is impossible to live up to. But isn't this the role contemporary western societies have assigned to physicians, though not explicitly? Physicians may reject it but the tasks that they meet in their everyday work seem to demand that they at least take on some of the tasks that were earlier assigned to priests and that nowadays are also the area of psychotherapists.
[15] Op cit, 62
[16] Ivan Illich´s classic book *Limits to Medicine. Medical Nemesis. The Expropriation of Health.* London: M. Boyars, 1976, was an unprecedentedly brilliant attack on modern medicine. However much one may think that Illich misunderstands and exaggerates certain facts, there remains a strong and worrying call for continuous medical self-scrutiny emanating from his work.
[17] In *Academic Medicine* from October 2003 a broad over-view is given which clearly shows the scope of the medical ethics project.
[18] Beauchamp, Tom& Childress, James: *The Principles of Biomedical Ethics.* New York: Oxford Univ Press, 1983.
[19] Holm, 139
[20] Brody, Howard: *The Healer´s Power.* New Haven and London: Yale Univ Press, 1992, 265
[21] The Swedish directives for physician talk about "vetenskap och beprövad erfarenhet" as the basis of clinical work. This is hard to translate. "Science and tried experience" may be a possibility, "science and solid experience" another. The idea is that not all experience is trustworthy and that there may be something of interest between the unique anecdotal case and the meta-analysis of several large studies.
[22] We see this physician character appearing in late 19th century literature, for example in the dramas of Ibsen and Chekhov.
[23] Cassell, 1991, 249
[24] Op cit, 62
[25] Stolt, 1998, 8-14

[26] Greaves, op cit, 149-159
[27] Feinstein, op cit, 12
[28] Ibid, 291-297
[29] This translation is used for example in the 1911 translation published under the title *Aristotle´s Ethics* and reprinted latest by Dover Publications in 1998 as *Nichomachean Ethics.*
[30] Montgomery, Kathryn: *How Doctors Think: Clinical Judgment and the Practice of Medicine.*New York: Oxford University Press, 2006, 37
[31] Ibid, 45
[32] Ibid, 47
[33] Ibid, 86
[34] Ahlzén, Rolf: " Medical humanities – arts and humanistic science" In *Medicine, Health Care and Philosophy* (2007), 10: 385-393
[35] This assertion could be exemplified at length. I believe that *King Lear* is a wonderful example. Cordelia's silence, her stubborn refusal to answer the cruel question of her severely imbalanced father, is rational in the deepest sense of the world, while the consequences of Lear's irrationality become almost intolerably clear to the spectator – and finally to himself.

Chapter 5

Literature' s offer to medicine

> *The physician's training also encourages the dangerous fallacy of over-literal interpretation of accounts best understood metaphorically.*
>
> Arthur Kleinman[1]

The purpose of this investigation is a better understanding of clinical medicine and of the role literary texts may play in the development of the physician's skills. In the previous chapter, I have outlined what I see as the essential parts of clinical competence, and linked it to the idea of clinical judgement. This in turn has been seen to relate in complex ways to what Aristotle called phronesis, a mode of knowledge that coexists with the other two forms, episteme and techne. I have argued that in describing clinical rationality in this way, as linked to phronesis, we may be inspired by Stephen Toulmin's idea of a partly different rationality from the one that has gradually come to dominate the Western world since the revolution of the sciences in the 17th and 18th centuries. Finally, I have presented a way to think about literature and literary experience that I believe has obvious implications for clinical skills.

It is now time to let literature meet medicine. The focus here will be on the contribution that literary experience may give to the physician's clinical skills. What is it, then, that literature may contribute? Under what circumstances may this happen? May we expect this type of benefits from all encounters with literature, or only from some? And are all readers susceptible to this influence, or

only some and in various degrees? These are all intricate questions that must now be addressed. They will not and cannot, as underlined in chapter 1, be conclusively answered. What I hope for is conceptual clarification, heuristic insights, a more comprehensive understanding and the demonstration of potentials. The emphasis will be on literature as invitation, indeed as *call* to the reader (chapter 3.1.4). I must once again underline that I propose to look upon literature as a potential contribution to clinical skills, not as a definite and instrumental remedy for the ailments of medicine.

The chapter is divided into two parts. In the first, I outline what I believe are the potentials of literary experience in relation to clinical work. This analysis heavily relies on what has been written in chapters 2, 3 and 4. I then, in 5.2, go on to discuss the literary encounter and how it may affect the reader's response. I will take specific interest in the question whether discussion about literary texts with others may in some ways enhance the chances that important insights be delivered. Also, questions about the texts themselves will be analyzed. As texts differ very much from each other, it is tempting to hope for some sort of aesthetical, and perhaps also ethical, demarcation of texts that may be valuable from texts that are not likely to be so. I will attempt to adress also this question, but I will underly the difficulty to give any definite answer.

5.1 A potential for learning

A good deal of writing on the importance of literary experience for clinically active physicians warns against any assumption that the physician will become a more moral person through this acquaintance with written narrative.

Admittedly, it is sometimes said that we may learn things about life in novels, poetry and drama, but any assumption that these insights would make us morally better is denied.[2] This rejection of literature as a way to moral growth is interesting and mirrors, as I see it, a confusion of what moral virtue really is. If phronesis, practical wisdom, as I have proposed, means *both* to identify *and* to actualize what is good - then a richer, more nuanced and more complex understanding of the world would seem to be a necessary, though not sufficient, condition for a person to be good. The conclusion from this would be that anything that works in this way, that enriches a person's view of reality, will also contribute to this person's moral growth. I will argue that literature has this potential.

Jane Macnaughton gives us an interesting example of the reluctance to concede any moral effects to literature when she analyses Ian McEwen's novel *Saturday* and reaches the conclusion that Perowne, neurosurgeon and main figure of the story, seems to be a good physician and a decent man, *though he doesn´t read very much* (and indeed, inspired by his widely read daughter, accuses himself of this).[3] What Perowne knows about life and about being ill and vulnerable, he must obviously know from other sources than fictive stories – from his early life experiences, from his patients, from his family, from his interest in public matters. And it also seems as if this is sufficient for his tasks as a neurosurgeon who meets people in extremely delicate situations where one would expect imagination and moral sensitivity to be of crucial importance. Perowne probably strikes the reader as reasonably empathetic (though, admittedly, we know too little of his clinical performance to say for sure). Hence, may we conclude that literature is unnecessary for the physician?

This is a far too hasty conclusion. The fact that some physicians that read little or no fictive literature are good physicians does certainly not exclude that for others, literature may be of a certain importance or even of great value. Literary acquaintance may neither be a sufficient nor a necessary condition for being a good physician – but it may for some clinicians, perhaps many, be a contributing factor of some strength. Perowne may just be one of those persons who have assimilated his medical training in a way that comes in no tension to his knowledge of and interest in human beings. Possibly, he has managed to face the challenges that I have outlined in 4.3. In this and many other senses, Perowne strikes the reader as being an unusually happy man.[4] And it is of course possible that had Perowne read novels and poetry now and then, and also discussed his reading with his wife and daughter (and perhaps also other persons), he might have been an even better physician.

The rejection of literature's capacity to make us into more moral persons is often, as in Macnaughton's article, based on a denial that empathy will result from reading "good books". Empathy is then presented as a virtue characterizing a good person. And, the argument goes, for most people we see around us, there seems to be a weak or even non-existing relation between number of read novels and moral virtue. The rejection of literature's capacity to work for moral improvement would then be founded on a sort of everyday empirical basis. If so many scoundrels are very well-read, this must surely mean that literature is either morally inert or even detrimental to a person's morality?

But should we stay content with this conclusion? Good will and moral dispositions need perhaps not be much affected by reading – they may or they may not. But if literature, as I will soon attempt to show, offers us a chance to see

the world in a richer, more complex and more nuanced way – surely this is of the greatest ethical importance and highly clinically relevant? If a number of the phenomena that fill the physician's working day – bereavement, birth, fear, longing, pain, hope, ambiguity, paradox – escape scientific understanding, or are only partially understood through scientific concepts….. doesn't from this follow that the clinician who develops a richer understanding of such aspects of the clinical encounter will also be able to do more good? If a complex understanding of some clinical phenomena is necessary for the attainment of the goals of medicine, it seems as if all roads to such an understanding will increase the physician's skills. My point here is that the physician with this capacity has acquired the skills to do more good. It is a matter for moral philosophy to discuss whether this means that he is also a morally better person. Whatever the answer may be to this, he or she is most certainly a better physician.

If my analysis is right, the question is *how* and *when* the physician may learn about reality in a clinically relevant way from stories about fictive persons that do not exist, at least not in the ordinary everyday sense of the word. I have laid a foundation for this argument in chapter 3.2, relying on among others Booth and Nussbaum, and I will soon return to it again here in order to analyze it further. Before this, however, I wish to summarize what in physicians´ skills may be absent or at least inconspicuous, given their present training.

5.1.1 The challenge

In chapter 4, I have tried to summarize some challenges facing the physician. They are the following:

- handling in a morally acceptable way the vulnerability of the patient and the doctor's superiority in power;
- taking into full account that there is often a clash of languages between the ill person and the physician, that also mirrors a clash of epistemologies (the lived body vs the medicalized body);
- living in practice with the uncertainty that often permeates clinical work, so well described by Kathryn Montgomery;
- being able to work with precision of observation in combination with warmth and respect for persons under often distinctly "suboptimal" conditions of time pressure and a mixture of too much and too little information;
- developing a consciousness of the continuous presence of ethical obligations (however these are formulated) that constitute the very foundation of the clinical work (what Sören Holm calls "protective responsibility");
- balancing distance, necessary for sound clinical judgment and emotional survival, with active interest and participation in the experiences of the ill person;
- finding a way of "translating" vast amounts of clinical information on a general level to unique clinical cases, without losing either the person or the diagnosis out of sight;
- living with the harsh realities of disease, suffering and premature death without being emotionally numbed and cynical.

In the following, I will of course not suggest that there is a direct link from literary experience to these complexities of clinical work. I will, however, try to argue that the potential for learning from literary experience do carry also a potential to grow in capacity to see, accept and handle these challenges.

The physician has to reach an understanding of her patient. What does "understanding" in this context mean? It is important, I think, to realize that it is another kind of understanding than that implicit in everyday phrases like "Now I understand her", or "I gradually came to understand him". Understanding in the clinical context is both more and less than this. It is less because it does not necessarily invove a deep acquintance with another human being. It is more because it must include an understanding of bodily mechanisms that is beyond everyday reach. I hence suggest that clinical understanding means the attainment of such knowledge of the patient that makes it possible for the physician to reach the goals of medicine – i.e., the restoration of health, of a "homelike being-in-the-world". I have attempted to make clear, in the preceding chapters, how complex this understanding is. In particular, I have wanted to show that it can not rely on scientific knowledge of bodily processes alone.

Still, the physician's training rests heavily on a scientifically based understanding of the body in health and in illness. It must do so because without this understanding almost all the advances of modern medicine would have been impossible. As I have shown in chapter 2.1, the breakthroughs are real enough and there will certainly be more of them. If I am right when discerning the challenges that the clinician faces, some of them new and some with us since long, he must also employ other modes of knowledge in order to reach the goals of medicine. If the illness experience is given its right place as a fundamental road to diagnosis and treatment, as well as constituting the foundation for the mutual trust between patient and doctor – then we have to look for ways to broaden our understanding of which experiences physicians ought to have in order to be good clinicians. I suggest that literary experience may, under certain

circumstances to be investigated in this chapter, be part of this more complex base of knowledge that the physician needs.

A number of circumstances make the physician's challenges particularly hard to face. Some of these I have mentioned earlier. Doctors are generally not very similar to their patients. They may be younger (usually) or older (perhaps less often). They are well educated and often well off. They have often been successful during their earlier life, worked strenuously to get degrees to get into medical school and laboured hard during medical studies. They are used to taking decisions on behalf of other people. They may sometimes have been ill themselves, though probably most often not very seriously. They rely on a combination of clinical experience and scientific knowledge of the body that is alien and incomprehensible to the medically untrained. How, then, may a thirty-two years old, upper middle class physician, never more than casually ill, understand a seventy-six year old worker, deprived of job and family, marked by aching shoulders and back and abuse of alcohol since several decades?

Moreover the physician searches for a diagnosis in the unique case. The individual has to be subsumed under the general disease category. This category is founded on the language of the objectified body, the scientifically described body. Diagnosis is reached through the interpretation and further investigation of symptoms and signs. Symptoms are reported through language. Language differs from individual to individual, and may be incoherent and idiosyncratic. Furthermore, the will of the patient, his feelings and his attitudes, are often difficult to grasp, as different contradicting emotions may coexist or the person may be affected by disease and/or treatment in ways that decrease his competency for decision-making. Ill persons are often ambivalent and their

discourse vague and ambiguous, but diagnosis has to be unequivocal. Love and hate may stand close together, as may hope and despair

Helping someone to recover, or to live a decent life while ill, requires some degree of understanding of his/her experiences, attitudes, intentions, strengths and weaknesses. The skilled physician is aware of this, but this knowledge – as well as the knowledge presented above – cannot be found within the medical science (or sciences). It may even be said in some ways to be in tension with these, as the aim of the sciences is unequivocal knowledge of a material world stripped of almost all the characteristics of the lived body, while knowledge of human reactions and intentions necessarily to some extent involves paradox, ambiguity, uncertainty, and complexity of a specific sort. It hence seems that the physician is in urgent need of experiences of widely different sorts, which it seems unlikely that a strictly medical training will provide – and neither always "life itself", especially, perhaps, given the background that most physicians can be expected to have. Hence the challenge is for a broadening of the clinician's perspectives, facilitating imaginative empathetic understanding as a complement to the crucial but insufficient scientific training. Clinical judgment requires imagination, precise and patient observation, solid scientific knowledge, moral sensitivity, and a capacity to handle uncertainty, ambiguity, and complexity.

Again: Does medical training, as it has developed during the 20th century, provide doctors with this – or at least, does it prepare them for moving in the direction of sound clinical judgment, as they become clinically active? And does the continuous improvement of the physician's skills include the right balance of theoretical and practical elements – and reflection on these? Are the ways practicing physicians themselves understand their tasks – curing, ameliorating,

and consoling – such that they facilitate for them to reach the goals of medicine? It is of course risky to generalize about "medical education" and "physicians´ self-understanding". But I believe that some things may be said in spite of the obvious variations. These things are connected to the historical fact, outlined in chapter 2, that clinical medicine became successful due to breakthroughs in the sciences and through the introduction of statistical methods and critical scientific evaluation of treatment results. No wonder that basic medical training became almost totally reliant on scientific modes of thought. These, in turn, generally exhibit the same kind of basic rationality that Toulmin asserts are inherent in the standard account of the scientific revolution. Among these ideals are a preference for logical reasoning, for causality of the kind found in the sciences, for unequivocal knowledge, and for models and theories that follow Ockham's razor, that is: strive for the largest possible degree of simplicity. Downie notes that scientific understanding is much concerned with the recognition of systematic patterns on the basis of inductive observation, and moreover,

> A second feature of scientific understanding should be noted. Sometimes the phenomena to be understood are of very great complexity and the scientist is unsure of the systematic connections in the pattern. In this situation, understanding can be created by the development of a model, or a simplified pattern which ignores some of the complexities. Models in this sense are theoretical templates.[5]

As we have seen in 2.1.9, Toulmin assumes that there are ways of conceiving what is rational which are wider than the rationality inherent in the standard scientific models, and that these modes of thinking and feeling were pushed aside with the growth of modern science. Models are needed and are of great importance, but these templates must not be misunderstood to be reality itself.

The world of science is a material world, where regularities appear according to natural laws in the order of physical time. Ambiguities, paradoxes, and inconsistencies ought to be eradicated or avoided as far as possible – even though they actually do seem to appear also in some areas of the sciences, as for example in quantum physics. The world of the patient, on the other hand, is a world where time floats at a different pace at different times, where paradox is rule rather than exception, where subjectivity reigns, and where the objectively described body, "the medicalized body", is an abstraction from an overwhelmingly real lived experience of the peron's own existence.

I have several times returned to Stephen Toulmin's essay where he distinguishes two modes of rationality, two epistemologies: The epistemology of the sciences and the epistemology of biography.[6] I have found this distinction extraordinarily well suited to understand the challenges of the modern physician. In chapter 2.2.2, I cited medical anthropologist Byron Good´s study of medical students at Harvard medical school. Good describes the "formative" power of medical education as a process of "coming to inhabit a new world". In the "construction" of this new world, language is of course crucial. Medical education, writes Good, is "like learning a foreign language". This goes both literally and metaphorically. The students are supposed to be able to turn-on and turn-off this new world, this language, this discourse. The reason is, of course, that neither their own lives nor most human relations – and of course not the experiences of the ill person – can be understood only by means of these categories.[7]

How does this "on-and-off" occur? Obviously, one reflects when reading this, the physician must switch from looking upon the patient as a piece of nature to

looking upon her as an intentional human being several times during an encounter.[8] This often works well enough. But it is easy to see the risks inherent in this challenge. The strength and the precision and the security that "the medicalised body"- look offers the physician may become an escape from facing the more unclean, messy, and emotionally involving and challenging aspects of the encounter. The "turn-on-and-off" mechanism between the two "languages" then doesn't work as it should. The physician remains locked in a "medical gaze" that prevents a human encounter from taking place. He may not even see this himself. "The fallacy of misplaced concreteness" tempts him to see the abstract world of the sciences as more real than the concrete lived experience of his patient.

Christian Hick has approached this aspect of clinical work in an interesting essay.[9] Hick suggests that we call an analysis of the different perceptions of medical procedures between physicians and patients, and within these groups, *medical aesthetics.* Hicks´ analysis is phenomenological and employs the notions – e.g. life-world, lived body - that I have introduced in several passages in this investigation. Following Husserl, he starts with an analysis of the very phenomenon of perception. He notices that

> The different approaches of scientific and ordinary perception are best seen as *concentric* forms of investigation motivated by different goals and trying to elucidate different sectors of reality.[10]

Hicks uses the word "closed" perceptions for the scientifically governed gaze and open perceptions for the experiences of the life-world. The adjective "closed" is employed in a non-pejorative sense. It is closed, not in the sense that

it does not change (obviously, it continuously does), but that it has a physical correlate in pathological anatomy that is seen as the solid base for knowledge, the "real" object to be studied. This has consequences for medical education, as Hicks notes:

> At the beginning of students´ medical education, this switch (from the lived body to the medicalized and back again, *my comment)* tends to happen spontaneously when students are equally concerned by the still mostly unfamiliar problem in medical science with which they are presented, as by the concrete illness experience of the patient exhibiting this problem: "How might he manage to live with it? What is everyday life like for this patient?" However, in the course of medical education, with its heavy emphasis on biomedical sciences, this capacity to switch perceptions tends to be progressively unlearned and to be replaced by the ever more unambiguous, ever more knowledgeable absolute perception of scientific medicine.[11]

I think this is a description of the fallacy of misplaced concreteness. I also believe that it is this fact, more than anything else, which constitutes the reason why clinical medicine needs to approach the arts.

To conclude: Western medicine, as I showed in chapter 2, developed slowly to begin with and then, as a consequence of the breakthroughs of the 17th and 18th centuries, at an ever higher speed. The victories were truly great. There is still a lot to be done within the paradigm of scientific medicine. But, as I also attempted to show in 2.1, during the last few decades it has become increasingly obvious that "the old model" isn't really able to meet all the challenges that we face. The morbidity of the 21st century calls for partly different approaches.

Individualisation demands increased attention to unique personal experiences. Complex syndromes escape understanding within a strictly biomedical model. The life styles of the affluent societies increase risks for degenerative disorders. Technological progress necessitates temperance and restraint. One answer to this challenge is what Drew Leder has called "a medicine of the intertwining", where Toulmin's two epistemologies coexist and in a way merge in clinical practice (see 2.2.5). Medicine would then take the very reality of the illness experience as its most basic fact from which to depart and then return to. As Alfred Tauber states,

> Too often we confuse the technology and the science medicine employs as the discipline proper. The humanistic concerns are not mere appendages to the science of medicine in its various forms, but rather the very basis of medicine: medicine is grounded in the moral relationship of clinician and patient.[12]

The medically constructed disease concept and the scientific knowledge about bodily mechanisms would then of course still be urgently needed, but not as the ultimate reality of disease but as a devise to affect the patients experiences in such a way that his/her life becomes better and obstacles to potentials and plans are removed – making a more "homelike being" possible (2.2.4).

What would facilitate this intertwining, so crucial for medicine to reach its goals? What may invite clinicians also into modes of understanding that are more akin to Toulmin´s rationality of the Renaissance thinkers, make them prepared to face situations where emotions are both acknowledged and recognized as important, where the lived reality of the patient appears in all its nuances and rich complexity, where particularity coexists with generalization, where uncertainty and inconsistency are inevitable aspects of reality? The full answer to this is of

course far beyond the scope of this investigation. My position here is that one out of probably several answers to this question is: acquaintance with narrative in the form of fictive prose, poetry or drama. This is what I will now attempt to show.

5.1.2 Learning from literature

In chapter 3, I argued that literature may provide knowledge and that literary imagination is of importance for ethical awareness. If so, a physician may learn from literature. This is not obvious and in a sense it is quite remarkable, given that fiction by definition is about non-existing persons and phenomena. I hope to have provided a reasonably solid ground for my arguments in chapters 3 and 4, and will now further develop them with the help of British philosopher Frank Palmer.[13] I have deliberately chosen to present his analysis in this chapter instead of in chapter 3, where one would perhaps have expected to find it. The reason is that I find it so eminently suitable to illuminate how literary experience may increase the physician's understanding of clinical realities. Hence I will first present some of Palmer's arguments at length and then attempt to see how applicable they are to the physician's experience, by using the earlier presented concepts of phronesis and clinical judgement.

Palmer's first question is a necessary one. If we assume that we learn, or may learn, from literature, is this fact then the reason that literature is valuable? This would seem to pave the way for a rather instrumental attitude to reading. It would also, as Palmer rightly remarks, risk being self-contradictory, since there are at least some reasons to believe that reading with the sole purpose of learning certain things might prevent exactly this from happening. So, if medical students

are presented with a collection of literary texts from which they are supposed to learn about death and dying – which is not an unusual scenario – the risk might be that the very fact that their reading is so explicitly directed to a purpose will prevent them from accomplishing this or at least make it difficult for them. It is, however, possible that this risk is over-estimated and that "purpose-driven" reading may work well, at least at times (to this interesting question, I will return in 5.2).

But still, if we learn from literature, isn't that in fact the value of literature? I cite Palmer:

> Suppose we say that a serious engagement with literature (and regarding it purely as a means would not count as "serious") can provide moral insight, deepen our understanding of human conduct, show us things about the nature of evil, help us see beneath appearances and thus distinguish the genuine from the phoney – all fairly common claims – then it cannot be that is the "purpose" of literature to inform our understanding in this way. If our interest in art is not to be merely instrumental, literature must therefore be distinguished from propaganda, politics or preaching. The "message-seeker" or "ideology-hunter" will not see fictional characters as individuals, but as embodiments of this or that idea, this or that political innuendo – and the work will judged according to such criteria.[14]

I find this warning against too instrumental reading reasonable, but will soon modify it a little. Related to it is Palmer's scepticism concerning literature as "telling" us things about life: "A literary work (if it is any good) is not a series of edifying propositions dressed up in artistic clothes which may be strip-teased away as the content reveals itself."[15] It follows that we should be reluctant to

look for general truths in literature. Palmer exemplifies with *Macbeth.* Does it make sense to say that Shakespeare in this play tells us, or teaches us, that murder is evil? Of course not. We don't need *Macbeth* to know that murder is evil and if Macbeth is evil it is certainly not any general or average sort of evil he exhibits – if there is such a thing. Rather, as Palmer rightly reminds us, reading presupposes moral understanding and knowledge of the world. Reading acquaints us with the world with its complexity and contingency and paradoxes. Rather than teach us anything, Shakespeare may help us to nuance and make more subtle our attention to the world and our understanding of it. Macbeth may be evil, but passing judgement on him is not easy and we are helped to see how partly uncontrolled circumstances combine in an intricate way to move him in this direction. Shakespeare makes it more difficult to reach moral conclusions, rather than facilitating our judgements.

