

Medicine, the body, and an invitation to wonder

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There is, I think, a resonance between being a patient and having a greater sense of wonder at things in the world around us: a sense of wonder at things that become, briefly and intermittently, intensely and newly-present. As with experiences of art, or of humour, or of love, or of strong ethical motivation, in experiences of wonder it seems to me that we live more intensely. And if it is a good thing to live, then perhaps living intensely may, while it lasts, be an intensely good thing. In this paper I will try to reflect on this resonance within my personal experience, within the context of a number of related undertakings. These are as follows:

- to argue that there is something enduringly and inescapably wonderful about the challenge facing the clinical medical practitioner;
- to disclose something personal about myself as a patient within primary care;
- to recognise the wonder of our embodied state;
- to review the importance of a sense of wonder for doctor and patient alike;
- to argue for a reassessment – and a reassignment – of the moral centre of gravity of clinical medicine;
- to consider whether an ethics grounded upon wonder is compatible with virtue ethics
- to explore aspects of wonder and suggest future research; and
- to sketch out how a sense of wonder at our mortality – our finitude – helps us all in acknowledging and responding to ‘the lives of others.’

These undertakings cumulatively constitute the ‘invitation to wonder’ that I would like to issue.

1. to argue that there is something enduringly and inescapably wonderful about the challenge facing the clinical medical practitioner

In medical practice, where the existential as well as the material grounds of patients’ experiences of health, illness, disability and mortality are equally prominent and equally precious, clinicians have a characteristic form of contact with their patients that, to me as a layman and as a patient, seems to be both an unparalleled richness and a form of liability.

I realise that clinicians see their patients in a bewildering variety of ways, of course, but clear patterns emerge of a kind of relationship that, especially in general practice, is both long-term and episodic, whilst still being often intense at intervals. Perhaps it is general practice medicine that most frequently exhibits these specially interesting characteristics of the doctor-patient relationship in primary care, since most clinical encounters occur within the context of general practice medicine, the entry-point for specialist consultations and treatment courses. As patients – at least, traditionally – we imagine that our GPs are familiar with us to a degree that is made possible only by their disregarding the other two thousand or so patients with whom we share them. Moreover we may expect that their knowledge of us concerns not only our medical

history but also the other things in our lives that shape how we fall ill, and shape our hopes of recovery. We are in some ways rather like the GP's pen-friends, correspondents, from whom they hear now and again, without warning, but with every expectation that we (and our families, and our emotional turmoils, and our thwarted ambitions, and the daily demands upon us) were precisely on our GP's mind just when our letter arrived, and that as result she or he can renew the acquaintance, intimately and in full, just where it left off last time.

This is perhaps an exaggeration but it is not essentially untruthful, I think. It is somewhat paralleled by the engagement sought from other health professionals with responsibility for 'longitudinal' care, particularly if that care be episodic in nature (as for instance in the management of respiratory or neurological conditions). However for most patients most of the time, it is to the GP that one first turns – largely, or entirely, as-yet-undiagnosed. In short, clinicians providing 'longitudinal' care, GPs prominent among them, have both the stern challenge but also the extraordinary privilege of being invited *to live alongside the lives of others* – to glimpse the unfolding interiors of those lives over time, and to make intelligent contributions to the way that they are lived in relation to whatever these 'others' – that is, you and me as patients – interpret as health and sickness, suffering and disability, finitude and mortality. And this brings me to my first brief reflection on wonder and wondering, in relation to medicine and the body. Here I am setting the scene in relation to doctors' engagement with the many aspects of 'the lives of others.'

Wonder, wondering and states of wonder are among life's joys. Like humour, health, music or poetry, wonder requires no justification; but unlike them – unlike even health – we do not ourselves *make* wonder: rather we stumble upon it. Wonder is, I propose, a transfiguring encounter between ourselves and the world, under some aspect that we did not expect, or did not fully understand, or did not know we knew until then. While wonder lasts, the world is subtly changed, or we are changed, or both. If in its larger sense 'health' refers to a life that goes well, years to which life is added, then in that larger sense wonder upholds health. Confronting something wonderful, our sense of ourselves is suspended and we become intensely mindful of the thing wondered at.

