Medical humanities and the place of wonder

H M Evans

ABSTRACT

This chapter advocates openness to a sense of wonder at embodied human nature as contributing to 'critical medical humanities.' It is argued that many aspects of critical medical humanities are continuous with – hence already found in – mainstream medical humanities, and are not necessarily a distinct development now. Nonetheless the chapter affirms that the critical eye of 'critical medical humanities' is legitimately turned upon, *inter alia*, shortcomings in 'mainstream' conventional medical humanities hitherto. One such shortcoming is the traditional assumption that the conceptual challenge in thinking about clinical medicine and healthcare concerns the neglect of the patient's voice – the materiality of the patient's body being somehow *un-problematically* self-evident. This assumption needs to be challenged by a confrontation with the mystery of our embodiment, and the chapter argues that an openness to wonder is a crucial element in that challenge. Acknowledging the inescapably dualist character of self-conscious wondering reflection on our materiality, the chapter brings a conception of wonder to bear upon our bodies as vibrant matter – objects that are special in large part because they share the specialness of matter as such. This reversal of a traditional medical humanities critique gives wonder a particular role in critical medical humanities.

KEY WORDS

Wonder; embodiment; critique; materiality

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SUGGESTIONS FOR FURTHER READING

Bennett J., *The Enchantment of Modern Life*; see chapter 7, 'Ethical energetics.'

Evans H.M., 'Wonder and the clinical encounter,' *Theoretical Medicine & Bioethics* 2012; 33, pp. 123–136; see p. 127

Magee, B.., *Confessions of a Philosopher* (London: Weidenfeld and Nicholson, 1997); see especially chapter 1, 'Scenes from Childhood,' and chapter 24, 'Left Wondering.'

Rudebeck C.-E., 'The body as lived experience in health and disease,' in M. Evans, R. Ahlzén, I. Heath and J. Macnaughton (eds) *Medical Humanities Companion Volume One: Symptom* (Oxford: Radcliffe Publishing, 2008), pp. 27-46.

Toulmin S., 'Knowledge and art in the practice of medicine: clinical judgement and historical reconstruction,' in C. Delkeskamp-Hayes and M.A. Gardell Cutter (eds), *Science, Technology and the Art of Medicine* (Dordrecht: Kluwer Academic Publishers, 1993), pp. 231-249

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Introduction

It will be the argument of this chapter that, among the critiques that could be thought to contribute to 'critical medical humanities,' at least one may turn out to bear upon an important – but generally tacit – presumption in mainstream medical humanities. The presumption in question is that, taking our materiality and embodiment for granted, medical humanities' principal task is to return the patient's voice to prominence within the clinical encounter. The particular critique I have in mind involves disputing this very taken-for-granted-ness of our embodiment, and cautioning against replacing medicine's neglect of the personal with medical humanities' neglect of the material.

Medical humanities is still 'under development' in terms of its scope, methods, presumptive goals and scholarly security. Returning the patient's voice – due attention to her or his experiences, hopes, fears, interests and will – to a central place in the clinical encounter remains a key concern of much legitimate work within mainstream medical humanities. But in undertaking it, we should avoid or curb *simplistic* forms of opposition to medical materialism, bio-reductionism or mechanistic views of health and illness. The point is not that those views ought not to be opposed, just that they should not be opposed simplistically. An emphasis on the patient's story, the biographical narrative, ought to take seriously also her being a material object – her thing-hood – lest the narrative emphasis inadvertently compound that 'disenchantment'[1] of the material body that, we often suppose, is wrought by the scientific gaze. Our bodies-as-objects sustain an experience proper to *material things that know themselves from the inside, have agency, and have a finite duration*. These characteristics defy ordinary understanding, are essential to our nature, and are at risk of wholesale neglect by simplistic opposition to biomedical reductionism.

Although this critique can be stated in dry analytic terms – as I have here – the source of its motivation, its 'energetics' (to use Bennett's term[2]) need not be. In my own case, this 'energetics' arises in a sense of wonder at embodied human nature. And since turning critique upon mainstream medical humanities should be among the additional virtues of a 'critical medical humanities,' then my claim will be that critical medical humanities may be done valuable service by a well-attuned and wide-awake sense of wonder.

Critique, 'the critical' and critical medical humanities

First let us review the ideas of critique and 'the critical' in relation to the critical medical humanities. There are perhaps four pertinent senses of 'critical' in this

context. First, something may be critical in the sense of dispassionately and rationally analytic, as when one undertakes a critical appraisal of a work or an idea. Typical of this within a humanities discipline is David Raphael's oft-cited characterisation of analytic philosophy as being 'the critical evaluation of assumptions and arguments.'[3] Second, and perhaps most commonly-encountered in daily life, someone is typically described as being critical of something if he or she is negatively disposed towards it, aversive or hostile (we often speak of 'being critical of' a suggestion or a proposal). Third, something may be vitally necessary – for instance, correct tyre pressures are critical to the safe and predictable behaviour of a car on the road. And fourth, a pivotal or future-shaping moment or phase may be thought to be 'the critical point' as when the capture of a key stronghold is seen to be the turning point in a battle.

Now how does critical medical humanities fare under these different senses of 'critical'? It should, I think, always be dispassionately and rationally analytic, at any rate when undertaken in an academic spirit. It may well often be contingently negative, as when it is undertaken to bring about change – medical humanities is after all the continuation of medical ethics' response to the perceived shortcomings of excessively managerial and technical conceptions of healthcare. Naturally this Volume entertains the ambition that critical medical humanities be vitally necessary to the continued and extended relevance of medical humanities in understanding and developing organised healthcare. Whether its present turn – of which this Volume is an expression – will be seen to be pivotal is of course something that can be judged only retrospectively by future scholars. We shall simply have to wait and hope.