A way of expressing this is to use the distinction between *tell* and *show.* History, sociology, psychology, psychiatry and even the neurosciences may have many significant things to tell us about evil and about persons who are considered to be evil. However, this is distinctly different from being *shown* something about how evil may appear at a certain time in relation to one or some individuals. The latter will show us how filled with tension and uncertainty any interpretation of another person is. It will, at best, immunize us against too hasty conclusions, too sweeping generalizations, too simplified explanations. It will make our view of life more complex rather than simplify it.

According to Palmer, "the writer who merely tells us things is deficient in creative power".[16] Of course, authors do *tell* us things in books – about diseases, about death, about goodness and evil, about guilt and about pain. But these

statements, these propositional truths, are – if it is good literature – only parts of a greater whole: the artistic endeavour to show something of value for us. This is not done to "inform" us, but to, in Palmer's words, invite us to "yield ourselves" in order to get amused, chocked, thrilled, to take part, to feel and to experience. It is an invitation to a widened experience and it is exactly this widened experience that is the heart of what we learn from literature. And the fact that our acquaintance with the fictional characters – an acquaintance that may be strong and close – is an imagined acquaintance does not in any way restrict our chances to learn in this sense. On the contrary, it might provide a better opportunity to do this because

> ….the fact that we are in one way "drawn into" and in another way distanced from the objects of aesthetic contemplation means that we can be acquainted with things which if the acquaintance were actual might give rise to emotions or predicaments that would be a bar to this kind of understanding.[17]

Louise Rosenblatt expresses the same position when she states that

> A great work of art may provide us the opportunity to feel more profoundly and more generously, to perceive more fully the implications of experience, than the constricted and fragmentary conditions of life permit.[18]

I believe this has obvious implications for what physicians experience with their patients. The strength of these experiences, and the contexts in which they occur, do not always invite clinicians to the kind of reflection that facilitates learning from them, especially not if their scientific training sometimes creates a filter in front of their eyes that threatens to sort out those aspects of their experience that

are inconsistent, paradoxical, uncertain, ambiguous. If the physician as a complement to his professional experiences encounters human predicaments in fictive form, there is a potential for insights to appear that may beneficially affect clinical reasoning. I believe that this attention, this keen eye for the particulars that make up our general knowledge, is the very core of phronetic knowledge and of the utmost importance for the clinician. As Gert Althuis formulates it:

> Phronesis should be considered as a capacity that motivates appropriate action in particular situations. It is a quality that enables someone to deliberate about what is good or bad for a human being in a particular situation and as a consequence enables the deliberator to act appropriately.[19]

Althuis rightly stresses "appropriate action", not only theoretical deliberation. Phronesis in the clinical context is the basis of clinical action. How experience relates to action may be described in the vocabulary of philosophical hermeneutics, as outlined by Gadamer and Heidegger, and applied to the clinician. The life-world of the physician is the sum total of the experiences that she has made. Among these are of course her medical training – a strong and forming experience as Good shows us – as well as clinical cases, and other life experiences including to different degrees also literary and other aesthetic experiences. It is a whole constituted by, but transcending, the separate experiences. Every new act of experience occurs in relation to a context, which is the life-world. This means that the physician's interpretation of every new clinical encounter or reading experience is formed, or rather: textured, by a life-world which it in turn influences and changes. In this way, reading experiences as well as clinical work become part of a continuous flow of experiences that constantly, to some extent, remake the world-view of the physician. The clinical

judgement of this physician will be intimately connected to her life-world, because this life world makes up character and character is the soil for action.[20] This leaves us with the idea of a human being, in this case a clinician, who is in constant movement due to the never ending absorption of new experiences. Character is thus not stable. It changes over time. New experiences will help the physician see new things and hence modify her action repertoire. Some of these experiences are connected with things that have actually occurred, but others may be the result of fictive acquaintances, of – in Wayne Booth's words (see 3.2.2) – the literary company that the physician has kept and keeps.

We may again wonder how this relates to Lisa and her physician in chapter 4? What kind of professional knowledge was crucial for these two scenarios to reach an outcome that we find satisfactory? What were the challenges requiring phronesis in this clinical situation? As noted in chapter 4, it is obvious that without a thorough knowledge of diseases, their aetiology, pathogenesis, and their symptoms and treatment, the physician here would be dangerous. However, and this is just as obvious from my narrative, this will not be enough. In both scenarios there are elements that to be handled appropriately *also* require modes of understanding and forms of knowledge that can not be called scientific in the usual sense of this word. They are forms of practical wisdom, of phronesis, and are crucial to clinical judgement This includes a wide range of aspects of the encounter: How to meet and relate to Lisa at the first encounter in order for confidence to result, how to infer from her linguistically reported symptoms to possible bodily dysfunction, how to inform her about the procedures of further investigation, how to relate to her while waiting for the results and how to inform her about these, how to handle her reactions to this information, how to decide together with Lisa which treatment options should

be chosen and how to motivate and encourage her to follow these, how to evaluate the outcome of the treatment(s), how to reassure Lisa in the face of serious disorder (scenario 1), or how to both encourage to reflection about her present life situation and handle the results of her doubts (scenario 2), when and how to leave responsibility to another professional (for example a psychotherapist). All of these challenges require the physician to possess well developed skills in medical theory and practice, at the same time as being able to meet Lisa where she *as the person* is. They require attentiveness, a finely tuned judgment, a sense for nuances and delicate signals, a capacity to imagine (to some extent) another life and its challenges and options, a reasonable degree of self-understanding, a capacity to inspire to realistic hope.

Downie suggests that literature has the capacity to help the physician to a "whole person"- understanding of patients. He specifically mentions three ways that this may come about: Firstly, through giving rise to an understanding of human predicaments that involve emotions, and through this help the physician (or nurse) to develop a "a perception of real need"; secondly, to increase the capacity to handle those strong emotions that are bound to arise in clinical work; thirdly, to make moral aspects of the physician's everyday work more visible as it "explores for us the many facets of our ambiguous attitudes towards illness". To this I would like to add that literature also has the potential to make us aware of *the limits* of "whole person" understanding, in its capacity to show human beings as enigmatic, often unpredictable, hard to capture in models or patterns and transcending definitions and determinations. I want to call this an invitation to humility and temperance.[21]

To summarize: Physicians may learn from literature. The knowledge they may reach is an acquaintance resulting, not from being told, but from being shown things about the world. It is not easily translatable into general truths or propositions about the world. The knowledge is, like the doctors knowledge of a specific patient's disease, a knowledge of particulars, at the same time requiring and enhancing knowledge of a general kind. This knowledge affects character. Character is central to the accomplishment of the physician's tasks. Character may be affected, or it may not - hence my stress on the notion of potential.

I will now look more closely at this potential and attempt to distinguish more precisely what it may consist in. The potential for growth in clinical skills has been divided into six aspects. These are very closely related to each other, and it may seem as if they overlap considerably. However, they are here separated for heuristic purposes so that the potential of literature will hopefully be seen as clearly as possible. We may keep the challenges outlined in chapter 4.2 in mind, while at the same time realizing that the relation between the potential and these is indirect.

5.1.3 A polyphony of voices – changing perspective

In Albert Camus´ *The Plague,* written shortly after the war, the reader encounters a group of persons, in the centre of which is the physician Rieux, who share the fate of being locked into the city due to the arrival of a deadly disease, the bubonic plague. The threat grows more and more imminent as the disease spreads around and more and more of the citizens of the city succumb to it. The population exhibits a wide variety of attitudes when facing this danger. So do the persons with whom we become acquainted in the novel.

Camus´ novel is an obvious example of a literary text dealing with events of very immediate and direct relevance to physicians or physicians to be. What may there be of clinical relevance to bring from the reading of this novel, apart from medical details?[22] (Note that I emphatically do not mean that the novel should be read exclusively *in order to* achieve this.) I have argued that there is a potential for learning from encounters with art. The essence of what we may learn is a widened experience. It is the result of the author's invitation to the reader to participate in a number of other persons´ lives: our field of vision grows and becomes sharper, "deeper".[23] As readers of for example Camus´ novel, we become familiar with a number of perspectives, with different ways of seeing and interpreting a series of events. The remarkable thing that happens is described by Rosenblatt in a way that is clearly relevant to the understanding of clinical rationality:

> Literature permits something resembling ideal experimentation because it offers such a wide range of vicarious experiences. We can live different kinds of lives; we can anticipate future periods in our own lives; we can participate in different social settings; we can try our solutions to personal problems. We are able to apprehend the practical and emotional results, the reactions of others, the social praise or blame that may flow from such conduct; we find some of these temperamentally more satisfactory than others.[24]

Rosenblatt's formulations invite us to think that the very basis of what we do when reading is to compare ourselves to the figures of the novel or drama. But of course, this is not all there is to it. What we do is to reach out in basically the same way as we reach out towards another human being in an encounter, leaving ourselves behind for a moment, and to some extent *seeing with his/her*

eyes. This "reaching out" is made possible by an openness, a readiness to take part in experiences that are more or less different from our own. I maintain that literature both presupposes and reinforces such a readiness.

Reading Camus´ novel, there are rich opportunities to get acquainted with a wide diversity of human reactions when facing an overwhelming threat. This is bound to occur on several levels of consciousness. Some readers will be strongly emotionally involved and may later reflect upon this involvement. Others will rather read the novel in a more "intellectualizing" way. These ideal types of reception may of course be combined with different emphases. (Some, of course, will find the novel neither intellectually nor emotionally inviting.) As will be shown later there are ways of stimulating different modes of reading and reflecting on what is being read. The interpretation of the novel is unique for every reader, though similarities will appear and all interpretations are not as good as others (see 3.1.5). The reading physician may be expected to read with a keen eye for the medical details and related dilemmas. The figure of Rieux offers rich opportunities to reflect upon the responsibility of a physician during prolonged medical emergency. Rieux is not talkative, not fond of large words. His ideals speak through his actions.

Very few physicians reading this will ever face anything even remotely similar to the plague in Camus´ novel. Nevertheless, an attentive reader, who is prepared to accept the novel's invitation to share the reality of Oran those months in the forties, will probably be moved by the fate of the persons, be angry with them, or feel strong sympathy or even admiration. Of course, as in all reading, there may be obstacles to this. If the form of the novel does not "fit" with the reader's aesthetic preferences, or if the story contains elements that

"alienates" him, the invitation to share reality will not be accepted. The "call" from the author, to speak with Anders Tyrberg (chapter 3.1.4), is not answered.

Camus´ novel is not a psychological one. The author does not take us into the minds of the persons of the story. The reason for this is given at the very end, as it is disclosed that the person telling us the story is Rieux himself. This is of course a circumstance that may be expected to make the novel even more relevant to a physician. But I believe it would be a mistake to think that the physician necessarily will, or ought to, have an exclusively "medical" understanding (whatever this may mean) of what he reads. There is more than enough in this novel to nourish a wider reflection on human predicaments, and there are so many human dilemmas that are actualized by the disease threat that any very limited frame of interpretation would be unfair to Camus.[25]

A novel hence invites the reader to change perspective, to see a context, a series of events, from several different persons´ perspectives – or sometimes almost exclusively from one person's, but a person that may be very different from the reader. I believe this is what Kundera means (see quotation at the beginning of chapter 3) by saying that the novel is immoral if it doesn't discover (or should one rather say "uncover"?) a "hitherto unknown segment of existence". It is interesting, and in line with my position in this investigation, that Kundera does not use the word "invent" here. We discover new reality in the novel. The physician who reads *The Plague*, or *Saturday*, or *The Magic Mountain,* or *Kassandra,* will under certain circumstances to be analyzed in 5.2 be likely to close the last page of the book with more knowledge of things that are potentially clinically relevant – and will have taken part, for some time, in a group of peoples´ lives, thereby expanding the own field of vision and

facilitated for that imaginative empathetic capacity that I have stressed as crucial to clinical judgment.

But the sceptic may insist. Why should imaginary lives of strange sorts under extreme circumstances say anything at all about the challenges of a 37 year old woman with strange bodily perceptions – or the challenges of any other person in the early 21st century falling ill? It is important to understand again the difference between telling and showing. When McEwan shows us how Perowne, in *Saturday*, reacts to an immediate and unexpected threat to his secure and happy existence, he invites the reader to be acquainted, in the specific way that fiction makes possible, with someone she hasn't known before. Perowne's reactions do not directly point to any general truth about life. Still, by thus adding to our "bank" of experience of human reactions, by showing us how a life may be lived and experienced, it has the potential for deepening and broadening our knowledge of life. And if someone still insists by asking what *clinical* relevance this has, one can only, I believe, again point to the vital and intricate interplay in the clinical encounter between personal and scientific knowledge.

But again: The physician's most obvious road to acquaintance with differing human perspectives and to diagnoses must be the clinical experience – that is, all the encounters with persons who have fallen ill and come to seek help. A rich clinical experience is what the physician needs and aren't, compared to this, literary experiences of very minor value? I believe no one would deny the decisive importance of clinical experience, both for understanding diseases in their restricted biological meaning, and in order to become familiar with human

reactions to afflictions. As Hunter notes, case stories make up a considerable part of the knowledge base of physicians, however sceptically they may regard them ("anecdotal knowledge"). But it seems to me that it is equally obvious that clinical experience can be importantly textured and stimulated by reading experiences, so that they become more nuanced, richer, more "true". Hence, what the clinician perceives during the clinical encounter, the interpretations made, will potentially be less prejudiced, more nuanced, more complex, due to the influence of reading on her character. Also, the important emotive component in understanding (that I will deal further with in 5.1.4) is facilitated through fictive stories. And the author's gentle guiding, through aesthetic means, of the reader's attention to certain aspects of the fictive context facilitates that "judicious" attention to what goes on in the story that is crucial to learning from it. It is hence not that the well read physician, when encountering a complex case, starts seeking in his literary experience for guidance – rather that his way of perceiving and interpreting, his whole clinical experience and clinical rationality, has been modified in a fruitful way by the fact that he is keeping good literary company.

The "polyphony" of the novel has been stressed by Russian linguist Michael Bakhtin, who specifically analyzed Dostoyevsky's work. Bachtin writes that "The multitude of independent, and not united voices and minds, the true polyphony of full voices, actually constitutes the basic characteristic of Dostoyevsky's novels". And he continues: "… here are combined (but not fused) in the unity of one event exactly a multitude of minds on equal conditions and each with its own world." *(my translation).* [26] According to Bakhtin, Dostoyevsky created a radically new genre of the novel. One may doubt whether he is right on this

point. Milan Kundera, as a contrast, asserts that this radical openness, this exploration of possible life worlds, is the very essence of the European novel:

> A novel examines not reality but existence. And existence is not what has occurred, existence is the realm of human possibilities, everything that man can become, everything he's capable of. Novelists draw up *the map of existence* by discovering this or that human possibility. But again, to exist means "being-in-the-world". Thus *both* the character *and* his world must be understood as *possibilities.*"[27]

There is a difference of emphasis between Bakthin and Kundera, the former more addressing the formal aspects of the novel and the latter rather the ideas expressed. However, I believe that they both share the same conviction: that the novel may offer a narrow opening of freedom and potentiality in a world of determinism. To the physician this may be of great importance. If there are, as is the case in many novels, several voices, all of them with unique ways of relating to the world, including their bodily being, and if the novel has a capacity to show this - then the interest, the appetite for human individuality, for the patient's unique "being-in-the-world", may thrive.

We are back to where we just were. To appreciate literature – novels, drama, poetry - with its many voices and its capacity to "creep into the heads of" the figures of the story, one would need at least some interest in other peoples´ lives and their actions. The same interest that hence seems to be the very condition for approaching literature at all and reading "proactively" (see 5.2.5.1), may then be reinforced, nourished and thrive though the acquaintance with literary narrative. As doctors may usually be assumed to have such a basic degree of interest in other human beings, it seems reasonable also to assume that they are

prepared to meet the "polyphony of voices" in the European novel, and to be affected by them. For, again citing Kundera, if the novel is concerned with "the enigma of the self"[28], isn't that what the physician also is, in his everyday work?

I must again stress how central interest is. Nobody can expect physicians to like all their patients. Rather we would expect emotions like sympathy, and even attraction, to alternate with dislike or even revulsion in the encounter with patients. Physicians almost always learn to handle this, though as I will soon show, it may become a problem if the fact that such emotions do arise is repressed. What is more dangerous is indifference, often disguised as cool instrumentality. At certain stages of the encounter such instrumentality may be both necessary and advisable, as for instance during operations and some technical procedures – or indeed even for moments during the physical investigation (such as the auscultation of the heart). But without an interest in the *person* in front of him, or in the bed, the physician will be hopelessly handicapped and the patient liable to feel deserted, "objectified".

5.1.4 The clinical relevance of emotions

I have, in section 3.2.4, dealt with feelings and emotions related to the act of reading and to literary experience, and I hope to have shown with sufficient clarity how they appear in and affect reading. In chapter 4 I have pointed to the role of emotions in clinical judgment, and the way they may influence the clinical encounter. These two aspects will now be brought together.

In the formative process where young students become clinically competent physicians, one of the most central elements is the handling of strong emotions in

relation to situations that, in all other contexts, would be likely to give rise to very powerful reactions. Obvious examples may be autopsies, gynaecological investigations, serious traumas, abuse of vulnerable persons, unexpected and perhaps threatening human behaviour in mental illness. If physicians gave way to "ordinary" emotional responses to such situations, they would desert those who need their help. So in some way the standard repertoire of emotional reaction must be modified, checked, brought under control. This does not necessarily mean that emotions should be suppressed *entirely*, or that this would even be possible. Rather, it means that emotional energy is "converted" into something that may be called professional resolve. The disordered chaos of very strong emotions are "channelled" into professional activities that are systematically directed to the restoration of function, of the patients well being. Sören Holm's "protective responsibility" (see 4.2) captures this attitude well. No doubt, emotions are of value in the process of coming to understand the experiences of the ill person, but, as I will show in 5.1.5, not primarily as "feeling-with". The physician who entirely numbs, or attempts to numb, his emotional life in the clinical encounter as well as the physician who from the start lacks contact with her emotions will lose the capacity to enter into a clinical dialogue in a meaningful way, and hence will be deficient in clinical skills.

This process is hence liable to go wrong every now and then. Too much "numbing" takes away the emotional energy that is so important for the basic moral endeavour and jeopardizes the relation to the patient. A cold instrumentalism may result. Or, on the other side of this continuum, emotions are not brought under control. The physician is then overwhelmed by sadness, guilt, fear or anger. Work becomes difficult and even unbearable. And clinicians

who, like Gregers Werle in Ibsen's *The Wild Duck* (see below, 5.1.5), seriously misunderstand their own motivating forces, become dangerous to their patients.

We are then facing two capacities, both dependent on character and both crucial to *phronesis,* that the skilful physician must possess to a reasonable degree: understanding the emotions of the ill person and understanding the emotional reactions that occur in herself. These tasks are of course closely interrelated, and both have important limitations. They are of a combined emotive-cognitive nature and both are dependent on the possession of words and concepts apt to capture these phenomena. As Katarina Elam notices

> The kind of concepts and terms one has access to will also have an influence on how one emotionally understands a situation or an event.(…) Our language proficiency constitutes the net we use to grasp the world. Loosely tied meshes will not catch the differences as well as fine ones."[29]

What, then, may be literature's contribution in order for this challenge to be constructively handled? Isn't it rather psychotherapeutical guidance that doctors would need? We must, I believe, again look for the answer about literature's potential in an understanding of literary narrative and the mode of understanding that is related to it. I have several times earlier, in chapter 3, asserted that literature conveys emotions and that this is one of the central elements in the act of reading. But emotions are elicited in so many ways. Why should the clinician be in any particular need of emotions resulting from the encounter with fictional characters? What may fiction do that real life does not already richly provide?

My answer to this is what I would like to call *tempered* emotion. And the answer to what physicians need in their clinical work is also tempered emotion. In both cases, this facilitates judiciousness. But, one may object, the reason that these two sources result in tempered emotive reactions is different: Clinicians *when meeting real persons* learn to handle emotions in a controlled way, in order to reach that delicate balance that is necessary for clinical judgment. But the tempered emotive response of the reader is due to the fact that the fictive figures of the novel *do not exist in real life*. Surely, this is very different?

I believe one answer to this is presented by Katarina Elam, when she uses the notion of "emotional freedom".[30] And, again using Palmer's terminology, as fiction *acquaints* the physician with emotions of different sorts, these become easier to recognize and to handle in a constructive way. This *extension* of the domain of understood emotions, familiar emotional states, and importantly also different reactions to emotions that literary narrative offers the physician, provides him with tools for meeting the complex clinical reality in a more nuanced way, with a more sensitive perception. At the same time, recognizing the emotions is also a way of keeping them at some distance permitting clinical judgment and therapeutic action.

But psychological theory could do this, couldn't it? The physician should use concepts like transference and counter-transference, projection and sublimation. These are, one may argue, theoretical concepts that are of value in different clinical situations, exactly because they are general and based on psychological insight and experience. They are solidly based in a theory of the human psyche. But how useful are they? What kind of understanding will result from the physician's suspicion that a patient's reaction must be an indication of a strong

transference reaction? A valuable kind of understanding, no doubt, in case the concept in a fruitful way covers a clinical reality. But the concept is of a general, abstract sort that has no immediate bearing on a specific clinical context. Its *situated* usefulness seems to be limited. It must hence be translated into the contingent, ambiguous and complex world of the clinical encounter to be useful. "Transference" is always occurring in a unique situation, experienced by (at least) two individuals. Acquaintance with literary narrative offers knowledge of unique, unexpected reactions, situated in contexts – and does so by giving the reader insights that are of a combined emotive and cognitive nature. No doubt, a familiarity with some psychoanalytical concepts is of value for a clinician, but the application of these, their actual meaning in the very context of the encounter, remains something to be *shown.* Narrative shows what science attempts to tell us.

A good deal of western literature deals with the consequences of strong emotions and desires, how these may lead people astray, motivate them to the highest and lowest deeds. It is reasonable, I believe, to say that literature has the potential of showing us the complex role that emotions play in our lives. Also, fiction is able to show how beliefs are intimately intertwined with emotion, so that the one can hardly be separated from the other. How extraordinarily useful are such insights for physicians, who in their everyday work must all the time relate to situations where emotions strongly texture their patients´ apprehension of what is going on in their bodies and which consequences this will have for their lives. Emotions are a mode of understanding, in Katarina Elam's words:

> We can now discern an interconnection between our emotions, narrative, reflection and the self, where language is a recurring theme. This means we are engaged in both a receptive and a creative activity in our understanding of

> ourselves and the world. This is a never-ending circle or spiral in which a prereflective and a reflective mode of being cooperate, with both levels equally important to a person's development and sense of self.[31]

Will self-knowledge result from reading novels and poetry or from going to the theatre? Will, specifically, the physician leave *Uncle Vanya* or *A long day's journey into night*, or close Knut Hamsun's *Famine* or Elsa Morante's *History*, with deeper insights into her own mental life, insights of clinical relevance? Again the answer is: yes, possibly, as an increased self-understanding is a potential, not a certain result, of encounters with verbal art. More will be said about the conditions that may favour such an outcome in 5.2. The reading physician's concern for the world will become wider and more richly nuanced, when vague, hitherto nameless and obscure reactions are made to take shape and form, if the reactions of the fictive figures sometimes resemble his own or those of persons he know, who affect him deeply and to whom he has reacted strongly. Such an understanding of self and others is central to phronesis and to clinical judgment.