In his poem 'Ambulances' Philip Larkin's gaze alights briefly upon a form of wonder at our own mortality – a wonder that is shaded simultaneously with understanding and terror: children catch sight of the white 'wild' face of someone desperately ill being stretchered into the back of an ambulance before being driven off; they momentarily glimpse our – and their – finitude...

And sense the solving emptiness
That lies just under all we do,
And for a second get it whole,
So permanent and blank and true.[1]

Wonder illuminates some of the most intense aspects of living – and dying – and the habit of being open to its illumination would I believe be valuable in any area of clinical medicine – and perhaps especially so in general practice. As I will suggest in more detail later on, a sense of wonder offers a more generous source of ethical regard towards the patient than does, say, respect for rational autonomous choice-making. A sense of wonder can help sustain the clinician and defend her against the numbing effects of excessive routine and the commodification of healthcare. Virtually nothing is more worthy of wonder than human embodiment; rarely is that particular wonder more intensely at stake than in sickness and recovery; this is particularly important in our relationships as patients with our general practitioners, our family doctors – who

somehow must somehow support an engagement with how we patients run the courses of our lives, and confront our mortality and their finitude.

Apart from anything else, that mortality, that embodiment and that finitude are also the doctor's own.

2. to disclose something personal about myself as a patient within primary care

I am not a doctor or a scientist of any kind, but from time to time I am a patient. And – as I've got older – I realise that from time to time I am also a wonderer, and I shall say a little about both of these credentials.

I once caught an alarming glimpse of my GP's notes about me; I just managed to see the beginning of a sentence 'Patient has a long history of...' but the file was whisked away from view before I could read on. My own view of myself is of an unremarkable patient with an unremarkable 'career' of health and illness, and (I previously imagined) with no 'long history' of anything remarkable worth medicine's attention. And yet, remarkable or not, from time to time the *wonder* of human embodiment in general has been borne in upon me in my own case. By this, I mean the relationship between the fabric of our flesh, and our experience of the world. When we pause to reflect, it is exactly this relationship that lies at the core of our concerns with health and illness. We do not generally go to the doctor unless there is an unwanted change or impediment in the way that we experience the world and ourselves within it. Symptoms are after all precisely *alterations in experience* that are unexpected, or unexplained, or unwanted, or un-ignorable, or all of those things.

A few of these 'alterations in experience' stand out in my mind. When I was a young lecturer I persistently suffered from anxiety speaking in front of an audience – rather inconvenient for the role. It was fashionable at the time to prescribe beta-blockers to dampen down some of the physical symptoms of anxiety without apparently harming performance. I have never suffered from hypertension, which at the time was the primary indication for beta blockers, so it was curious to find pharmacologically active medicine being prescribed for a strictly existential problem – the problem of being uncomfortable in one's professional role. It is easier to be clear about the validity of prescribing direct-acting medicines to control the gastro-intestinal symptoms of anxiety, or indeed direct anxiolytics. While such substances are acting upon us, they are also quietly provoking the metaphysical mystery that fuses flesh and experience – that unites passion with our clay, as William Blake might have put it.

I have been seriously ill only once in my life so far – with pneumonia, some ten years ago. It was misdiagnosed at first, and I was really quite ill before someone recognised that I needed a chest X-ray. I had found myself increasingly unable to utter a complete sentence without coughing; the act of coughing had become both painful and terrifying. Thankfully, once recognised, the illness was treated fairly straightforwardly and I recovered fully. For me this was the most dramatic demonstration of illness, and of medical intervention, as alterations of experience. Illness transforms the world; its capacity to do so also provokes wonder, albeit of a shocking kind. It reminds us how in times of health we regard our bodies as accessories; when we are ill this fragile conceit is no longer available to us – we *are* our bodies, come what may.

