Jon Halberg, MD

“Last May, Fast Company magazine published an article titled, “The Doctor of the Future.” To show us what we’re in for, Chuck Salter profiled Brooklyn’s Dr. Jay Parkinson, 33. He’s bearded and muscular, wearing black jeans and a black t-shirt, black leather bag in hand, black stethoscope draped over his shoulders—the epitome of cool. Dr. Parkinson doesn’t have an office; he sees his patients through e-visits and house calls. He doesn’t take insurance; he works with PayPal. He has a website and a blog. This “digital doc” understands and embraces technology and he’s changing the face of medicine. But is his “micro-practice” version of healthcare really where we’re headed? I think he’s really onto something, but I’m not ready to give up on actual clinics…yet.

As a family physician I’m convinced there’s a need for “medical homes,” clinics that provide compassionate, coordinated care. At the same time, I love the idea of using technology to improve access, reduce paperwork, and save money. But the thought of practicing alone, without support staff and without a physical clinic, is hard for me to grasp. Something’s missing in this version of primary care’s future. If your provider doesn’t have an office, where’s your medical home? Though this technology seems cool and cutting-edge, it also seems lonely—a little sad, even. Instead, I think it’s time to re-invent the clinic.

In Clinic 2.0, new technology meets humanistic practice. Evidence-based medicine melds with compassionate care. Great physical design complements design thinking—a focus on how to design everything better, from greeting patients to refilling prescriptions. Healing space blends with lean ideas—a quest to reduce repetition, overhead, and ultimately cost. Music soothes the soul, art pleases the eye, dramatic readings stir the heart. Frequent evening receptions and gallery openings encourage conversation among patients, neighbors, and clinic providers. Here, a trip to the doctor is something you want to come here. As a result, your health might actually improve—an idea worth studying.

In November 2008 I helped open a clinic like this in Minneapolis, a new kind of clinic and a true medical home. The Mill City Clinic was designed to be an incubator of innovation for our system—and for primary care. Tucked into the ground floor of a new condominium building located near the Mississippi River and across the street from the spectacular Guthrie Theater complex, it’s a place where art, science, the humanities, and medicine are given equal measure. Our Clinic 2.0 is more than a clinic, it’s a gathering spot: a place for reflection, new ideas, and great care. It’s not virtual; it’s not a concept. It’s a real physical space that completely changes your notion of what a clinic can—and should—be. Marcus Welby would feel at home here. And so would Dr. Parkinson.

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“Doctors tend to have a fierce commitment to the rational…. If there is a credo in practical medicine, it is that the important thing is to be sensible.”

—Atul Gawande

“What I fear and desire most in this world is passion. I fear it because it promises to be spontaneous, out of my control, unnamed, beyond my reasonable self. I desire it because passion has color, like the landscape before me. It is not pale. It is not neutral.”

—Terry Tempest Williams

My first firm clue that something was wrong came with the blessing of the candles. The secular Jewish family I married into blessed the candles every Passover, and the traditional prayer always fell to my wife Ruth. She stood and stretched her hands—palms down, elbows raised—above the lighted candles and softly, slowly, as she had done ever since childhood, sang the ancient Hebrew words.

Ba-ruh a-tah A-do-nai, E-lo-hey-nu me-leh ha-o-lam….

Ruth’s trancelike state as she re-entered this ritual space softened the armor and edginess that served her well as a mid-level administrator and corporate crisis manager. The blessing, in a reversal of her everyday skepticism, seemed to draw her into a deeper order of time or being.
Serious illness is all about losing control, so it shares one prominent feature: it is about being under the bed. But illness both functions also as a metaphor—a theoretical space often occurs. In medicine, the bedside is a real-world place not just clinical but ethical: What do we do—what unacknowledged aversion to lost control and to non-compliance helps medicine (as medical technology) put in the service of a controlling agenda. Its eros, but illness and eros both tend to push us into unexplicable beyond reason. I could have been the child apart in my own fury and enjoyed it. Eros crashes into an ordinary health care visit like a thunderbolt. William’s story shows how the consequences of individual human attraction and revolution reconfigure eros as an ethical—not just natural, biological, or libidinal state.

Even when darted from abstract to particular, the archetypal bedside dyad of doctor and patient is also inaccurate, or, at minimum, incomplete. On the patient’s side of the bed, Kirsten Smith and Nicholas Christakis recently wrote about the impact of what they call “supra-dyadic effects” on health and illness. It also calls in question traditional descriptions are often more useful than definitions, but the folly of a diagram at least indicates some of the forces and difficulties involved in eros: The diagram depicts eros as an energy associated with the human libido that passes in and out of people around it. My whole family has Crohn’s disease.

The web of relationships also includes an ambiguous figure: the unpaid caregiver. Professional caregivers may ultimately belong on the doctor’s side of the bed. When the caregiver (a healthcare surrogate) is a family member, however, the bedside metaphor begins to wobble out of control as the expanding supra-dyads explode traditional notions of the doctor/patient dyad. As Ruth’s disease grows worse, doctors tend to disappear from patients’ consciousness, and death is a frequent topic—our new, and partly imagined, postmodern milieu.

If the truth is that eros is the element of care in medicine, it may sound surprising that my wife’s illness threw me back into thinking about eros, but illness and eros both tend to push us into unexpected territory. In A Midsummer Night’s Dream, the infamous eros of Puck appends a Cupid-tanned juice that implicates Titania to fall in love with the first creature she sees upon waking, who turns out to be Bottom the Weaver. Eros so upturns control that the immortal queen of the fairies nowton WCs a working-class mortal whose head Puck has transformed into the features of a jackass. Before my wife’s illness, I had read and enjoyed it. Eros, moreover, in the most distressing implications is unquestioned, eros has become a subject of debate. For the early Greek poet Hesiod Eros was the oldest of all the gods, a primal cosmic creative force. Several centuries later, in Plato’s Symposium, while its importance is unquestioned, eros has become a subject of debate. Description is often more useful than definitions, but the folly of a diagram at least indicates some of the forces and difficulties involved in eros: The diagram depicts eros as an energy associated with the human libido that passes in and out of people around it. My whole family has Crohn’s disease.

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attending to histories and methods in women's studies and the medical humanities

Lisa Diedrich, PhD

As someone whose training, teaching, and research cross two interdisciplinary fields, women's studies and medical humanities, I am frequently struck by the remarkably similar ways in which each of these projects is articulated from within and perceived from without. Defenders of these programs often argue for them in terms of their ability to open up a space for those who have historically been marginalized or silenced in liberal arts and medical education—women and patients. By creating these new spaces in which the voices of the marginalized might speak, we challenge the hegemonic view of men and doctors on how to approach scholarly and medical diagnoses and treatments. Women's studies and medical humanities bring into view the binaries of woman and doctor/patient, and investigating these leads us to other related binaries: reason/emotion, mind/body, self/other, public/private, universal/particular, hard/soft, active/passive, autonomy/independence...the list goes on and on. Women's studies and medical humanities stress the importance of the second term in the binary, the one that has been less valued in the hierarchical relationship between the two sides.

The many detractors to these counter-hegemonic projects reduce them to identity politics masquerading as scholarship at best, and therapy at worst. Many supporters reinforce this emphasis by highlighting the importance of the space itself as a refuge for the victims of an unfeeling or even hostile larger academic or medical world. I want to suggest an alternative to the identity politics, therapy, and refuge models for both women's studies and medical humanities by thinking further about the particular histories and methods of these two interdisciplinary fields of study. In doing so, I want to argue for an end to innocence in each field's conception of itself in relation to power. I'm calling for we practitioners of women's studies and medical humanities to resist making sentimental claims to the innocence of our positions in relation to the larger institutional and transnational structures in which we do our work. Giving up the comforting illusion of our own innocence might begin by first attending better to our histories (the multiple and conflicting historical, social, and political factors that resulted in the emergence of these two fields) and our methods (the pedagogical and research practices that are encouraged, rewarded, and passed on—or not).

Attending to Histories

What forces shaped the emergence of these two interdisciplinary fields and how has each field been transformed since its emergent moment? Because Arriel's purview is the medical humanities and bioethics, I will focus my discussion here on the histories and methods of the medical humanities, and not women's studies. Still, in a historical conjunction that I don't think is coincidental, it's important to note that women's studies and medical humanities emerged at roughly the same historical moment, in the late 1960s and early 1970s.