The potential of art in general, and literature specifically, is not only to invite us to see more of ourselves, to face larger parts of our inner lives, our selves as Elam expresses it. It is also important that what we then see, which will surely not always be very nice and reassuring, may nonetheless be seen with some degree of reconciliation. Meeting fictive persons that exhibit all sorts of weaknesses, shortcomings and ambiguities may make me feel less alone when I discover that these traits are also, to some extent, part of my own character. Human fallibility and weakness are not only wide-spread, they are a fact for all of us. More or less consciously doctors often internalize the expectations of them from patients and sometimes also from staff to be invulnerable, beyond human limitations. Medical

training indeed sometimes contributes to such an identification. Of course, projective expectations from patients for medical omnipotence are very far from the harsh realities of medical fallibility and uncertainty, but still physicians may be inclined to repress totally the awareness of their own weakness, their fear and guilt. Sharing their fallibility with fictive persons may not only help the physician discover such traits within her but also to harbour and without remorse accept the existence of them. Again, it is the very acquaintance, though fictive, with human diversity and plenitude that is the key to personal growth.

Finally, a few words about intuition, specifically clinical intuition. There is a common tendency to view intuition as a capacity that is almost exclusively linked to emotions and moods. This is true, I believe, also for so called clinical intuition. Unfortunately, there has come to be some sort of slightly mystic quality about this. Intuition then becomes the equivalent of "sensing" something wordless, of a vague inner feeling that something is the case. But this is not a very meaningful way of using the concept, if it should be used at all. The physician who "senses" that something is behind the complaints of a patient, perhaps something that has more to do with the way the ill person's conditions of life has developed than with deviances in bodily function - should this physician be called "intuitive"? One may of course express it like that, but I would prefer to use the notion of *perception*. This would here mean a combined emotive-cognitive capacity to register and interpret a combination of discrete signs in facial and bodily expressions, in tone of voice, in words chosen, in the movements of the eyes, in the results of clinical investigations. Indeed, such a capacity is of great value to the clinician, at least when handled with temperance and restraint. It has sometimes been associated with "tacit knowledge", because of the difficulties of expressing in words exactly what goes on in this act of

sensitive and attentive perception. My position is that in connection with the potential contribution of literature to clinical skills, we need neither this word nor the notion of intuition. I would rather talk of a finely tuned perception which results from attention, experience and keen interest, all key elements in *phronesis*.[32]

5.1.5 Empathy in the clinical context

From what I have just written one may be inclined to conclude that literature, at least some literature, is likely to increase the reader's capacity for empathy, as empathy so often is understood as a capacity to "take part" in an other person's experiences, particularly emotive, and to some extent share them and to use this understanding to do good. Whether this is the case or not depends, of course, largely on our understanding of what empathy is. It will be seen that this is not at all clear and there are considerable differences of opinion on the matter.

What, then, may be meant by empathy? One way of understanding this concept is exemplified by Eric Cassell, who uses it as synonymous with the capacity to "care for", "feel sympathy for", "engage oneself in". Empathy is linked to altruistic behaviour. This attitude is contrasted with an attitude of distance:

> The most skilful practitioner raises the relationship to an art, not only encouraging its growth and promoting trust and faith on the part of the patient, but negotiating between intimacy and separateness, between empathy and objectivity.[33]

Such an understanding of empathy hence stresses its essence of good will, of benevolence. Suzanne Keen notices, in her rich book on *Empathy and the Novel*[34], that empathy is most often seen as feeling the same feeling as another human being. Such a position seems to take for granted that if I feel your sadness and grief I will be moved to protect you, to console you and to help you to come through your difficult time – if there is anything at all that I may do in this direction. No doubt, one may expect that this is rather often the case. But there are several limitations to this assumption. First, I may very well feel what you feel and do nothing about it, *exactly because* I empathize in this sense. My "feeling-with" may not evoke sympathetic responses at all, on the contrary, I may feel revulsion and disgust at your weakness and disgust at the ugliness of your predicament. One may, of course, further qualify empathy to mean affective response with a basically sympathetic texture and a will to help, but then the argument seems to be circular. Second, and even more problematic in our case, I may to some extent share your emotions and I may try to act in ways that alleviate your suffering (in case the empathy is concerned with negative affects, which often seems to be taken for granted), but I may act in such ways that I instead reinforce your problems. Acting from good-will on the basis of empathetic emotions is by no means a guarantee for doing good. Hence, "feeling" with, if this is what should be meant by empathy, is insufficient as a basis for benevolent action.

Looking at the clinician's challenges, I thus believe that some of the serious problems with the concept arise out of the explicit or implicit assumption that empathy is an almost exclusively emotive concept. But, as I have several times stressed, there are very seldom emotions without cognitive elements and just as seldom thoughts without emotive components. Hence, I believe that this implies

that experiencing empathy is always a combined emotive-cognitive thing. In the context of clinical medicine, I believe that the emphasis is usually rather on the cognitive side, in the sense that a physician neither may nor ought to feel very much what the patient feels, but may still understand her well. Strong emotional empathy would threaten to make the physician hopelessly incapable of acting rationally on an ill person's behalf (see 5.1.4). The physician attentively observes what a patient communicates through language, gestures, and bodily expressions, and combines this with a knowledge of, acquaintance with, the emotions that often accompany certain physical conditions and her knowledge of the whole situation of the ill person. From this she acts from the benevolent intentions that guide her work, based on the basic ethical attitude of protective responsibility (4.2), hopefully with the restraint that comes out of an understanding how limited our empathetic capacity always is, and how difficult it at times is to discern the acts that will really do good.

Most physicians are benevolent and act with the intention of doing good for their patients. They neither may nor should feel what their patients feel. In the two scenarios in chapter 4.3, the physician meeting Lisa neither can nor need feel what Lisa feels. But she must *know* a bit of what she feels, in the sense of recognition. And she must, just as importantly, *learn* through attentive listening how Lisa looks upon her situation and her body, in order to be able to help her. I cannot see that these are basically emotional mental operations. To me they rather seem to be of a predominantly cognitive nature, though in some sense originating in very basic emotions as driving forces for the ethical impulse to come to rescue.

.

Therefore, I will suggest another understanding of empathy that seems to me to be more adequate in the context of the clinical encounter. Empathy in this sense is a morally neutral concept. It denotes the capacity to reach a reasonably adequate, though of course inevitably limited, *understanding* of what goes on in another person's mind. This, to my judgment, is a combined emotive-cognitive process with an emphasis on the cognitive aspect and it does not require sympathy or compassion – but certainly it requires interest. It does not presuppose that my intentions are benevolent, nor does it necessarily make them so. Empathy is in this sense neutral and might be used for good purposes or bad.[35]

Empathy in the clinical context is, if my suggestion is accepted, a clinical skill that may or may not be used by the clinician in order to reach the goals of medicine. The reason why we tend to identify empathy with good will and benevolence is, I assume, that we take for granted that persons in health care *are* benevolent and hence wish the best for their patients – and this is surely most often the case. If so, empathy becomes a tool for the sake of the good. It may even be said to be a necessary requisite for doing the good, in so far as it decreases the ever present risk, also in clinical contexts, that good intentions are transformed into vicious results.

This is how I will employ this widely used, and sometimes over-used, concept. I believe that my understanding illuminates the connection between empathy and knowledge and helps us to avoid identifying it with the broader concept of *phronesis*. The capacity for phronesis, the third of Aristotle's basic modes of knowledge, is clearly connected to character. Empathy then seems to be one of the capacities that "build" phronesis. Any *phronesiology*, in the words of

Kathryn Hunter, must take empathy into consideration as a key component. To identify what is good for someone is a matter of fine attunement to the particular circumstances of a situation, while not ignoring general knowledge and rules. The capacity to perform those acts that realize these goods for a person is the second aspect of phronesis. This second aspect, the practical wisdom of *doing* the right thing in relation to a certain goal, is dependent on empathetic knowledge but should not be confused with it. It is indispensable to clinical skills.

The clinician, as I noticed in my previous discussion on emotions, must temper his emotive response to his patient's suffering. This does not mean that emotions are totally brushed aside, rather that they are "transformed" into an ethically grounded attitude of resolve and determination. When Rieux in *The Plague* works fourteen- fifteen hours aday under ghastly conditions, he feels almost nothing but his feelings are nevertheless there, converted into determination to stand up against the evil of the deadly disease. When the physician in our story meets Lisa, she may feel something of her anguish and loneliness, but it would be more appropriate to say that she *recognizes* Lisa's experiences, she *knows* them and she knows how to handle them in a sensitive and respectful way. Without an interest in Lisa's more general situation, her recognition would not be there, however much she empathized emotionally, and she would not be able to help.

To conclude: The assumption that literature – novels, poetry, drama – will increase the empathy of physicians or medical students then, at a closer look, ought to be qualified in the following way. If empathy is defined as the benevolent and compassionate and sympathizing sharing of another human being's emotions, in our case an ill person seeking medical help, there are

reasons to be sceptical. If, on the other hand, empathy, as I suggest, is seen as the morally neutral capacity to approach another human being's life world and reach some degree of emotive-cognitive, predominantly cognitive, understanding of this, then the odds are considerably better. This is indeed a potential residing in the act of reading, as I hope to have shown with sufficient clarity in chapter 3 and will develop further in 5.2.

It is important not to misunderstand the scope of this potential. It is a constant argument against any claim that literature increases the reader's empathy that we see very few signs of this in everyday life. Persons who read extensively, like academics who study literature or critics reading very much, do not seem to be empathetic in relation to the amount they read.[36] But is this a convincing argument? Perhaps, if empathy is regarded the way that Cassell seems to suggest – that is, as an emotive identification leading to altruistic actions. It will be obvious from what I write in this chapter that I consider this to be an unfruitful understanding of the concept. If reading is about a widened experience of the world, if it is *acquaintances* that we acquire from literary experience, the potential is more subtle than that. Reading textures the experiential background of the clinician that new experiences must in some way fit into. The "mental context" of the physician, strongly formed as it is by medical training and the resulting "the medical gaze", may be subtly and marginally changed by each reading experience, in a way that can't possibly be disentangled from the influence of other life experiences gained in other ways. It is thus usually rather pointless to ask people how this or that book changed their life or made them do things they had otherwise not done (though occasionally one may receive such answers). What is reasonable to expect are, in the longer run, cumulatively significant shifts in the physician's repertoire of action, in his dispositions, his basic attitudes –

shifts which can considerably affect clinical skills. What results are hence not specific identifiable acts "caused by" reading, but rather accumulated modifications of attitudes, patterns of action, ways of relating and modes of experiencing clinical reality. It follows from this that there can be no guarantee that this change is exclusively for the better. Reading may have negative effects in relation to the ethically defined goals of medicine.

I want to conclude this section by some comments on what I would like to call the risks of good will in combination with self betrayal and weak empathetic capacity. When "person-oriented medicine" came on the agenda, and by this I mean the wave of interest during the last decades in the "humane" aspects of medical encounters, there also appeared second thoughts on how it would be possible to avoid a careless and insulting interest in patients´ lives. An exaggerated and insensitive way of approaching a vulnerable and dependent human being may hurt just as much as, or even more than, a lack of interest or a cool indifference. If empathy ought to be pointed out as an important capacity for clinicians, it must be of great importance to investigate whether there are also pitfalls involved in the search for empathy and where the limits of understanding may be found. I do believe that there are important such limits, and I will now address the question of self-knowledge, restraint, and empathy. I intend to do this by using a literary example: Henrik Ibsen's well known play *The Wild Duck*.[37] In order to put my arguments through, I make a short summary of the story. It will be clear that I believe it to be a potential of literary experience to invite some degree of scepticism concerning the scope of empathetic knowledge.

The Wild Duck, like so many of Ibsen's plays, is set in a small town in south Norway in the late 19th century. We meet a family of three – Hjalmar and Gina,

husband and wife, and their daughter Hedvig, an early and very sensitive teenager. Hjalmar is a photographer, or at least: thinks of himself as a photographer, though we understand that it is rather Gina who does most of the work. Hjalmar seems to prefer lying on the sofa, dreaming of the revolutionary invention in photography that he is about to make. To the family also belongs Hjalmar's father, a somewhat eccentric old man who shoots imaginary rabbits from the window of the house.

Hedvig is a very sensitive girl. She is tied to her father in the way that a child may be dependent on the love of a parent who is too egocentric to be able to give the affection and attention she is yearning for. Hedvig projects her attention and care on a duck, a wounded wild duck, which rests in an obscure chamber in the inner part of the flat. This duck, it will turn out, was once injured by a shot from the industrialist Werle, the powerful and possibly also ruthless "strong man" of the little town. Between Werle and the family run hidden and dangerous threads. These will turn out to be disastrous.

Into our little family comes Gregers Werle, the industrialist's son and a friend of Hjalmar since childhood. Gregers has been away from town for many years and comes back to find his old friend, of whom he expected much, as a deplorable daydreamer, taken care of by his very able wife. Gregers, who is allowed to rent a room in the house, gradually uncovers secrets about the family's relation to his father, whom he hates and despises. He intervenes, in order to get the family to "live in truth". He is, in the words of the other tenant, the physician Relling, "possessed by an acute passion for truth" which is a dangerous state that Relling understands and warns will bring about a catastrophe.

This is in very short form the story. What has this then got to do with empathy? Gregers Werle is not a man of bad intentions. He thinks of himself as compassionate and caring. He wants the best for his old friend and his family. He has high ideals. His contempt for his father seems to spring from a deeply felt disgust for arbitrary exercise of power, whether inside or outside the family. But his deeds – it later transpires - provoke a young girl's death. How can this be possible?

We must return to the notion of phronesis, of practical wisdom. Gregers Werle may possess large amounts of good will, but he surely does not possess the moral judgment necessary for knowing when and how to do what in a specific, exceedingly complex situation where he is not any more a distanced observer but a deeply involved participant. One might be inclined to mistake Gregers' good-will for empathy, and probably he does so himself, but empathy is exactly what he lacks. His understanding of what moves the persons around him, as well as himself, is rudimentary. He is probably able to understand some of the feelings of Gina, Hjalmar and Hedvig – and is in this sense capable of emotional empathy. But he lacks the self-understanding and the perceptive attention to the life-worlds of those he wants to help, and hence also phronesis. He is an elephant in a porcelain shop.

I believe the parallel with physicians' interventions in their patients´ lives is not very far fetched here. The more the clinician takes an active interest in the illness experiences of those who seek help, the greater the need for wisdom in the sense of empathetic knowledge in combination with restraint and temperance. The doctor who goes to the theatre to see *The Wild Duck*, or possibly reads it, is not *told* this by Ibsen. It is not like being told a moral lesson or reading a book on

normative ethics. The point of theatre being a form of art, an aesthetic form, is that this is something that is *shown* by Ibsen. If this insight about the dangers of good-will gone wrong appears in the mind of the physician, it is delivered through the combined emotional-cognitive involvement with the play and its figures, not from being presented with a "moral fact". This carries, I contend, a potential for growth in clinical skills.[38]

5.1.6 Moral sensitivity and imagination

The concept of imagination has already appeared several times in my investigation. I have assumed that imagination is a central capacity in clinical judgment, due to its relation to *phronesis.* In doing this, I have treated this concept as if it were reasonably unequivocal. This is not the case, however. Rather, as David Novitz notes in his *Knowledge, fiction and imagination,* imagination is a polymorphous concept.[39] Novitz reminds us that imagination has usually been regarded with scepticism in the western philosophical tradition. He specifically points to what he calls *fanciful imagination* as something that has evoked suspicions from philosophers like Kant and Hume, not to mention Plato's outright hostility to it. Fanciful imagination is, according to Novitz, "the ability which people have to fabricate or invent by combining ideas, images, beliefs, words, or physical objects howsoever they choose."[40] He contrasts this with what he calls *constructive imagination,* which is more controlled, orderly and obeying the rules of logic and consistency.

To imagine, we believe, one needs imagination – as if there were a special mental faculty concerned with this. There is, of course, not. Imagination is an aspect of our mental operations – of emotions and thoughts intertwined – not a separate

mysterious faculty. Imagination, in this context, will mean not only the capacity to think things that are not (yet) the case, for example a successful transplantation of a brain or a flying saucer landing on the helicopter tarmac of the hospital. I will use the word to connote a flexibility of thought and emotion, a capacity to think meaningfully starting from "if this were the case" or "if this were not so, what would.…". This involves "counter-factual" thinking ("what would have been the case had not this event happened") and also fruitful thinking about the consequences of alternative options ("if we act like this, such things will result and they will mean this and that, but if we instead act like that….").

No doubt, a central aspect of imagination is to be able to understand, to some extent, what goes on in another person's mind. I have dealt with this both in 5.1.3 and 5.1.5 under the concepts of widened experience and empathy. It would be easy, then, to say that this is almost all there is to clinical imagination. But this is wrong. To imagination in clinical contexts also belongs the capacity to think about the existing options, given slightly changed preconditions ("if we take this or that measure, what then would our options and their resulting consequences be?"). Especially this last capacity is of value in genuine moral predicaments - that is, those very common clinical situations where all alternatives seem unacceptable. The imagination required to "open up" this situation may suggest a way to reconfigure the accessible alternatives in a way that seems to offer the chance of, if not ideal, at least permissible lines of action. Finally, it must be remembered that a key capacity associated with clinical imagination is the skills of differential diagnosis. As mentioned in 4.3, physicians only too often seem to land on a diagnosis at an early phase of the clinical encounter – and are then not

able to reconsider it. The imaginative question "what if this is not the case?" is not asked.

In my interpretation of the concept, it becomes evident that imagination is associated with a sort of flexibility of thought and emotion, a "freedom of mind" that permits the imaginative person to think richly and in nuanced ways about the context where he is and the consequences of different lines of action. Imagination in the clinical context is often concerned with "what seems not to be the case but what might be". Harbouring several hypothetical thoughts, several possibilities, in mind at the same time is imaginative. Tentative reasoning, preliminary diagnosis, conditional clinical action all benefit from an imaginative capacity. If so, we can also see the obvious link to uncertainty, so prominent in clinical contexts.[41]

Swedish bioethicist Mats G. Hansson and his collaborators have developed the concept of "imaginative ethics", based on experiences from clinical rounds at a university hospital. His conclusions are important and I cite at length:

> The participants in ethical rounds seem to draw on a kind of moral competence based on personal life experience and professional competence and experience. On the basis of this experience they have a capacity to recognize and to identify the morally salient problems associated with the individual case, and, by listening to other perspectives, they see the risks and benefits as they appear from other points of view. (…) In listening to the story about the care of one particular patient, with the help of colleagues, they imagine if and how the story might have been different. They entertain the possibility that the chain of events could and should have taken another course of direction at one particular junction. They imagine how it could

> have been otherwise. By listening to other perspectives and other experiences related to one particular patient´s story., the participants imagine alternative horizons of moral experience and explore a multitude of values related to clinical practice that might be at stake.[42]

This description of the role of imagination illuminates how crucial imaginative deliberation is when dealing with ethical challenges in clinical practice.

It is hence important to note that regardless of which ethical theory one is inspired by, imagination seems to be involved in the deliberation on and handling of ethical challenges. In virtue ethics, the notion of *phronesis* is crucial and, as noted, imagination is closely related. The utilitarian will have to consider closely which actions are open to pursue and their short- and long term consequences, as well as what these would mean in terms of, usually, happiness. This task (that some believe to be hopelessly beyond reach) requires a good deal of imagination in combination with extensive factual knowledge. The deontologist, who necessarily has to define some rules as prima facie and some not, will have to go looking among a rich gallery of first, second and third order ethical principles and weigh them against each other – a process that most certainly involves imaginative capacity. And whatever ethical theory inspires the clinician, she has to take as many different aspects of the actual clinical context as possible into consideration. Flexibility of thought and feeling will facilitate this attentive perception.

Of great clinical interest is Martha Nussbaum's remark that imagination is crucial to deliberation, notably ethical deliberation, and that this imagining has a

certain concrete quality about it. Nussbaum as so often relies on Aristotle and writes:

> …he (Aristotle) ascribes to human beings a capacity for a special sort of imagining, which is called "deliberative *phantasia"* and which involves the ability to link several imaginings and perceptions together, "forming a unity from many". All thought, for Aristotle, is of necessity (in finite creatures) accompanied by an imagining that is concrete, even where the thought itself is abstract.[43]

In case Nussbaum (and Aristotle) is right, it is not far-fetched to infer very obvious conclusions for the clinician, from the conditions for making diagnosis to the handling of complex ethical dilemmas. Consequently, everyday clinical thinking is not threatened by imagination, but refined by it.

But why should the reading clinician be more imaginative than the non-reading? The answer has been given in several sections above. Returning to Palmer, we may again stress the notion of *acquaintance.* The reader becomes acquainted with a wide variety of stories about how humans live their lives, and does so in a way that allows for a kind of learning that is not always possible to acquire in "real life". The physician who reads about Hans Castorp's arrival to the sanatorium in Davos, about his gradual, almost imperceptible transformation from young healthy man, to sick, hospitalised patient, can hardly avoid being both emotionally engaged with Hans and, at the same time, intellectually stimulated to reflect on why he reacts the way he does, the nature of illness, the social forces at work when someone is diagnosed as ill, the metaphorics of illness and the consequences of the "sick role" for bodily identity and interpersonal relations.[44] It is the combined emotional and intellectual involvement with the fictive story

that opens up learning, in combination with the relative freedom of interpretation and reflection that the fictive distance gives. When our reflections on actions are freed from the sometimes inhibiting considerations of everyday life (such as "Who is responsible now?, "What is my own role and responsibility in this, am I guilty of something?" "What do they think of me?") that often prevent the kind of fruitful reflection required for learning, imagination will thrive.

The last aspect of imagination that I want to mention is closely related to the next section, 5.1.7 (on metaphor and ambiguity). There is certainly a sort of linguistic imagination involved in the clinical encounter. The quotation from Arthur Kleinman at the opening of this chapter elegantly points to this. The language of illness is often strikingly vague and may easily be interpreted in a way leading to misunderstanding. If the physician does not meet it as such, if interpretations become too literal, clinical judgement will suffer. John Nessa illustrates this well in his book on the communication between patient and general practitioner. Nessa departs from the assumption that spoken language is the most important tool in general practice. Doctors and patients interact in symbolic ways, where talk dominates.[45] The patient's narrative must be interpreted by the physician. There is no escape here into the seemingly certain terrain of biomedical concepts without great losses. On the contrary, some of these words will be used by the ill person but in a quasi-scientific, metaphorical way. Cecil Helman and Susan Sontag have, in different ways and for different purposes, shown how symbols and metaphors penetrate the illness stories, and to this I will soon turn.[46]

5.1.7 Metaphor, symbol, ambiguity

Imagination is involved in the understanding of linguistic communication, especially as communication so often is characterized by the frequent occurrence of metaphors, symbols, vagueness and ambiguity. (I have dealt with this earlier in 3.2.5 , where I have also outlined how I use the concept of ambiguity in this investigation.)