A further example is both trivial but, in its way, metaphysically the most troubling. I was a few years ago obliged to undergo colonoscopy. The requirement for an aware patient, responsive to instructions, rules out ordinary anaesthesia; the procedure instead requires midazolam which sedates, and produces amnesia, but leaves the patient in a

curious state of present consciousness. In my own case I experienced the event as a completely continuous conversation – with the surgeon prior to the investigation, and with a nurse in the recovery room afterwards – but miraculously joined end-to-end with nothing, *absolutely* nothing, in between. I asked a question of the surgeon, received an answer, was asked a question by the nurse, and responded in time – as though these were consecutive elements in seamless thirty-second discourse. What had happened to me during the intervening forty-minute procedure remains as obscure to me as does the status of whatever ‘me’ it was who persisted during that period of conscious oblivion.

This is not the whole of my medical history but I have left out nothing interesting to medical science. It is an unremarkable history, and it does not qualify me to speak with any authority about anything scientific or medical; but it has enabled me from time to time to connect personally with those standard questions about patient-hood, compliance, consent, authority, vulnerability and responsibility that occupy so much of the philosophy and ethics of medicine. More particularly, it has – on reflection – offered me a series of intimate reminders about the mystery and wonder of our embodied state. It is with these rather modest credentials that I will turn not to recognising the wonder of our embodied state, addressing the third of my undertakings.

3. to recognise the wonder of our embodied state

Think for a moment about the resting state of ordinary being – doing, feeling or thinking nothing in particular, awaiting the next thing to think or do but not yet engaged or embarked, twiddling our thumbs. In such a state we are aware, if we choose, of our bodies as it were idling, in ‘neutral gear,’ sensing briefly what Rene Leriche called ‘the silence of the organs.’[2] In such a state the extraordinary phenomenon of simply being alive, and of the ascent of experience from the preposterous physico-chemical cornucopia of organised flesh, swims into view momentarily, and if we are even half-alive to the prospect we must surely gasp.

For at all other times, we accept without question the synthesis of sensory experience with the scope of bodily action and inner, ‘blindfolded,’ proprioception: somehow are brains orchestrate this into a symphonic unity of experience, yet we can have no awareness of the processes involved. The textures of chalk or shell or bark or steel, the taste of almonds, the filtered light of woodland in fog, the yelp of a braking vehicle or the ‘velvet diapason of the Wagnerian orchestra’[3] – even the last of these approached only remotely and crudely in verbal description – have a living immediacy for us in sensory experience that is as un-ignorable as it is ineffable. Somehow our sensory experience is unconsciously integrated into a single symphony – without our having the slightest sense of authorship or composition. Somehow we fall asleep every evening, and every morning we awake to re-join that self-same symphony.

Equally, our plans and purposes are attempted through deliberate willed action, which we experience as ordinary, largely thoughtless, movement – known by us directly in a way that is hidden from others whose own actions are in turn known directly by them alone, merely observed by us. How is the intention to turn my present thoughts into words on a page actually accomplished? I cannot understand, still less describe, the processes connecting thought and muscle; yet I could achieve not a single keystroke without taking those processes utterly for granted. (Indeed, as is well-observed in the case of riding a bicycle, *not* taking them for granted and concentrating on them too analytically is usually disastrous.) I cannot understand it – but from time to time I cannot avoid reflecting on the inexpressibility of my own willed actions in a material world. Recalling, as science tells us, that every atom of calcium in our bodies was once ejected

from a distant sun,[4] I cannot help from time to time wondering at what it is for this infinitesimal fraction of the material universe, this contingent assembly of energy and particles that is my own person amid myriad other such persons, to have such an experiential interior and, without understanding, nonetheless to know that I have it.

Is there a greater glory or wonder in embodied experience than this? – the sheer impact of encountering for ourselves our own capacity for experience writ large, written as it were by our own bodies but by means that are forever hidden from us, yet somehow inscribing all that we do or think or feel.

