

Professionalism, Medical Humanities and the Art of Medicine

Medicine is both an art and a science, the axiom says, locating it firmly in both the humanist and the empirical traditions (Herman 2001). However, the most immediately familiar identity of medical education in the Western intellectual tradition (Tarnas 1991) is as a means of teaching a science, drawing on a technical-rational idea of ‘facts’ – items of knowledge that are universal, observable, repeatable and, above all, amenable to the ‘scientific method’ of quantification and verification.

What, then, is the art of medicine? The answer that science lies in the theory of medicine, and that art, therefore, lies in the practice of medicine, is an attractive one, conjuring up an image of gentle scientists using their hard-won, specialist, empirical knowledge to alleviate the suffering of unfortunate humanity, whatever people’s rank or creed. This answer should not be neglected, since it points both to the emancipatory purpose of education, and to a role in social justice that lies at the heart of medicine, combining both qualities in the idea of medical education. However, attractive though this idea may be, it should not be taken as an adequate answer. It is problematic to formulate ‘medical’ as meaning science, theory, and quantity, and to formulate ‘education’ as meaning art, practice, and quality. First, such a formulation sets up a binary between the two sets of terms, positioning each as exclusive. Second, it suggests that the practice of medicine is secondary to its theory, rather than that both inform each other, as happens in the real-life clinical encounter. Third, it suggests that medicine focuses on only one kind of knowledge – theory, ‘knowing that’ – a view that does not reflect the actual progress of learners from undergraduate to postgraduate medical education [PGME]. As Chapter 2 discusses, more than one kind of knowledge is needed to learn the practice of medicine, since ‘knowing that’ must be accompanied by ‘knowing how’. Finally, that formulation, and the image of the doctor relieving the pain of the patient, expresses a clear relationship of power, benign power it is true, but still suggestive of the patient as the passive object of the doctor’s work. This provides a quite different feeling from the idea that the clinical encounter should be a meeting of doctor and patient for a shared discussion, to a common purpose, as required by two key tenets of the General

Medical Council's [GMC] *Good Medical Practice*: 'Treat patients as individuals and respect their dignity'; and 'Work in partnership with patients' (GMC 2009, frontispiece).



A Sufficient Curriculum

At the time of writing, understanding the right relationship between the art and science of medicine is more important than ever, since all of the National Curriculum Frameworks [NCFs] for PGME are being rewritten for implementation in Local Education Providers [LEPs] across the whole of the UK. As indicated in Chapter 1, *The Gold Guide* requires that every NCF must contain 'Professionalism', and that every postgraduate doctor must learn and demonstrate 'psychosocial and humanistic qualities such as caring, empathy, humility and compassion, social responsibility and sensitivity to people's culture and beliefs' (MMC 2010, 110). The requirement for professionalism is absolute as far as the GMC is concerned, since the standards set out in *Good Medical Practice* must be adhered to by all doctors, 'whether or not you hold a licence to practise and whether or not you routinely see patients' (GMC 2009, 5). GMC uses the term 'must' in a very particular way, saying "'must" is used for an overriding duty or principle' (GMC 2009, 5) and so the requirements of *Good Medical Practice* have the ethical force of Kant's Categorical Imperative discussed in Chapter 2. This means that curriculum development for medical education is a morally charged activity.

In Kent, Surrey and Sussex Postgraduate Medical Deanery [KSS], we use Stenhouse's (1975, 5) definition of a curriculum:

The means by which the experience of attempting to put an educational proposal into practice is made publicly available. It involves both content and method, and in its widest application takes account of the problem of implementation.

Stenhouse's requirement is for an explicit curriculum, one that can be made 'publicly available', so that the qualities that comprise 'professionalism' can be understood, discussed, explored, and accounted for. Further, this definition foregrounds the idea of a curriculum arising out of practice, which, as well as being explicit about principles, purposes, content, experiences, outcomes, and processes, also requires explicitness about its ethics, since ethics form a fundamental part of a curriculum statement for clinical practice.