This is the case also with clinical dialogue. We must therefore look at how ambiguity may appear in the clinical context and the role of metaphors and symbols in the communication of the illness experience. Metaphors and symbols may permeate many other aspects of clinical medicine, such as physical investigation and diagnosis, but I will mainly limit my analysis to the understanding of the situation of the ill person through the illness narrative.

The quotation from Kleinman that introduces this chapter does, if it is to the point, tell us two things: that metaphors do actually appear in clinical practice and that it is of importance that the physician be able to interpret and use these in a fruitful way. But is this really so? And if so, in what way? This is a tricky field to enter into, because of the extremely wide use of metaphors and because of the many different sorts of metaphors that appear in both everyday and specialized language, as well as in our conceptual ordering of the world. For my purposes here I will make some remarks of importance for the understanding of literature's contribution to clinical skills. I will largely follow George Lakoff and Mark Johnson in their small but rich book on metaphor, *Metaphors we live by.*[47]

What, then, is a metaphor? Lakoff´s & Johnson´s definition is simple enough: "The essence of metaphor is understanding and experiencing one kind of thing in terms of another." Such a definition raises a number of intricate philosophical questions, of which some are presented by the authors, that I will mostly ignore. For my purposes here, it is worth noting that the authors stress both experiencing and understanding, which seems to me related to different degrees of reflection. To put it in a somewhat simplified way, one experiences without too much of reflection and then one understands as a result of the ensuing reflection. This is interesting because as I have shown in chapter 2, the illness experience is both prereflective and reflective. If Lakoff and Johnson are right, metaphor permeates both these phases. And because disease is so elusive, and very often experienced by the ill person as *something* that is nameless and insidious and in some strange way *behind* the symptoms, it calls for understanding in terms of something that *is* intelligible, possible to name and perhaps also visualize. The lump of malignant cells becomes, yes a *cancer,* or a foreign intruder whose armies in the form of aggressive warrior cells attack the integrity of the body and break it down. Such metaphors are a strange mixture of common sense medical knowledge and symbolic thinking in terms of almost archetypical human phenomena (like in this case warfare). It is striking how many metaphors that are in some way connected to the body. This means that concepts from the bodily sphere are used in metaphorical thinking when speaking about other areas, but of course also the other way around.

Thus, when patients attempt to communicate their illness experiences they are bound to use metaphors, not only because their thinking about what goes on in their bodies is largely metaphorical but also because some of the most common symptoms of illness - like fatigue, pain, dizziness, nausea, itching – are very hard

to capture in words.[48] Some of their metaphors may already be well established, that is: as parts of a commonly shared linguistic frame of reference. These will often not be seen as metaphors at all, due to their everyday character. Others, however, may be inventive, tentative, ambiguous, even desperate and highly vague, on the verge of being obscure. The characteristically imprecise communication of such symptoms is rich in metaphors and in symbolic thinking and often seems to express ambiguity. Most people's illness experiences will inevitably rely on a peculiar blend of scientifically based ideas and completely non-scientific imaginings of the body and how it works in health and illness.[49] Along with their basic knowledge of how the body works, many patients (and probably also to some degree medically trained persons) seem to fall back on what Cecil Helman calls "body myths" to give meaning to what happens with them when strange and enigmatic bodily perceptions appear.[50] Such mythic thinking is permeated with metaphor and symbol. Helman exemplifies with ideas of contagion (e g aids, tuberculosis, venereal diseases), the reproductive cycle and its disturbances, organ transplantation, diseases of the heart, the use of electricity as treatment (as in cardio-pulmonary resuscitation and electro-convulsive therapy). Such contexts seem to invite to metaphorical thinking, but metaphors and symbols appear in almost all clinical contexts. If this is not understood as such, but rather literally or just ignored as being nonsensical, crucial information will be lost as well as the possibility of establishing a trustful dialogue. Hence, the empathetic capacity that I have just outlined (5.1.5) will largely depend on the amount of semantic sensitivity and imagination that the physician possesses.

Swedish bioethicist Anders Nordgren has proposed that the nature of commonly used concepts in clinical ethical contexts – like autonomy, integrity, justice,

beneficence, dignity – is fundamentally metaphorical.[51] Nordgren is inspired by Mark Johnson, the co-author together with Georg Lakoff of the just-mentioned book on metaphor. Given his view of the role of metaphors, it is not surprising that ethical concepts, as well as almost all concepts, are seen by Nordgren as having a metaphorical aspect, that is: they are at least partly understood by us in a metaphorical way, by using experiences from two different areas. Nordgren argues that this fact should warn us against thinking about ethical concepts as well defined and as understood by deduction, but rather see them as rules of thumb based on reflection and deliberation on what Johnson calls prototypical cases. From such cases, which could also be seen as ideal types in Weber´s sense, and which define the typical situation where a certain moral principle applies, we use imagination to interpret whether the far less typical and more ambiguous case that we presently face could be understood and handled according to what the principle and the prototype case tell us. This makes good sense, and is well in line with the study by Mats G Hansson, mentioned above in 5.1.6, but I am not sure that Nordgren's polemics against "principlism" is very much to the point and that more than very few advocates of what he calls "principle based ethics" really believe that ethical principles work by deduction or that they are well defined. Even so, it may be of value to stress how interpretation of abstract principles involves imagination and that metaphorical thinking permeates also the language of moral philosophy. It is also important that Nordgren, like Kathryn Hunter, emphasizes the role of casuistry, of case telling. It is not unreasonable to assume that a considerable amount of the "ethical training" of clinicians takes place through the sharing of narratives of disease and illness, as more or less prototypical cases (both in medical and ethical regard).

The metaphorical nature of much discourse on illness and disease is of course not uncomplicated. Metaphors may work in a way that some find dangerous, as distorting our understanding and as leading our associations in the wrong way. This is, I believe, what Susan Sontag wanted to express in her influential and much discussed book on *Illness as Metaphor.* Her primary target was all the metaphors that she found associated with cancer, a concept now regarded as scientific but obviously originating in a metaphor for how a malignant tumor may spread into the surrounding tissues making it resemble a cancer. Sontag's anger focused primarily on those metaphors that entailed looking upon cancer as "meaningful", as a signal to the ill person about her life and how she had lived. Such metaphors are cruel, Sontag meant, because they blame ill persons for a disease that is threatening to kill them, hence increasing the already heavy burden on them. However, Sontag failed to realize that a totally non-metaphorical language freed from all associations except those strictly scientific, is an utter impossibility. Illness strikes humans in their whole "being-in-the-world" and understanding what this means will necessarily involve metaphor, myth, and ambiguity. However, there are sound reasons to attempt to fight those interpretations that are cruel, unjust, and unfounded.

By an ambiguous situation I here, as earlier outlined, mean a situation where two or more meanings appear at the same time and when both seem to be relevant for understanding a phenomenon. These meanings, these different understandings, may be more or less in tension with each other. A clinical encounter where the patient continuously expresses both strongly positive and strongly negative feelings towards the physician is an ambiguous situation. This communication may be manifest in language, in gestures, in posture, in facial expressions. Often these different ways of communicating are the source of

ambiguity, when the attitudes expressed are in tension with each other. Linguistic ambiguity is important to acknowledge and handle. Ambiguity is about nuances of words, but also of voice and expression. Metaphors often express such ambiguity. Linguistic fantasy and attentive, imaginative observation are tools that the physician uses to approach the illness experience and through this, the biomedically definable disease.

What reasons do we have to assume that acquaintance with literary narrative would increase a physician's capacity to recognize and handle ambiguity in the clinical setting? The answer, I believe, is that literature both uses ambiguity and vagueness as means of expression and also shows us how ambiguity is part of our everyday life. Poetry characteristically employs metaphors that create ambiguity, in order to approach a phenomenon that demands a rich and nuanced understanding. One may, I believe, even assert that poetry often depicts the world as basically ambiguous, filled with tensions of meaning, demanding complex forms of understanding. One typical form that such tensions may take is that one and the same phenomenon – let us say a disease – may be seen in two different but equally valid ways that do not seem to be reducible to each other and that may seem to create some tension. Illness as subjectively experienced and disease as scientifically describable exemplifies this, originating in the fact that we have all learnt to experience our bodies in two "modes": the first person mode ("I am identical with my body") and the third person mode ("I have a body and it can be viewed and investigated from the outside") . Other ambiguities that permeate clinical practice, and that constitute central elements of much literary narrative, are: human beings as free rational actors vs human beings as biologically and/or socio-culturally determined; illness as a challenge to human dignity and freedom vs illness as an escape from responsibility and a

source of gratification and attention; treatment as a road to recovery and liberation from the prison of a serious disease vs treatment as a punishment with harsh side-effects and humiliating procedures. Ambiguities abound, in literature as well as in clinical practice. They are often described in the illness narrative and any attempt to ignore them would impoverish clinical judgement.

I will conclude this section with a long quotation from Lakoff's and Johnson's book, a quotation that remarkably well summarizes why a widened experience of human attitudes and world views, as well as a linguistic sensitivity and imagination, is so urgently needed for the clinician:

> When people who are talking don't share the same culture, knowledge, values, and assumptions, mutual understanding can be especially difficult. Such understanding *is* possible through the negotiation of meaning. To negotiate meaning with someone, you have to become aware of and respect both the differences in your backgrounds and when these differences are important. You need enough diversity of cultural and personal experience to be aware that divergent world views exist and what they may be like. You also need patience, a certain flexibility in world view, a generous tolerance for mistakes, as well as a talent for finding the right metaphor to communicate the relevant parts of unshared experiences or to highlight the shared experiences while deemphasizing the others. Metaphorical imagination is a crucial skill in creating rapport and in communicating the nature of unshared experience. This skill consists, in large measure, of the ability to bend your world view and adjust the way the way you categorize your experience.[52]

Physicians need to negotiate meaning with their patients through metaphorical imagination, through a flexibility in world view, through adjustment of experiential categorization. Literary experience, for reasons explored in this

chapter, offers an invitation to cultivate such capacities. The authors call this capacity *imaginative rationality*.[53] I suggest we see this as the rationality that Toulmin writes about as characteristic of the Renaissance thinkers and of the epistemology of the person. Clinical judgment is impossible without this rationality.

5.1.8 Catharsis

Perhaps the most conspicuous element in medicine is the over-whelming presence of human suffering.[54] Suffering, in a sense, permeates clinical everyday life. If, as I have argued, recognition is a key part of clinical judgment, and if recognition means really *seeing* the person that is ill – then the existence of suffering has to be both understood and handled. This is one of the major challenges for the physician.

There can be no way that a clinician can react to his patients in the ways that we would expect him to in "ordinary life". As noted in 5.1.4, the reactions appropriate outside the hospital to the appearance of life-threatening diseases, or other not so serious disorders, are inappropriate and counter-productive inside it. As I have several times stressed, the physician must combine knowledge of the personal consequences of a disease with the necessity to observe clearly, to diagnose on the basis of attentive observation, to proceed towards the right treatment (sometimes very tough), and to be able to console by giving trust and reasonable hope. This precludes excessively strong emotional reactions. But which clinician hasn't, inside herself, cursed a cancer striking against a small child or the dementia slowly transforming an elderly woman? Somehow such reactions have to be silently "discharged" – so that they do not destroy clinical

judgment, but instead are transformed into the driving forces for a resolution to go on with the work against the disruptive disease (as for Dr Rieux in *The Plague).* This may, I contend, be done only by a deeper understanding of suffering in all its aspects.

In a very basic way, clinical reality contains tragic elements. However, the concepts "tragedy" and "tragic" are often used in two fundamentally different ways. In everyday language it is said that something is tragic if it, like the symptomatic definition in Wikipedia, is an "…event with a sad and unfortunate outcome". Tragedies, then, are all around in media – and of course in hospitals. In the stricter sense, the tragedy is a literary genre. This is, however, not entirely helpful because, as Brian Vickers rightly notes:

> Studies of a literary genre face the difficulty that while everybody feels they can recognize an example of that genre, not many people are willing to risk a definition of it.[55]

In spite of Vicker's warning here, we may conclude that tragedy as a concept is connected to disaster or strongly negative outcomes that are brought about by an actor, or a group of actors, and where these outcomes are rooted in their very attempts to avoid them. As the *Free Dictionary* online defines tragedy it is

> A drama or literary work in which the main character is brought to ruin or suffers extreme sorrow, especially as a consequence of a tragic flaw, moral weakness, or inability to cope with unfavorable circumstances. [56]

One may, I propose, also understand the idea of the tragic – particularly as an adjective - in a more general way. Tragic elements appear whenever there is a painful gap between our aspirations and what we, given our resources and our determination, are able to achieve. Thus, in the following, the concept of tragedy will be used as meaning any fictive representation of a sequence of events where the crucial element is the tragic discrepancy between human aspirations, longings, hopes, and desires – and the realities of human life. If we accept this definition, it is obvious that illness will often have a tragic dimension, as it typically (see 2.2.3) strikes against our capacity to fulfil our plans, our wishes and our hopes. Clinical life is dense with tragic elements; their presence is a very basic point of departure for any clinical work.

I will here focus on the feelings that Aristotle identifies as crucial to the tragedy, that is "pity and fear", and I will attempt to relate them to the physician's work and to clinical judgement. I will particularly look at the notion of catharsis and also briefly at Freud's idea of catharsis as insight and relief. In Aristotle's *Poetics* the word *catharsis* is mentioned in chapter 6. Aristotle points to it as constitutive of the tragedy but then leaves it after just one sentence, notoriously hard to translate. Malcolm Heath translates it as "effecting through pity and fear the purification (*katharisis)* of such emotions".[57] Such an interpretation has tempted several scholars, as Sigmund Freud, to think of catharsis as a way to get rid of unpleasant feelings, of cleansing oneself emotionally. Vickers violently opposes to this:

> My main point is that we must not turn away from suffering in tragedy, that we must allow our response to it to take the forms of pity or outrage. Yet again, various critical traditions have insulated themselves

> from this direct involvement: suffering is said to have some positive, compensatory purpose; while pity is downgraded as "weakening" or "condescending".[58]

Catharsis, then, is a way of "training" difficult emotions rather than doing away with them. Only a fool can avoid realizing that life is harsh, that suffering is all around, that our plans are often obstructed, sometimes violently. The proper reaction to this, when we see it around us, is pity and compassion and fear. But there is, of course, a limit to how much of this we may experience and express before we succumb to it, particularly in medical contexts. And there is also the challenge to understand and interpret the origins and the results of suffering. The moral dimensions of suffering may be understood in the drama in a way that they would not be understood in "life itself". This is crucial, as it seems as if the drama, or for that matter the novel and other stories, may help us to see the darkest aspects of life and to experience the proper feelings that go with this, and *at the same time* understand in a better way the contextual circumstances that gave rise to suffering, hate, revenge, guilt, and reconciliation.

My point, in line with Vickers, is then not that the spectator – or reader of the novel – is "purified" or "cleansed" or "purged" in or of his emotions, rather the contrary. The true pity for the sufferer in this fictive form helps us to recognize this element of life, not to ignore it; it helps us to react to it in a proper way and hence in a way to handle it, not by suppression or by denial but by a bold recognition. This is where I believe the physician's situation becomes highly relevant. The physician is just as dangerous if he ignores - or does not recognize - the suffering of the ill person, as he is if he is over-whelmed by it and not able to act in a professionally responsible and responsive manner. The Greek drama, or

for that matter Chekov, Ibsen, Strindberg or Dostoyevsky, presents tragic suffering to us, shows us what it does to human beings, how mercilessly it may strike and how little of dignity and self-respect are usually associated with it. It carries the potential of promoting emotionally responsible knowledge, acquaintance and recognition of the darkest aspects of human existence. Can any physician do without that knowledge?

Again, it may be argued that this is better shown by "life itself" – and in the case of physicians, in their work with their patients. But this is for obvious reasons not always so. The drama and the novel *show* us aspects of human existence in a richer way than we are usually able to perceive in our everyday lives. And even more important: it is the relative emotional detachment, what I earlier called *tempered emotion,* that permits the reader or spectator really to experience in a sense that facilitates emotional growth. Catharsis is not a cleansing away of emotions – it is the opposite: it is a recognition of their weight in our lives, of their origins and their complexity.

But, may one argue, why should doctors search for tragedy and tragic aspects of human existence in literature and in drama? Aren't there more than enough of these in their everyday work? Diseases crush people's life plans, mutilate them, transform them into what they were not before. Ought we not rather to discourage physicians from placing the increased burden of fictive tragedy upon their already existing awareness of human suffering in "real life"? The answer is yes, if we look upon tragic elements in literature as "burdens" on already weighed down shoulders. The opposite is the case if, as I have proposed, we see tragedy as a way to "emotional refinement", as a way of becoming truly human, of relating to the world in a responsible and responsive way.

There are of course numerous further elements of the Greek tragedy – and of its modern successors in the drama of the 19th and 20th century and the great novels – that are of great interest in connection to the clinical experience, such as questions of death and denying (Claudel called the tragedy "a cry in front of an open tomb"), of physical vulnerability, of honour and disgrace, of respect. I have focused here on catharsis in order to point to a crucial element in the clinician's everyday work: the recognition and handling of human suffering. Literature is not the full answer to this challenge but it is an offer for a deeper understanding and a more humane response.

5.2 What happens to the reader?

The Muse is an enigmatic Lady.

Norman N. Holland[59]

In the first part of this fifth chapter I have presented the potential that I consider literature to have in relation to the physician's clinical skills. I have described this using the the Aristotelian category *phronesis.* The analysis is closely linked to the understanding of the nature of clinical medicine outlined in chapter 2 and a view of what literature is elaborated in chapter 3. Chapter 4 was devoted to the capacity that I believe links the reading of literature to clinical skills. This link is *clinical judgement,* and in 5.1 I have shown that key elements of this clinical judgment are potentially cultivated in encounters with literature.

My assumptions so far - and also my repeated stress on literature as a potential for the clinician - point to a number of critical questions. The sceptic may insist that there are, indeed, weak reasons for us to believe that such a good effect as the one outlined above will come out of reading. Isn't it just another in an almost endless array of well-meaning claims on behalf of literature – and especially "good literature"? Would we not need more empirical evidence, or at least indications, to be prepared to accept that the company of literature is of importance for clinicians? If we assume that there is a potential like this, which are then the circumstances under which we may see it realized?

In this second part of chapter 5, I will first present a model for the situation when a reading physician meets a literary text and perhaps comes out of this encounter as not quite the same as before. Departing from the model I will then proceed to say a few things about the complex of questions that arises when we ask ourselves *what*, *when* and *how* a physician may read, and try to relate this to what may come out of the reading. This analysis will be of course related to the potential outlined in 5.1

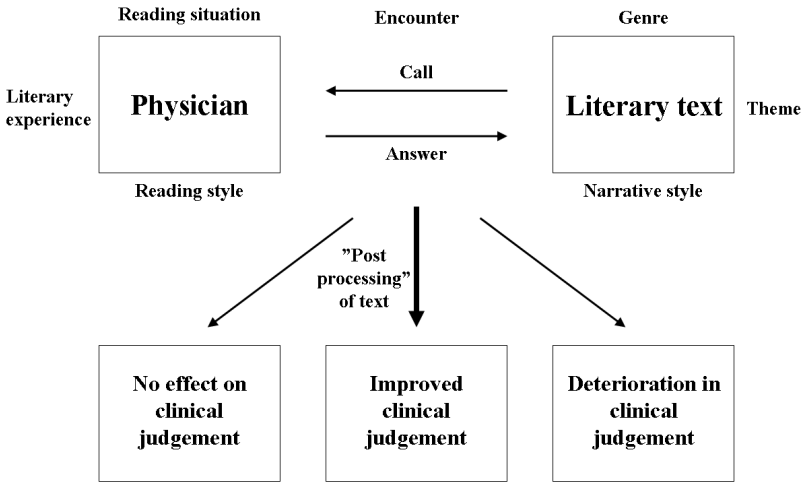
It is a truism to say that any encounter between reader and text is unique. This is the reason why it is so difficult to present general statements on reader reception. In spite of this fact, acknowledged by all researchers, empirical research on literature reading attempts to present corroborated knowledge on outcomes of encounters with texts. This research is extensive, but, as I will show, difficult. In spite of this, it cannot be ignored in my investigation. We cannot and need not attempt to cover this comprehensively here; instead, I rely on selected sources that I judge to have a good over-view of the field and that I find valuable for my purposes. The most important source on reader reception research has been

Jèmeljan Hakemulder's *The Moral Laboratory: Experiments examining the effects of reading literature on social perception and moral self-concept.*[60] I will cite some other sources, some of which have already been mentioned - either empirically oriented or more analytical - that I have found valuable. Finally, I will try to summarize my position in relation to the many questions about what we have reasons to expect will happen to physicians who read and how these outcomes may be influenced.

5.2.1 An *ad hoc* model

In order to approach the cluster of questions arising when we approach the role of literary experiences for clinicians, I will first venture to present a model for the encounter between reader (physician) and text (novel, drama, poem), and for the outcome of that encounter. This must be seen as an *ad hoc* model, in the sense that it does not take all aspects of the encounter into consideration (what model could?). This model is not specific for the reading physician, though it has been elaborated in order to highlight some of the aspects I find of particular importance in relation to the aims of this investigation. The model provides a way to structure the analysis of the act of reading, and, in the context of my investigation here specifically, to treat the question of what happens when the physician reads a novel or a poem or goes to the theatre, which influences are at work and what may be said about different outcomes under different circumstances. It is important to underline that the categories used do *not* pretend to be fully in line with narratological vocabulary or theories of reader reception. They are meant to provide illuminating categories useful for the ensuing analysis.

I suggest that the physician's encounter with the literary text be illuminated by the following model:



Some comments are necessary to make at once in relation to this. The central relation is that of the text (the novel, or poem or play) and the reader (the physician or medical student). As explained in chapter 3, I consider the text to be intimately connected to the author, and in this I decidedly reject theories of the autonomous text.[61] The text, the story, is a call to the reader, an invitation to take part, to be moved. The text has certain characteristics, sending signals to the reader - and I have chosen to call these genre, theme and narrative style – which

will have a decisive influence on the way the reader approaches it. The reader answers to the call made on him by the author, through the written text. How he answers is, of course, crucial for the outcome of the encounter. His value-orientation (the basic convictions and orientations that he has in life), and his life-experiences, including literary experiences and, in my case, professional experiences of clinical situations and training, are crucial factors in deciding this response, as well as a number of contextual factors such as when and where the book is read or the drama seen and which "style" of reading this entails (which may of course be largely dependent on very casual circumstances). To respond to the narrative in a way that takes the call, the invitation, of the author seriously is a responsibility of the reader, and this responsibility may or may not be faced. The interpretations of the reading physician, the meaning that he "delivers" in the encounter with the text, will hence depend on a wide and heterogeneous spectrum of factors. As a consequence they can never be fully predicted. The reader will then go on to reflect over what has been read, for a period of time which may be long or short. Inspired by Hakemulder, I will, using a somewhat technical term, call this activity "postprocessing". Such postprocessing might consist in just a casual thought now and then, or in intense and ongoing discussions about it with others, vivid and reflected inner images, and further reading around and in this very text.

The heaviest arrow points to an outcome of reading – and by this I mean anything from a very marginal to a substantial shift in the sum total of experiences that make up the reading physician's "life world" – that enables her to use her clinical skills in a better way: more imaginatively, more attentively, in ways more open for complexity and ambiguity, more capable of handling insecurity and tragic aspects of illness and death. But the model also provides for

another outcome: that the physician becomes less capable of reaching the goals of medicine outlined in chapter 2.2, or that clinical judgment is not affected at all. I will show that, in order that we do not give up our hypothesis that literature may have a considerable influence on who we are and how we react and act, these outcomes have to be taken into account because they are indeed risks of any reading.