In “Engaged Humanities: Moral Work in the Precincts of Medicine,” Ronald A. Carson offers a fascinating snapshot of the milieu out of which medical humanities emerged.1 The section entitled “Where Do We Come From?” opens with this statement:

In one sense, the medical humanities are a product of the turbulent ’60s, when authority and expertise were being destabilized and redefined in new and traditional ways of doing things were being challenged. Hermeneutics of suspicion was the intellectual weapon of choice, and “relevance” the preferred criterion for what mattered most in the mastery of ideas. America’s students wanted to know not only what their professors said, but why they said it—with suspicion. There was no one way to read a text, no one way to interpret. The humanities were caught up in one of their periodic identity crises. Philosophy was stuck in an analytic mode (philosophy was all but moribund), and literary criticism was about to experience an epistemological revolution. The large question was, “What is the proper role of the humanities in an age of science and technology?”

The ways of doing things that propelled the construction of a new field. First of all note that there are two, and only two, sides of the academy—already there is a cleavage between medicine and the humanities—and this binary structure is literally materialized in the architecture of many campuses. On the one side of campus, there is a generally turbulent mood, out of which come diffuse challenges to authority and expertise, and a demand for the relevance of research and teaching practices. This side of campus has "identity crises," a phrase that succeeds in personalizing the humanities, like many individual humans, have identity crises. This is an interest-

(continued on next page)
than with how that disease is enacted through practices. Mol calls her method “praxiography” because it “foregrounds practicalities, materialities, events” (12-13). Illness, for Mol, “is something being done to you, the patient. And something that, as a patient, you do” (20). In this way, she also gives us a model for thinking small through her assiduous attention to how specific practices, like angiography, surgery, and walking change the object, atherosclerosis.

Mol’s methodological interventions are in terms of how we gather and analyze material, and in terms of the way we structure the presentation of the material we gather, which is why her text gets divided into an upper and a subtext. The upper text presents ethnographic material about how atherosclerosis is done at one hospital in the Netherlands, along with her analysis of that doing. In the subtext she relates to the literature that has led her to this particular example of the practice of empirical philosophy. There is a foundation, literally in the text, to her work.

There are many interventions in *The Body Multiple*, but I’ll just mention one other, which is about writing better. She pays attention to writing itself, because she believes that, we need “to enrich, complexity, and change academic writing practices” by taking our writing methods “as seriously as our methods of gathering and analyzing materials” (2002, 162). In her subtext, she celebrates another text with a decidedly un-sexy title, *Health and Efficiency* by Ashmore, Mulkay, and Pinch. What Mol likes about *Health and Efficiency* is that it “brims with conversations, shifts in scenery, alternative presentations of material, self-reflexive remarks, and jokes.” To me, this sentence could also describe *The Body Multiple*. There aren’t many scholarly books that I have read that frequently make me smile, and sometimes laugh, as I’m reading.

In *The Body Multiple*, Mol teaches us not to take ourselves too seriously, while at the same time she offers us an exquisite example of how to do critical medical studies.

**Postscript: Why critical?**

At the *Books to Bedside* symposium at Northwestern University’s Feinberg School of Medicine in April 2009, I was invigorated by the robust exchanges about the past, present, and future of the medical humanities. It seemed to me that translational work wasn’t just talked about at the symposium; translational work was enacted, sometimes smoothly, sometimes less so. In the final plenary, I presented a version of this attempt to describe critical medical studies, and was thrilled when Tod Chambers ended the conference with a rousing Manifesto for Medicine Studies. Medicine studies, as Chambers articulated it, takes medicine as an object of study, using similar methods that have been developed in science studies by the likes of the French sociologist of science Bruno Latour, who was one of Annemarie Mol’s teachers. Chambers urged that we “cast aside the shackles of practicality and morality” as we seek to understand the conceptual object of medicine. I will be with him at the barricades!

Our slightly different names for the project, medicine studies and critical medical studies, do, however, reveal a slight difference in our conception of the object of medicine. Chambers admitted that he didn’t want what we do to be critical yet, I believe he means that there’s much important work still to be done in simply describing medicine better prior to getting into the messy work of politics. In some respects this is exactly what Annemarie Mol attempts to do in *The Body Multiple*, which is why she takes up a relatively apolitical disease like atherosclerosis of the leg. Still, perhaps it’s my background in women’s and gender studies, but I take the object of medicine to be always already political. I don’t believe we can put the critical to one side. Certainly, there is a danger in between, either an over- or un-articulated ideology to the study of the object of medicine. But this object that we study must also always include medicine’s relationship to power—and our own.

That seems to me to be critical.


1 Ronald A. Carson, *Engaged Humanities: Moral Work in the Province of Medicine*, *Perspectives in Biology and Medicine*, vol. 50, no. 3 (Summer 2007).

2 Carson goes on to discuss what I agree is an important strand in the development of the medical humanities. As he notes, “[it was] mainly from the ranks of moral theology and moral philosophy (and later, from religious studies—itself a hybrid field) that medicine’s earliest conversational partners came.” *Engaged Humanities*, 323.

3 Interestingly, Carson’s history of medical humanities sounds like the history, according to Michel Foucault, that medicine likes to tell about itself, with an unchanging idea of the clinic at its center. “Medicine has tended, since the eighteenth century, to recast its own history as if the patient’s bedside had always been a place of constant, in contrast to theology and law terms, which had been in perpetual change and masked beneath their speculation the purity of clinical evidence,” *The Birth of the Clinic: An Archaeology of Medical Perception*, trans. A.M. Sheridan Smith (New York: Vintage, 1973), 54.

4 In her now classic essay, “Piking Women in History: Definitions and Challenges,” Gerda Lerner describes the development of the field of women’s history from one concerned primarily with “compensatory history” or “contribution history” to one that develops entirely new methodologies for approaching the category woman in history. *Perspectives in Biology and Medicine*, vol. 3, No. 1/2 (January 1978), 5-14.


7 *The Body Multiple*, 162.

**Manifesto for Medicine Studies**

As I write this essay, there is an ongoing crisis within bioethics and the medical humanities. The University of Tennessee’s College of Medicine is considering expunging their Department of Human Values and Ethics. Many in bioethics and the medical humanities had thought that their presence within any reputable medical school in North America was at this time simply a given, but this crisis has made me wonder about the status of bioethics and the medical humanities as disciplines. Suppose that there was some odd medical school plaque that wiped out all of the bioethics and medical humanities departments, programs, and centers. Would the disciplines continue to exist? For bioethics I believe the answer is yes. Bioethics has existed within medical arenas due to its ability to provide answers, guidance, and helpful structures to moral dilemmas, but the discipline also has an existence outside of its practicality. Philosophers and religious studies scholars would, I believe, continue to work on the moral problems in biomedical research even if there were no financial support from the medical or research environment.

I believe, however, that if the medical humanities were eliminated from medical schools, it is highly likely that medical humanities would cease to exist. There may be a few stray literature courses for pre-meds on images of the physician in 20th century American literature or religious studies courses on death and dying, but the medical humanities is intellectually anchored to (and in doing so restricted to) its ability to demonstrate its practicality in improving the moral ethos of contemporary health care.
In a recent essay in Academic Medicine, Johanna Shapiro, Jack Coulehan, Deale Wear, and Martha Montello demonstrate this very feature. *They define the medical humanities as an entity possessing three characteristics:*

1. They use methods, concepts, and content from one or more of the humanities disciplines to investigate illness, pain, disability, suffering, healing, therapeutic relationships, and other aspects of medicine and health care practice.
2. They employ these methods, concepts, and content in teaching health professions students how to better understand and critically reflect on their professions with the intention of becoming more self-aware and humane practitioners.
3. Their activities are interdisciplinary in theory and practice and necessarily nurture collaboration among scholars, healers, and patients.

The authors of this article state explicitly that, "Conditions 1 and 2 imply that medical humanities have a significant moral function."

I'm not against an academic discipline having consequences, I'm against academic disciplines that are defined by their consequences. In order for the medical humanities to become a full academic discipline I believe it must become fully impractical, amoral, and indifferent to its potential social consequences.