Be that as it may, critical medical humanities is inevitably a *critique* – a further idea that may itself fulfil the four senses, above, of 'critical.' Any considered critique is (or ought to be) dispassionately and rationally analytic, and individual cases will frequently, though not inevitably, reflect an at least negative or sceptical view of their object. As a general phenomenon (I do not here speak of individual critiques) the very idea of critique is essential to the testing of thought and hence to its development or elaboration; it is in this sense critical to almost any kind of progress. From time to time, given this general role, individual critiques will be seen to be pivotal. (Some examples even go by the very name – Immanuel Kant's *Critique of Pure Reason* is the first and most blazing to come to mind, in its altering forever the possibilities available to western thought when considering the relationship between mind and world.[4])

Progressive critique within mainstream medical humanities

I should say at the outset that while critical medical humanities is self-evidently named as a sub-set of a wider mainstream medical humanities, I do not myself see it as necessarily a late or current epoch but rather as an emergent tendency that is always immanent within (at the very least) philosophical forms of medical humanities enquiry, perhaps becoming more recently *apparent* as it accumulates, but there all along.

Patterns of its emergence can be found, I think, that vary with the interests of the enquirer. But most observers would recognise the view, put forward by Angela Woods and Anne Whitehead,[5] that the broad field of medical humanities has roots in ethics, education and experience, and most would agree with them – I certainly would – that it is the last of these that has typically received central attention from medical humanities researchers, focusing on the experience of illness, diagnosis and treatment.

Woods and Whitehead identify a 'primal scene' for 'mainstream' medical humanities, subsisting within the clinical encounter and typically involving 'the moment when a doctor gives the diagnosis of cancer to a patient' – a moment that gives rise to trenchant and characteristic questions concerning experience, engagement and response, and human frailty. As they rightly observe, these are the questions that have received most attention in conventional medical humanities.[6]

For Woods and Whitehead 'the critical medical humanities' offer a two-fold advance on the mainstream, in method and in agenda. The gain in method consists in the attempt to 'pose more critical questions' to this 'primal' scene, taking greater account of societal and political context and factors and of how the ideas pertinent to health, illness and disability are used in public spheres; Woods and Whitehead thereby question the adequacy of medical humanities scholarship hitherto.[7] The enlarged agenda consists in a reflexive turn whereby medical concepts are taken up and interrogated within the 'theorisations and operations' of humanities and social sciences themselves.[8]

Pace Woods and Whitehead, I would myself regard many aspects of these important advances as having been long implicit in what I would call a *progressive critique* that is visible in the mainstream of medical humanities and is indeed in some respects traceable back to forebears in medical ethics and in philosophy and sociology of medicine, as I shall summarise below. Similarly, when they survey the range of pertinent senses of 'critical,' there is much to agree with – but not, however, because it is newly arrived-at, but rather because it is perhaps a little more mainstream than they suggest. For instance, although some mainstream medical humanities writers may have been guilty of upholding a supporting role for humanities in the service of medicine, a progressive critique has explicitly contrasted this with an alternative, and preferable, integrated role for the humanities in response to the perceived neglect of the patient's experience in technical and managerial forms of healthcare delivery.[9] Again, humanities have been seen as critical in the sense of being *vital* to medicine since long before medical humanities emerged as a discrete field of study, among writers as diverse as William Osler,[10] René Dubos[11] and more recently Eric Cassell.[12] Moreover while I strongly uphold the insistence that critical medical humanities 'sets research agendas reciprocally in the humanities,'[13] it is not new: I myself have been proposing it over many years,[14 15 16] partly inspired by Stephen Toulmin's earlier example;[17] signally, such an insistence is fundamental to the conception of the project 'Medicine and Human Flourishing' for which the Durham Centre for Medical Humanities was awarded a Wellcome Trust Strategic Award in Medical Humanities in 2008.

The 'progressive critique' that I have in mind has its own history. For some decades, commentators in both medical ethics and, subsequently, medical humanities have recognised and protested the fragility of the patient's voice, story

and experience in clinical encounters that were conceived within the biomechanical form of the medical model. Thus a standard medical humanities critique sought to affirm or re-affirm the patient's voice within the clinical encounter. For example, the standard critique is implicit or explicit in work by Susan Stephenson and Gillian Walker,[18] Jack Coulehan,[19] Eric Cassell,[20] Trisha Greenhalgh,[21] Trisha Greenhalgh and Brian Hurwitz,[22] Raimo Puustinen,[23] Jeremy Holmes,[24] Rita Charon,[25] Alex Mauron and Micheline Louis-Courvoisier,[26] Sven Frederiksen[27] and Cecil Helman.[28]

What I think these instances of the standard critique have in common is that they presume or openly acknowledge the materiality of the patient's body as being self-evidently crucial, while somehow not being 'the problem.' The challenge and the mystery lie elsewhere, in successfully integrating the person into the clinician's conception of the patient, and thus the patient's voice into the clinical encounter. Cassell at times exemplifies this:

> The job of the twenty-first century is the discovery of the person – finding the sources of illness and suffering within the person, and with that knowledge developing methods for their relief, while at the same time revealing the power within the person as the nineteenth and twentieth centuries have revealed the power of the body.[29] EXT

> Physicians' manifest knowledge of disease has been the focus of medicine for these last 150 years while knowledge of sick persons and doctors has languished – left to intuition and unfocussed experience.[30]

….as does Charon:

> Sick people need physicians who can understand their diseases, treat their medical problems, and accompany them through their illnesses. Despite medicine's recent dazzling technological progress in diagnosing and treating illnesses, physicians sometimes lack the capacities to recognize the plights of their patients, to extend empathy toward those who suffer, and to join honestly and courageously with patients in their illnesses.[31] EXT

She, like Greenhalgh and Hurwitz, is an exponent of alternative 'narrative-based' conceptions of medical practice largely in response to bureaucratic and commodified forms of medical care.