A sufficient curriculum for PGME, therefore, must provide an expression of its whole theory and practice: the art of medicine, as well as its science; professionalism as 'knowing how', as well as 'knowing that'. The KSS approach to developing professionalism, therefore, is to explore what the art of medicine comprises, what tacit understandings about the 'psychosocial and humanistic qualities' of medical practice might be made explicit, and how professionalism might be taught and learned. We believe that these explorations will broaden and deepen practitioners' understandings of their practice, extend important interdisciplinary aspects of the real-life clinical workplace, and provide a means of developing

that most elusive of all clinical qualities, 'insight'. Ultimately, of course, professionalism has an immediate and direct patient-safety agenda, and it is with this purpose in mind that KSS and Birkbeck College teach a part-time MA degree in Medical Humanities, to seek new ways of improving patient care, for the new National Health Service [NHS].

Like all other aspects of our work described in this book, the subject of Medical Humanities in KSS begins with the real-life, messy, problematic world of everyday clinical practice, and focuses on improving patient care. It is concerned with local complexity, creativity, and diversity, and thus recognises the interdependency of theory and practice, of art and science, and of humanistic and technical principles, as they arise in usual patient care. It allows the particular person to be understood in the light of universal values, and vice versa since it promotes questions about individual needs, experiences, and understandings, and how they might change in different contexts and circumstances. From this standpoint, patients cease to be objectified as raw material, as passive bodies to be acted on by active scientists. Their intersubjectivity is recognised, that is, they are seen as people, with agency and autonomy, as owners of their bodies and lives, and as having a voice and a choice. Such views intertwine humanism with technology, so that they overlap, illuminate each other, and create a 'third space', an interstitial area, or contact zone, where real-life learning and practice co-construct each other. In curriculum terms, this is the Curriculum in Practice [CiP], that is, the curriculum as it is experienced and created by patients, learners, and teachers, in their processes of creating explicit, mutually agreed roles, responsibilities, boundaries, and expectations.

These ideas, principles, and values have always been held implicitly by Western medicine, communicated in powerful ethical statements such as the Hippocratic Oath, the Oath of Maimonedes, and the Physician's Oath of the World Medical Association. Enmeshed in the inspiring, poetic language of these Oaths are ideas about knowledge, history, intuition, and the imagination – that is, the humanities – and their relationship to patients, doctors, and scientific medicine. Exploring these ideas, and making them available for discussion, is the remit of Medical Humanities.



Two Kinds of Knowledge

The implication of my opening idea, that the science of medicine lies in the theory, and its art lies in its practice, is that each clinical encounter is a synthesis of theory and practice. In Chapter 2, I describe this as the relationship between part and whole, the logical relationship between the 'necessary' and the 'sufficient', in which the part is contained within the whole, a smaller term contained by a larger term, as a yolk is part of a whole egg. So, the part is necessary, but not sufficient, to describe the whole. These are logical relationships, expressed in Chapter 2 as 'fried egg' diagrams, but shown more formally in logic as a set of analogies. So, the relationship between part and whole is analagous to the relationship between the necessary and the sufficient, usually written as:

part: whole ↔ necessary: sufficient

Such a logical relationship is a basic building block of Western philosophy, operating throughout our daily lives, as, for example, the relationship between the particular and the universal, between time and eternity, or between *bios* and *zoe*:

particular: universal ↔ time: eternity ↔ *bios*: *zoe*

In terms of different kinds of knowledge – different epistemologies – a similar logical relationship exists between *episteme* and *gnosis*. By *episteme* is meant knowledge of fixed systems, things that stand in a specific, unalterable relationship to each other – mathematics, anatomy, or the laws of the physical universe, for example. *Gnosis* is a different kind of knowledge: it is knowledge arising from relationship, created by different people and things operating together to form a whole, which can be fluid, provisional, changing, and developing. The knowledge arising from relationship includes the knowledge of fixed systems, and so *episteme* as the smaller term is contained by *gnosis* as the larger term, although, of course, *episteme* can never contain *gnosis*. *Episteme* is vitally necessary to medical practice but only *gnosis* is sufficient to describe professionalism's requirement for caring, empathy, humility, compassion, social responsibility, and sensitivity to people's culture and beliefs.