Intellectual disciplines must have some conceptual object that they are trying to reach. For example, Ferdinand de Saussure established linguistics as a distinct discipline not by inquiring about the characteristics of French, English, or Chinese, but rather by asking what is language. And the medical humanities have the potential in its core to do something bioethics has largely been uninterested in doing; to understand medicine as a conceptual object. I think that we need a discipline that looks at medicine itself without a concern for any facility to improve it as an enterprise. I tend to refer to this as "medicinal studies." I have colleagues who believe such a name brings both the strengths and the weakness of an association with science studies, which at its best forces us to dehumanize science and at its worst leads us to the Sokal affair. Others have proposed other names for such an entity—critical medical studies, mediprudence—but I am not concerned about the particular nomenclature. The central issue is an intellectual move from being a field that serves as a handmaiden of medical reform to a legitimate academic field. The academic study of medicine has been fragmented across a number of disciplines: medical sociology, philosophy of medicine, history of medicine, medical anthropology, literature and medicine, rhetoric of medicine. That many of these disciplines tend to overlap in their intellectual work without being aware of one another's contributions has kept the study of medicine stunted in its intellectual growth. These disciplines need each other in order to avoid presenting merely a series of partial descriptions of the various parts of a medicine elephant. These are some of the key features of what I believe would entail the creation of this new field, medicinal studies.

1. It aims toward understanding the conceptual object medicine.
2. Its purview is limited to the understanding of allopathic medicine.
3. It is critical of medicine's own self-understanding.
4. It focuses on the actual practice of medicine. To make a parallel to a methodological rule of Bruno Latour, it studies in action.
5. While it is multidisciplinary in its foundations, it strives toward an interdisciplinary understanding of this conceptual object. It admits that such an understanding of medicine requires the disciplinary tools of such academic fields as history, social science, performance studies, rhetoric, literary criticism, visual studies, law, philosophy, and religion.
6. Its primary aim is the description of medicine, not the prescription for any particular practice of medicine. It is separate from bioethics and is agnostic toward bioethics' objectives. It under stands bioethics as simply another component of contemporary allopathic medicine. Thus it eschews moralizing but can permit a form of ethical realism when it interacts with bioethics.

This direction can transform the medical humanities into an academic discipline toward which it has only made tentative steps. Manifestos require first-shaking endings, so in homage to the genre's most infamous representative, here's mine: Let the medical humanities scholars tremble at a medical studies revolution. The scholars have nothing to lose but their practicality. They have a discipline to win.


To: Chambers@northwestern.edu


Provocation:

There’s No Such Thing as Research in the Medical Humanities (And It’s a Good Thing, Too)

James Lindemann Nelson, PhD

We can do this the easy way, or the hard way.

The easy way is to see this thesis as a recommendation about what we should call things, like so: what passes as "research" in the medical humanities is better understood as "scholarship."

The proponent of the easy way, a con clu sory sort, will likely admit (or perhaps even insist) that the goals are common: like research—which I'll understand as, copied from Peirce, as exemplified by what is done by bench scientists in their most characteristic ly professional moments—scholarship aims at uncovering the truth about significant features of the world and those who live inside it.

There are also commonalities of method: like research, scholarship requires of its devotees methodological skills, turning to the domain, and creative and critical imaginations. There are commonalities in significance: like research, scholarship is both intrinsically valuable and instrumentally vital to human forms of life.

But here we come to: unlike research, scholarship operates in domains that don't lend themselves to high levels of precision and the attainment of wide and enduring consensus. A conclusion supported by humanities scholarship often stands on a basis of extended inference from data whose meaning is highly complex and contestable. History suggests, alas, that the forms of reasoning that support scholarly conclusions lack the power conclusive to settle many of the most significant questions about method and conclusion among those learned in the field at any given time. The day may come when medical humanities scholarship will morph into real research. Maybe neuroethics or cliometrics or cognitive literary criticism will trans figure us. But that is not this day.

Why is this the "easy way?" Because there's really no reason for us to ruffle anyone's pinfeathers. It's merely a classificatory recommen dation, supported by observations that seem pretty plausible. If you don't like the recommendation, and want to dig in your research heels insisting to your deans that what medical humanities do is different from what medical geneticists do only as what physical chemists do is different from what evolutionary biologists do—mere matters of degree, mere details—no bones broken. You just push the likenesses, and when someone brings up the differences, change the subject. Whatever the potential stakes might be, it's not clear that much else of substance hinges on nomenclature one way or the other.

Thus, it's the easy way of approaching this thesis: sweeter reason a ble, rather boring. I think it also suffers the drawback of being false. Now let's do it the hard way. The hard way is to insist that the humanities and the sciences don't aim at the same goal at all—including the store of information that is publicly endorsed and consensually accepted knowledge is not what the humanities, and a fortiori, the medical humanities aim at. The hard way is telling your Dean that the persistence of controversy about key issues of method and substance among the learned is not a feature that the future may fix—medi cine and literature is not looking for its Newton or religious studies for its Darwin. Persistent controversy is not an inferiority to be lamented, but a characterizing feature of this enterprise that helps account for its value.

Appeals to method won't help you with a research-oriented dean either—on the hard view, there are no distinctive, essential methods to the humanities as such. Some humanists in their professional moments will draw on the findings of scientists, and some will have their own little tricks (needing to know obscure languages or how to decipher old texts without wrecking them, close reading or phe nomenological reduc tion) but generally speaking there's just honing up and focusing some general human cognitive and affective abilities: testing arguments for their soundness, attending to likensesses and differences, alertness to context, being creative, empathetic, having good judgment, and so on. It's a disputable point, I realize, whether there is indeed a "sci entific method." But no one has ever been tempted to talk about a "humanities method," have they? For this small blessing, much thanks.

What about intrinsic and instrumental value? Here, the hard way asserts this: if the intrinsic value of research is a function of the way in which it leads reliably to the truth—or to better and better approximations of...
the truth—whatever is important about the humanities, it isn’t that. If the instrumental value of research is that it leads to technological spin-offs that cure diseases or enable humans to fly or play video games, you can forget that, too.

So what is the point of engaging in the humanities, and in particular, in the medical humanities? The humanities grope toward making sense of things, toward what Wittgenstein called the “notions of a sound understanding”—a process that will draw on the best accounts of what is known, and may, incidentally, actually add to them, but aims at achieving a perspicuous grasp of the world considered as a field for living, generally, not exclusively for contemplation or for focused themes. There is in much of what humanists do in their professional hours a kind of normativity that goes beyond simply the value of truth or of efficiency in achieving set ends. It extends to questions of how best to understand oneself and others, and of what patterns of action and feeling make most sense of the lives that are ours to live.

Now, to take the hard way to swim upstream: in my own academic department, I have to report to my own research every year, and we refer to the Ph.D. we award as a “research degree.” I don’t think there is anything unusual about this—I expect it is repeated through humanities disciplines. So why bother insisting that our work is not research? Is it not easier, to say nothing of more politic, to say that we philosophize and critics and historians do research in our own way on our side of the river, and the high energy physicists and the entomologists and the folks in the sheep center do research in their own way on the other side of the river. Our “research” is small potatoes, since it generates nothing the university can patent, and even when we get external funding, the indirect costs are usually very low. But the easy framing argues that though we may be junior partners, we’re still in the family.

It’s that last plea that the liability of the easy way, as I see it. In allowing the humanities to be configured as a collection of research disciplines the best we can be is junior; at worst, we are on sufferance. (Where I work, we have a president who has many virtues, but who has been quoted as saying “I just don’t get the humanities.” The impression wasn’t left that she saw this as her problem.) Even worse, I think, we humanists may allow our own work to suffer from a kind of research envy: we know those folk who do “real” research have these impressive methodology, this, that, and so forth, and that therefore our knowledge, if that’s the image that is before our eyes, we will be tempted to misunderstand ourselves. Our own aims, our methodological aspirations, and our sense of our own value will be unrealistic, inapt to our needs, and, not to put too fine a point on it, doomed.

Everything I’ve said here about the hard way of understanding the relationship of the medical humanities to research holds for the humanities in general. Is there anything special about the medical humanities that keeps research from being one of its proper aims? The medical humanities have not infrequently sold themselves (or allowed themselves to be sold) instrumentally: they minister to students stretched on the tough rack of medical education, keeping alive their sense of themselves and their patients as persons by dispensing judicious doses of Emily Dickinson, or William Carlos Williams, or John Stuart Mill. If this is indeed the whole of what’s characteristically about the medical humanities, then it provides another ground for distancing this practice from research: the point of the enterprise is decidedly not to generate new knowledge of an objectively existing world, but, like other nurturing crafts—parenting, for example—to build and refine (or retard the erosion of) character. I confess to some discomfort about this special justification for the medical humanities, and the attendant argument about research. At most, there may be something like the paradox of hedonism operating here: just as happiness is most reliably obtained when we don’t seek it, engagement with the humanities may possibly have a good effect on a person so long as good effect is not what she seeks—no “gaining thoughts” as the Buddhists say.