Others however extended the conventional critique to acknowledge that clinical medicine needed a more sophisticated understanding of the body itself, and not simply as it were a re-attachment to it of the person. Fritjof Capra for instance takes the biomedical model as his target for a critique within the medical arena that nonetheless exemplifies what can go wrong with the inappropriate application of mechanistic thought:

> By concentrating on smaller and smaller fragments of the body, modern medicine often loses sight of the patient as a human being, and by reducing health to mechanical functioning, it is no longer able to deal with the phenomenon of healing. This is perhaps the most serious shortcoming of the

> biomedical approach, Although every practicing physician knows that healing is an essential aspect of all medicine, the phenomenon is considered outside the scientific framework; the term 'healer' is viewed with suspicion, and the concepts of health and healing are generally not discussed in medical schools.[32] EXT

Similar challenges to the way we see and understand our own materiality underlie the work of David Morris,[33] Byron Good[34] and Stephen Toulmin[35] for example. When these challenges are taken up within work that is more obviously badged as medical humanities, I think that the result is plausibly to be found as prototypical or already constitutive of 'critical' medical humanities in the area that interests me for our purposes in this chapter – a recognition that 'the problem' lies not solely in understanding (and responding to) the experience of the patient but also in understanding how that experience is fused with the materiality of the body, and hence in better understanding the meaning of what it is to be human in the intense context of the clinical encounter. Greaves asserts the scale of the challenge:

> …the most notable feature of Western medicine … is not mechanistic medical monism, but lopsided medical dualism, with the technical and the sciences dominant, and the personal and the arts recessive, but without any complete supremacy.[36]

He subsequently argues that the biomedical model cannot adequately be redressed; it must instead be replaced with a radical 'new medical cosmology.[37]

This takes seriously Toulmin's challenge as do, in their different ways, medical humanities writers as diverse as Marjorie Sirridge and Kathleen Welch,[38] Steve Wainwright and Bryan Turner,[39] and Carl-Edvard Rudebeck[40] to give but a few examples. I think each of these constitutes emergent 'critical medical humanities' in one or more of the senses that I have noted above.

The importance of this is, for me, increasingly tied to a kind of inversion of where I think medical humanities (and medical ethics before it) set out. Instead of taking our materiality for granted in search of the interpersonal and experiential within the clinical encounter, I am more inclined to take for granted at least the fact of the interpersonal in the search for a fuller confrontation with our own materiality. If, given their success in restoring the patient's voice, the conventional medical humanities critiques have neglected her materiality then I take it as one among the many tasks of a more critical medical humanities to protest this neglect and to try and reverse it. To do anything like justice to the task requires, I suggest, a confrontation with our embodiment that does justice to its mystery. That confrontation, my personal adventure in critical medical humanities, is constituted in the sense and experience of wonder at embodied human nature.

What is this thing called wonder? – a prefatory note

If exploring wonder has a role in the 'business' of doing medical humanities, then in this chapter I will try to discern at least one aspect of that role. To attempt it, then I

first need to say what I mean by wonder. Here is a provisional definition that I have previously put forward in the context of the clinical encounter:

> Wonder characterises a special kind of transfiguring encounter between us and something other than us: it is an attitude of special attentiveness that arises within us, prompted by circumstances that may be entirely ordinary yet, through our active and responsive imagination, can yield an object in which the ordinary is transfigured by and suffused with something extraordinary as well. The attitude of wonder is thus one of altered, compellingly-intensified attention to something that we immediately acknowledge as somehow important – something that might be unexpected, that in its fullest sense we certainly do not yet understand, and towards which we will likely want to turn our faculty of understanding; something whose initial appearance to us engages our imagination before our understanding; something at that moment larger and more significant than ourselves; something in the face of which we momentarily set aside our own concerns (and even our self-conscious awareness, in the most powerful instances).[41] EXT

This is admittedly a rather ponderous attempt – and there is a much shorter way of putting the matter that, I think, implies the foregoing and catches something of the poetry of experiences of wonder: *in wonder the world is made newly-present to us.*

Now wonder is not unique in this general regard, of course. I see wonder as one of the varieties of intensified experience among others – mystical, religious, ecstatic, aesthetic, sublime; or an experience of overpowering love, or of unusual moral clarity. Within all of these kinds of cases there is no doubt something that we can encourage, and perhaps cultivate. What may be true of all of them, but is usually true of experiences of wonder, is that we cannot summon them up on demand, like rubbing a lamp to produce a genie. Another characteristic of wonder is shared by some, but definitely not all, of the other varieties of intensified experience: experiences of wonder are typically valuable and it would be appropriate to encourage them and seek them out, but wonder is also certainly capable of a double edge. Just like the aesthetic imagination, it may sharpen what we already are, for good or ill. It is one thing to see, intensely, the future of the world in a new-born child; but perhaps not only in fiction (Hans Castorp is the modern prototype here in Thomas Mann's *The Magic Mountain*) does a damaged imagination find wonder in necrosis and death.[42]

So the sense of a world made newly-present is not the sole property of the morally upright, or the aesthetically-mature, any more than is the experience of religious or mystical ecstasy. With intense experience comes, perhaps, intense responsibility. Along with these, wonder is liable to lead to an alteration in our apprehending the world, an alteration that clearly bears on how we derive our conception of 'the good.' It may intensify what we are inclined to see as good and it may give us a fresh conception of why good things are good. For instance, there is a deal of difference between those who see in the natural world a panoply of reasons to be humble about who we are and what we can do, and those who see in that same natural world a dazzling array of opportunities for commercial gain.