5.2.2 Hakemulder on *The Moral Laboratory*

The arrows pointing downward in my model are enigmatic. How do they come about? Do they exist at all, except the left one pointing to indifference, no effect?? Is it possible to know anything about this, or are we confined to guessing?

Of great interest when approaching these questions is the above mentioned book of Jèmeljan Hakemulder. His study departs from the fact that many claims are made on behalf of literature's beneficial effects on readers, at the same time as empirical evidence for this is scant or absent, at least if we ask for systematic and scientifically based evidence. As he rightly notes, one may of course accept this situation with the support of different arguments: that such effects do exist, but are impossible to verify by methods with reasonable validity and reliability; or, that there are no such effects at all and that hence no research on them is meaningful; or, that there are indeed effects but that these are of a sort that per definition could not be verbalized, particularly not in the words of researchers´ language. Hakemulder acknowledges these positions, but rejects all of them. He insists on the possibility of finding out at least some things of value about the outcomes of reading in relation to certain effects that can be operationalised. He is careful to pay attention to weaknesses and inherent problems in the empirical

research carried out on effects of reading. He is aware of the challenging conceptual questions that inevitably arise. And he presents, before turning to the empirical questions, a comprehensive list of arguments retrieved from the discussion of the effects that reading literature may have. Several of these arguments resemble the ones presented in 5.1. But here they are presented without any specific consideration of what a particular group of readers group might benefit from reading fictional texts and what effects could be of particular interest to members of that group. I will very shortly summarize and comment on Hakemulder's list of "the benefits of reading", and then on the empirical material he presents.

We must first identify exactly what it is that Hakemulder is looking for. The title of the book, borrowed from Robert Musil, suggests that it is morals and morality that is at stake and the concept "laboratory" gives associations to hypotheses, experiments and outcomes. But ethics is immediately brought into the picture. Hakemulder explicitly states that by "ethical effects" – such effects as he conjectures may be the result of reading – he means "enhancement of ethical reflection"; and "moral effects" are taken to mean "actual persuasion in favour of some moral position". Admittedly this leaves many questions unanswered. He does not define the concept of "ethical reflection". Even more problematic is the distinction established between what he calls "pre-ethical", "ethical", and "moral effects". This notion, "pre-ethical", is introduced to mean effects that "pertain to the enhancement of abilities that are likely to help us in making ethical inquiries."[62]

Hakemulder´s goal, then, is to see whether a number of very plausible, sympathetic, and wide spread assumptions about the effects of reading literature

on those who read (and it is usually implied that it has to be "high literature", literature generally considered to be of good quality) can be supported by empirical evidence. He lists these effects in a concentrated way, by grouping them under the categories just mentioned. The way he defines "pre-ethical" effects is bound to place the majority of the proposed effects in this category. Examples are effects on beliefs about causality in everyday events, an increased understanding of the complexity and ambiguity of ethical problems, stimulation of imaginative role-playing, an increased acquaintance with various moral perspectives, "defamiliarization" of moral perception (meaning a chance to look with fresh new eyes on very ordinary situations), emotional relief and self-awareness. It is immediately seen that some of these "effects" are very close to what I have proposed as the potentials of literary texts to contribute to clinical judgment. Why they should be called "pre-ethical" is enigmatic to me. These capacities are, as I see it, closely interwoven with any sort of ethical deliberation and are as such part and parcel of decision-making in ethically relevant situations.

The proposed "ethical effects" are consequently considerably fewer. Hakemulder mentions the capacity to "…try our roles and reflect on the consequences of these roles", and "...an enhanced ethical reflection on problems in everyday life also in contemporary society"[63]. The way he has distinguished "pre-ethical" from "ethical" effects hence leaves very little left, and it is hard to see why these should at all be separated from each other. The "moral effects", finally, are here suggested to be four, all of which seem to be different formulations of the assumption that reading affects behavioural norms by way of imagination and of rhetorical persuasion.[64] Again, it is hard to understand why Hakemulder stipulates the way he does. There are, as I see it, few reasons to distinguish

"moral" from "ethical", and even fewer to consider "effects on behavioral norms" moral but not ethical.

The next step in his analysis is to look closely at a material of experimental research during the period 1980-1995, psychological studies found to deal with the questions he has posed. This material was followed up by information directly from the authors of the works found. His search yielded 54 studies which were grouped into eight categories according to what effects the researchers were looking for. Among these, the first three concerned moral attitudes and development, including "Empathy" – and the rest dealt with attitudes that have moral import but may not be primarily thought of as "moral": "Outgroup attitudes", "Sex-role concepts", "Self-esteem", "Critical thinking" and "Anxiety reduction". Hakemulder scrutinizes these studies in order to find weaknesses and "confounders". He finds that of these 54 studies (a few were grouped in two categories), 26 were unreliable, due to various methodological weaknesses. The rest were considered to show results that may be seen as reasonably valid. Of the reliable studies, five were seen as having no effect and 23 had. No very clear pattern could be discerned concerning different outcomes in the different categories.[65]

What kind of studies then are these? The typical research scenario seems to be this: a group of young people are selected (usually not at random). The subjects are asked to read some text, a story from a literary work or even sometimes a story written by the researchers for this specific aim. Only occasionally has a "control group" been used, i.e. subjects made to read a non-fiction text dealing with the same issues, and thereby allowing for systematic comparison with the subjects of the "narrative group". The group is seldom "blinded", in such a way

that they do not know the point of the study or what the researchers are looking for.

The outcome of the reading is then "measured" in some way, using already existing methods for assessing certain abilities in the field of moral development and attitudes or explicit moral norms concerning certain areas (like sex roles or attitudes towards "outgroups"). Sometimes the effects are measured only after discussions in the group, with or without a "supervisor" ("postprocessing", as Hakemulder calls it). Very few studies attempt to find out whether effects are still there after some weeks, that is: whether they have been "internalized". No study deals with repeated exposure to reading over a longer period, and only three of the studies were able to say anything about effects on behaviour, and these were severely confounded[66] and, in my opinion, difficult to draw any conclusions whatsoever from.

As already noticed, Hakemulder very frankly discusses the deep-going difficulties involved in this kind of research. Without control groups, how could we know that it is the *reading* that accounts for the results, when these are "positive", and not other factors in the research situation? It could be the very attention given to the group, or it could be the "postprocessing" in itself. To try the latter question, Hakemulder attempted to distinguish the effect of literature per se, and found ambiguous results. Sometimes it seems as if effects were independent of ensuing discussions and sometimes it seems as if they were the results of such. Furthermore, the texts read and the circumstances under which they were read and then evaluated are very peculiar in relation to the everyday phenomena we want to understand, in which we find persons choosing and

reading novels out of interest, inclination, curiosity, and a longing to be amused and thrilled. To draw more general conclusions from this material seems unwise.

And most important: What *is* it that should be measured (that is, what does validity mean in this case)? If a physician goes to see (and perhaps also reads), say, *Uncle Vanya,* and if this person then goes to a restaurant and discusses, at least for a while, the play with some friends and the following days now and then reflects on the play – what then may have happened, in the shorter and longer run, to this person (who may be an active clinician)? Would we suppose that he or she has undergone some measurable "moral development"?[67] That he or she has become more "empathetic"? This seems both too ambitious and also to restricted. What one *could* expect is that the physician in question has added to her understanding of the world, her "life world", a small piece, in itself perhaps insubstantial but still of potentially major importance, that has made it richer, more nuanced, more complex and more open for ambiguity (as outlined in 5.1.3). This person, if she has opened herself to the play and allowed it to "work on her", *knows* something more about the world. The sum total of her experiences of life is not the same and hence new experiences will fall, so to speak, into a very marginally but still different soil. Whether we, like Hakemulder, call this pre-ethical or ethical or moral seems totally irrelevant. But my conviction is, and I hope to have substantiated this in what I have written so far, that such knowledge of the world is potentially highly clinically relevant – and I seriously doubt that it is measurable in any valid way.

So the weaknesses of these studies are both obvious and serious. It is doubtful if they really help us say anything very substantial about the effects on practising physicians or medical students of literature reading. First of all, I consider the

very short time that the influence is allowed to go on - the reading of, usually, one rather short story followed by immediate measurement of effects - as fundamentally different from that kind of company-keeping that I have been talking about. I doubt that this is only a question of the quantity of reading-time and the time for reflection, so that we can just multiply the effects of one reading situation with the number of instances that it is performed. The company of literature, as I will try to show, means keeping one´s literary imagination alive, like continuously training one of our senses and in doing this having an ongoing inner dialogue – and sometimes also outer – about the experiences provided by the narratives. This is not likely to come about at all after one single instance of story reading, except perhaps very occasionally.

The second basic shortcoming of these studies is that if effects on behaviour are not also somehow brought into the picture, the effects estimated will not relate to the influence of reading on phronesis, at least not as this concept has been elaborated above, but rather to the effects of reading upon capacities of deliberation and theoretical value orientation. This may be important enough, and is arguably one essential part of a phronetic capacity, but the stress in this context has all the time been on the close connection of deliberation to action. Physicians act and they act all the time with far reaching consequences for ill persons. It is how the ongoing company of literature affects clinical judgement that is at the centre of my interest here – and the empirical material presented by Hakemulder tells us very little about this. In other words, it lacks relevance.

Could these weaknesses be overcome? Is there a way to conduct an empirical study that would tell us more about exactly those effects I am interested in here? My answer is a cautious yes, and before proceeding to discuss in more detail

some aspects of reading situations, I will tentatively outline what such a study could look like. I must stress that this should be seen as a very hypothetical sketch of a prospective qualitative study, rather than as a detailed suggestion.

5.2.3 A sketch of an empirical study

Three groups of 7-8 students each are randomly selected from a course of newly admitted medical students. The first of these groups functions as a "non-treated" control group. It is followed and subjected to the same evaluations (interviews, questionnaires, observation) as the ones described below for the two other groups. The second group gathers at regular intervals with a medically trained supervisor to exchange experiences from their studies. The dialogue in this group should be very open and undirected. The third group is led by the same supervisor. This group is also invited to discuss experiences gained from their studies, but the primary target of discussions should be common reading experiences. The group members are invited to read a number of novels, short stories, and poems, and visit some theatre plays. Some of the literary works may have medically related themes, but this is no necessity. The books read and the theatre seen must qualify, in general, as "good literature" (a concept I will return to later in this section). These experiences are discussed continuously within the group, parallel to the discussions of other matters like studies, clinical experiences and so forth.

The three groups are then subjected to evaluation by means of interviews and perhaps also questionnaires at regular intervals during their studies, at the end of them and also after some time when they have started practising. This evaluation should be done by independent and "blinded" observers, and could

well include also practical performance in clinical situations (how the group members relate to patients, in which way they reach an understanding of their problems, how they come to conceive of their own role and responsibility, how they handle difficult situations). Evaluation could include case based stories of ethical dilemmas and also possibly how such dilemmas in real clinical contexts were handled. Finally, it could be of considerable interest to know to what extent persons in the groups still, after finished studies, keep the company of good books and to what extent they have developed different habits in this connection.

Of course, a longitudinal, qualitative study like this does not take away all the weaknesses in the studies that Hakemulder presents, but certainly removes some of them. Most importantly, it would permit us to say at least some things about long term effects of reading, of keeping the company of literature, upon attitudes and behaviour ("clinical judgement") of physicians, and it would at least to some extent avoid the many "confounders" that plague the research that Hakemulder describes. Of course, causality questions abound also here. The second control group may help to control the parameter "common discussion with supervisor", but we do not know the relative importance of the reading experience in itself in relation to the ensuing discussion of it, "the post-processing". (This could of course have been dealt with by having yet another control group who only read books and reported this in essays, or something like that.) It would say little about which books are suitable and which are not, and it would not help us to know whether another supervisor and another group context may have had another impact on the participants.

How serious is this relative lack of empirical support for the alleged effects of reading on readers? If one accepts that it will probably not be possible to reach

very much further in empirical research on reading outcomes, which is what I have proposed, does this then mean that it is illegitimate to assert anything on behalf of literature in relation to clinical skills? Should all conjectures concerning the importance of literary experiences in relation to clinical skills be linked to very strong reservations and limitations? My answer is no, and it is based on the collected weight of the indications we have, many of them from everyday experiences of a non-systematic nature, on the subjectively reported importance for most people of reading experiences, on the inconclusive but still interesting empirical research and also on the theoretical analysis that I have presented in this thesis. It will be possible to reach further, through both analytic reflection and empirical research, but nothing will be proved beyond doubt. But is that so different from many other areas? Do we, for example, have any solid evidence to "prove" that the teaching of ethics in medical education has the effects that are usually assumed (increased awareness of ethical dilemmas and a better capacity to handle these in a way that is in line with the goals of medicine)? How would an empirical study be designed, that "proved" this?

However, this difficulty does not free us from the responsibility to try to find out as much as possible about the conditions under which the potential that I have outlined may be realized. There are some tentative answers to be found in the empirical material, and some to be assembled from everyday experience of how, why and what people read. The rest of chapter 5.2 will be devoted to an attempt to say some, inevitably limited, things about this.

5.2.4 The literary work: What to read?

The Moral Laboratory raises many questions of crucial importance. One of these concerns the potential for harmful effects. If, as Hakemulder does and as this investigation proposes, we look upon literature as a way of increasing one's knowledge of the world and, in doing this, of affecting the attitudes and actions of those who read – is it then not inevitable to conclude that reading might be dangerous, in distorting instead of informing, or in propagating prejudice and hatred? The question will be dealt with in 5.2.6, but it will also be present when I now proceed to discuss what readers should read; in other words, what the effect will be of different works of literature, of different genres, of different narrative styles, and of different "themes". Again, of course, the questions raised have very far-reaching ramifications. What I intend to do is to make certain remarks in connection to my over-all aim of understanding the contribution from literature to clinical judgment.

General statements, like "reading novels will increase medical students´ capacity to understand the challenges that their patients face", are bound to meet sharp counter- questions, among which probably the most difficult concern exactly *what* it is, then, that they should read? Literature is an immensely heterogeneous phenomenon, and even texts already subcategorized as "novels" may be of very different character. The questions multiply: Novels, short stories, poetry, drama? Realism or fantasy or romance? Contemporary or historical? Focused on illness experiences or on other human matters? First person perspective or third? Main focus on inner worlds or rather on actions and their "outer" results? Experiences of middle or upper class people – or of deprived? If this vast range of different genres of fiction, themes and different narrative techniques is taken into account

and combined with the unique character of any encounter between reader and text – then it may seem hopeless to even attempt saying anything at all about this. As Louise Rosenblatt notes:

> There is no such thing as a generic reader or a generic literary work; there are only the potential millions of individual readers of the potential millions of individual literary works.[68]

However, the situation for generalizations is not altogether gloomy. Some assumptions may be underpinned by some degree of empirical evidence. Some may be supported by reasonable arguments, based on everyday experiences of the reading of oneself and of others. Some may be based on shared characteristics of certain social groups. Physicians are indeed a very heterogeneous group but they do share a common training, some basically similar professional tasks and certain experiences that most physicians make in their professional roles.

When we ask what physicians ought to read, the most challenging questions are bound to concern quality. Quality in this context must mean those characteristics of a literary work that are conducive to the attainment of clinical judgment. Attempts to contrast "bad" literature" with "good" have, of course, run into critique, as have most wishes to define "canons" of (western) literature[69], but nonetheless this dichotomizing seems to be with us. I will try to argue that, even if there are several traps in such an endeavour and even if the criteria used will never be unanimously accepted or stable over time, we should nevertheless consider that there are some solid grounds on which to raise such judgments. And I will argue that in relation to clinical judgement it is definitely possible to say at least some things about more or less valuable literature. And what I see as

valuable literature is not surprisingly often within the "Western canon" – as well, of course, as some books that have not yet quite made their way into it, but might become part of it.

I have several times stressed the fact that an increased capacity to shift perspective, to see with "new" eyes, is a potential outcome of the encounter with a literary work, and crucial to the physician's tasks. This connects aesthetics to perception, through the Greek word *aisthesis,* meaning capacity to perceive. Perception is a crucial element in *phronesis,* and I have in chapter 3 cited Martha Nussbaum asserting that a "finely tuned perception" is a potential in encounters with literature. This lends support in some empirical research on reader reception. David Miall, in trying to elaborate a meaning for the concept *literariness*, proposes a three step process, relevant to the question what the physician should read[70]:

(1) The reader encounters a narrative feature that in some way captures her attention and holds on to it.
(2) Some phenomenon or context – natural or linked to humans – is through these aesthetic means presented in a new and unfamiliar way that prompts reinterpretive efforts.
(3) This individual concept or phenomenon is understood in a (partly) new way.

"Character identification" is proposed by Suzanne Keen as a reason why the reader is moved by what is being read.[71] As the characters become familiar to the reader, the reader sees parts of herself in them, or at least what could be or have been herself. This captures her attention, her affects are involved and she will need to interpret what she reads in order to "make sense" of her feelings and

thoughts. This seems similar to the process described above and which Miall calls defamiliarization. By some degree of identification, the reader is "captured" by the story and his attention is held there. He is hence open to the unfamiliar circumstances and interpretations that the narrative may present (or imply). But I hardly believe character identification to be necessary for defamiliarization, at least not what we ordinarily mean by "identification".[72] The reader may be puzzled and somewhat disquiet about circumstances in a story without having the remotest degree of identification with the characters. Interesting they must be, yes, but not at all like the reader herself, and the challenges they face may be totally improbable for her to ever encounter. And it also seems that the opposite may be true. Character identification may be important without defamiliarization, if, for example, the physician recognizes elements of her own existential dilemmas and struggles in the characters of a tragedy, this may have the cathartic effects that I have argued may be important for clinicians. It is also important to remember that defamiliarization does not necessarily mean deep-going reinterpretation of held convictions. It may mean that the reader's convictions are affirmed but in a richer and more complex way. He may, to take an example, on an intellectual level be of the conviction that most human beings are morally ambiguous creatures, with a potential for both good and evil acts. The reading of a novel may, by bringing in the reader's "emocognitive understanding", affirm this conviction, but make it more nuanced, more "palpable", more lively, more real.

In the beginning of this chapter, as well as in the second part of chapter 2 and large parts of chapter 4, I devoted my attention to the professional "filter" through which a physician is shaped. Such professional forming comes about through training and experience and helps her to perceive the everyday realities

in which she is professionally involved. I have stressed that a capacity to shift "gaze" from the "medicalised body" to "the lived body" is crucial for a physician to attain clinical judgment. Is this a clue to what the physician should read? If we follow Miall, what we should look for seems to be books that deal aesthetically and thematically with the lived realities of other persons in ways that help the physician to take a step out of the world view that she has grown into, books that "defamiliarize" this perspective in such ways as to stimulate her openness for ambilvalence, for complexity, for paradox and for unexpected thoughts and feelings. Reconnecting to 5.1.2, she is *shown* phenomena that are directly or indirectly related to his everyday professional world in a new light. We are hence looking for literary works that "defamiliarize" predominantly through aesthetic means – like poems may do – or mostly by their choice of perspective(s) on reality (like polyphonic novels do). This challenge to the physician's ingrown perspectives ought not to be more demanding than that it offers a chance to take the third of Miall's proposed steps – the integration of the new and unexpected perspective into a partially new understanding of the world, a richer and more nuanced understanding of, in the words of Milan Kundera, "… some unknown aspect of existence".[73] Or, as Umberto Eco puts it: "Reading a story means being seized by a tension, a thrill."[74]

But why should we expect defamiliarization to result in new perspectives and in a richer understanding? It could instead be met by irritation and a closed mind from the physician, and Miall´s three steps hence would not be at work, and no "thrill" is there. It is hard to answer in general here. In what I would call good literature, the aesthetic means have greater chances to work because they are the result of a creative process that is honest, deep-going and skilled. Defamiliarization then comes about, because the story is able to capture the

attention of the reader. It does so by overcoming some of the everyday reluctance of most readers against new perspectives and worrying re-evaluations. (This is of course also a dangerous potential in stories, as they may be so well done and seductive as to break down also sound scepticism against certain perspectives.)

Albert Camus´ short novel *The Stranger* could offer a useful example. Mersault, the protagonist, is a person likely to provoke the reading physician's standard repertoire of interpretation of human behaviour. One would guess that anyone encountering someone like Mersault would consider the man to be almost psychopathic in his inability to react emotionally or morally to what is going on around him. But it is just as probable that our reader at the end of the book will find Mersault more ambiguous and will have great difficulties in passing unequivocal judgement on him. Our reading physician has then been "defamiliarized" with his standard assumptions about how people react in certain situations, his everyday "typologization", and will face the challenge to adjust his understanding to make it comprise the possibility that there are actually "Mersaults", persons with more or less similar patterns of experiencing and reacting, in the world where he lives and works. Moreover, as Camus´ novel never lets the reader fully into the mind of Mersault, the physician reading this novel must, in order to get anything out of her reading experience, make inferences and conjectures about what goes on in Mersault – his intentions, his fears, his hopes, his conscious and unconscious motives. This invitation to imagine something new, to modify a given pattern of interpretation, by ways of cognitive-emotional empathizing with a literary figure, seems to me to be exactly what this physician must do in her everyday work facing patients that react in enigmatic and unforeseeable ways.

5.2.4.1 Genre

Genre is a tricky concept. It is meant to delineate certain sort of literature where some common traits are shared. Anders Tyrberg proposes that:

> Through the genre the conditions are clarified in the contract that author and reader establish in the act of communication. (*My translation*)[75]

Encyclopaedia Brittannica defines genre as "a distinctive type or category of literary composition, such as the epic, tragedy, comedy, novel, and short story".

.

It is obvious that the definition of the Encyclopaedia creates very difficult questions of delimitation. Books may contain elements of comedy, tragic elements, romance, and strong realism. Not surprisingly categorizing them as belonging to a certain genre will sometimes be more or less arbitrary and will risk over-shadowing the complexity of their content. It is possible to argue that some novels, for example, are good exactly because they are so undecided in relation to genre. Is *Crime and punishment* an epic novel, a criminal story, a tragedy, a realistic account of a murder – or even a religious pamphlet intended to show the dangers of secularism and nihilism? Good reasons could be mobilized for any of these suggestions and it seems very reasonable to say that this novel is all these at the same time – and that different readers will perceive these aspects with different emphases.

I will limit my remarks on genre to a few comments on four very general genre concepts: novel, poetry, short story and drama. Does, then, the physician's

choice between these genres mean anything in relation to the outcomes presented as potentials for increased clinical judgment? I think that this can hardly be the case. It is hard to see that genre matters very much here. Different physicians may of course have different genre preferences. Some may not like poetry and find it strange and indifferent. Some may be reluctant to watch Greek tragedies, finding them too schematic and too far from our own time. So genre would hardly be the question here, but rather the kind of invitation that the author through the text makes to the reader. This invitation might be more or less demanding. If the text only underlines and affirms the convictions and the prejudices of the physician, it will hardly invite defamiliarization, although it might perhaps invite character identification. If, on the other hand, the text is able to capture her attention through aesthetic means and through a theme that grabs and holds the attention, and if it then introduces enigmatic, partly unfamiliar elements, calling for new perspectives and a more complex and ambiguous understanding of the events and persons in the story – then the invitation of the author to the reader to participate in an act of common creation of new realities has been accepted.