4. to review the importance of a sense of wonder for doctor and patient alike

The deepest questions about our nature have existential and ethical dimensions as well as material dimensions, what is true of our nature in general may – must – also be true of our *ills* in particular. I would suggest that clinicians may understand our health and illness better by embracing from time to time these same existential puzzles concerning our nature, especially in routine clinical life with its unremitting, but unglamorous and unsung, demands.

In these contexts the phenomena most apparent to the doctor – a succession of patients mostly with routine signs, symptoms and stories – do not seem remarkable or even unusual; they provoke little surprise, they will be increasingly familiar as the doctor's experience lengthens, and they gradually constitute the 'staple diet' of the doctor's work. In precisely that guise, they bring challenges.

What I would call the 'small change' of ethical obligation in clinical life is also its most pervasive aspect and, probably, its toughest yet most important challenge – to sustain sensitive, well-attuned, dignified and respectful attention to that unrealistic surfeit of patients that is the typical case-load, especially in publicly-funded and under-resourced healthcare. The wonderful nature of our bodily constitution is of course the arena of the ills and ailments that produce this case-load; yet perhaps it is also the clue to the clinician's ethical response: however challenging, however impaired, however lacking in capacity, or compliance, or responsiveness, or even civility, all patients share the full complement of bodily wonder. An unmanageable case-load sorely constrains the opportunity for wondering reflection of course, but if respect for patients can be vested at least partly in the respect for the wonder of embodiment, then it is better-proofed against, first, the challenging range of individual patients' needs and attitudes and, second, the inevitable vagaries of clinicians' own responses, human like the rest of us. This is possible precisely because sense of wonder involves our attending to something for *its sake*, and not for our own – it is inherently other-facing, and as such a possible source of ethical regard.

Beyond this, a sense of wonder animates the imagination, helping the clinician to see beyond familiar patterns – recognising them but not chained to them, being guided by the accumulation of related cases but free to see what is crucially (perhaps vitally) different about the ostensibly-similar patient being diagnosed right now. As I have elsewhere put it, 'The doctor's ability to see new patterns – a key basis, surely of hypothesis formation – has its edges sharpened by co-existing with a sense of wonder.'[5]

An openness to wonder at embodied human nature draws the doctor and the patient closer together, recognising that they share the same extraordinary basis for their experience, their actions, their purposes, and their vulnerabilities. This is both a consolation and an inspiration, but it also brings the responsibilities very close to home:

the patient's sickness and fragility are, on another day, the doctor's too. Like all other human agency, the doctor's agency is also an embodied one.

But what of the *patient's* sense of wonder? This question has been raised explicitly by a rather noted patient – the sociologist Arthur Frank whose encounter with cancer prompted him to recognise and develop his own sense of wonder at human embodiment. He contrasted what he called an 'ideal of wonder' at the body with professional medicine's 'ideal of control' of the body; control, he saw, was frequently unattainable in medicine, yet wonder was always possible, and the patient who could 'focus on an ideal of wonder in place of control' might find that 'living in a diseased body can recover some of its joy.'^[6] Wonder then takes its place among other, arguably more familiar, sources of joy such as laughter, imagination, kinship, friendship, intimacy, beauty and so on, inasmuch as a life in which wonder is possible is preferable to one in which it is not – wonder is part of what a flourishing life consists in.