The philosophical exploration of wonder is an enduring challenge even if one confines oneself to those aspects most obviously provoked by the concerns of medical humanities, since one of wonder's chief provocations is also the core business of healthcare and any ensuing medical humanities worth the name, that is embodied human experience in sickness and in health. I have scratched the surface with enquiries into wonder in relation to the clinician, to the patient, and to human finitude and mortality;[43 44] such enquiries presume the connection of different people's imaginations through wonder, and our engagement with the lives of others through shared wondering experiences. These and other enquiries engage the question of wonder's phenomenological content; its characteristic dynamics (for instance, in relation to normally-perceived time); the question of whether it can be cultivated; whether there is such a thing as a 'talent' for wonder; whether wonder is in any sense gendered; whether it can be silenced, defeated or annulled; and whether it can coexist meaningfully with explanation. And so on. All of these distinguishable enquiries, I believe, are capable of contributing to medical humanities enquiry as well as furthering the understanding of wonder in its own right.

Turning the tables: a reverse 'critical-medical-humanities' critique

If our bodies' materiality is important, and particularly if it is important in ways *beyond* those that are the obvious focus of that mechanistic form of medicine against which medical humanities conventionally protests, then obscuring that importance may at best be misleading, and at worst risk a harmful distortion in the way we conceive the goals of clinical care. We should avoid such a risk, initially by pointing out the error of ignoring our bodies' materiality, in a reflexive critique proper to the critical medical humanities. If pointing out and, ideally, demonstrating the importance of our bodies' materiality helps us avoid obscuring it, then that would be both a morally and an epistemically good thing, on the story so far. So balancing a conventional and traditional medical humanities critique with this reverse critique would be an important constraint upon – or, perhaps, a more sophisticated version of – the conventional medical humanities view. Accordingly, in this chapter I put forward this reverse critique as a candidate instance of critical medical humanities in action, in this instance turned reflexively upon one of conventional medical humanities' chief concerns.

Now to take this reverse critique forward one must establish its own grounding assumption, that our materiality, our 'thing-ness,' is important in other ways than as the contested or reductive objects of the biomedical gaze. Accordingly I will try to take for granted neither experience nor materiality, neither passion nor clay – and nor will I take for granted their wondrous fusion together in us now as we live, nor their apparent (and equally wondrous) dissolution when we die. (Nor, at the risk of a whiff of pan-psychism, would I willingly rule out even their apparent latency in the physical world around us, although my argument does not depend on this.) For I fear that even while objecting to an ostensibly-depersonalised view of the patient one

may risk taking too impoverished a view of objects or material things in general – which, of course, include our own material selves.

A whiff of dualism?

There's an unavoidable caveat at this point, in that we must acknowledge the risk of expressing the reverse critique in somewhat dualist terms. The conventional medical humanities critique generally assumes that the biomedical view, allegedly so negligent of the personhood of the patient, arises from a crude mechanistic dualism blamed (rather unfairly, I think) on René Descartes, whose attractions for medical *arrivisme* are impishly summarised by Roy Porter: 'A huge KEEP OUT notice had, as it were, been pinned to the body, excluding theologians, moralists, and anyone else considering fishing in medicine's pond.'[45]

It is this broad attribution of dualism – together with a tacit but more or less dogmatic supposition that no form of dualism is tenable – that I think supplies the metaphysical underpinnings of the conventional critique, whose primary focus is of course ethical. I have clear sympathies with the ethical intent, but anxieties about too-simple an adoption of the anti-dualist foundations.

Essentially, if the critique is objecting to a medical dualism it must itself be free from any dualist taint, such as promoting the experiential self at the expense of the bodily self, for instance. It's no good talking about narrative and the making of meaning without paying close attention to the bodily grounds of narrative and meaning, as Mark Johnson has expounded at length.[46] Some defensible alternative to dualism must be implicit in the conventional critique, and I think it generally behoves the critic to make clear what that alternative is. I myself struggle to know how to talk about embodied human experience in wholly non-dualistic terms. When Christoph Rehmann-Sutter and Dominik Mahr characterise sufferers of inherited disease as facing the problems of 'living a body' they disclose the difficulty of suppressing a duality joining the life and the body by which the life is lived.[47]

I turn for help here to something like aspect-dualism. There may indeed be no mental *substances* of the kind presumed in 'substance dualism,' but I do not know how to talk about ideas, about mental causation, or about the antecedents of mind other than as logically-distinguishable aspects of processes that cannot be described in solely-physical terms. Some writers, health geographers prominently among them, appear to concede this but try to downplay the significance of the concession – perhaps in the hope of avoiding opprobrium – through emphasising the importance of the affective over against the rational, and its grounding in embodiment.[48] [49] In particular, 'non-representational theories' aim at enfolding external objects of experience into shared habits and practices in which meaning, signification, and symbols are conceptually subordinated to affective bodily reactions. As has been argued elsewhere,[50] this reduces rational and intentional engagement with the world to mere epiphenomena, grievously undermining an otherwise laudable attention to the grounding of our experience in embodiment. But there is more to experience than affect – without due regard for cognition and intentionality (in all senses, the Husserlian included), we lose all purchase on the content of experience.[51]

Still more radically, ardent exponents of anti-dualist theories of mind – Susan Blackmore is an example – leave me wondering what their own self-experience can really be like, if they genuinely feel that the self is dispensable or illusory, a phantom created by philosophising.[52] By contrast, after we have acknowledged (as we certainly should) the substantial proportion of perception, thought, action and response that arise from our combined body-brain's automatic, embodied, instinctual, sub-conscious operations, there is for me (and, I take it, for the reader) an irreducible inner, felt, qualitative remainder of mental life – what we call mind, or experience, or will, bursting alive in our longings, our purposes, our contemplations, our realisations, and so forth – that simply cannot be made intelligible in exclusively material descriptions. (Nowhere is this more preternaturally clear to me than in considering the content, and the self-abnegating mode, of experiences of wonder; but it is clear *enough* in virtually all other experiences as well.) The crude mechanistic dualism alleged of much post-Enlightenment science may well be guilty of all the sins attributed to it, but I have never understood why anyone thinks that the solution to one entrenched folly lies in adopting a fresh one.