Yet I think there is something that, at least as a matter of emphasis, distinguishes the practice of medical humanists from their sister scholars in the arts and letters. Medical humanists often deeply underestimate and vividly concretize intricate dimensions of the struggle to make sense of human lives. Rather than focussing, say, on common humanities tropes such as “human reality” as a general feature of human reality, medical humanists more often attend keenly to the dying of something in particular—even of someone dying of something in particular. It’s rather hard, I think, to convince oneself that much of what’s important about death on that level of specificity can be exhausted by even the best designed research protocol. If that’s right, then one of the particularly valuable things about the medical humanities, despite (or perhaps because of) it’s having taken up lodging near research’s very heart in the modern medical center, is that here more than elsewhere, it’s clear that whatever humanists are up to, it isn’t research.

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I interpreted my invitation to be a “provocateur” at the ASBH Spring Meeting as an invitation to rant. I found this very liberating, I’ve been known to rant from time to time, but never with permission. It was always the opposite—the organizers instructed me to give a sober balanced account of some situation, but before I knew it a thinly veiled rant emerged. This time things are different. This time I’ve been asked to rant!

So I started with some general research. I turned to the classic rant in American literature, the one let loose by Huck Finn’s alcoholic unschooled racist father.

Call this a govtment? why, just look at it and see what it’s like. Here’s the law a standing ready to take a man’s son away from him—a man’s own son, which he has all the trouble and all the anxiety and all the expense of raising, Yes, just as that man has got that son raised at last, and ready to go to work and begin to do something for him and give him a rest, the law goes for him. And

That ain’t all, neither... Now that’s a rant! Huck’s father goes on like this for a couple of pages, and I encourage everyone to go savor it. Along the way, Twain highlights a classic feature of the genre—in a rant it is entirely possible to mix dead certain conviction with absolute idiocy and misguidedness. So, dear reader, if you notice any of that in this essay, you can applaud me for staying true to genre.

The topic I was asked to rant about is this: Medical Humanities are unnecessary to patient care and clinical practice. The standard way to make this argument is to start with a sharp distinction between human agency and social structure. Medical humanists undertake to improve the clinical encounter by changing the clinician’s human agency, while paying little attention to the social structure of medicine. But, with the distinction between agency and structure firmly in place, it is easy to argue that the problems with the clinical encounter (that it is too cold, too rude, too arrogant, too patriarchal, too controlling, too in bed with the pharmaceutical and device industries) have little to do with the human agency of the clinician and all to do with the larger political, economic, and cultural structures in which the encounter is embedded. Using this perspective, one can easily argue that medical humanities is irrelevant to the problems of the clinical encounter. Indeed, from this perspective, medical humanities is not only irrelevant, it is part of the problem rather than part of the solution because it works as a ruse that obscures and effaces the social and political conflicts inherent in institutional medicine. It allows leaders of medical systems to point toward the grand ideals of humanism and empathy while doing very little to change the very standards of care which make it impossible to live up to those ideals. In effect, medical humanitites blames the victim—individual students and practitioners—for the system’s inability and unwillingness to deal with structural problems and conflicts. Anthropologist Michael Taussig put all this succinctly years ago: “Humanistic medicine is a contradiction of terms.”

But alas, as fun as it is to rant about, it is more provocative than I wish to be. For I am one that medical humanists make an effort in medical training. Creating too sharp a binary between agency and structure obscures the subtleties. Medical humanities may not be able to do much to help the clinical encounter in the face of larger social forces, but it can do a little. It can help clinicians develop a kind of “wiggle room,” an expanded space for navigation within a highly structured standard of care. That’s worth a lot. Not a lot, but a little. And sometimes a little is a lot.

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However, a little is not enough. To have a more significant impact (and here comes the rant I do want to make), medical humanities must connect the dots between two crises: the crisis in healthcare and the crisis in the humanities. As someone who has gone back and forth between medicine and the humanities it is clear to me that these crises are not separate. They are deeply interconnected. But what are these twin crises?

The newspapers tell us that the crisis in healthcare is about a crisis in finances (how are we going to pay for it?) and a crisis in administration (how are we going to distribute it?). As humanities scholars we cannot stop there. We must insist that the healthcare crisis is a cultural crisis, and that financial and administrative problems are symptoms of larger human issues. The healthcare crisis is a crisis of meaning; a crisis of how we think about health and healing, about living and dying. It is a crisis of biomedical reductionism run amok and out of balance.

It will not be enough to reform healthcare finances and administration without also reworking the unsustainable faith this culture has put into the biomedical model and biotechnology. As a result, medical humanities should be at the forefront of helping breathe life into more holistic and humanistic models of medicine, and connecting those more humanistic models of medicine to a new renaissance in primary care.

The reason medical humanities should engage in the healthcare crisis is not simply an altruistic desire to save medicine from biomedical reductionism and unsustainable expenditures. The reason is that the crisis in healthcare is the mirror image of the crisis in humanities. The crisis in humanities is also not primarily about financial and administrative issues like low salaries and limited jobs. These too are only symptoms of larger cultural issues; they center on the fact that the humanities have limited cultural value. They have so retreated to the ivory tower that few care about them. The humanities, in short, have become increasingly worthless to the culture at large. For humanities to gain value again, they have to contribute directly to solving problems people care about—like helping the culture move beyond its current crisis in meaning regarding living and dying. And that is exactly what humanities scholars do. They are deeply invested in making the humanities more relevant as it works to make healthcare more humane. This will happen not simply by adding values to facts or attempting to use facts wisely. It will happen by setting up an intellectual infrastructure that recognizes and works through the value-laden nature of all facts. It will happen by setting up centers of excellence where scholars tease out the values at issue in the many facts that shape our life. And it will happen by creating a world where there is more stakeholder and citizen engagement in the making of facts as a process of making life-worlds and ways of living. When the humanities play this role, it’s no longer an ivory tower luxury—it’s part of the real struggle over culture and the world we live in.

In short, my rant is this: The humanities cannot save itself without also saving medicine. Medicine cannot save itself without also saving humanities. And nothing short of saving both (or at least striving in that direction) should be called “medical humanities.”

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1 Mark Twain, Adventures of Huckleberry Finn, ed. E. Ellin (Oxford University Press, 1999), 25.
4 Judith Butler, Bodies That Matter: On the Discursive Limits of Sex (Routledge, 1993).

...medical humanities should be at the forefront of helping breathe life into more holistic and humanistic models of medicine, and connecting those more humanistic models of medicine to a new renaissance in primary care.

Catherine Belling, PhD
Since we can never perceive perfectly the absolute whole of anything instantaneously, all perception is impure, a reading of signs rather than an apprehension of things. The condition of reading is the human condition.

—Robert Scholes, Protocol of Reading

The title of the ASBH spring conference “Books to Bedside: Translational Work in the Medical Humanities” raises the question of application: does work in the medical humanities translate to patient care in ways that are analogous to translations of bench science’s descriptions of its objects into useful treatments? The medical humanities have been defined by usefulness; the field exists because it’s expected to have broadly salutary effects on medical students, and hence on physicians, and thereby on patient care. This effect is usually described as “humanism,” or “professionalism.” But what is used to cause this effect, and should application ever precede investigation? What is the “bench science” of medical humanities? “Books” is an obvious (and suitably alliterative) substitute for “bench” in the standard translational formula, “bench to bedside,” but the term raises some tricky questions. Which books? It’s not the primary texts we read, and have our students read—focusing on primary texts is analogous to science translating from bacteria to bedside; from an examined object to application. That’s not what science does, and that’s not what humanities work does either.

Those primary texts, be they books, poems, films, or instances of human behavior, are the objects of our study. A text is an interpretable entity that need not manifest in the form of a book or even in words. When you read or interpret something it becomes your text. As a humanities scholar, your work

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is also to produce a new text that articulates your readings, just as bench scientists must articulate and publish their findings. Our initial product is what we publish. So a more fitting analogy to the scientist’s bench is the books and articles we write. (The overlap in form between our object of study (often writing) and result of study (our written scholarship) is the source of some confusion—but more on that later.) But translational medicine is not “Nature article to bedside” either.