Now of course the notion of an 'ideal' of wonder carries with it some exhortatory burden, as if the attitude of wonder were something for which we *ought* to strive, and which we could attain if only we tried hard enough. Yet, odd though this sounds, I think there is truth in it. Notwithstanding the societal inequalities and injustices that will so often constrain the attempt, in principle we can at the least try to cultivate an openness to being intelligently aware of what is around us and within us, particularly of that which we ordinarily take for granted – the grounding of our own willed actions, for instance, or the basis of our own continued conscious identity through profound bodily change over time. If doctors and – so far as it lies within their power to do so – patients alike do this, then they share the sense of the gravity of what it is to grapple with and attempt to relieve suffering: the clinical encounter can become an occasion of greater mutual respect (even – or perhaps particularly – when the patient's and clinician's initial views diverge), of greater imaginative possibility, and of what I have called a 'more strongly shared commitment to the clinical endeavour.'^[7]

5. to argue for a reassessment – and a re-assignment – of the moral centre of gravity of clinical medicine

I have already touched on this in considering the doctor's engagement with wonder, but I would like to emphasise it again because I think it is important, and overlooked. I spent the early part of my professional academic life in teaching topics in medical ethics, mostly to clinicians, but I became disillusioned with doing so. As a patient, or even as a citizen, I was entitled to my views on moral questions in the context of health and medicine – but as a philosopher I increasingly felt that I had no expertise or authority of any moral kind.

As Jonathan Miller has observed, we all have PhDs in ethics, and he had a point. We learn moral judgment and responsibility through living, not through reading books – although we may perhaps become more richly aware of our responsibilities through reading and reflection. Generosity and compassion are made more powerful by a penetrating imagination. Unfortunately someone who is manipulative or spiteful will also find ways of being more effectively manipulative or spiteful if they develop their understanding of others through reflective reading. I did not see how philosophy could be of much help in fundamentally altering people's moral instincts. Bryan Magee, in his otherwise-comprehensive philosophical autobiography *Confessions of A Philosopher*, says nothing of substance about ethics. The reason, he admits, is that he thinks philosophy has offered him no help. He didn't need philosophy to tell him what he ought

to do – he knew it full well on his own. But that was never the difficulty. The hard part was not knowing what to do, but doing it. And philosophy couldn't tell him that.[8]

There has been a second problem in formal medical ethics teaching, I would argue. The typical medical ethics syllabus at one time concentrated too much on the extreme challenges posed by radical new technologies – multiple organ transplants, gene therapy, artificial prolongation of life, paediatric intensive care – and the questions they appeared to pose concerning the limits of personhood. These make good topics for heated debate, they feature endlessly in the media; and they must be addressed by law and regulation to protect relevant groups of patients and the comparatively small number of clinicians engaged in such specialties. But they are not representative of what most doctors face in their everyday work. As we noted above, the clinician's toughest daily moral challenge is to treat every patient with the fullest respect and compassion, regardless of the characteristics of the patient and regardless of the limits on medicine's ability actually to resolve problems that are in part existential and not simply biological. In publicly-funded healthcare systems, this must be done while under endless, grinding pressure to deal with far more patients than it is reasonable to expect or possible to satisfy. In general practice, this is still-further intensified by the patients' expectation that their doctor have a personal as well as a scientific knowledge of them.

How does an openness to wonder help the doctor here? I have already suggested that a respect grounded in the wonder of embodiment is a more generous and less discriminatory alternative to the familiar medical-ethical grounding in autonomy. After all we are variously rational, but we are all wholly embodied. Moreover, in an attitude of wonder one is outward-facing, and self-diminishing – concerned for the object of wonder for *its* sake, not for one's own. This is I think a good basis for humility, and few professions would be very much harmed by making more room for humility.

I think a sense of wonder also gives us permission to pause and be mindful, and listen attentively – instead of rushing in to *act*; 'Don't just do something – stand there!' as the famous witticism has it. We are gripped by the will-to-act, especially in such agent-centred contexts as liberal industrial societies, and this is at least as true for doctors as for patients or citizens at large. The attitude of wonder invites a preparative pause – *before* trying to understand and intervene – and this involves an implicit recognition of the limitations of the self and of one's own agency. Together these features of the attitude of wonder offer a good foundation upon which to build what I have (with Jane Macnaughton) elsewhere termed the 'cool intimacy' of the dispassionate physical examination in the clinical encounter.[9] This too contributes a further aspect to what I would like to see as the re-grounding of medical ethics.