Nor can a conventional medical humanities critique simply try to 'dissolve the question' as meaningless (once a favourite Oxford-school response to troublesome questions in philosophy). One cannot easily put forward a substantive view on an insubstantial question; if the problem of the relation between brain and mind is ultimately meaningless, then the anti-dualist critique is just slicing through air, and energy would be better deployed elsewhere. Rather it seems to me that we should take neither experience nor embodiment for granted. Recognising that the conventional critique has in ethical terms a perfectly legitimate target, we might better say that an unthinkingly mechanistic biomedical approach errs by neglecting the patient's experience through taking it for granted (or leaving it for others to deal with elsewhere – theologians perhaps, in Porter's waspish caricature). The conventional medical humanities riposte to that error must avoid the danger of mirroring it, in somehow taking our materiality for granted.

Keeping materiality in mind

There are, then, two conditions here that the standard medical humanities critique must meet. First, to complain in general terms about dualistic understandings of the patient without providing a satisfactory alternative monistic account will not do. That is a task that I do not think has been satisfactorily undertaken (and in the meantime I myself am sticking to some kind of modified aspect dualism). Second, whether one takes a monist or a dualist view of the patient, the one-dimensionality of biomedical materialism will be improved upon only by an alternative view that takes for granted neither experience nor embodiment – that manages to do justice to both the saturation of experience and the vibrancy of flesh as matter.[53]

This problem is of course not the sole responsibility of medical humanities to address; indeed the question of how we are to think of *matter* as such drives (how I would have liked to say 'animates'! But that is to beg the question) the cross-disciplinary field of 'thing studies.' Yet typically 'thing studies' addresses questions of our identification of and relationships with objects, artefacts, things and their traces,

and the signification they have for us (for instance as tokens of loss, remembrance or of betrayal, than questions of our actually *constituting* things ourselves.

Nearer to the point I have in mind, howsoever difficult it may be found, is the work of the French performance artist ORLAN who purports to take the body seriously in many aspects of its materiality, such as its plasticity and above all its contingency – available for inscription and re-inscription as though it were canvas or plaster, or for use as a measuring instrument or even the prototype of a slot-machine. The enmeshing of our experience among many other kinds of material experiences is the concern of David Herman's work on human-animal relations.[54] Jane Bennett, whose work I mentioned earlier, sees the blending of humans, animals and inanimate things as part of the more general dancing vibrancy of matter, in a world whose former enchantment she urges us to rediscover.

Shorn of Bennett's ethical programme, and shorn of its (apparent) dependence on the more bizarre and transgressive enmeshings of bodies and technology, this resurgent emphasis on the vibrancy of matter including our bodies' own matter is part of what I think medical humanities requires in its overthrow of traditional dualism. (The vibrancy is not separable from the material – one could no more contemplate a vibrancy detached from matter than contemplate the smile left over from the Cheshire Cat. Yet nor is it wholly-subsumed into the material; it is not, for instance, a merely causal property whose impact is independent of the mind and imagination of the beholder. Aspect-dualism here again supplies the least-unsatisfactory account of the phenomenon and what it is for us to notice it.)

For a wonder-filled exploration of the vibrancy of matter, and of how a kind of consolation is possible through understanding that we are built of the very calcium that was formed in the stars above our heads, see the extraordinary documentary about the Atacama desert, *Nostalgia for the Light* by the Chilean film-maker Patricio Guzmán.[55] It is a dizzying thought – literally as well as metaphorically. And if we really needed a reminder that, just as bodily events give rise to thoughts (think of worrisome conjecture in response to an unexplained symptom) so too thoughts give rise to bodily events (think of the erotic imagination, though please defer any extended consideration until after finishing this chapter), then the idea of a *dizzying thought* surely supplies it.

Our bodies as objects

And so at length – and here via Chile! – I reach an arena that (for me) irrefragably summons our sense of wonder. It's an arena that I have elsewhere started to sketch out[56] [57] and it comprises aspects of reflection on our nature as embodied experiencing beings.

Our bodies-as-objects *sustain experience*. It is worth letting this sink in from time to time. Faced with our finitude, there are obviously very many who rely on the thought of an immortal soul and, in consequence, the hope after death of accessing an experience that is independent of a body. So inconceivable is such an experience that an alternative hope, adhered to by those who look instead to the resurrection of the body in the life to come, seems modest by comparison. But if embodiment is necessary for experience, it is not sufficient. So far as we know, inanimate objects do

not sustain experience (even if as in the case of some computers we have programmed them to mimic its expressions), and we presume that we share the phenomena of experience – and a universe accessible *in* experience – only with those other organic living creatures whose animation and behaviour strikes us as consistent with it.