The novel is perhaps the first genre to come to your mind when the question of perspective is raised. As noted in chapter 3, the European novel rose in the 18th century, and developed into a richness and subtlety and complexity that made it the leading literary genre. Novels may be more or less "polyphonic". The physician reading Dostoyevsky will become acquainted with a bewildering number of life-worlds. The "ways of world making" of the figures in his novels are truly ambiguous and often filled with tensions and conflict. Of course, to a greater or lesser extent this goes for many of the great European novels.[76] The kind of defamiliarization this may prompt in the physician, if the aesthetic means

work, is such that reinterpretive efforts may develop into an understanding that has the characteristics of Stephen Toulmin´s "Renaissance rationality", complementing the rationality of the sciences that the physician uses in his everyday work. If Dostoyevsky's polyphony succeeds, or that of any other polyphonic novel, the physician will face individuals with rich and complex inner lives, who react and interact in unexpected and paradoxical ways, who are ambivalent and sometimes self-destructive, and who are struggling with the meaning of their existence. This is how many of the patients a physician encounters act and react.

However, one might well imagine a not very polyphonic novel, for example focusing on exclusively one person's experiences over a limited sequence of time, that may also widen the reading physician's experience. This may be said of Lars Gustafsson's *The Death of a Bee-Keeper,* where a lonely man, his dog, and his impending death constitute the focus of the story.[77] The bee-keeper, as the novel proceeds, takes shape as an increasingly complex human being, at one and the same time very reflective, but also with what seems to be a great fear of seeing some aspects of himself. The bee-keeper, like Mersault and like many other key figures in European novels, changes over time. They are, as it were, in motion. And the more the reader gets familiar with them, the less certain can he be of who they really are. The physician who reads Gustafsson is invited to a complex understanding of the bee-keeper, and to reflect on his life-story, his motivation, and his choices – and hence through these interpretive efforts answer responsively and responsibly to the call of the author. Physicians may learn from such novels to suspend judgement on their patients, to be reluctant to jump into conclusions on the reasons for their behaviour and, finally, to avoid labelling

unless such labelling is inevitable - and in that case use labels with a sceptic's eye.

If they are well written, novels, as Kundera reminded us, help us discover hitherto unknown reality. The world of the reading physician potentially grows. She learns something new about the world. The novel, in relation to many other literary forms, also has the capacity for capturing and holding the reader's attention over a longer period, thereby helping the physician to see a sequence of events developing over time. This aspect, the temporality of all experience and the embeddedness of all humans in their history, is of crucial importance to the understanding of disease processes and experiences of illness. The physician who cares for and treats patients with chronic disease (and most physicians do) must be able to see how her patients´ experiences, emotions, thoughts and hopes and fears change over time. If not, the patient risks being trapped by the rigid expectations of the physician, expectations which may to some extent become self-fulfilling.

Reading novels may be time-consuming and time is what physicians seldom have, or at least seldom think they have. In this respect, if physicians are to meet literary texts, poetry seems to be more promising. Poems are usually short, dense, very concentrated and do not take much time to read. Poems may be carried in the pocket and read during or after a working day – perhaps for consolation, to arrest the flow of events for a while, to give oneself the chance of seeing a well-known reality in a partly new light. An interesting example comes from the Medical School at Tel Aviv University.[78] The authors dispute that long literary texts must be the only option if medical students are to receive a complement to their medical texts. Time is short and novel reading during the

basic medical training may sometimes be too much to hope for. The authors sent a poem every week-end to the six medical students on their ward during their clerkship in internal medicine. When appropriate, e-mail messages also pointed to the connections between the poems and some discussion that had taken place at bedside. Two situations where poems became particularly relevant to cases on the ward were presented together with some student responses. Similar findings have been made by Horowitz who let residents read and also discuss poems during ward rounds.[79] These two examples show how poetry may be introduced, but what the reading of a poem meant to those who read and how it perhaps affected their professional behaviour remains totally unanswered.

Poetry may, perhaps more than any other genre, need time for reflection in order for defamiliarization to work. At the same time, poetry is probably the most demanding genre, as poetic language may seem very alien and "unnatural" to some readers. Poetic metaphors sometimes work, sometimes not. Poetry often benefits from "post-processing", in the form of discussion together with other readers and perhaps also some more trained reader. Physicians reading poetry may grow in linguistic flexibility and sensitivity, and how much they gain in these respects will largely be dependent on the extent to which they are able to respond to the poem, explore its different levels of meaning, reflect on them and also to see how linguistic factors are deeply intertwined with questions of meaning. Dialogue with others will in many cases facilitate this .

Neil Pickering has argued that the idea that poetry may be deliberately introduced to serve specific purposes – as, for example, could be the case when poems become part of a medical education – is misconceived. The outcome of any one episode of the reading of a poem is fundamentally and inevitably

unpredictable. Outcome, for Pickering, seems to mean the interpretations that arise in and after the reading process. If we want something very specific to happen in the reader(s), a certain understanding to result, we have not understood the very nature of a poem, which is to resist such instrumentality.[80] To this, Ahlzén and Stolt replied that even if specific interpretations should not be expected or predicted, it is not the case that one may not at all predict in which directions the interpretations of a group of poetry readers reading a certain poem will go. Furtermore, by reading outcome we may mean not specific interpretations but rather the understanding that there are several possible interpretations and meanings arising in one and the same reader, and even more within a group of readers. Poems make possible a familiarity with the range of human interpretations and show us the crucial role of language in shaping these. This is indeed an "outcome" that *is* possible to predict, at least to some extent, by choosing poems that invite to a multitude of interpretations – and by giving chances to "post-process" what was read.[81]

The fact that poems are usually short and do not take as long time to read as do novels does not mean that their potential to affect the reader is smaller. Poems may, through the use of bold metaphors, "open up" the world to new unexpected perspectives. When poetry works, it seems to be the very essence of defamiliarization, that is the more or less unexpected introduction of a new perspective, an unexpected point of view, a new light on a well-known phenomenon. Poetry takes eminent advantage of linguistic nuances, and is able to integrate and respect ambiguity and paradox in a way that the language of science is not. Sobel and Elata note that

> …poetry may be an antidote to the precise, expository language of medicine. The language of poetry opens reality, uncouples it from convention. Poetry invents worlds, and in so doing invites the reader to share in its inventiveness and appreciate the way in which language shapes reality.[82]

An interesting and perhaps also paradoxical aspect of poetry that may easily be overlooked is that while poetic expressions are, at best, able to push the limits of what may be said, they at the same time also remind us of the limits of language – where words end and what is beyond linguistic expression. Some poems seem to be struggling with exactly this fact. The words may be so precise, yet delicate, that they are close, close to silence. The linguistic sensibility and sensitivity that may arise from familiarity with such poems are very similar to what the physician needs when facing ill persons struggling with their words and grappling for the right expressions for very complex and enigmatic experiences.

Stories need not be long to affect readers profoundly. Raimo Puustinen has shown how Chekhov in a short story, *The Visit of a Country Doctor,* presents an encounter between a "psychosomatically" ill young woman and a country physician charged with tensions and ambiguity.[83] Chekhov leaves a great deal to the reader but through small nuances and subtle formulations he is able to show the reader how complex this encounter is, both emotionally and cognitively, and how many the traps are on both sides. Authors who, like Chekhov, are masters of their art are able to concentrate a story into this rather small size. There are a number of advantages with short stories in relation to reading physicians. An obvious one is that, like poems, they can be read fairly quickly, which seems to be what some readers prefer. Short stories lend themselves well to "group reading", followed by dialogue on the texts read.

Can short stories promote those components of clinical judgement that I have outlined in 4.3 and in 5.1? It is hard to see why not. Nothing fundamental distinguishes short stories from novels. Novels may, admittedly, present a larger number of themes, persons and narrative techniques. They may be more "polyphonic". But a short story may be easier to see as a whole, it may in some cases affect the reader more quickly and more deeply. A short story may leave riddles unsolved, just because circumstances and persons have just been hinted and not comprehensively introduced, and much is left to the reader to fill in. This is, I take it, in many respects similar to the clinical situation where inferences must sometimes be made from scant information about the actual circumstances of a person's life. There are potentials and risks in this that every physician should be aware of, and short stories may be particularly suitable to cultivate such insights.

Ernest Hemingway's *Hills like white elephants* provides a good example of how inviting a short story may be to our interpretations.[84] The reader is given rich opportunities to make inferences about character, motives and intentions. The story closes itself around a secret that is only hinted at. The reader is invited to conjecture, to infer, to interpret what may be behind the laconic dialogue. It would not be quite right to say that this story "defamiliarizes" – rather it holds the reader in a state of uncertainty from the very beginning, thus prompting efforts to understand, to make patterns of behaviour intelligible that may at first seem incomprehensible. This is what doctors do all the time. Furthermore, Hemingway´s story may help a physician to what I in chapter 3.1.6 called "suspension of knowledge". The characters are so enigmatic, we know so little

about them and the circumstances seem so complex that any categorical judgement would be unfounded.

A work of dramatic art may be read or seen or both. Probably, most people who go to the theatre neither have read nor will read the play they see. Why should physicians go to the theatre? Why read Ibsen, or Becket, or Pinter, or Fosse? I fear we have again as scant evidence of what particularly this literary form does to its audience as we have with novels and poems and short stories. The wealth of plays is overwhelming. All sorts of stories may be dramatized. Diseases, or imagined diseases, may be the core of a drama, like in Molière´s *Le Malade Imaginaire* or Margaret Edson´s *Wit,* or they may a constitute a more or less important background like in Ibsen's *Ghosts* or Strindberg'*s The Father*. Irrespective of the degree of medical association, dramas may have an emotional immediacy the printed page does not always have. Dramas are enacted by human beings, they are actually there on the scene and this fact may for some persons be of considerable importance and give a very strong impression, involving thoughts, emotions and fundamental life orientations. The fact that they also exist in written form, that there is a manuscript, may open up a return to what was seen, through reading and "imaginative re-enactment" of the story. A drama invites to common discussion with others who were also there. One seldom goes to the theatre alone. Theatre is communal in a sense that book reading is not quite. It is seen together with others, known and unknown. Perhaps a physician having attended Pinter's *A slight Ache* is more liable to post-process this story with others, to go on reflecting in and after discussions, than the same physician having read *Tess of d'Urbevilles.* But again, it might well be the other way around. Thomas Hardy's novel is rather long, it is complex, and by its

richness of composition may stay in mind in a more lasting way than a drama, however well performed and well-written it may be.

5.2.4.2 Narrative style (situation)

There are numerous narrative techniques that an author may employ in order to "capture" the interest of the reader. As just noted, some researchers see this as crucial to the attainment of character identification and of a defamiliarizing effect on the reader. If aesthetics doesn't work, if the reader's perception is not aroused, she will lose her attention even to a theme that is potentially interesting to her. May anything be said about which of all narrative forms carry a greater potential for physicians to learn – while acknowledging the irreducible uniqueness of any literary encounter and the risks of "purpose driven reading"?

Suzanne Keen takes some time to investigate whether empathy is more likely to arise from some of these narrative techniques than from others. She refers to several studies on effects of, for example, focusing the characters´ inner life (motives) rather than their behaviour (traits), or of different plot structures, of inserted repetitions, of gaps, of anachronies. The results are discouraging.[85] It just seems hopelessly difficult to define certain techniques as causally related to certain outcomes. The whole reading situation is so complex that the identification of certain elements with certain effects on the reader is just not possible. And the immense variability between literary encounters makes generalizations utterly risky.

However, something may be said of the role of so called perspectivation. Perspectivation as a concept refers to the fact that a literary text always presents a

sequence of events from a particular perspective, or even from several perspectives. I have several times noted that physicians urgently need to be familiar with other ways of thinking, other ways of "world-making", than their own. May we assume that this is facilitated by literature that very consciously uses perspectivation as a narrative technique? This concept, as narratology has developed it, refers to the "point of view" of the narrator, the one who tells the story. First or third person perspective are the most obvious of these. It may be assumed that if a story is told from "within", it will create more nearness and immediacy to the story. A physician reading an illness story narrated by the person who is ill may be more deeply affected than if the same story is told from outside. As van Peer and Pander Mat express this:

> A character's feelings reported by him or herself (in the first person), therefore, creates a stronger appeal to take these feelings as genuine and motivated than (again, ceteris paribus) when these feelings are reported by someone else (usually an invisible narrator) who implicitly claims to have access the character's inner world.[86]

First person perspective is, by definition, a "psychological perspective". It lets the reader, more or less, into the inner world of the narrating character, while the other characters around remain seen from this person's point of view. A third person perspective may be psychological or it may not. The narrator may take on the God like capacity of moving in and out of the minds of the characters. This is, one may say, a "psychological narrative", while if the narrator stays outside the minds of the characters, does not move inside them, we face a non-psychological history.

Would any of these perspectives – first/third person, internal/external – be preferable if the outcomes for the reading physicians are to be those that I find valuable? Again one may be disappointed:

> Although narratology has devoted considerable energy to describing the various textual devices that constitute the "point of view", not much is known of its real effects on the reading process and its outcome with any certainty.[87]

A reading physician, or a group of reading students, may indeed be strongly affected by a story of an illness experience narrated in first person, but it seems equally likely that a story from an external third person perspective, like *The Plague*, may through interpretive inferences deeply influence their ways of looking at illness, disease and also at themselves. In a way, these perspectives are perhaps complementary, the way they always are in our own lives where we experience the world as "first persons", but are all the time forced to interpret other peoples´ behaviour "from the outside"?[88]

The concept perspectivation can, as noted above, be used in a broader sense, for a story's capacity to make the reader interested in how several different characters in the story perceive of their lives, their bodies, their past and future. Again one would be inclined to assume that many perspectives are inviting to a richer understanding, but I have already exemplified how a strict one person perspective may leave the reader with enough riddles for a substantial interpretive effort to be made – and hence with a potential for learning about human reactions.

My reflections in this section largely support Pickering's thesis on the unpedictability of outcome of literary encounters. But as reminded earlier, it is possible to accept this conclusion, and to keep the distinction between showing and telling in mind – while still making very cautious assumptions about which texts may invite certain interpretations, which may be valuable to illuminate discussions on certain topics, which may help readers reflect on certain dilemmas and predicaments of, for example, ill persons.

5.2.4.3 Theme

It is often assumed that if physicians are to be advised to read, the rationale for this must be that what they read concerns medical situations. In this way, the physicians - or physicians-to-be - will come closer to the illness experiences of their patients and hence become more "empathetic". This has often been the principle governing the selection of texts for literary anthologies for medical education.[89] These texts are ordered in a chronological sequence, so that Molière appears early and Richard Selzer late. The authors are often, but not always, mostly physicians. The texts are generally excerpts lifted out of their context within a larger work, but they may consist of short stories or poems printed in full. There may or may not be short comments attached to the texts, of a more or less didactic import. One may also encounter thematically organized collections of text, where the texts are either assembled under general headings ("Death", "Birth", etc) or are used as examples in a more systematic analysis of elements of the clinical situation. A very ambitious example of the latter is Australian physician Solomon Posen's *The Doctor in Literature: Satisfaction or resentment?*[90] Posen's book may be read either in itself as an introduction based on fictive illustrations of many of the challenges that physicians face, or it may be seen as

the point of departure for explorations of the rich world of fiction with illness and its medical treatment as theme.

Is it possible to make any well founded suggestions concerning the importance of Literature On Medical Situations (henceforth LOMS) for active clinicians? Is the ubiquity of anthologies concerning such situations really motivated by their superior capacity to bring insights to physicians? We face the same challenge here, that the outcomes of reading are largely unpredictable. However, some things may be said, and I should like to make the following propositions:

- LOMS is valuable for physicians in its capacity to show medically relevant situations in a complex way, rich in perspectives and perhaps also paradoxes and ambiguities. LOMS may give the physician an imaginary access to illness experiences that he would otherwise not understand in such a rich way and may in this way constitute a counterweight to many physicians´ tendency to equate illness with disease and look at it predominantly or exclusively from a biomedical perspective. Hence, insights into the complexities of illness experiences and the rich variety of ways to meet the challenge of injury, illness and impending death could result from reading *The Death of Ivan Ilyich,* or *Wit,* or *King Lear.* Furthermore, new, hitherto unreflected aspects of the physician's profession may be illuminated in a nuanced and still engaging way in reading *The Plague, Saturday* or *Doktor Glas.* As I will soon show, "postprocessing" in the form of discussion is likely to increase this potential under the condition that it be done in a way that permits these insights to be delivered.

- There are few reasons to assume that LOMS must necessarily be the only or even the major category of literature from which physicians may gain relevant experiences. Fiction about medical situations may well mean that physicians direct their attention more to medical details and disease symptoms than to the richer and more general interpretation that the literary work also offers. It may hence lead to a situation where the richness of perspectives of good literature is lost in favour of a search for "medically interesting" aspects in a more narrow sense.

- Literature showing human beings in life situations where challenges appear that are similar to those people face when ill – loss, uncertainty, ambiguity of feelings, identity challenges, hope and hopelessness, trust or lack of trust, dependency – is relevant for the physicians´ skills irrespective of whether these challenges arise in medical contexts or not.

- These challenges may be set in a contemporary context or they may not. Though the feelings, thoughts and actions of the persons in the Greek tragedies of course are in some ways totally different from what we would encounter today, there may be important similarities on a more profound level. And also the fact that human predicaments and dilemmas are differently perceived and handled at different times and in different contexts carries a potential for learning something about human existence.

Should physicians read stories about situations and persons in the world they live in or should they read about past events to widen their horizons? Once again I am forced to answer: both. The past is, in a way, defamiliarizing. It requires our frames of reference to be adjusted to understand the conditions of past times.

This in itself may be of value, and physicians certainly need to be reminded of the relativity of, for example, ways of looking at the body, diseases, and human affliction in general. But stories set in the present, of course, offer an easier "transfer" from story to "reality". This may in some circumstances be an advantage, as it creates an immediacy of the story that may sometimes be felt more strongly.

In 5.1.8 I have pointed to the Greek tragedies and their potential for *catharsis*. It may be that the very fact that some human predicaments and existential challenges seem to retain their full force and immediacy over time is of particular importance to the physician. Modern medical science is young, while the existential problems forcing us to apply this scientific knowledge are often very old. Coming to know of Medea´s ghastly losses, or Orestes´s struggle with his pride, sense of duty and compassion, or Antigone's imprisonment between her love of the dead brother and the demands of the state, may deepen the physician's understanding of some existential dilemmas that seem to be the company of human beings in all times.

5.2.4.4 The question of quality – good and bad literature

The seemingly eternal discussion about "good literature vs bad literature" deserves some final attention, however tricky and dangerous it may be to venture into it. Good literature in the light of my present investigation is literature that serves the end I am interested in – i.e. the capacity to improve the physicians´ clinical judgment. But there remains a question whether such literature is always what is in the general debate called "good literature", or "high literature" or within the "canon"?

Bad literature is often equated with popular fiction. If a book is sold in mass numbers, it is popular fiction and then likely to be "bad" literature. But good literature may be popular or not, just like bad literature. Quality is not something to be judged by numbers, and the fact that much good literature is not very much read doesn't have anything to with the question of its quality. Aesthetical relativism is just as untenable as ethical.

Why, then, do almost all the examples I have given in this thesis belong to what Harold Bloom called "the western canon"?[91] Why do I not cite those authors that sell in millions and millions and that seem to give so much pleasure to their readers? The reason may be expressed in terms of what I have just called defamiliarization and perspectivation. Good literature has some degree of complexity. It is, by its choice of themes and the aesthetic means used, able to show us the world as rich, open to many interpretations and in a very basic sense enigmatic. It is free, or almost free, of clichés, simplified typologizations, moral dichotomies, truisms. It challenges, more or less, our conventional ways of seeing, invites to reinterpretations and new modes of understanding. This may not always be a prominent feature but it has to some degree to be there.

Physicians who read do not need stories which confirm their already held convictions and underline the world-view that they have grown into by upbringing and by professional training and practice. They need to have their life-orientations at least to some degree challenged. This is the essence of being defamiliarized and invited to reorientation: to encounter perspectives that are richer and more complex than those I am able to uphold in my everyday life, and in doing this add to my capacity for phronesis. The obvious objection is that this

may not happen at all, that the physician may just not want to readjust, to grow in experience, may just want to be confirmed and amused. Of course this is so, and of course much reading is like that. The literary work is an invitation, and the outcome I hope for a potential. No text, however rich in content and aesthetic subtlety, can guarantee anything. The reader may just reject the potential there is. This is the outcome illustrated by my two oblique arrows, and there are reasons to believe that it is not so unusual.

5.2.5 The reading physician

No act of reading will be identical with another. But there are patterns of reading and there are more or less responsible ways of meeting the call of the author. A reading physician will, like any other reader, have to be prepared to meet the literary text with receptive eyes, prepared to be changed by it. If he predominantly reads in what Rosenblatt calls an "efferent" (see 3.1.2) way (i.e. for the explicit purpose of gaining some useful information to bring from the reading to be employed for some purpose – and this is eminently what physicians do in their training and their continuous education) he will not be open to what literature may show him. Afferent, or "aesthetic", reading of course always contains efferent elements, and circumstances around the reading (like group discussions, reading for certain purposes, intense reflection after reading) may bring out "efferent" elements from the first, predominantly afferent reading. The affective response has thus caught the attention of the reader, created a "thrill" and a "tension", which prompts a cognitive "post-processing".

5.2.5.1 How to read?

A physician reading for her relaxation or amusement or stimulation – all of which seem perfectly reasonable motives for reading - can hardly be expected to reflect deeply on the circumstances under which she reads. She is not likely to reflect whether her reading is really proactive, in Kevin Vanhoozer's sense: attentive, earnest, open-minded (3.1.8). But this physician may be lucky enough to have developed such a way of reading from earlier experiences. She may be inclined to read in such a way by a combination of education into the world of literature, her own reading experiences, and a "spontaneous" attitude towards works of art that includes exactly this receptivity. But she may, of course, instead be a hyperactive reader, which may be the case if she approaches the text with the same attitude as if it were a textbook of internal medicine – i.e. if she mistakes a text suited for afferent reading for a text that should be read efferently. I suspect that not so few medical students during their training period experience exactly this challenge: to switch from one way of reading, the one they apply for their biochemistry or pharmacology, to another, suitable for a poem or a short story. Still, if they succeed it may benefit them greatly. I believe that this may again be expressed by using the idea from Stephen Toulmin of two (partly) different though complementary forms of rationality. The young physician is often briskly socialized into the rationality of the natural sciences. But this is not the rationality of the world of fiction. If reading goes on during a physician's life, if she keeps the company of good fiction, and if her reading is proactive, she will make it easier for herself to smoothly employ the complementary modes of rationality that are needed for clinical judgement.

It is a reasonable conjecture that proactive reading may be facilitated by some form of organized post-processing of the literary experience. This is supported by my own experience of having read the short novel *Doktor Glas*, by the Swedish author Hjalmar Söderberg, for several years with medical students during their first semester. *Doktor Glas* is a story from the last turn of the century where the very lonesome Stockholm physician Tycho Glas falls in love with one of his patients, who is abused by her much older husband, and step by step is led to murder him. The novel is written from a first person perspective and all figures except Glas himself remain non-transparent and are presented only as they appear to him. *Doktor Glas* is a non-polyphonic, yet very ambiguous novel, rich in motives and written in a dense and saturated prose. The young students read this novel with strong emotive reactions, on which they were invited to reflect. Over the years, the discussions emanating from this story have ranged over a surprisingly wide spectrum. It is as if through the fictive form these young students felt more free to approach sensitive and delicate matters – like death, sexuality, abortion, euthanasia, guilt, remorse, longing, dignity. Their ways of reading must, of course, have been considerably influenced by the fact that they knew they were to discuss the book, that they were in some way expected to associate to their "doctor role" (though this was deliberately de-emphasized) and also to write a short reflection after reading. My impression, though not validated, is that these students read in a mostly proactive way, and hence were able to learn things from this book in a way that would not have been possible if these things had been *told* them as facts, like in psychology text-books or basic presentations of clinical ethics.