6. to consider whether an ethics grounded upon wonder is compatible with virtue ethics

It was Ronald Hepburn's 1984 essay 'Wonder' that really prompted recent discussion of wonder's relevance to ethics. His insistence that 'The attitude of wonder is notably and essentially *other-acknowledging*...' [10] announced the first of four 'ethical affinities' – the others being compassion, gentleness and humility – that have found favour in, for instance, feminist ethics [11] and environmental ethics. [12], [13]

More particularly, these 'affinities' are also recognisably modern *virtues* – particularly in the clinical context – so perhaps a habitual openness to wonder, too, might qualify as a virtue. Kathleen Moore takes this very possibility seriously in her acute and tender homage to environmentalist Rachel Carson. Noting that 'the moral significance of wonder goes beyond its instrumental value,' she declares:

I think that a sense of wonder is a virtue in at least this sense, finding what it means to be fully human in a celebration of our place in the more-than-human world. [14]

Although contexts are not interchangeable, perhaps for the clinician too an openness to wonder might be the *source* of an ethic, for instance what it is to develop a flourishing life. Consider this from Jane Bennett, concerning the *cultivation* of a virtue:

... the more aware of wonder one is – and the more one learns to cultivate it – the more one might be able to respond gracefully and generously to the painful challenges posed by our condition as finite beings in a turbulent and unjust world. [15]

This sounds very much like the formation of a virtuous character (and such cultivation is part, after all, of the attraction of virtue-ethics). The upright, flourishing, ethical life is learned by example and through imitation. Yet ultimately, for virtue ethics, doing the right thing should also *feel* right to us: we should *incline toward* doing it, it should ‘come naturally’ to us, by developing the right habits of thought, action and attitude over a lifetime.

Now to my mind there is a pitfall here. Inclining towards something, feeling right about it, seems to tempt some writers on virtue ethics to ground their moral dynamic in *emotions*. For instance, Howard Brody asserts that

... relative to virtue ethics, emotion plays a role in the manner in which one carries out an action, and often that determines the sort of action that it is – a kind or compassionate act is an act which is carried out in a certain emotional state. [16]

Rosalind Hursthouse appears similarly convinced – to the point that, in deriving from Hepburn’s pioneering essay the notion of wonder as a virtue, she uncritically and quite erroneously imputes to Hepburn the view that wonder itself is an emotion. For instance:

The interesting question for virtue ethics is whether the *emotion of wonder* might resemble the emotions of fear and anger in being one whose correct orientation amounts to a virtue. ... If Hepburn is right, *this emotion* can be felt in accordance with, or contrary to, reason just as fear and anger can. [17]

Actually Hepburn says nothing about emotions; he simply analyses wonder as a *concept*. Even if any of the usually-acknowledged virtues is plausibly regarded as an emotion, I doubt that wonder could be simply added to their number in this respect. Wonder is a vibrant response, an openness to wonder is an attitude and a disposition, but these are quite different from emotions.

Another difference between an ‘ethics of wonder’ and virtue-ethics concerns the Aristotelian notion of a mean, a moderate disposition that lies between two extremes. But in what sense – and between which extremes – might an attitude of wonder be ‘moderate’? *Experiences of wonder* can carry a kind of temporary exaltation, after all: the very title of Jerome Miller’s *In the Throe of Wonder* begins from this recognition.[18] Jan Pedersen [proposes a ‘balanced sense of wonder,’ a reflective disposition contributing to a flourishing life.[19] He distinguishes between deficient wondering (the inability to look beyond one’s preconceptions and assumptions), and excess wondering (addictive indulgence in the exaltations of wonder). The deficit leads to a life that is drab;

the excess puts at risk what Alasdair MacIntyre calls the ‘narrative order’ of a human life, both across one’s concurrent roles and along the length of a life lived well:

In what does the unity of an individual life consist? The answer is that its unity is the unity of a narrative embodied in a single life. To ask ‘What is the good for me?’ is to ask how best I might live out that unity and bring it to completion. [20]

The unity comes in part from the growing constancy of our attitudes and dispositions, and we have a choice to make:

The virtues therefore are to be understood as those dispositions ... which will furnish us with increasing self-knowledge and increasing knowledge of the good. [21]

Wonderment in excess seems unlikely to bring this about.