Together with those other creatures, in our bodies-as-objects we proclaim that from a universe of cold, hard, material externalities there emerged at some stage of evolutionary complexity that extraordinary, intimate, felt interior reality that we call 'conscious being' – namely ourselves (to take our own case from among perhaps uncountably many other cases) *known from the inside*. Extraordinary but also inalienable too: we have no choice in the matter – something chillingly explored in C.S. Lewis's *That Hideous Strength*.[58] Moreover it is conspicuous that we share a world with indefinitely many other kinds of creatures whose perception of that world is to some extent, and in some cases utterly, unlike our own. Confronting the fact that a moth's world is not merely apprehended but actually constructed by its own peculiar perceptual apparatus should remind us that our world is equally constructed by our equally peculiar sensory complement. Yet since these are aspects of a shared reality then we are (arguably) a special but (certainly) not an exclusive case of experiencing beings.

As well as experience, our bodies are also the ground of our agency. We purposively move, lift, crush, build, nurture, dissect, condemn, pursue, ingest, flee from and collaborate with a myriad things in the world around us including other examples of the sorts of things that we ourselves are. So, in their own way, do cats sharks, bees and weaver birds. They are unable to reflect as we can on the puzzle of willed action, but this does not mean that their actions are unintended or haphazard. For them no less than for us (albeit less vividly) their agency consists in actions known both externally by others and from the inside by themselves.

A further curious aspect of our embodiment shared with the other animals is its finitude – we all wind down, inexorably, within remarkably reliable limits characteristic of each species. Biological finitude draws our attention to two existential puzzles. The first is that, although (I suggest) it is impossible to conceive of consciousness in wholly-material terms, it arises apparently without non-material antecedents. The second, and counterpart, is that when we die it apparently ceases without remainder – nothing is left that is knowable by either ourselves or others. That means that even in the course of reading these lines you inhabit a temporary spark that emerged from a prior blackness that was nothing to you, and that will be extinguished within a further blackness that will be nothing to you. Your continuity stretches in both directions from the rolling present, but in each direction it comes to a stop, beyond which it was and will be as though you had never been. (I have elsewhere tried to grapple with a miniature form of this shocking puzzle in contemplation of the idea of 'experiectomy' through memory-obliterating sedation.[59])

Special objects – but how special?

The position we have arrived at is this. We want to uphold a motivic concern of medical humanities, namely to redress biomedicine's tendency to objectify patients where that tendency means insufficiently attending to their individuality and their experience. But we also want to avoid replacing one form of reductionism with another, in particular to avoid disregarding or downplaying the object-hood of the patient. One would not wish to deny that patients are also more-than-objects. But to regard medicine's error as viewing the patient as a *mere* object is in a sense to compound that error: no object is a 'mere' object in the dismissive sense of that phrase! What we need is a view of patients that does justice to their personhood and their object-hood alike – and is capable of coping with (if we think it really needs coping with) the taint of dualism that this way of putting the matter enjoins.

We humans are both buoyed, and bounded, by the experience of material creatures – creatures who *as objects* know ourselves from the inside as well as the outside (we can, after all, see the more distant parts of our own bodies quite as well as others can see them, and in precisely the same way), who have agency, but who also have non-negotiable beginnings and endings. Doubtless we are a special kind of animal; and that in turn makes us a special kind of object or thing. But how special? It seems to depend on what sort of a line one is moved to draw, and where one draws it. Let us briefly consider some possibilities.

An obvious criterion for specialness might be rationality – much appealed to by those in medical ethics (John Harris is a prominent instance) who regard the capacity for autonomous rational choice as the chief marker of moral worth.[60] By this criterion, we are pretty special; our shared experience is one that admits of the analysis of past actions, the conjecture of alternative possible future actions, and the capacity for reflective self-contemplation. Of course, it takes the operation of rationality to identify, and thus to value, the capacity for rationality. Even within medical ethics debates, what else follows from the specialness of rationality, and its inbound capacity to *intend*, is contested. Not all, for instance, think that moral worth (an evidently separate scale of specialness) is tied to rationality, either actual or potential, although within medical ethics debates this view is ordinarily held with regard to exceptional cases of particularly unfortunate human beings, and frequently by those holding human life in general to be special. It is the exceptions that trouble them rather than the broad attribution of specialness to humans, which they will tend to ground elsewhere in order to protect exceptional non-rational or pre-rational cases (such as the unborn child).

So another conceivable criterion for what makes us special is sacredness – here, the extent to which our general (human) form of life can be held to be sacred. The evident difficulties, both of defining 'the sacred' and of demonstrating and defending the claim that some stake for humanity within the territory of the sacred, limit the appeal of this way of drawing the line.

If by contrast your criterion for specialness is a more generous approach to experience as such, a capacity for experience that is not stipulated under forms of rationality, then our specialness is shared with abundantly many other creatures going all the way back almost as far as the sponge.[61] The material world obtains for itself what I can only call 'an experiential *inside*,' or a *felt* interior, very early on in evolutionary terms, and certainly a long way before you reach the capacity for rational choice. Drawing the line here encircles a very large class of experiencing

creatures of a myriad different kinds – kinds that are mutually unintelligible for the most part, but sharing a world that somehow supports them all and supports their irreducibly different experiences of it.

Contrasted with the experiences of other creatures, our rationality is joined by – or is expressed through – a further possible criterion. This is *agency*. It arises from our capacity for purposive intentional action that is moreover considered, deliberated. How special is this? Other creatures act, and they have needs and goals, and their actions may be directed towards those goals: their actions may, in the philosophical sense of the term, have intentionality, which is directedness. Certainly, this makes it as true of other creatures as of ourselves that their agency is not the same thing as causation: agency has the element of intentionality that is obviously missing from causation. What sets ours apart seems to be the aspect of contemplative choice, deliberative reflection. But agency is in one important sense not wholly detached from causation. Agency in the existential sense is possible only because causation is possible in the material sense.