The reading physician will meet the text from the point of view of his life world, from the sum total of his life-experiences. Wayne Booth reminds us that

> Every appraisal of a narrative is implicitly a comparison between the always complex experience we have had in its presence and what we have known before.[92]

This fact more than anything else makes it impossible to predict the outcome of the encounter with a literary work. The more open the physician is able to be, the greater the chances that there will be a "fit" between her and the text. The introduction of literature in various forms during the basic training of medical students, if it is done in a good way, seems to carry a potential for facilitating the physician's proactive reading, both through increasing his interest for and familiarity with fiction of different genres, and also through helping to develop a mode of reading, an attitude to reading, that is likely to facilitate learning from literature.

Ultimately, if during training and during their professional lives physicians are helped to see that their professional skills require an understanding of the thoughts and emotions, the motives and the intentions, of other human beings – in short: their illness experiences – they will be more likely to find literature, like other forms of creative art, a valuable source for professional development. This will not mean that they read with the sole and explicit purpose of becoming better clinicians. But if their interest in others' experiences is stimulated, reading will be more likely to follow by inclination. And if this inclination is not obstructed by a fear that reading literature always diverts time from far more valuable things – like meetings with pharmacological companies, courses within the biomedical area, clinical training – they will both long for and be open to the company of good books.

5.2.5.2 The reading situation

I have insisted on the uniqueness of every encounter between reader and text. Texts and readers are limitlessly varied. This goes also for the context in which the reader meets the text. Generalizations about this are as difficult as they are about the other aspects of the reading process. However, some things may be said.

In chapter 3 I have mentioned Katarina Elam's distinction between prereflective and reflective understanding of works of art. A text may be read without efforts to "think further", without a search for meaning and further implications. Much reading is probably of this character. But more or less, the reader may go on to reflect on what was read, come back to it in his thoughts, perhaps discuss it also with others who have read the same text. In this process, what was "prereflective" gradually becomes more and more reflected. I suggest that this is an essential element in what I have called proactive reading, a reading where the reader allows the text to affect and potentially also to transform him.

Under which conditions is there an increased likelihood for a proactive, reflective reading? My repeated stress on the responsibility of the reader includes a degree of responsibility for the reading situation. Readers may "educate" themselves to be better readers, to read more proactively, in being more true to the text. This can of course not mean that the reader should approach the text the way she approaches a very complicated working task, tense and filled with ambitions and worries. It should rather mean that readers do well in cultivating circumstances around their reading such that reflection becomes possible, circumstances that invite further "processing" of potentially important elements of the text.

Discussing reading experiences with others is an obvious candidate for such "postprocessing". In 5.2.2 I have, in connection with Hakemulder´s over-view of empirical reading research, noted that there are indications that persons who discuss what they have read with others may "gain" from this (though, as was shown, the evidence from this kind of research is inconclusive). But group discussion during and after reading, for example, a novel is not only a way of facilitating a reflective understanding of what was read. It may also, under certain circumstances, be a valuable help in developing an attitude to reading that is responsible and proactive. By engaging in serious and frank discussions about common reading experiences, the participants may be invited to go back to the text, interpret and perhaps reinterpret what they read and in doing so, become aware of the multitude of possibilities inherent in a literary text and also receive an invitation to understand the understanding of others.[93]

The circumstances in which persons exchange reading experiences may be extremely different. Groups may be organized formally as a part of an education (e.g. during the training of medical students), they may appear informally among colleagues at work or it may be two friends or spouses that sometimes or often share reading experiences. Formally organised groups may have leaders, supervisors, who are experienced readers. This may be an advantage for young readers who may be inspired to read in a more responsible way. Rosenblatt stresses this in her discussion about the role of reading in basic school education. The teacher has the responsibility to choose books that have the potential to affect the young readers. But this is not enough:

> An atmosphere of informal, friendly exchange should be created. The student should feel free to reveal emotions and make judgments. (…) When the young

> reader considers why he has responded in a certain way, he is learning both to read more adequately and to seek personal meaning in literature.[94]

The atmosphere of a reading group is of course essential. But, as Marc Edmundsson argues from his experiences with college students, friendliness is not enough. He describes how he has come to react to the attitude of cool distance that many students adopt towards their reading experiences. As if reading were not about life and death! The young reader must be invited by the teacher to be daring in her reading:

> If a professor truly believes that nineteenth century domestic fiction can expand the reader, make him more than he was, that is wonderful. I respect the daring. The independence of mind is to be admired. But to teach without the conviction that the book at hand might become someone's secular Bible is to betray the heart of the humanities.[95]

There may not be any big conflict between Rosenblatt's and Edmundson's position. Reflection on one's own reactions, and those of others, is not necessarily in opposition to an active, engaged, transforming way of reading. And a reading situation that allows for the reader to be taken away, to respond fully and intensely, may also be what is needed for him to later reflect on exactly why this book gave him such intense pleasure, or was so upsetting and worrying.

Physicians, like all other readers, may be expected to meet literary texts in different contexts – alone, sometimes in groups, to relax after work, for distraction from tough professional or private experiences, or very consciously to be edified. They may find reading very personal and reject any discussion of

what was read with others. Or they may look for other readers to share their experiences with. These may be colleagues or they may not. It may be of great value to discuss with persons who have other professional experiences, but it may also in some respects be valuable to share thoughts on literary texts with colleagues, who share certain crucial experiences which are not so common outside the circles of clinically active persons.

5.2.5.3 The role of literary experience

Some physicians read a lot, some very little. Henry Perowne, in Ian MacEwen´s *Saturday*, reads a great deal but seldom literary fiction. Is he, then, not interested in stories? What about his patients´ stories? A physician that does not find it interesting at all to get the chance to look into other people's lives through his patients´ stories obviously risks losing a lot of valuable information – and also of having a more boring job. But Perowne *does* seem interested. Still, he rejects fiction. Maybe he has enough anyway? Could we imagine a physician so filled with his patients´ stories that he just can't take any more? Perowne´s fascination with facts, his inclination towards "faction", should maybe not be seen as an outflow of a neglect of personal experience. He may just want to take a rest from what fills his working days: strange and dramatic stories with very different plots and endings. But for some of his colleagues, the rejection of fiction may actually be exactly this: a sign of a lacking interest in persons, in their stories, in their "ways of world making". If people's lives are not interesting, why keep the company of imagined persons, why bother to enter into dialogues with ill persons?

It goes without saying that a physician who is by inclination and habit a devoted fiction reader will read in an at least partly different way from that of a colleague who is an inexperienced reader. His associations will largely be to other literary works, he may be more sensitive to the aesthetic choices of the author, he may be more critical in relation to composition and style, he may make more demanding comparisons of quality. This does by no means imply that he necessarily "gets more out of" his reading. Reading is not a mechanical matter of accumulation of merits in the form of length of texts covered. One is not affected by what is read in relation to the amount of text covered. We have few reasons to expect those who are exceedingly well read to have also *automatically* acquired more *phronesis.* Literature is an invitation, not an accomplishment.

However, having said this, there may still be some important things to say in favour of being reasonably "well read". Given that what one has encountered (what I have presented as "the call of the author") has been met and answered to in the way I have tried to outline above, and given that the choice of literary company is such as to carry the potential for the development of those qualities mentioned in 5.1, I think one must say that it is a good thing for a physician to read a lot. But it would be ridiculous to try to specify what "a lot" means here. A physician reading five novels each year may get as much as or even more out of this than one who reads fifteen. It may even be that too large a "book consumption" is dangerous to the kind of reflection and "post-processing" that I have argued for as being important. The right choice of work, the responsive reading and the responsible reflection on what was read are the factors that decide whether literature's potential in relation to clinical judgement will be actualized. If these may be respected also in extensive reading, then extensive reading is a good thing. If not, the reader should rather cut down.

Elias Canetti, the Austrian Noble Prize winner, wrote a novel called *Die Blendung*.[96] This should be worrying reading for anyone who assumes that the benefits of literary experience may be measured in numbers of books read. The main figure has virtually retreated from the world, locked himself up in a house that is totally filled from floor to ceiling with books. It becomes painfully obvious that for this man, fiction is a means not to approaching the world but to getting away from it – and in the end he succumbs to his obsession. I believe that this really *is* more relevant than one would guess to many readers, as it seems that what Canetti´s man does is what we all do to some extent: read to be carried away, for escape, for relaxation from the harsh realities of everyday life. This does not at all preclude the view of literary texts that I have presented, rather the contrary. If good books were not also able to do this with us, we would hardly read as much as we do.

Are physicians already too over-loaded with tasks to comply with and live up to – so that an invitation to them to keep the company of good books will be met by many of them as one more of those cumbersome tasks that their whole lives have been filled with? I have dealt with the risk for "doctor over-load" in an article[97], and my answer to this relevant worry is: yes, physicians may well be over-loaded and they may well be inclined to think of reading as one more duty that must be met. But reading fiction could and should be presented as one of those perhaps rather few occasions in a physician's life where the relaxing may combine with what could be professionally valuable . It is potentially pleasant, amusing and stimulating to read – and it is also edifying, enlightening, revealing. Katarina Elam eloquently formulates the full potential of literature:

> But the interaction with narrative art may also, as has been shown, reach beyond the familiar and allow us to merge with the whole of humanity.[98]

Most persons, and certainly most physicians, would consider this opportunity not as a burden, but rather as a gift.

5.2.6 Dangerous reading and indifferent reading

It is remarkable how seldom those who in strong words praise the power of narrative and its capacity to influence and change people's lives also remind us of the fact that this potential may be for good or for bad. If fiction is so strong, if words are so powerful, then it can't possibly be that literature – fictive stories – works only in one direction, i.e. along the arrow pointing straight downwards in my model. Obviously, some texts leave us indifferent (the left oblique arrow) – perhaps most would if we did not at least sometimes select those that we expect will not – and some may be harmful for us (the right oblique arrow). In relation to this investigation, it seems impossible to ignore the fact that there are texts that may influence physicians for bad in relation to their clinical judgement. If this is so, which are these texts and may we identify them and "disarm" them?

American literature professor Mark Edmundson, in an article in New York Times, exemplifies with Marquis de Sade:

> The abominable Marquis de Sade influenced many consequential writers in the 19th and 20th centuries. Often, you can imagine, he made what was cruel in their hearts yet crueler.[99]

Are we to conclude that a few books are vicious while most books are good and benevolent? The evil potential of a book may differ very much, but it seems likely that any book could be read in a way as to tempt to evil acts. It seems equally likely that there is a continuum among books in how easily they "give in" to such reading. What I have called "good books" strike me as more resistant against the kind of reading that I would see as conducive to narrow-minded thinking, to hatred, and to clumsy carelessness towards others. My main argument against some literature is that it impoverishes reality, establishes simplifying dichotomies, shuns complexity, and reduces humans to less than they are. Such books qualify to be called vicious, though they could of course be read in a critical way so as to reveal rather than reinforce prejudice.

It hence seems as if we must add to any recommendation to a physician to keep the company of books, that they ought to be good books and then also add an explanation of what may qualify as good books. There is no absolute norm here, of course, but I am convinced that it would be possible to establish a number of criteria, on both aesthetic grounds and on the basis of content (though virtually inseparable), allowing for a distinction to be made between literature likely to carry a potential for professional growth and literature likely to impede professional growth. However, to develop this further and develop supporting arguments, further research and more practical experiences from reading with clinicians would be needed.

A part of what we read, perhaps a substantial part, is bound to be nearly or totally indifferent in relation to clinical judgement and phronesis. There is nothing very shocking about that. As I have already made clear, we often read

for pleasure, for relaxation, and for amusement. Sometimes this goes together with learning and enlightenment, sometimes it doesn't. Learning from fiction is not a matter of all or nothing. It must be seen as a continuum, from indifferent reading, which comes and goes and hardly leaves any traces in us, to deeply moving reading that may shake us profoundly and occasionally change our lives. Physicians, like any other readers, will read at different points along this scale. Some will more often choose books demanding their attention and maximizing the potential for learning, some rather seldom. However, the reading physician may seem to be moving along the scale due to the action of certain stimuli during education and during professional life. If a physician is stimulated to read what I have delimited as "good" literature, the familiarity with such reading and the appetite for it will grow and the potential I have outlined here is more likely to be actualized.

[1] Kleinman, Arthur: *The Illness Narratives: Suffering, Healing and the Human Condition.* New York: Basic Books, 1988, 52

[2] Interestingly enough, persons who professionally deal with literature seem to be particularly resistant to such assumptions. They may as professor Merete Mazzarella in Helsinki point to their colleagues as disproof of the morally beneficiary effects of reading. But, on the other hand, who knows how these persons would have been had they not read so much?

[3] Macnaughton, Jane: "Literature and the ´good doctor´ in Ian McEwans *Saturday*". In *Journal of Medical Ethics: Medical Humanities* (2007), 33, 70-74

[4] This is indeed also what McEwen intended: to give the reader a portrait of a basically happy man who is suddenly threatened by extremely unexpected events in his everyday life, yes in his home.

[5] Downie, R.: "Literature and medicine". *Journal of Medical Ethics* (1991), 17: 93-98

[6] Toulmin, 1993. The use of the word biography here may be misleading for some who connect it to the literary genre of biographies. Perhaps" the epistemology of the lived world" would be more precise?

[7] Good, op cit, 70-76

[8] I must warn against thinking about this as a *total* detachment from either the humanity of the body or the corporality of the person. It is a question of focus of attention, which shifts from the objectified body to the intentionality of the person.

[9] Hick, Christian: "The art of perception: From the life world to the medical gaze and back again". *Medicine, Health Care and Philosophy* (1999), 2:129-140
[10] Ibid, 136
[11] Ibid, 137-138
[12] Tauber, Alfred: *Confessions of a Medicine Man: An Essay in Popular Philosophy.* Cambridge&London: The MIT Press, 1999, 83
[13] Palmer, Frank: *Literature and moral understanding: A philosophical essay on ethics, aesthetics, education, and culture.* Oxford: Clarendon Press, 1992, specifically chapter 8.
[14] Ibid, 182
[15] Ibid, 188
[16] Ibid, 190
[17] Ibid, 203
[18] Rosenblatt, op cit, 37
[19] Olthuis, Gert: *Who cares? : An ethical study of the moral attitude of professionals in palliative care practice.* Doctoral thesis. Nijmegen, 2007, 30
[20] Floistad, Guttorm: *Filosofi och vetenskap*. *(Philosophy and Science.)* Lund: Studentlitteratur, 1994, 384-393
[21] Downie, op cit
[22] The book is precise when describing the origin of the contagion in the rats and lice, and also the symptomatology of the ill.
[23] Of course, this response will only come about if the reader is familiar with and accepts the conventions of reading a novel.
[24] Rosenblatt, op cit, 190
[25] As well known, the most common interpretation of the novel is that it is an allegory for what happened in France during the German occupation from 1940 to 944. This does of course not exclude that it is interpreted also in many other ways.
[26] Bachtin, Michail: *Dostojevskijs poetik.(The Poetics of Dostoyevsky).* Stockholm: Anthropos, 1991,10
[27] Kundera, op cit, 42-43
[28] Ibid, 23
[29] Elam, op cit, 64
[30] Op cit, 128. Elam borrows the concept from Ronald Hepurn who in his *Wonder and Other Essays* (Edinburgh: University Press, 1984, p 90) also proposes that "an aesthetic education is an introduction to countless alternative possibilities for feeling".
[31] Ibid, 142
[32] Kathryn Montgomery altogether avoids using the notion of clinical intuition, as well as "the art of healing". I agree with her that *phronesis* and *clinical judgement* in a better way capture what these concepts are meant to connote.
[33] Cassell, 1991, 79
[34] Keen, Suzanne: *Empathy and the Novel.* Oxford & New York: Oxford University Press, 2007
[35] Successfully manipulative persons (if we may speek of such) are often extremely clever at sensing where to direct their attempts at controlling other persons' lives. I think one would find that these persons are often empathetic in that they know well what goes on in other persons' minds, particularly their weaknesses.
[36] It has always struck me as peculiar that those who argue this way do not take into consideration the possibility that these persons (who are not empathetic in relation to how much they read) would otherwise have been even more "un-empathetic".
[37] Ibsen, Henrik: *The Wild Duck.* London: Faber&Faber, 1980. (translated by Christopher Hampton)
[38] There are, of course, numerous other potential insights to be gained in Ibsen's play. Depending on who meets the play, when and how, some of these will be delivered, others not. A play is, like a novel, an aesthetic whole and what happens in the encounter with the person at the theatre is not possible to foresee in any detail.
[39] Novitz, David: *Knowledge, Fiction and Imagination.* Philadelphia: Temple University Press, 1987, 2-20
[40] Ibid, 27

[41] Perhaps it should once again be reminded that imagination that is not tempered by a solid sense of reality may be dangerous. However, physicians do not seem inclined to such excesses in unrealistic imagining, formed as they are in a tradition of clinical realism and factualism.
[42] Hansson, Mats G.: "Imaginative ethics – bringing ethical praxis into sharper relief". *Medicine, Health Care and Philosophy* (2002),5:33-42
[43] Nussbaum, 1990, 77
[44] Mann, Thomas: *The Magic Mountain.* London: Minerva, 1996. One could of course continue the enumeration of themes in this rich novel further, including broader philosophical and historical questions.
[45] Nessa, op cit. Nessa shows that paralinguistics (intonation, hesitation, pauses, over-lapping) and extralinguistics (gestures, facial expressions, gaze) are of great importance in the clinical dialogue.
[46] Helman, Cecil: *Body Myths.* London: Chatto&Windus, 1991. Sontag, Susan.: *Illness as Metaphor*. New York: Farrar, Straus&Giroux, 1978.
[47] Lakoff, George & Johnson, Mark: *Metaphors We Live By.* Chicago & London: The University of Chicago Press, 1980.
[48] Metaphors are also crucial for medical science, for example such metaphors that Lakoff & Johnson call "ontological", employed in different ways to make the most common scientific concepts like pressure, power, energy etc intelligible. On the whole, the authors convincingly argue that most conceptual thinking is metaphorical.
[49] Ahlzén, 2008, op cit
[50] Helman, op cit.
[51] Nordgren, Anders: "Ethics and Imagination: Implications of Cognitive Semantics for Medical Ethics". *Theoretical Medicine and Bioethics* (1998), 19**:** 117-141
[52] Lakoff & Johnson, op cit, 231
[53] Ibid, 235
[54] Eric Cassell links suffering in illness to the "destruction of personhood", but also to the potential for this to be healed. See Cassell, 1991, 44-47
[55] Vickers, Brian: *Towards Greek Tragedy: Drama, Myth, Society*. London: Longman, 1973, 52
[56] *The Free Dictionary*, 091106
[57] Aristotle: *Poetics.* (Introduction and translation by Malcolm Heath). London:Penguin, 1996, xxvii
[58] Vickers, op cit, 64
[59] Holland, Norman N.: *The Dynamics of Literary Response.* W.W. Norton&Company: New York, London, 1975, 3
[60] Hakemulder, J.: *The Moral Laboratory: Experiments Examining the Effects of Reading Literature on Social Perception and Moral Self-Concept.* Amsterdam/Philadelphia: John Benjamins Publishing Company, 2000.
[61] The fact that the author may not be known, or may has lived very long ago, does not change this. The reader approaches the literary work as an invitation made by someone (yet perhaps unknown). This is crucial to my conception of reader responsibility.
[62] Ibid, 3-4
[63] Ibid, 26
[64] ibid
[65] Ibid, 32-37
[66] Confounded here means that there was a deep uncertainty as to which factors were really causal.
[67] In 1995, David Miall introduced a *Literary Response Questionnaire (LRQ),* which has been extensively used in reader reception research. In his own words, LRQ "… measure seven different aspects of the readers´ orientation toward literary texts: Insight, Empathy, Imagery Vividness, Leisure Escape, Concern with Author, Story-Driven Reading and Rejection of Literary Values." This instrument is designed to increase understanding of what happens when readers meet texts, but this of course also has important consequences for how we look upon the outcomes of reading. See Miall, David S.: "Aspects of Literary Response: A New Questionnaire". In Rusch, Gebhardt (ed): *Research in the Teaching of English.* Siegen: Inst. for Empirical Lit. & Media Research, Siegen Univ., 1995, 359-367
[68] Rosenblatt, op cit, 24
[69] The intense debate around Harold Bloom's controversial *The Western Canon* illustrates this, but it also illustrates the importance of controversy concerning literature. Without such, it seems that literature risks

sliding into being a more or less indifferent, though usually benevolently regarded area of human concern that almost everyone endorses but no one is really deeply affected by.
[70] Miall, David: ”What is literariness? Three components of literary reading” In *Discourse Processes* (1999), 28(2), 121-138
[71] Keen, op cit, chapter 3.
[72] In a very weak sense, character identification may mean just being “immersed” in the reading, taking part and being absorbed by what is read. But this is of course a prerequisite for being affected at all by a narrative.
[73] Kundera, op cit, 144
[74] Eco, op cit, 13
[75] Tyrberg, op cit, 21
[76] Polyphony does, however, seldom characterize what is sometimes called popular fiction. The attraction of this heterogeneous area of literary works rather seems to be the shallowness of its characters, the dichotomized moral patterns and the stereotyped narrative conventions. It seems to me very dubious if popular fiction really defamiliarizes at all. Is it perhaps not rather in order *not* to be challenged but rather reaffirmed that one reads such literature?
[77] Gustafsson, op cit
[78] Barilan, M. & Hertzano, R. & Weintraub, M.: “A Vision from the Renaissance and two case reports from the present”. Israel Medical Association Journal (2000), 2:327-331
[79] Horowitz, A.W.: “Poetry on rounds: A model for the integration of the humanities into residency training”. *Lancet* (1996), 347: 447-449
[80] Pickering, Neil: “The use of poetry in health care ethics education”. In *Medical Humanities* (2000), 26(1): 31-36
[81] Ahlzén, Rolf/Stolt, Carl-Magnus: ”Poetry, interpretation and unpredictability: a reply to Neil Pickering” In *Medical Humanities* (2001), 27(1): 47-50
[82] Sobel, R. & Elata, G.: “The problems of seeing and saying in medicine and poetry” In *Perspectives in Biology and Medicine* (2001), 44(1), 87-98
[83] Puustinen, Raimo: “Voices to be heard – the many positions of a physician in Anton Chechov’s short story ‘A case history´”. *Medical Humanities* (2000), 26(1), 37-42
[84] Hemingway, Ernest: *Hills like White Elephants.* From *Men without Women: Stories.*London: Cape, 1964.
[85] Keen, op cit, 92-99
[86] W. van Peer & H. Pander Maat: “Perspectivation and Sympathy: Effects of Narrative Point of View” In Kreuz, R.&Mac Nealey, M.S. (eds): *Empirical Approaches to Literature and Aesthetics,* Norwood, New Jersey: Ablex Publ Corporation, 1996, 143-154
[87] Ibid, 145
[88] Van Peer and Pander Maat conclude from their own empirical investigation of the effects on readers of ”point of view” that these effects may be strong but are “not as general as could be expected”, that they are “not independent of the story´s subject matter”, and that that they may “not be independent of readers´ world view”. This underlines my general position that literary encounters are complex to a degree that make them almost impossible to generalize about.
[89] The anthology *On Doctoring* is a good example and representative for many other anthologies. It was first published in 1991and has then been revised and expanded twice. The most recent version is from 2001. It contains over four hundred pages of texts that extend from John Donne to the very present. As the editors note, many contributions are written by physician writers, and almost all in some way concern, directly or indirectly, “medical situations”. See Reynolds, Richard&Stone, John (eds); Lois, LaCivita&Wear, Delese (ass eds): *On Doctoring: Stories, Poems, Essays.* New York: Simon&Schuster, 2001
[90] Posen, Solomon: *The Doctor in Literature: Satisfaction or Resentment?* Oxford: Radcliff Publ., 2005
[91] Bloom, Harold: *The Western Canon: The Books and School of the Ages.* New York: Harcourt Brace, 1994.
[92] Booth, 1988, 71
[93] Ahlzén/Stolt, 2001, op cit
[94] Rosenblatt, op cit, 67
[95] Edmundson, Marc: *Why read?* New York: Bloomsbury, 2004, 124
[96] Canetti, Elias: *Die Blendung.* München : Hanser, 1963.