In the humanities, our practice, equivalent to the empirical activity that constitutes laboratory science, is analytical, interpretative, and critical: reading. Our object is not the natural world but the cultural world that humans always make of it. (And for this reason, science and medicine themselves are among our object-texts.) Our metaphorical (or metonymic) “book” (or “bench”), then, is not the text we interpret, or the one we produce, but the practice the word stands for, the descriptive-interpretive-explanatory method of doing our research (or scholarship, if you will), before application is an issue. It is our exploration of meaning as an end in itself. We put medicine under our metronymic microscopes and read it in order to find out what, and how, it means.

For some time, narrative has been our key into the curriculum and the clinic. The term “narrative” connotes a range of skill-based contribution humanities approaches offer to thinking about clinical interactions, patient experiences, and the story-based functioning of medicine in all its cultural manifestations. It also meshes nearly with the current move in medical education to a model based on competence attained rather than courses passed. “Narrative” is a term, however, that is defined poorly and used loosely within the medical humanities. It is both too broad (often used to encompass everything non-quantitative) and too narrow (the humanities do not read only narrative texts). Instead, our work would be better framed in relation to practices of reading—which includes reading the written and oral narratives that constitute so much of medical practice and thinking and experience.

The humanities scholar—a professionally-trained reader and teacher of reading—can show how texts usually come with basic instructions for reading them (generic protocols, in effect) and that a good reader must find ways to recognize and transcend these; reading critically means that the medical humanities should become evidence-based, capable of giving an account of how and why something is known about a text, even if that knowledge is speculative. Intention is not enough. Semantic, linguistic, textual evidence must be expected, from scholars and from medical students. Edgar and Patton make the difference between arts and humanities clear:

The humanities … perform the role of checking the propagandistic, conversionist potential of the arts [or any other cultural artifacts, include those produced and used by bioscience and in medicine]. The humanities can say that [a] particular vision, however pleasing or exciting it may be, is, epistemologically, morally, or politically wrong, and provide arguments and evidence for that claim. Rather than using the arts for their “conversionist potential” (assuming that watching Wir will inoculate students against the bad behavior of the play’s doctors), the medical humanities must provide students with the ability to ask more complex questions (Are the doctors in Wir stereotypes? If they’re “unrealistic” shouldn’t we just dismiss them? How do they work as representations? How do literary representations compare to professional shadowing? How do real patients read and transcend these representations conveyed in the subtexts of the medical school curriculum? What assumptions underlie these? What intellectual tools and strategies do students need to identify and resist them?). Such questions are often asked in medical humanities scholarship, and sometimes asked in medical humanities classes, but they are not often highlighted in accounts of the value of the medical humanities. We should be less modest about a discipline that allows such questions to be identified and asked in ways that, if conceptualized and taught with the technical and intellectual rigor—the discipline—that the humanities offer, could enable students and physicians to read their work in medicine with sustained and skilled attention to meaning.

Medical educators who limit the contributions of the humanities to the Romanic idea of literature as an unteachable art with no transferable effects are depriving medical students of a useful set of tools: a technical vocabulary enabling physicians to understand and articulate how representations work, how they’re made, and how they’re understood in all human spheres—from lab notes to drug ads to a mom’s explanation of why she doesn’t want her child vaccinated. Learning to read (and yes, practicing those reading skills on John Donne or John Stone or Atul Gawande or Tess Gerritsen or a CT scan) should enable physicians to navigate the old science-art divide, to enact the phronetic thinking required of them, and to convey their knowledge clearly—to themselves, to their patients, and to their students. In this way we might come up with something robust enough it won’t get lost in translation.

The Medical Humanities as Reading (continued from previous page)

domain of the heart (or the gut), and that the mind’s brain-based cognitions are capable of cold reason untrammeled by feeling or language. It’s a surprisingly unmedical view of human thinking. The humanities disciplines are profoundly cognitive and rational, and they can be taught, measured, and evaluated, but they tend not to be taught in medical schools. Instead their contribution has been limited to what we trust will be conveyed by the good intentions of teachers. This puts an unnecessary burden on those teachers and renders the value of the medical humanities ephemeral, undefinable, and resistant to assessment. While the argument that the humanities promote humanism has worked to establish a sphere of contribution, it has also limited that contribution by merging the humanities disciplines with the fine or creative arts. Our field must move beyond this argument before it can make its full contribution to the field of medicine. The more productive position is not to cut through the books/bench distinction on a different plane: Andrew Edgar and Stephen Patton argue that the role of the humanities—in medicine and anywhere else—should be equivalent to their role in relation to their more traditional texts (novels, paintings, and so on) as a “second order critical activity.”4 In other words, the humanities scholars is to cultural texts (including, but not only, literature and art) as the lab scientist is to natural phenomena. This means that to think of the medical “humanistic competence” in terms less clearly defined and clear on how it is to be practiced also means that the medical humanities should become evidence-based, capable of giving an account of how and why something is known about a text, even if that knowledge is speculative. Intention is not enough. Semantic, linguistic, textual evidence must be expected, from scholars and from medical students. Edgar and Patton make the difference between arts and humanities clear:

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MK and I went out for a drink after that talk, the one where the ancient surgeon started figuratively vomiting during the Q&A. I got the sense MK needed the drink more than I. By then, I was kind of used to that experience, used to it enough that I had stopped fighting these mutinous old twits when they took over my talks. That’s why, when this one came to the podium, I just found a chair, breathed deeply, held a polite smile, and silently repeated my favorite Taoist meditation: “Give evil nothing to oppose, and it will disappear.”

But the whole scene had obviously bothered MK a lot. As I listened to her work through her reactions over a bottle of wine, I wondered if I was witnessing the composition of a new cartoon by the master’s student known to us also as Comic Nurse. She seemed to be setting up story blocks in the way she talked.

And as I listened to MK, I found myself increasingly surprised. She was obviously angry with the old guy, but wrapped up in that was her growing sympathy for him. Even with the wine sedating me, this pissed me off. Because I like MK, and MK likes me, and well, it felt like a betrayal. I found myself silently defending against her seemingly misplaced sympathy. I mean, I was the one who was cleaning up these surgeons’ messes! I was the one covered in the tears they had long since washed off their hands! Or rather, I was the one who had met and helped a few of the people wrecked by the surgical interventions meant to save them. The aged surgeon and I had in common an unjustified sense of self-importance in the history of medicine. But maybe not an unjustified sense of self-importance in the lives of individual patients. He had changed their lives by using his scalpel to try to make their bodies look more like people like him. I had come along a few decades later to show that didn’t work as well as one
might hope. And when I met the people left literally and figuratively scarred, I had sometimes worked on taking their histories. Most of the time I took these people’s histories as part of my scholarship or my activism, in order to let doctors know what really happened to those patients who were labeled in the medical literature “lost to follow up.” But in the process of doing that, I often ended up helping the individual former patients understand their personal histories, and so reclaim them. Practically speaking, I took what they told me and what I knew of the historical context, put it all into a cohesive narrative, and gave it back to them. The kernel of iatrogenic pain in their lives was now suddenly uncoiled into a cohesive little tale. And they told me having these three or four pages of laser printer ink on ordinary white copier paper changed their lives.

At first I thought they were just being polite. But over the years it has become obvious how incredibly powerful this little service is. So now and then I offer it up, pro bono and private, to someone I meet. “Would you like me to help you understand your history a little better, to write it up for you?” I ask, slipping them my card. Ostensibly, I do it for them. In fact, it’s the most meaningful work of my life. I feel embarrassed that they thank me at all.

So why not institutionalize this, I wonder more and more? Rita Charon has taught us the power and importance of “the parallel chart,” the private place where a doctor may tell her story of the medical encounter. But what of the patients? What of all the people left through bad insurance, bad luck, bad social norms supposedly healed, but actually harmed? We don’t need my anecdotal experience to know more narrative disimpaction would help. There is plenty of evidence that stories help with trauma. Indeed, there is plenty of evidence that stories are inherent to trauma; they appear to be a natural part of scarring. Story-telling around trauma and loss is so universal that it looks like it must serve an evolutionarily adaptive purpose; such story-making may literally help us survive. So why is it that in medical care we have ointments and bandages and physical therapies designed to optimize physical scarring, but we have no systems to optimize psychological scarring?