Part of medicine, then – the science, the facts – is *episteme*, but it is held within, and given meaning by, *gnosis* – the understanding of how the science interacts between the patient and doctor, their contexts, the setting, the other people involved, everyone's needs, abilities, and achievements. *Episteme* describes the particular place, time, and sequence of events, but their meaning is created and contained by *gnosis*, the web of relationships, through which the events are understood as having quality and feeling. *Episteme* is created by these factors being brought into context with each other. *Gnosis* supplies the art of medicine, as *episteme* supplies its science: science and technology are necessary to medicine, but not sufficient to describe its whole practice. Expressed logically:

part: whole ↔ necessary: sufficient ↔ *episteme*: *gnosis* ↔ science: art



Two Kinds of History

In the Western mind's collective narrative of events, *episteme* appears as history, in the form of a detailing of recorded, verifiable facts, gathered and interpreted by careful historians. These are used to make increasingly complete accounts, from a range of perspectives, working in the tradition of *episteme* to provide a detailed, balanced, complex narrative of the past. However, such historical accounts are always partial, both in the sense of being a record of only a part of what happened, and in the sense of providing a particular viewpoint, since proverbially, history is written by the victors. Furthermore, because this task of *episteme* is an important and engaging one, it is dominant in our understanding of the term 'history', and thus it can be easy to overlook history as *gnosis*. *Gnosis* is history as a set of strong, recurrent relationships, not just between people and other people, but between people

and the whole world they occupy. It supplies a sacred history – ‘sacred’ means literally, ‘making whole’ – the literature, arts, music, landscapes, buildings, and artefacts that express a culture’s mythology, the *zoe* of the individual *bios*: life out of time, rather than life-in-time, the meaning of life as an absolute value.

This is important to medicine, where reverberant symbols of a staff with two snakes and a staff with one snake, speak to its sacred ancestry. The staff with one snake is an attribute of Asklepios, teacher of Hippocrates, himself taught by the centaur Chiron, who received the sacred knowledge from Apollo. It indicates medicine’s life-in-time, its *bios*, a genealogical inscription, traced through a line of inheritance, as a traditionally historic, sequential account. For medicine’s *zoe*, the eternal, categorical valuing of human life, that is fundamental to clinical ethics and practice, it is necessary to go to the caduceus, the staff with two snakes, which is an attribute of Hermes, and which indicates the liminal positioning of doctors, literally at the borderline between life and death. Of all the Olympic pantheon, only Hermes can travel between Hades, the dark realm of death, and the everyday world of light and life. Mythologically, then, both Apollo and Hermes are needed to represent the whole of medicine’s work and realm, both the single and the double snakes, the *bios* and the *zoe*. Indeed, as the Homeric *Hymn to Hermes* makes clear, the two gods are brothers (Cashford 2003, 55-84).

Unsurprisingly, then, ‘health’ also means ‘whole’, from the Anglo-Saxon ‘hale’, and in order to ‘make whole’, the first hospitals were places that evoked eternal values – temples to Asklepios, since ‘temple’ arises from the root ‘tempus’, meaning ‘time’, so that ‘temple’ is literally ‘out of time’, in eternity, where *bios* returns to *zoe*, to be restored to wholeness. The literal meaning of these words has been lost, or has declined to denote some kind of superstition, but their resonances are still present. Today, too, as for thousands of years in Western Europe, to enter a hospital is to seek to be made whole, in a place that is outside the usual constraints of daily time, surrendering to life and death possibilities, asking for help from people whose exceptional practice positions them every day on that chthonic borderline – doctors, the priests of Asklepios – and hoping for health, for wholeness, for the literal sacredness of their life to be restored.

History as *gnosis*, then, expresses and arises out of a view of the world as entire and whole – it is a ‘sufficient’ view. It reflects what the poet W. B. Yeats called the ‘*Spiritus Mundi*’ (1950, 211), the life of the world, which his contemporary, psychologist Carl Jung referred to as ‘the collective unconscious’. As the literary critic Northrop Frye puts it (1982, xviii):

Man lives, not directly or nakedly in nature like the animals, but within a mythological universe, a body of assumptions and beliefs developed from his existential concerns. Most of this is held unconsciously, which means that our imaginations may recognize elements of it when presented in art or literature, without consciously understanding what it is that we recognize.