[97] Ahlzén, R.: "The doctor and the literary text – potentials and pitfalls". In *Medicine, Health Care and Philosophy* (2002), 5:147-155
[98] Elam, op cit, 143
[99] Edmundson, Mark: "The risk of reading: Why books are meant to be dangerous." The New York Times, 04 01 08

Chapter 6

A concluding remark

> *The education in question is not about facts and data; art's purposes have little to do with information. No, the voyage is visceral and experiential; it entails vicarious immersion in other's lives, endowing us with new eyes and ears, perhaps changing our hearts.*
>
> Arnold Weinstein[1]

One would wish, of course, that it had been possible to outline, with reasonable precision, those conditions of reading that are favourable for learning from fiction. I have made a number of suggestions about this. Empirical research may bring us further. Furthermore, experiences from the introduction of literature in medical education will also increase our knowledge. But it is my conviction that the uniquely personal character of any encounter between a literary work and the reader will mean that our knowledge will remain uncertain and that reproducibility will be limited. We will not be able to predict, for example, that "if medical students read this book under those and those circumstances they will learn that and that". This, of course, goes for clinically active physicians' reading as well. I have presented a potential and said some general things about the conditions of reading that may influence the chances that this potential comes into actuality. But who may predict how surgeon X will respond to *Saturday*, and what she will bring with her from this literary encounter? And if psychiatrist Y reads *Oryx and Crake*, how could we know before, or even after, what the "effects" of this book has been on his way of looking upon himself, the world, his professional tasks - and even more difficult: upon his imagination, his capacity to tolerate ambiguity and paradox, and on the amount of cathartic insight and relief

gained from the book? I insist that this is ultimately impossible to capture, even though I admit that *some aspects* of it may be "measured" in empirical research.

This investigation has been undertaken in the spirit of an attitude towards literature that I have found best captured by Swedish literary theorist Anders Tyrberg (chapter 3.1.4). In this way of looking at narrative art, the fundamental openness of any literary encounter is linked to the moral core of the act of reading. I do not think this can be expressed better than it is by Tyrberg in the introduction to his book *Call and Responsibility: Narrative Art and Ethics,* which I have presented extensively in chapter 3. Tyrberg deals with four very influential Swedish authorships and he does this in a way that richly illuminates his title. I will conclude by a longer quotation from his introduction, which I believe in a sensitive and sensible way summarizes also my position in the preceding chapter - and in the whole of this investigation:

> The communicative act – the claim and the call of the author and the surrender and responsibility of the reader – may thus be described as an agreement, an implicit contract. It is through a pact between narrator and listener that the performative power of the narrative becomes possible. But in spite of such an implicit agreement the aesthetic act of communication is risky: a price must be paid by the author/narrator as well as by the listener/reader. Words are powerful and to narrate is to expose a reader or a listener to an exertion of power and an act of seduction. But to expose oneself as a reader also implies an implicit consent to such an attempted seduction. (…) To read a book is to make oneself morally disposable to influence, be it contagion, seduction, persuasion, seemingly neutral information, or amusement. And to make oneself accessible to someone else's influence can never be an act of total innocence.[2] *(my translation)*

Two major themes of my investigation meet here. The conditions of the reading act is a fundamental mark of and invitation to the rationality that I have used Stephens Toulmin's analysis to discern – a rationality that would be less inimical to a focus on human experience, on human agency, and on human vulnerability than the one that now pervades the medical sciences and, through them, often also clinical practice. This rationality is at its very core of an ethical nature. The call of the narrator becomes the call of the ill, the one in need, the one who needs recognition and professional intervention. Physicians reading in a responsible and responsive way open themselves to this basic human mutuality, this essential human communality. In doing this, they are invited to grow in clinical judgement.

[1] Weinstein, Arnold: *A Scream goes through the House: What Literature teaches us about Life.* New York: Random House, 2003, p xxi
[2] Tyrberg, op cit, p 27

References

Academic Medicine, Oct 2003: "The Humanities and Medicine: Reports of 41 U.S., Canadian, and International Programs", thematic section

Ahlzén, Rolf
- "Autonomins triumf?" *Nedsatt beslutsförmåga. Vem bestämmer för patienten?* Stockholm: Ersta Vårdetiska Institut, 1998, 9-32
- "Medical humanities – arts and humanistic science" *Medicine, Health Care and Philosophy* (2007), 10: 385-393
- "Giving meaning to symptoms". In *The Radcliff Companion to Medical Humanities,* Volume I, *Symptom,* Oxford: Radcliff Publishing, 2008, 115-129

Ahlzén, Rolf/Stolt, Carl-Magnus: "Poetry, interpretation and unpredictability: a reply to Neil Pickering" In *Medical Humanities* (2001), 27(1): 47-50

Aristotle
- *Nichomachean Ethics.* Dover Publications: New York, 1998
- *Poetics.* (Introduction and translation by Malcolm Heath). London: Penguin, 1996

Bachtin, Michail: *Dostojevskijs poetik.* Stockholm: Anthropos, 1991

Bal, Mieke: *Narratology: Introduction to the Theory of Narrative.* Toronto & Buffalo & London: University of Toronto Press, 1997 (second edition)

Barilan, M. & Hertzano, R. & Weintraub, M.: "A Vision from the Renaissance and two case reports from the present". *Israel Medical Association Journal* (2000), 2: 327-331

Beauchamp, Tom L. & Childress, James F.: *The Principles of Biomedical Ethics.* New York: Oxford University Press, 1983

Berger, John: *A Fortunate Man: The Story of a Country Doctor.* London: Penguin Press, 1967

Bliss, Michael: *William Osler: A Life in Medicine.* New York: Oxford University Press, 1999

Bloom, Harold: *The Western Canon: The Books and School of the Ages.* New York: Harcourt Brace, 1994.

Booth, Wayne:
- *The Company We Keep: An Ethics of Fiction.* Berkeley, Los Angeles, London: University of California Press, 1988
- "The Ethics of Medicine, as Revealed in Literature" Charon, Rita & Montello, Martha (eds): *Stories Matter: The Role of Narrative in Medical Ethics.* New York, London: Routledge, 2002, 10-20

Brody, Howard: *The Healer´s Power.* New Haven and London: Yale Univ Press, 1992

Bullington, Jennifer: *The Mysterious Life of the Body: A New Approach to Psychosomatics*. LInköping: Linköping University Press, 1999

Camus, Albert:
- *The Stranger.* Cambridge: Cambridge University Press, 1988.
- *The Plague.* Harmondsworth: Penguin, 1960

Canetti, Elias: *Die Blendung.* München : Hanser, 1963.

Cassell, Eric:
- *The Place of the Humanities in Medicine.* The Hastings Center, 1984
- *The Nature of Suffering and the Goals of Medicine*, New York & Oxford: Oxford University Press, 1991

Charon, Rita: "Reading, Writing and Doctoring: Literature and Medicine" In *The American Journal of Medical Sciences* (2000), 319(5): 285-291

Charon, Rita/Montello, Martha (eds): *Stories Matter: The Role of Narrative in Medical Ethics.* New York, London: Routledge, 2002.

Clarke, Jean M./Bostle, Eileen (eds): *Reading Therapy.* London: Library Association, 1988

Coulter, Harris: *A Divided Legacy: A History of the Schism in Medical Thought.* Washington D.C.: Wehawken, 1973-77

Damasio, Antonio.: *Descartes´ Error: Emotion, Reason and the Human Brain.* New York: G.P. Putnam, 1994

Dekkers, Wim: "Hermeneutics and Experiences of the Body. The Case of Low Back Pain". *Theoretical Medicine and Bioethics* (1998), 19: 277-293

Downie, R.: "Literature and medicine". In *Journal of medical ethics* (1991), 17: 93-98

Edelstein, Ludwig: *Ancient Medicine: Selected Papers of Ludwig Edelstein.* Baltimore: The John Hopkins Press, 1967

Eco, Umberto: *Interpretation and Overinterpretation.* Cambridge: Cambridge University Press, 1992

Edmundson, Mark:
- "The risk of reading: Why books are meant to be dangerous." The New York Times, 04 01 08
- *Why Read?* New York: Bloomsbury, 2004

Elam, Katarina: *Emotions as a Mode of Understanding: An Essay in Philosophical Aesthetics.* Uppsala: Uppsala University Press, 2001

Empson, William: *Seven Types of Ambiguity.* London: Penguin, 1995 (third edition)

Engel, G.L.: "The need for a new medical model: A challenge for biomedicine." *Science (*1977), 196(4286):129-36

Evans, Martyn:
- "The ´medical body´ as philosophy's arena" *Theoretical Medicine (*2001), 22: 17-32
- "Medical Humanities – Stranger at the gate or long lost friend?" In *Medicine, Health Care and Philosophy* (2007), 10(4): 363-372

Evans, Martyn/Macnaughton, Jane: "Should medical humanities be a multidisciplinary or an interdisciplinary study?" *Medical Humanities* (2004), 30: 1-4

Faber, K.: *Nosography in Modern Internal Medicine.* New York: Paul B. Hoeber, 1923

Feagin, Susan L.: *Reading with Feeling: The Aesthetics of Appreciation.* Ithaca and London: Cornell University Press, 1996

Feinstein, Alvan: *Clinical Judgment.* Baltimore: The Williams&Wilkins Company, 1967

Fish, Stanley*: Is there a Text in this Class?* Cambridge, Mass.: Harvard University Press, 1980.

Floistad, Guttorm: *Filosofi och vetenskap*. Lund: Studentlitteratur, 1994,

Foucault, Michel: *The Birth of the Clinic: An Archaeology of Medical Perception.* New York: Vintage Books, 1994

Gadamer, Hans-Georg: *Uber die Verborgenheit der Gesundheit.* Frankfurt am Main: Suhrkampf Verlag, 1993

Good, Byron J.: *Medicine, Rationality, and Experience: An Anthropological Perspective.* New York: Cambridge University Press, 1990

Gustafsson, Lars. *The Death of a Beekeeper.* New York: New Directions, 1981.

Greaves, David: *The Healing Tradition: Reviving the Soul of Western Medicine.* Oxford: Radcliff Publishing, 2004.

Hakemulder, J.: The *Moral Laboratory: Experiments Examining the Effects of Reading Literature on Social Perception and Moral Self-concept*. Amsterdam/Philadelphia: John Benjamins Publishing Company, 2000.

Hansson, Mats G.: "Imaginative ethics – bringing ethical praxis into sharper relief". *Medicine, Health Care and Philosophy* (2002), 5: 33-42

Harrison's Textbook of Medicine. New York: McGrawHill, 7th edition, 1974

Hellström, Olle. *Patienten som person: Om mening och dialog i allmänmedicinsk praktik.* Umeå: Umeå University Press, 1999

Helman, Cecil: *Body Myths.* London: Chatto&Windus, 1991

Hemingway, Ernest: *Hills like White Elephants.* From *Men without Women: Stories.*London: Cape, 1964

Hick, Christian: "The art of perception: From the life world to the medical gaze and back again". *Medicine, Health Care and Philosophy* (1999), 2:129-140

Hippocrates: *The Aphorisms.* The Internet Classics Archive (translation Francis Adams), 1994

Hoffmaster, Barry: "Can ethnography save the life of medical ethics?" *Social Science and Medicine* (1992), 35(12): 1421-1431

Holland, Norman N.: *The Dynamics of Literary Response.* W.W. Norton&Company: New York, London, 1975

Holm, Sören: *Ethical Problems in Clinical Practice – a Study of the Ethical Reasoning of Health Care Professionals.* University of Copenhagen, 1996

Horowitz, A.W.: "Poetry on rounds: A model for the integration of the humanities into residency training". *Lancet* (1996), 347: 447-449

Hudson, Robert P.: *Disease and Its Control: The Shaping of Modern Thought.* Westport and London: Greenwood Press, 1983

Hunsaker Hawkins, Anne: "The Idea of Character" Charon, Rita & Montello, Martha (eds): *Stories Matter: The Role of Narrative in Medical Ethics.* New York, London: Routledge, 2002, 69-76

Ibsen, Henrik: *The Wild Duck.* London: Faber&Faber, 1980

Illich, Ivan: *Limits to Medicine. Medical Nemesis. The Expropriation of Health.* London: M. Boyars, 1976

Johannisson, Karin:
- *Medicinens öga: Sjukdom, medicin, samhälle – historiska erfarenheter.* Stockholm: Norstedts, 1990
- *Tecknen: Läkaren och konsten att läsa kroppar.* Stockholm: Norstedts, 2004

Josephsson, Ulla: *Life View of Medical Students at the Karolinska Institute, Stockholm, Sweden.* Doctoral thesis. Stockholm, 1994

Keen, Suzanne: *Empathy and the Novel.* Oxford & New York: Oxford University Press, 2007

Kleinman, Arthur: *The Illness Narratives: Suffering, Healing and the Human Condition.* New York: Basic Books, 1988

Kuhn, Thomas S.: *The Structure of Scientific Revolutions.* Chicago: University of Chicago Press, 1970

Kundera, Milan: *The Art of the Novel.* New York: Grove Press, 1988

Lakoff, George & Johnson, Mark: *Metaphors We Live By.* Chicago & London: The University of Chicago Press, 1980

Lantz, Göran: ”De två språken” *Det öppna rummet: Festskrift till Merete Mazzarella.* Helsingfors: Söderströms, 2005, 321-330

Le Fanu: James: *The Rise and Fall of Modern Medicine.* London: Abacus, 2000

Leder, Drew:
- ”Clinical Interpretation: The Hermeneutics of Medicine” *Theoretical Medicine* (1990), 11: 9-24
- ”A tale of two bodies” In Leder, Drew (ed): *The Body in Medical Thought and Practice.* Dordrecht: Kluwer Academic Publishers, 1992: 9-24

Macnaughton, Jane: ”Literature and the ´good doctor´ in Ian McEwans *Saturday*”. In *Journal of Medical Ethics: Medical Humanities,* (2007), 73: 70-74

Manguel, Alberto: *A History of Reading.* London: Flaminco, 1997

Mann, Thomas: *The Magic Mountain.* London: Minerva, 1996

McWhinney, Ian: ”Focusing on lived experience: The evolution of clinical method in western medicine” Toombs, S. Kay (ed): *Handbook of Phenomenology and Medicine.* Dordrecht: Kluwer Academic Publishers, 2001, 331-350

Miall, David:
- ”What is literariness? Three components of literary reading” In *Discourse Processes* (1999), 28(2), 121-138
- ”Aspects of Literary Response: A New Questionnaire”. In Rusch, Gebhardt (ed): *Research in the Teaching of English.* Siegen: Inst. for Empirical Lit. & Media Research, Siegen Univ., 1995, 359-367

Montgomery, Kathryn: *How Doctors Think: Clinical Judgment and the Practice of Medicine.* New York: Oxford University Press, 2006

Nessa, John: *Talk as Medical Work: Discourse Analysis of Patient-Doctor Communication in General Practice.* Universitas Bergensis: Bergen, 1999

Nilsson, Ingemar & Pettersson, Hans-Inge: *Medicinens idéhistoria.* Stockholm: SNS Förlag, 1998

Nordgren, Anders: ”Ethics and Imagination: Implications of Cognitive Semantics for Medical Ethics”. *Theoretical Medicine and Bioethics* (1998), 19**:** 117-141

Nordin, Svante: *Filosofins historia*. Lund: Studentlitteratur, 1995

Novitz, David: *Knowledge, Fiction and Imagination.* Philadelphia: Temple University Press, 1987

Nussbaum, Martha:
- *Love´s Knowledge: Essays on Philosophy and Literature.* New York, Oxford: Oxford University Press, 1990
- *Upheavals of Thought: The Intelligence of Emotions.* Cambridge: Cambridge University Press, 2001

Olthuis, Gert: *Who Cares? : An Ethical Study of the Moral Attitude of Professionals in Palliative Care Practice.* Doctoral thesis. Nijmegen, 2007

Ong, Walter: *Orality and Literacy: The Technologization of the World.* London: Methuen, 1992

Palmer, Frank: *Literature and Moral understanding: A Philosophical Essay on Ethics, Aesthetics, Education, and Culture.* Oxford: Clarendon Press, 1992

Pellegrino, E.D.: "Being Ill and Being Healed: Some Reflections on the Grounds of Medical Morality". Kestenbaum, V. (ed).: *The Humanity of the Ill: Phenomenological Perspectives.* Knoxvill: Univ of Tennessee Press, 1982, 157-166

Pettersson, Anders: *Verbal Art: A Philosophy of Literature and Literary Experience.* Montreal&Kingston, London, Ithaca: McGill-Queens University Press, 2000

Pickering, Neil: "The use of poetry in health care ethics education". In *Medical Humanities* (2000), 26(1): 31-36

Plato: *Phaedrus.* Oxford: Oxford University Press, 1992.

Posen, Solomon: *The Doctor in Literature: Satisfaction or Resentment?* Oxford: Radcliff Publ, 2005

Puustinen, Raimo:
- "Bakhtin's philosophy and medical practice – Toward a semiotic theory of doctor patient interaction" In *Medicine, Health Care and Philosophy* (1999), 2: 275-281
- "Voices to be heard – the many positions of a physician in Anton Chechov's short story 'A case history'". *Medical Humanities* (2000), 26(1), 37-42

Ramsey, Paul: *The Patient as Person: Explorations in Medical Ethics.* New Haven: Yale University Press, 1970

Reiser, Stanley: *Medicine and the Reign of Technology.* Cambridge: Cambridge University Press, 1978

Reynolds, Richard&Stone, John (eds); Lois, LaCivita&Wear, Delese (ass eds): *On Doctoring: Stories, Poems, Essays.* New York: Simon&Schuster, 2001

Rosenblatt, Louise M.: *Literature as Exploration.* New York: The Modern Language Association of America, 1995

Rothmann, David: *Strangers at the Bedside: A History of how Law and Bioethics Transformed Medical Decision Making.* Cambridge: Cambridge University Press, 1991

Rudebeck, Carl-Edvard: *General Practice and the Dialogue of Clinical Practice: On Symptom, Symptom Presentation and Bodily Empathy.* Sc J of Primary Health Care, suppl 1/1992

Rönnerstrand, Torsten: "Referenten är död. Leve referenten!" *Tidskrift för Litteraturvetenskap* (2000), 3/4 ,41-51

Sacks, Oliver: *A Leg to Stand on.* New York: Summit Books, 1984

Schwartz, Michael&Wiggins, Osborne: "Science, humanism, and the nature of medical practice: a phenomenological view." *Perspectives in Biology and Medicine* (1985), 28(3): 331-336

Sobel, R. & Elata, G.: "The problems of seeing and saying in medicine and poetry" *Perspectives in Biology and Medicine* (2001), 44(1), 87-98

Sontag, Susan.: *Illness as Metaphor.* New York: Farrar, Straus&Giroux, 1978

Steiner, George: *Real Presences.* Chicago: University of Chicago Press, 1989

Stempsey, William:
- *Disease and Diagnosis: Value Dependent Realism*. Dordrecht: Kluwer Academic, 1999
- "Medical humanities and philosophy: Is the universe expanding or contracting?" *Medicine, Health Care and Philosophy* (2007), 10(4): 373-383

Stolt, Carl-Magnus:
- *Den beprövade erfarenheten: Medicinsk idéhistoria och läkekonst i Boråsbygden 1780-1900.* Borås: Norma, 1994
- *Läkekonst.* Lund: Studentlitteratur, 1998
- *Medicinen och det mänskliga: Vårdkonst och vardagsetik. Humanism och humaniora.* Stockholm: Natur&Kultur, 2003

Sundin, Bo: *Den kupade handen: Människan och tekniken.* Stockholm: Carlssons, 1991

Sundström, Per: *Det hippokratiska arvet: Den medicinska etikens historia tecknad utifrån källtexterna.* Nora: Nya Doxa, 2001

Svenaeus, Fredrik:
- *The Hermeneutics of Medicine and the Phenomenology of Health: Steps towards a Philosophy of Medical Practice*. Linköping: Linköping Studies in Arts and Science, 1999
- "Hermeneutics of Clinical Practice: The Question of Textuality". *Theoretical Medicine and Bioethics* (2000), 21(2):171-189

Tarnas, Richard: *The Passion of the Western Mind: Understanding the Ideas that have shaped our World View.* London: Pimlico, 1996

Tauber, Alfred: *Confessions of a Medicine Man: An Essay in Popular Philosophy.* Cambridge&London: The MIT Press, 1999

Temkin, Owsei: "The scientific approach to disease". Crombie, A.C. (ed): *Scientific Change.* New York, 1963, 628-647

Toombs, Kay: *The Meaning of Illness*: *A Phenomenological Account of the Different Perspectives of Physician and Patient.* Dordrecht: Kluwer Academic, 1993

Toulmin, Stephen:
- "How medicine saved the life of ethics". In *Perspectives in Biology and Medicine,* (1982), 25(4), 736-750
- *Cosmopolis: The Hidden Agenda of Modernity.* New York: The Free Press, 1990
- "Knowledge and art in the practice of medicine: Clinical judgement and historical reconstruction". In Delkeskamp-Hayes, Corinna & Gardell
Cutter, Mary Ann: *Science, Technology, and the Art of Medicine.* Dordrecht: Kluwer Academic Publications, 1993, 231-249

Tyrberg, Anders: *Anrop och ansvar. Berättarkonst och etik hos Lars Ahlin, Göran Tunström, Birgitta Trotzig och Torgny Lindgren.* Stockholm: Carlssons förlag, 2002

van Peer, W & Pander Maat, H: "Perspectivation and Sympathy: Effects of Narrative Point of View" In Kreuz, R.&Mac Nealey, M.S. (eds): *Empirical Approaches to Literature and Aesthetics,* Norwood, New Jersey: Ablex Publ Corporation, 1996, 143-154

Vanhoozer, Kevin: *Is there a Meaning in this Text?: The Bible, the Reader and the Morality of Literary Knowledge.* Grand Rapids: Zondervan, 1998

Vickers, Brian: *Towards Greek Tragedy: Drama, Myth, Society*. London: Longman, 1973

Weinstein, Arnold: *A Scream Goes Through the House: What Literature Teaches us about Life.* New York: Random House, 2003

Wood, Michael: *Literature and the Taste of Knowledge.* Cambridge: Cambridge University Press, 2005

Wulf, Henrik & Pedersen, Stig & Rosenberg, Raben: *Medicinens filosofi.* Göteborg: Daidalos, 1992

Zachary Newton, Adam: *Narrative Ethics.* Cambridge, Massachusetts: Harvard University Press, 1995

Zaner, Richard: *The Ethics of the Clinical Encounter.* Engelwood Cliffs, New Jersey: Prentice Hall, 1988