My nine-year-old son recently wandered into my home office and read MK’s cartoon. After we talked about what it meant, I asked if he had any questions. “Why is the narrative laxative cherry-mint flavored?” I laughed and told him that I guess historians are cherry-mint flavored. He laughed back, and said, “No!” And then he asked, pensively, “Is there really such a drug?” And I started to cry. “No, there are just people who can listen to other people. That’s why I spent last night on the phone with Mark, asking him to tell me about his life with hypospadias, writing it up, so I can write it down, for him.”
What’s Wrong with Patient Safety?

Kathryn Montgomery, PhD

Much has been done to improve hospital systems: eliminating look-alike bottles and sound-alike medicines, making frequent hand washing convenient, instituting checklists, encouraging no-fault reports of mistakes and close calls. But many of these advances are hard to sustain, and none addresses cognitive error. Both the motivation necessary for improvement and the mistaken idea of certainty that leads to error would be improved by a better understanding of how physicians think.

Medicine is handicapped by the widespread assumption that it is a science. Patients’ often desperate need for certainty and physicians’ drive for thoroughness in themselves and their students leads us all to assume, even to think, that medicine—at least in our case—is a nineteenth-century positivist science: invariant, replicable, certain, and perfect. The assumption is fed by patients’ hopes, by the medical emphasis on the magic bullets of biomedical research, and by the status of science as certain knowledge. Medicine doesn’t explicitly claim to be a science (though it sometimes claims to be “the youngest science”); practicing physicians understand the uncertainty of their work. They were introduced to the idea that science isn’t simply the old-fashioned Newtonian revelation of the reality of the universe in the physics course they all had as pre-meds.

Nevertheless, this belief that medicine is a science affects the profession in many ways, none of them good. The first two years of medical school, despite reforms, still requires students to memorize mounds of soon-forgot-ten facts and neglects character and professional attitudes. Medical care itself is too often “scientifically” reductionist, treating lungs or gut and not the patient. Risk is misunderstood, and clinical trials are easily mistaken for medical care. Errors are seen as entirely an individual’s fault; a malpractice suit seems a reasonable response to failure. Where perfection is expected, mistakes are shameful and covered up.

But medicine is not a science: it’s a practice. Physicians are not scientists—not unless they have laboratories and NIH grants. They are more likely to be social scientists, especially those academic physicians who conduct clinical trials and observational studies. But research is separate from the work that makes them physicians: clinical prac-tice, the care of patients. Physicians spend long years learning to reason clinically—and they’re not engaged, as we might assume, in hypothetic-deduction. If syllogisms were all clinicians needed, medicine could be learned in the first two years, and patients could enter their sympto-moms into a computer and get a diagnos- is and a prescription. Instead, students acquire medicine through diagnostic reasoning (and education is clinical science [rather than being described for itself], little can meet its criteria and skepticism about reason itself is the consequence” ([Sources of the Self](https://en.wikipedia.org/wiki/Sources_of_the_Self) [1989], 74-5).

Recently, social and cognitive psy-chology has backed up the philosophers. Drawing on neuroscience, dual-process theory postulates two knowl-edge systems. System one is formed automatically and slowly, and gives us quick, almost effortless access to regu-lar, patterned generalities. System two is acquired consciously and more quickly, but it is a slower, more inten-tional process of rule-based inference that requires a measure of learning—that either from systematized observations from systematization for the purpose. Psychology uses both of these knowledge systems, and as a practice draws strongly on system one’s associative process. Quickly, often and often, the patient safety conversation is this dual-process view of medical thinking. Dual-process theory leaves room for uncer-tainty, contingency, incompleteness, and variability—in short, error and the correction of error. It fits the under-standing of philosophers and sociolo-gists of science, who from Mary Hesse to Steven Shapin have argued that science, unlike its objects, is created by the practical reasoning or phronesis needed in ethics, health, and navigation, from reasoning about objects, the scientific reasoning of episteme needed in biolo-gy and astronomy.” William James wrote that to distinguish two kinds of thinking, scientific hypothesis and veri-fication on the one hand “and narra-tive, descriptive, contemplative think-ing or the other—is to say only what every reader’s experience will corre-borate” ([Witings](https://en.wikipedia.org/wiki/Witings) 1899).

Yet Western culture has privileged science as the way of knowing—even when, as in history or anthropology (or, lately, economics) the scientific method is not suited to human objects. Philosopher Charles Taylor warns that our misunderstanding of practical rationality is so widespread that it corrupts attitudes to all ration-ality. Because the “model of practical reasoning,” he says, “is based on an illegitimate extrapolation from reason-ing in natural science (rather than being described for itself), little can meet its criteria and skepticism about reason itself is the consequence” ([Sources of the Self](https://en.wikipedia.org/wiki/Sources_of_the_Self) [1989], 74-5).

But medicine is not a science: it’s a practice, the motivation necessary for sustained improvement and the mistaken idea of certainty that leads to error would be improved by a better understanding of how physicians think.

Clinical thinking is well taught in medicine—so why aren’t physicians also taught about the way they think? It’s as if medical practice were one of Bruno Latour’s hybrids, asserting “science” as a cover story so as to achieve its pur-pose more efficiently ([Foucault, Nietzsche, deconstruction](https://en.wikipedia.org/wiki/Foucault,_Nietzsche,_deconstruction), 1993, 6). Or perhaps medicine’s willful ignorance of its epistemology might be necessary because thinking about thinking could make it impossible to act. For a long time I wondered if physi-cians might be like the ceni-tide that’s asked how it manages to walk with so many legs and, trying to think, it feels right over.

This obliviousness seems to be characteristic of all practice. As the philosopher Hans-Georg Gadamer observed, “Practice requires knowledge which means that it is obliged to treat the knowledge available at the time as complete and certain” ([The Enigma of Health](https://en.wikipedia.org/wiki/The_Enigma_of_Health), 1996, 4). And Pierre Bourdieu, master theoretician of practice, wrote that every practice “exclude[s] from the experience any inquiry as to its own conditions of possibility” ([The Logic of Practice](https://en.wikipedia.org/wiki/The_Logic_of_PRACTICE), 1990, 91). Some physicians know—and write—very well about the uncertainty of their knowledge. Yet even they become quite certain when they put on their white coats.

The obliviousness of practitioners to the grounds of their knowledge, even if unavoidable, is not a good reason to omit the philo-osophy of clinical medicine from medical educa-

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The erotic counter-movement toward self-transformation is important to recognize because Barbra and other theorists of eros usually ignore it, preferring to celebrate eros for its power to destroy bourgeois illusions, including the so-called illusion of a stable self. By contrast, anthropologist Helen Fisher melds neuroscience with mythic lore to suggest that both saves her from death and makes her immortal. It is this specific transformation—the moment when a mortal becomes godlike through the power of eros—that the neoclassical sculptor Antonio Canova represents: Venus, an unfulfilled mortal who avoids屈服 to the myth as expressing the soul’s desire for union with the divine. I read it differently, as reflecting the power of eros to redeem the loss and failure implicit in eros and in illness. Eros is both poison and antidote.

The myth of Cupid and Psyche is a paradigm in which radical loss and failure are linked to possible transformation. My experience suggests that transformation is not exactly the right concept, at least not if it denotes the attainment of a settled state. Eros and illness, I found, do not produce complete states but incomplete, tentative, brief transformations. Transformings—as a verbal noun—suggests ongoing, unfinished, fragmentary, even repetitive or circular activity, hard to live through but different from utter catastrophe and different, too, from emergence into a new, clarified higher state (like a butterfly emerging from a larva). Transformings, like healing, can occur in the absence of cure. The myth of Cupid and Psyche, then, might reward a sober revision in which loss and failure are not mutually exclusive, or denied with the promise of a miracle. A revised myth might honor the self-transformings (albeit uncertain, flawed, and incomplete) that lend to illness-inspired loss and failure an ethical dimension involving choice, action, awareness, acceptance, and deliberation, if unwanted, ways of being.