Frye thus distinguishes between ‘*Weltgeschichte*’, or history of the material world, and ‘*Heilgeschichte*’, the sacred history, which enables us to locate our felt experiences within the larger ‘mythological universe’. Similarly, the religious historian Mircea Eliade describes

both 'knowledge in the modern sense of the term, objective and compartmentalized information, subject to indefinite correction and addition', and "'sacred history" – mythology [which] is exemplary, paradigmatic: not only does it relate how things came to be; it also lays the foundation for all human behaviour and all social and cultural institutions' (1958, x-xi). These distinctions parallel Jung's 'two kinds of thinking': 'directed thinking', which he sees as exemplified by science and technology, and 'subjective thinking', 'actuated by inner motives . . . based on instinct', through which directed thinking 'is brought into contact with the oldest layers of the human mind, long buried beneath the threshold of consciousness' (Jung 1967, 7-33). In a similar formulation, feminist historian Diane Purkiss (1996) discusses *herstory*, history as affinity, which foregrounds the personal and emotional, in order to interpret and understand the felt, imaginative significance of recorded 'fact'. This distinction is crucially necessary to human consciousness since, as Cashford (2003, 11), succinctly points out, 'the world is not given us as fact but inhabited through interpretation'. Thus, as Martin Buber suggests, experience must be understood both as 'the events themselves', and 'the manner in which the participating people experienced those events' (1946, 16). Cashford quotes Einstein's sombre warning, made in 1964, of the penalties of not reaching for these new understandings: 'The unleashing of the power of the atom bomb has changed everything except our mode of thinking, and thus we head towards unparalleled catastrophes' (2003, 11).

It is crucially important to professionalism, therefore, to recognise that every patient has two histories, one contained in the other, as the part is contained in the whole, and as *episteme* is contained by *gnosis*. The patient's first, immediate history is their *bios*, absolutely necessary for treatment, a partial account of their life-in-time: age, sex, clinical history, injury, condition. This technical view of the patient, caught in a particular moment in time, focuses them as science, and identifies them by injury, so they become 'a fracture', 'an MI', or 'an overdose'. This is the *episteme* of the matter, but it is not the *gnosis* of the person, or of any of the people present, whether labelled as patient, doctor, nurse, patient's family, specialist registrar, ward clerk, or any other technical identity. The *gnosis*, the wholeness of each person, lies in their story, or mythology, in their personal experience of the universal, the affinities that have opened to them in their whole, 'sacred' history: the beliefs, views, feelings, perceptions, and ideas through which they inhabit the world. Succinctly, strong *episteme* is necessary, but only *gnosis* is sufficient for 'a whole team' to treat 'the whole patient' as part of an organisational 'whole systems' approach. The art of medicine lies in developing that *gnosis*, at every level of patient care.



Intuition, Imagination and Science

Science, of course, has always been aware of this 'other world' of artistic, imaginative truth. Even as Newton formulated his magisterially universal laws of gravity and thermodynamics, and ushered in the scientific revolution, he was working also as a noted alchemist, concerned with the alchemical quest for the philosopher's stone, spiritual perfection, expressed as the ability to turn base metal into gold. As Harpur (2002, 163-4) points out, in their search

for 'the union of the four elements, Mercurius quadruplex', alchemists referred to their work variously as 'our art, our science, and our philosophy', so that it is unsurprising to find Newton, at the end of his life, couching the relationship between his scientific and his metaphysical searches in terms of part and whole, reportedly saying (Brewster 1855, 407):

I do not know what I may appear to the world, but to myself I seem to have been only like a boy playing on the sea-shore, and diverting myself in now and then finding a smoother pebble or a prettier shell than ordinary, whilst the great ocean of truth lay all undiscovered before me.

Newton's contemporary, the visionary poet and painter William Blake, sought actively to reconcile *episteme* and *gnosis* through his art, pointing to the need for 'a double vision' (CW 816-8), and commenting:

Every body does not see alike. . . The tree which moves some to tears of joy is in the Eyes of others only a Green thing that stands in the way. Some See Nature all Ridicule & Deformity . . . & Some Scarce see Nature at all. But to the Eyes of the Man of Imagination, Nature is Imagination itself. As a man is, So he Sees. As the Eye is formed, such are its Powers (CW 793).