Wonder recalled

This fusion of causation and agency, world and purpose, will and flesh, is for us the mode of our experience, and notably the grounding condition – as it were the subject-matter – both of what we call health and of what we call illness. But I believe it is also an enduring provocation to our sense of wonder. So where we draw the line of 'specialness' is, I think, influenced by among other things our susceptibility to a sense of wonder, and reflects the things that we are disposed to find wonderful.

At all events, drawing the line distinguishes some objects – perhaps, ourselves – as special among other objects: in all cases their – and our – materiality is a part of the manner of their (or our) being special. The role of wonder in critical medical humanities includes at least a clarion call to us to remain mindful of our materiality, our object-ness, our thing-hood. We are, to recall, *things* that experience themselves from the inside and outside alike, in sickness and in health; no critique of medical reductionism can be adequate that does not begin from this recognition of our materiality.

In short, our materiality, agency and finitude legitimately provoke wonder, and recognising this is of enduring value particularly within longitudinal forms of clinical medical practice, where practitioners must somehow engage 'the lives of others.'

The scope of the 'reverse' critique – and of wonder's role in critical medical humanities

The 'reverse' critique upholds the aim of a standard medical humanities critique (challenging biomedical neglect of the patient's experience) while refusing the standard critique's unwitting neglect of the patient's materiality. Putting our own house in order is a worthwhile undertaking, but does the reverse critique matter

beyond medical humanities? In part this depends on whether medical humanities itself 'matters beyond medical humanities' – how big the house is, as it were, or less gnomically whether medical humanities' business begins and ends with medical treatment. That would be to say the least a conservative view. An alternative and more ambitious view is that medical humanities concerns our broader understanding of what makes lives go well or ill, and thus a contextualised understanding of the varying scope and pertinence of different aspects (and conceptions) of medical interventions in our lives. In this case, then the 'reverse' critique also has a wider bearing, reminding us that our materiality – together with the wonder that it can inspire – illuminates the other aspects of our flourishing. I hold this broader view, and I have come to think that an openness to wonder leads us to reconsider our flourishing, makes our flourishing newly-present to us.
Thus, I contend, an openness to wonder can play a critical role in 'critical medical humanities.' But does an openness to wonder, or the engagement of a sense of wonder, distinguish 'critical' from conventional medical humanities? The simple answer is 'yes.' If in conventional medical humanities wonder was confined to service as an 'educational good' in the nurturing of humanistic clinicians, then in critical medical humanities an openness to wonder animates our sense of the vibrancy of matter, including the matter that is ourselves – in and as our bodies – as patients, well or ill. This in turn allows us to be dissatisfied with simplistic opposition to medical reductionism, falling as it too-easily does into replacing this first error with a second – superficially more benign, but in the long run doing no more justice than the first, in the face of the wondrous complexity and mystery that is our embodied experience.

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April 2015

Notes

[1] J. Bennett, *The Enchantment of Modern Life: attachments, crossings and ethics* (Princeton, NJ: Princeton University Press, 2001).
[2] J. Bennett, *The Enchantment of Modern Life*; see chapter 7, 'Ethical energetics.'
[3] D.D. Raphael, *Moral Philosophy* (Oxford: Oxford University Press, 1994).
[4] I. Kant, *A Critique of Pure Reason* ([1781]; many English editions, for example transl. P. Guyer and A. Wood, Cambridge: Cambridge Univ. Press, 1999).
[5] A. Woods and A. Whitehead, this Volume, …
[6] Ibid.
[7] Ibid.
[8] Ibid.

[9] M. Evans and D. Greaves, 'Exploring the medical humanities,' *British Medical Journal* 1999; 319: p. 1216.
[10] M. Bliss, *William Osler: a life in medicine* (New York: Oxford University Press 1999), p. 461.
[11] R. Dubos, *Mirage of Health: utopias, progress and biological changes* (London: George Allen & Unwin, 1960).
[12] E.J. Cassell, *The Place of the Humanities in Medicine* (New York: The Hastings Centre, 1984)
[13] Woods and Whitehead, …
[14] M. Evans, 'The mind-body question', in P. Louhiala and S. Stenman (eds), *Philosophy Meets Medicine* (Helsinki: Helsinki University Press/Signe och Ane Gyllenberg Foundation, 2000), pp. 105-115.
[15] M. Evans, 'Medical humanities for postgraduates: an integrated approach and its implications for teaching,' in D. Kirklin and R. Richardson (eds), *Medical Humanities: a practical introduction* (London: Royal College of Physicians, 2001), pp. 61-72.
[16] M. Evans, 'The "medical body" as philosophy's arena', *Theoretical Medicine and Bioethics* 2001; 22(1), pp. 17-32.
[17] S. Toulmin, 'Knowledge and art in the practice of medicine: clinical judgement and historical reconstruction,' in C. Delkeskamp-Hayes and M.A. Gardell Cutter (eds), *Science, Technology and the Art of Medicine* (Dordrecht: Kluwer Academic Publishers, 1993), pp. 231-249.
[18] P.S. Stephenson and G.A. Walker, 'Psychotropic drugs and women,' *Bioethics Quarterly* 1980; 2(1): pp. 20-38.
[19] J. Coulehan, 'I treat all my patients aggressively,' *Journal of Medical Humanities* 1990; 11(4), pp. 193-197.
[20] E. Cassell, *The Nature of Suffering and the Goals of Medicine*, (Oxford: Oxford University Press, 1991).
[21] T.. Greenhalgh, 'Narrative based medicine in an evidence-based world,' *British Medical Journal*, 1999; 318(7179), pp. 323-325.
[22] T. Greenhalgh and B. Hurwitz, *Narrative-Based Medicine* (London: BMJ Publications, 1999).
[23] R. Puustinen, 'Voices to be heard – the many positions of a physician in Anton Chekhov's short story "A Case History,"' *Journal of Medical Ethics: Medical Humanities* 2000; 26(1), pp. 37-42.
[24] J. Holmes, 'Narrative in psychiatry and psychotherapy: the evidence?' *Journal of Medical Ethics: Medical Humanities* 2000; 26(2), pp.. 92-96.
[25] R. Charon, 'Narrative medicine: a model for empathy, reflection, profession and trust,' *Journal of the American Medical Association* 2001; 286(15), pp. 1897-1902.
[26] A. Mauron and M. Louis-Courvoisier, '"He found me very well; for me, I was still feeling sick." The strange worlds of physicians and patients in the 18th and 21st centuries,' *Journal of Medical Ethics: Medical Humanities* 2002; 28(1), pp. 9-13.
[27] S. Frederiksen, 'Diseases are invisible,' *Journal of Medical Ethics: Medical Humanities* 2002; 28(2), pp. 71-73.
[28] C. Helman, 'The healing bond' (introduction in:) C. Helman (ed.) *Doctors and Patients: an anthology* (Oxford: Radcliffe Medical Press, 2003; see especially pp. 3-4).