**AN ETHICS OF WAITING**

A bedside ethics of loss and failure—especially when expanded to the supra-dyadic circle of family caregivers—might consider the commonplace medical experience of waiting. Psyche is a mythic prototype in her years of waiting and wandering, but waiting as a trope for the existential despair that attends loss and failure. Postmodern waiting, however, is somewhat different. Amid the anxiety, disruption, loss, and failure of caregiving, writes psychiatrist and anthropologist Arthur Kleinman (a family caregiver too), is a “defining and perhaps a terminal” rule that both saves her from death and makes her immortal. It is this specific transformation—the moment when a mortal is governed by a single rule: Psycho must never see her winged husband, who visits her only after dark. The rule is impossible, at least for mortals, and Psycho’s failure breaks their union. Thereafter she wastes away wandering the earth in search of her lost husband. Finally, as she lies dying,9 a prophecy is spoken to her that both saves her from death and makes her immortal. It is this specific transformation—the moment when a mortal becomes godlike through the power of eros—that the neoclassical sculptor Antonio Canova represents: Venus, an unfulfilled mortal who avoids creased to the myth as expressing the soul’s desire for union with the divine. I read it differently, as reflecting the power of eros to redeem the loss and failure implicit in eros and in illness. Eros is both poison and antidote.

The myth of Cupid and Psyche is a paradigm in which radical loss and failure are linked to possible transformation. My experience suggests that transformation is not exactly the right concept, at least not if it denotes the attainment of a settled state. Eros and illness, I found, do not produce complete states but incomplete, tentative, brief transformations. Transformings—as a verbal noun—suggests ongoing, unfinished, fragmentary, even repetitive or circular activity, hard to live through but different from utter catastrophe and different, too, from emergence into a new, clarified higher state (like a butterfly emerging from a larva). Transformings, like healing, can occur in the absence of cure. The myth of Cupid and Psyche, then, might reward a sober revision in which loss and failure are not mutually exclusive, or denied with the promise of a miracle. A revised myth might honor the self-transformings (albeit uncertain, flawed, and incomplete) that lend to illness-inspired loss and failure an ethical dimension involving choice, action, awareness, acceptance, and deliberation, if unwanted, ways of being.

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Waiting as a philosophical theme involves complex reflections about time and duration.1 I propose a simpler distinction between transitive waiting (waiting for something) and intransitive waiting (waiting without an object or purpose). The residents I see almost daily at Ruth’s Alzheimer’s facility seem engaged in an intransitive waiting, with no aim or object, as they slump in a semicircle of overstuffed chairs. Are they waiting? Or have they entered a sedate-induced state of suspended animation? I don’t know how they experience their condition. Yet I too am waiting. I am not waiting for death to get better (which won’t happen) or to get worse (which will happen). I too occupy an intransitive state, without an object, without hope. Like Psyche I am on the go, engaged in nonstop para-medical management, so my intransitive state is more deceptive than Ruth’s. It would make more sense as accommodations for uncertainty—for oneself as well as those others. Teams and the contributions of their members would be better recognized; challenges up the hierarchy would be heard and rewarded. With uncertainty recognized as an insurmountable part of medical care, risk could be explained and rationally limited care might stand a chance in our do-everything culture. Above all, the shame of uncertainty would be learned.

Mistakes would be more widely studied; clinicians would read “Clinical Problem Solving,” the first-of-the-month section in the New England Journal of Medicine, with as much suspense-filled interest as the clinical-pathological conference it has replaced.

If physicians were taught to understand their own knowledge systems and thought processes, the ideal of “being scientific” that’s now used to reinforce thoroughness would be replaced by the ethical imperative to be thorough for the good of the patient. “Thoroughness” itself could be investigated: what is it and when is enough enough?

The culture of clinical medicine encourages skepticism, curiosity, and investigation. But epistemology needs to be added to etiology and epidemiology as a field of study. Until then the new, improved patients and physicians engineered for patient safety is like an excellent piece of hard-ware that won’t catch on until it finds its killer app. What’s missing is not a new label or a new procedure but a better understanding of how physicians think.
NEVER AN ORDINARY DAY: STRUGGLES OF A PERINATOLOGIST

Serena Wu, MD

Il prep the room before I call the family: I enlarge images of their fetus onto a 24'' screen, I put tissues on the round table, and I put a plasticine model of a brain dissected to the side so I can describe the pathophysiology of the defect when the time comes. The Smiths sit in the waiting room staring blankly at the TV. Today they've had an ultrasound, fetal MRI, and fetal echocardiogram. I'm one of many strangers this couple has to meet; but our meeting is the day's climax, the time when the pediatrician and perinatologist (a high risk obstetrician) will synthesize and distill all those test results. They look exhausted and apprehensive, but they smile tentatively as I usher them into the counseling room. Being a perinatologist is heartbreaking. I love giving my patients information and answers. It may be difficult to hear but it gives families the knowledge, and sometimes even the strength, to take the next step. I hate that too often I'm giving the diagnosis and offering no options. I'm usually the bearer of bad news, and sometimes pulling on her spinal cord, so her brain's affected. We felt so overwhelmed.

I review the day's radiologic findings with the family: “Ventriculomegaly.” “Myelomeningocele.” “V-P shunts.” “Open defect.” “Closed defect.” “Wheelchair.” “Leg braces.” “Incontinence.” “Intermittent catheterization.” “Bowel regimen.” “IQ points.” “Bell-shaped curves.” Drawings and a model seem to help, but I'm still not sure what they hear. For this family, I sense a lot of indecision and inner turmoil. Our doctor asked if we'd be interested in a repair. Open the uterus, cover the hole, close the uterus, and continue the pregnancy! Our hearts lifted a little. The pediatric surgeons step in. First he focuses on the technical aspects of prenatal surgery, then practical aspects like length of surgery, recovery time, complications for mother and fetus, and the absolute need for cesarean section for delivery. He discusses the research and outcomes for children with and without in-utero surgery. He states that this surgery is not a cure. It doesn't reverse what already has happened, the fact that the nerve tube didn't close and the spinal cord has been exposed to amniotic fluid. This couple is clearly looking for a miracle, but at what cost? I want to be sure Mrs. Smith doesn't compromise her health unnecessarily, and that she understands the risks of what she might be undertaking. I want to be realistic but hopeful. I emphasize that the bottom line is that fetal surgery is still considered experimental. I'm uneasy. It's hard to balance the difficulty and enormity of their decision making. Mrs. Smith's first pregnancy had been uncomplicated, this was going to be a little sister and their second daughter. After almost five months of carrying a pregnancy with many expectations and hopes, Mrs. Smith now faces an uncertain future. I present the options and attempt to be non-directive, but I don't think a physician can be truly objective and non-directive in counseling. We come to the table with our own morals and biases, our own life experiences, and our intimate knowledge of the physiology and how it impacts normal bodily functions. We also know about the worst of the worst scenarios. There are no guarantees until birth, only a range of possibilities, and we can't predict the impact each one will have on any particular family. No matter how many families I counsel, there is no way of conveying this intangible aspect. I can't predict the future, and I can't speak to the social, emotional or financial impact of their decisions.

So far we've been discussing quality of life in terms of the medical model, fixing physical problems to fit into society's understanding of "normal." I introduce a discussion that this fetus and pregnancy could be another version of functioning and try to juxtapose the concept of disability with the focus on correction and cure. It isn't an easy discussion. The Smiths are quiet as they look at me; I'm not sure if they hear me. Their questions about ambulation, incontinence, mental capacity and school leads me to believe they are really trying to fit this possible reality into their current life, and that makes sense—the families I see are generally focused on cure, not handicap. I'm not so different, years of medical training have taught me to think of the human body in terms of function and repair of functions to normal too. The mother I meet will usually sacrifice their health and body to achieve a chance of a cure. Acceptance of the disability usually isn't made until after all curative options are exhausted and it termination is not an option. Nevertheless, I feel a need to raise the "social model of disability" in this meeting. It may seem odd to the Smiths, they came to us to hear about repair. I feel off-kilter myself since they haven't made a decision yet. But if I don't raise it now, who will? Most medical offices aren't equipped to answer these questions or provide cogent answers. At the very least, we can provide resources and support if the families need information. It's exhausting. These counseling sessions weigh heavily upon me. My recommendations and description will influence a family decision that will alter their lives. I've never met these people before and this is probably the last time I'll see them. I usually get one snapshot of their lives and family dynamic, and one chance at a coherent explanation of what's going on. These strangers give me their trust, and in return I must use the power I hold responsibly and balance the mother and family's best interests. But what does that look like, exactly? I feel conflicted because the entire day's focus is on the problem, its diagnosis and solution. I am not sure how to shift the focus beyond the "problem" and focus on the child.