Where does this leave us? On the other hand it seems wholly reasonable to see in someone’s openness to wonder a disposition to perceive the world anew, and to seek that disposition for oneself and encourage it in others. There seems no reason not to regard it as a virtuous disposition, but whether it offers grounds for recruiting wonder into an ethics of virtue is another question.

Following Hepburn, I have conjectured wonder as ‘an ethical source,’ [22] but a source is neither a system nor a theory. Is an openness to wonder a virtue in the clinical context (or anywhere else)? Yes, quite plausibly it is. Could there be an ‘ethics of wonder’? Perhaps. But these are separate questions, and affirmative answers to both would still not make an ‘ethics of wonder’ into a form of virtue-ethics. Whether we can say more than that an ethics grounded upon our openness to wonder may be compatible with virtue-ethics is, I think, as yet unresolved.

7. to explore aspects of wonder and suggest future research questions

Relatively very little has been written about the philosophy of wonder in relation to medicine, and so I will now outline some questions that I propose to pursue in the future – questions that are of interest not only to philosophy but also to many practitioners in medicine, perhaps particularly in primary care.

What, if any, is the legitimate role of an attitude of wonder in scientific enquiry and understanding?

This is where we must be very careful to distinguish between wonder and curiosity. When curiosity leads to knowledge, the knowledge replaces the curiosity. But when wonder leads to the desire to understand, I believe that the wonder can persist – and may even be intensified by the understanding. The human body is surely *more* full of wonder, the more that we learn about how it works. Earlier I referred to an openness to wonder as a source of creative imagination and sharpened sensitivity in clinical diagnosis. This may have a useful counterpart in theory formation in medical science.

How do we relate wonder at the majestic (say, a comet) with wonder at ‘the everyday’ – for instance, the persistence of kindness and unselfishness in the absence of any acknowledgement?

If the world is made newly-present to us as a result of our encounter with either the majestic extraordinary, or the newly-revealed ordinary, then I think it is legitimate to regard both as transfiguring experiences. In general practice, would one patient's unexplained and dramatic recovery, or inspirational courage, tend to distract the doctor's attention from other more mundane or routine cases? I suggest that in science, philosophy and medicine alike, practitioners need to understand the relation between the dramatic and the ordinary in ways that allow them to do full honour to both.

How can we talk about our – or others' – experiences of wonder with any hope of shared understanding?

It seems plausible to suppose that this problem is related to that of talking about aesthetic experience, and of finding out whether we really do share an experience of, say, a piece of music or of abstract painting. It is surely an intense part of entering into the lives of others that we seek ways to enter into their experiences of art, or beauty, or ethics, or comedy, or wonder. And in general practice, it might sometimes be therapeutically – or even diagnostically – helpful to know exactly how far doctor and patient share meanings and descriptions of experiences that may be very intense.

How do we understand the relation between experiences of wonder and mystical or religious experiences?

This is a question to do with how seriously we take people's descriptions of their experiences. Like it or not, descriptions of overtly-religious experience are too-easily dismissed by others as incomprehensible or even, especially these days, divisive. Accounts of experience that are grounded in religious terms may too-easily offer us an excuse not to listen or to take seriously what may be in other terms – philosophical, ethical, even diagnostic– significant moments in someone's self-understanding.

How can medical science make responsible enquiries into a neurological framework that supports wondering experiences?