[29] E. Cassell, *The Nature of Suffering and the Goals of Medicine* (Oxford: Oxford University Press, 1991), Preface, p. x.
[30] Ibid., p. 137.
[31] Charon, 'Narrative medicine: a model for empathy, reflection, profession and trust,' p. 1897.
[32] F. Capra, *The Turning Point: science, society and the rising culture* (New York: Simon & Schuster, 1982; reprinted London: Fontana, 1983), see especially pp. 118-9.
[33] D.M. Morris, *Illness and Culture in the Postmodern Age* (Berkeley, CA: University of California Press; 1998).
[34] B. Good, *Medicine, Rationality and Experience* (Cambridge: Cambridge University Press 1994), see especially chapter 2.
[35] Toulmin, 'Knowledge and art in the practice of medicine.'
[36] D.A. Greaves, *The Healing Tradition: reviving the soul of Western medicine* (Oxford: Radcliffe Publishing, 2004), Preface, p. ix.
[37] Ibid., p.149
[38] M. Sirridge and K. Welch, 'Body image and the innocent eye,' *Journal of Medical Ethics: Medical Humanities* 2002; 28(1), pp. 35-40.
[39] S.P. Wainwright and B.S. Turner, 'Reflections on embodiment and vulnerability,' *Journal of Medical Ethics: Medical Humanities* 2003; 29(1), pp. 4-7.
[40] C.-E. Rudebeck, 'The body as lived experience in health and disease,' in M. Evans, R. Ahlzén, I. Heath and J. Macnaughton (eds) *Medical Humanities Companion Volume One: Symptom* (Oxford: Radcliffe Publishing, 2008), pp. 27-46.
[41] H.M. Evans, 'Wonder and the clinical encounter,' *Theoretical Medicine & Bioethics* 2012; 33, pp. 123–136; see p. 127.
[42] T. Mann, *The Magic Mountain*, ([1924] translated by H.T. Lowe-Porter [1927], London: Vintage Books 1999).
[43] H.M. Evans, 'Wonder and the patient,' *Journal of Medical Humanities* 2015, 36; pp. 47-58.
[44] M. Evans, 'Open futures, human finitude,' in J. Gordon, J. Macnaughton and C.-E. Rudebeck (eds), *Medical Humanities Companion Volume Four: Prognosis* (Oxford: Radcliffe Publishing 2014), pp. 105-120.
[45] R. Porter, 'What is disease?' in R. Porter (ed.) *Cambridge Illustrated History of Medicine* (Cambridge: Cambridge University Press 1996), pp. 82-117; see p. 95.
[46] M. Johnson, *The Meaning of the Body* (Chicago: Chicago University Press, 2007).
[47] C. Rehmann-Sutter and D. Mahr, […] this Volume.
[48] D. Bissell, 'Placing affective relations: uncertain geographies of pain,' in B. Anderson and P. Harrison (eds), *Taking Place: Nonrepresentational Theories and Geography* (Farnham: Ashgate, 2010), pp. 79-97.
[49] B. Greenhough, 'Vitalist geographies: life and the more-than-human' in B. Anderson and P. Harrison (eds), *Taking Place: Nonrepresentational Theories and Geography* (Farnham: Ashgate, 2010), pp. 37-54.
[50] R. Leys, **'**The turn to affect: a critique,' *Critical Enquiry* 2011; 37 (3), pp. 434**–**72.
[51] Evans, 'Wonder and the patient.'
[52] S. Blackmore, 'She won't be me,' *Journal of Consciousness Studies*, Singularity Special Edition, Vol 19, pp 16-19.
[53] L. Dolezal, […] this Volume.

[54] D. Herman (ed.), *Animal Worlds in Modern Fiction: an introduction*; edition of *Modern Fiction Studies* 2014; 60 (3).
[55] P. Guzmán, *Nostalgia for the Light*, Icarus Films, 2010
[56] Evans, 'Open futures, human finitude.'
[57] Evans M, 'Wonderful treatment,' in P. Louhiala, I. Heath and J. Saunders (eds), *Medical Humanities Companion Volume Three: Treatment* (Oxford: Radcliffe Publishing, 2014), pp. 17-32.
[58] C.S. Lewis, *That Hideous Strength* (London: The Bodley Head, 1945).
[59] Evans, 'Wonderful treatment.'
[60] J. Harris, *The Value of Life* (London: Routledge & Kegan Paul, 1985).
[61] I owe this suggestion to Professor Robert Barton, Department of Anthropology, Durham University.