Before the Smiths were able to decide on fetal surgery, that "middle option" was taken away from them—they didn't qualify for the trial based upon the prenatal diagnostic images. Maybe that was devastating, maybe having one less decision to make it easier—I wish I knew. Parents come to me in varying degrees of understanding and denial. They come for hope (maybe the initial diagnosis was incorrect), for confirmation, and for the possibility that "something" can be done. I've counseled over a hundred families, and I still can't imagine how my husband and I would react in the same situation. All I can do is continue to grapple with this quandary, and work to help families come to an understanding that encompasses all views, so they can make a truly informed choice.

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Wrecked marriages aren’t restricted to the medical profession, in real life or in novels. However, fictional physicians seem to be particularly exposed to marital unhappiness. In fiction a disproportionally high prevalence of infidelity is almost a side effect of the Hippocratic oath. Whether it’s a consummated betrayal, as in most of the cases, or simply an unfulfilled desire, as in Schnitzler’s Rhapsody: A Dream Novel (1927), the betrayed doctor is so recurrent a character as to approach the status of literary topos. The theme of betrayal, which transcends historical and geographical boundaries, often comes to constitute the very dramatic core of the story.

The infidelity of the physician’s wife in modern literature is not always due to boredom or caprice. Often the physician’s wife really falls in love, and often it’s with a man representing the very opposite of her husband’s professional and character attributes. It’s common to find that the rival is an artist or an intellectual, or at least a histrionic personality, counterbalancing the scientific and human phlegm of the physician. The instances of a doctor and a writer competing for the same woman are rather suggestive, and they provide an example of the literary representation of the rivalry between the “two cultures” of science and the humanities.

Don’t be misled—erudition doesn’t automatically grant the fictional doctor immunity to adultery, or guarantee marital happiness. Suffice it to think of Dick Diver in Scott Fitzgerald’s Tender is the Night (1934), or of Dr. Jevad Urbin in García Marquez’s Love at the Time of Cholera (1988). Moreover, the fictional character of the doctor wasn’t always sketched as a rough alternative to the man of letters. As Solomon Posen emphasized in The doctor in literature: Private Life (Radicliffe Publishing 2006), “authors of fiction portray both versatile and unidimensional doctors, contrasting the surprising erudition of some members of the profession with a total ignorance of non-medical topics among others” (p 140). However, although numerous and meaningful counterexamples can be counted, generally speaking, as Posen puts it, “the scholarly physician predominates in the nineteenth century, the ignoramus in the twentieth”.

In the twentieth century the character of the cultured family doctor is often replaced by the literate but competent technician, endowed with diagnostic acumen and refined ability. Such a combination can be found in the famous character of Dr. Cottard of Proust’s From the Days of My youth (1919), who can be considered the archetype of the professional success of ignorance. At first sight, this new typology of doctor can afford (quite unlike his nineteenth century predecessors) even a complete ignorance in the humanities without this lacuna seriously diminishing his diagnostic and therapeutic abilities, almost to the point of suggesting an equation between lack of wider cultural interests and clinical skills.

In Medical Humanities circles the instrumental role of a literary education for medical students and doctors is often justified by the argument that it enhances the capacity for identification and empathy, thus positively contributing to the doctor-patient relationship. If, as I suggest, we consider love affairs as a most symbolic kind of empathic relation, involving care and moral identification, then a closer analysis of the marital destiny of some fictional doctors might provide material for discussion about the usefulness of humanistic values to medicine. To this end, I’ll focus on three books, belonging to three different geographical areas and centuries: Gustave Flaubert’s Madame Bovary from 1857 (Wordsworth, 1993), Sinclair Lewis’ Martin Arrowsmith (Jonathan Cape 1925), and Ian McEwan’s Saturday (Jonathan Cape 2005).

The common denominator among the three doctor-protagonists of these novels is that they are all professionals who illustrate Posen’s figure of “the ignorable.” They all have a deep ignorance of non-medical subjects, if not a patent aversion for culture in general and literature in particular. It is no minor detail that Madame Bovary begins with Charles Bovary’s disastrous scholastic exordium, and that Flaubert repeatedly insists on the meagre culture of this doctor, not only fatally incompetent but also deeply ignorant, whose “volumes of the Dictionary of Medical Science, uncut […] occupied almost alone the shelf devoted to the medical bookcase” (p 25). On the contrary, his rival, the young and brilliant Leon, shares with Emma Bovary the passion for novels and music. It’s no surprise that the formal changeover between Charles Bovary and his wife’s lover takes place at the opera, where the doctor shows all his embarrassing cultural inadequacy. In Charles Bovary this inadequacy immediately translates into psychological insensibility, and his inability to intellectually stimulate his wife translates into the inability to understand, cure, and finally save her from suicide.

Quite unlike Charles Bovary, Martin Arrowsmith, the main character of Sinclair Lewis’ homonymous novel, is a brilliant scientist even though he cannot be defined a good doctor. Like Bovary, he shares responsibility for the death of his wife. Dr. Arrowsmith’s marital relation can be considered idyllic, but the superficiality that characterizes Arrowsmith brings him to the fatal error that will cost his wife her life. In Lewis’ book, the relation suggested by the author is not that between culture and psychological subtleness. The relation is that between a more versatile education and the insufficient moral imagination of the protagonist. In Arrowsmith the betrayer is not the wife but the doctor, who, for the sake of flattering the woman who later becomes his second wife, abandons the first to the atrocious sufferings of plague and, finally, to death. Few would disagree with Frank Palmer’s statement in his literature and Moral Understanding: a Philosophical Essay on Ethics, Aesthetics, Education, and Culture (Clarendon Press 1992) that “a man of fine artistic sensibilities may, in other respects, remain a swine” (p 240), but Lewis himself seems to suggest otherwise by repeatedly insisting on the ignorance of Dr. Arrowsmith’s character. Lewis describes Arrowsmith as “half educated.” He was supposed to be a college graduate but he knew nothing of economics, nothing of history, nothing of music or painting. Except for hasty bolting for examinations he had read no poetry […] and the only prose besides medical journalism at which he looked nowadays was the baseball and murder news in the Minneapolis papers” (p 185).

The humanistic education of the neurosurgeon Henry Perowne, the main character of Ian McEwan’s Saturday, is also remarkably defective. However, whereas Arrowsmith takes some timid step towards improving his general culture in the course of the novel, Perowne is an unrepentant illiterate. He thinks openly, and not without some pride, that “he has seen enough death, fear, suffering and courage to supply half a dozen literature” (p 6). In this case, as in Arrowsmith, it is the atrophied imaginative capacity of the doctor that puts his wife’s life at risk, as well as that of his whole family. It is Perowne’s lack of identification that leads him to publicly humiliate a dangerous neighborhood bully, who takes Perowne’s entire family hostage for revenge. His vast neurosurgical skills will not provide any remedy against that. It will be poetry, instead, to move and disarm the aggressor. Moreover, it will be a poem enounced by Daisy, Perowne’s intellectual daughter, upon suggestion of her grandfather, a famous poet named “John Grammaticus.” It might be a simple coincidence, but the fact Daisy insists her father read Madame Bovary seems to me an intriguing coincidence: “Look at your Mme Bovary again”–she says. “[Haufert] was warning the world against people just like you” (p 68).

In Jane Macnaughton’s essay on McEwan’s book, she argues “Saturday does not make a convincing case for the efficacy of a literary education for doctors” 1 . I do not fully agree. Wider understanding of culture may not have affected the clinical competence of the physician protagonists; it is difficult to maintain that reading Shakespeare would have improved their professional results. However, in all three cases a better cultural sensibility would have endowed the doctors with better analytic and interpretative skills. A more refined capacity for interpretation and identification probably wouldn’t have helped save more patients, but might have saved their marriages and, what is most important, their wives’ lives.

“Books are the ‘password’ for getting better than we are,” George Steiner wrote. Precisely — they are just the password. The correct pronunciation of the shibboleth is not a guarantee for the pronouncer’s identity, and erudition is not a guarantee for a better caring. Literature constitutes only a supply of culture may not have affected the clinical competence of the physician protagonists; it is difficult to maintain that reading Shakespeare would have improved their professional results. However, in all three cases a better cultural sensibility would have endowed the doctors with better analytic and interpretative skills. A more refined capacity for interpretation and identification probably wouldn’t have helped save more patients, but might have saved their marriages and, what is most important, their wives’ lives.

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