This is, for me, a question fraught with difficulties. As a musician I have sometimes fallen into despair at some of the things said about the supposed neurological basis for musical experience. If music were nothing more than a set of stimulus-responses, if it were to truly be 'explained' as *consisting* in neurological arousals, then I and many readers would have wasted a good part of our lives, and Mozart would have wasted all of his. Of course I do not believe anything of the sort – and I do wonder whether even the popularisers of neuroscience can really believe it either. However the danger is obvious enough. It would be interesting to know whether a persistent or well-developed capacity for wondering experiences has any other functional associations, or any diagnostic value. I am sure that someone will look into this – and it would be fascinating to know what they discovered. However I also hope that they will make sure that neuroscience is kept safely within its limits of authority while the investigators consider the implications of their findings in *experiential and existential terms*.

And, What would it be like to live in a world without wonder?

There are many ways of asking this question. Perhaps it might be best-asked if grounded in a specific way of life: indeed, perhaps I might begin by asking – with the help of

medical colleagues – what it would be like to engage in medical practice without wonder...

and finally...

8. to sketch out how a sense of wonder at our mortality – our 'finitude' – helps us all in acknowledging and responding to 'the lives of others.'

Wonder allows us, I suggest, to look differently upon our mortality, upon the limits, the finitude, of living a mortal life – whether as patients longing to get better, or as doctors (mortal themselves) longing to help secure recovery for their patients.

No doubt there are many ways of learning how we share in humanity's general fate of finitude and mortality; looking into the bathroom mirror every morning is certainly one of them. Yet perhaps acknowledging our finitude is the first step on the path of coming to terms with it; and prognosis in illness is an effective prompt to doing so, whether one is offering the prognosis as a doctor, or receiving it as a patient. As we get older, or as we brush more closely against illnesses that could one day be serious, we become more conscious of our finitude. Gradually we understand that we have more reason to wonder whether that finitude is total; and we become more conscious that the story of finite mortal existence is our story, too. We are, after all, born with an indeterminate sentence of death.

How does this matter, and how are we to understand it? Earlier I described the complete eradication of a piece of my life by strong sedation, with what happened during it reduced to absolutely nothing, not a gap, not even an emptiness. It was what I am tempted to call an 'experientectomy.' Death is, I suspect, more easily understood in relation to this than in relation to sleep. (Herbert Fingarette observes that sleep is in fact a poor metaphor for death.[23]) We walk and act, think, work, write, hope, sing, love, and wonder, all within that temporary fragile bubble of conscious experience that we presently inhabit. In the vast eternity of darkness, experience flickers briefly: and during the flickering we can realise and articulate this mystery; but soon we will be extinguished, and the bright interruption to the darkness will be so completely annulled that it will be as if the flickering had never happened.

Now it happens that I think even this fact is wonderful. When I reflect on it, the ephemeral nature of my own conscious experience is made vivid and acute for me – without sadness or regret, but certainly as an object of wonder. As I have elsewhere put the matter: 'At all levels of effect and power, human agency is somehow born of nothing and for a while simply cannot be repressed – it bristles and sparks and shoves almost unceasingly – and then it declines into extinction and, in most cases, oblivion as well.' [24] Somehow even our minds arise without antecedents; then they disappear, mostly without leaving much trace behind.

It has been said that we read to know that we're not alone. But contemplating our extraordinary embodied human nature is also a wonder-filled direct expression of our not being alone, and a wonder-filled resurgence of the question of *why* any of us – or any part of the world around us – is here at all. The odds against this happening, in the grand scheme of things, and of *our* being that 'happening,' are beyond contemplation. The wonder of simply *being* will have to suffice, but that is certainly worth contemplating. The lives of others – and the extent to which we can enter into them, or *abide* with them

– confirms the wonder that we sometimes glimpse in understanding the contingency of our own lives.

Clinical practitioners, perhaps most frequently in general medical practice, have an extraordinary, intermittent, difficult and highly privileged invitation into the lives of others, and a corresponding opportunity to reflect on the wonder of embodiment and on the wonder of simply being. It is this wonder that gives context and meaning to the good things that we can do (and be) both *in* health and *despite* illness. Wonder both enlivens and secures the business of being patients, and practising medicine.

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