In their different ways, both Newton the physicist and Hermetic alchemist, and Blake the poet and painter, were working within the same enduring philosophy, Neo-Platonism, which Raine (1979, 2-3) says:

may be compared to an underground river that flows through European history, sending up, from time to time, springs and fountains; and wherever its fertilizing stream emerges, there imaginative thought revives, and we have a period of great art and poetry. The works that taught Blake and the other English Romantic poets are the same that inspired the Florentine School of Athens, the American Transcendentalists, and in our own time laid the foundations of the Irish renaissance; many of the works Blake studied are on the shelves of William Butler Yeats's library, in Dublin, to this day.

In scientific practice, intuition and imagination act as a single, concurrent movement. Intuition, the knowing that comes before knowledge, prompts the scientist to notice a particular item at a particular time: it is, perhaps, the coming together of a lifetime's conscious and unconscious assimilation of knowledge, skills, and experience, to provide an inner prompting, to give particular attention to a particular detail. Concurrently, imagination paints a picture – an *imago*, or image – of what that intuitively perceived detail might, or could, represent or lead to. Suddenly, the whole of the person's power of inquiry is engaged in new discovery. These discoveries are inspired, we say, meaning, literally, that the *inspiro*, the 'breath of the god', has entered and moved the individual: a well-spring of previously unknown ideas has been tapped. It is in this way that Alexander Fleming intuitively noticed and imaginatively visualised the possibilities for penicillin, that Wilhelm Röntgen was inspired to discover x-rays, and that James Watson accounted for the breakthrough that led him to understand the structure of DNA. Similarly, in a contemporary scientific account (Association

of Medical Humanities 2010, 12):

In 2005, Francis Wells, a consultant heart surgeon at Papworth Hospital, Cambridge pioneered repair to damaged hearts from viewing Leonardo's medical drawing derived from dissections. Francis used the drawings to work out how to restore normal opening and closing function of the mitral valve, so that instead of repairing a floppy valve by narrowing its diameter - thereby restricting blood flow under exertion - he underwent 'a complete rethink of the way we do the mitral valve operation' . . . Francis Wells has completed over 2,000 mitral valve repairs, achieving a near 100% rate for fixing leaking mitral valves.

It is significant, perhaps, that Wells's guide, Leonardo, was a member of the Neo-Platonic Florentine Academy, established by Lorenzo de' Medici, poet and statesman, and led by Marsilio Ficino, a doctor's son like Aristotle, the first translator of Plato's works into Latin, in touch with all the great European minds of science, art and philosophy, and a leading humanist of his day.



Arts and Sciences Resolved

Newtonian science, and even Einstein's physics, have long since given way to quantum physics, in which light is both a wave and a particle, observation of any phenomenon alters it, and the number of dimensions has expanded to ten, or some say eleven, depending on the mathematical theory in play. The multiple vision that Blake found in the natural world has been rediscovered in the laboratory, as Thomas Kuhn, writing about the structure of scientific revolutions in 1968, said it would be reworked and re-envisioned. Kuhn coined the term 'a paradigm shift' to describe the tiny changes in perception, that mean that a whole scientific vision changes utterly, so that the Sun no longer orbits the Earth, atoms become divisible, and the Earth a self-organising entity. At the same time, the post-modern turn, and complexity theory, have elaborated Blake's axiom that 'as a man is, so he sees', through its recognition that complex systems are essentially intersubjective networks of relationships – Newton's 'great ocean of truth' or *gnosis*. Indeed, Lovelock's Gaia Theory (1979), coupled with real and present political concerns about global warming, suggests that working within that complex web of relationships – participating in *gnosis* – may be a matter of personal and species survival.

It is a loss of innocence that every responsible science, perhaps, has to undergo. Nevertheless, recognising the limitations of a purely technical-rational approach also offers an opportunity for science to re-acquaint itself with the larger world of which it is part, to learn to work within the ambiguities, uncertainties and possibilities that characterise the Humanities, which science is rediscovering in itself. In practice, this means learning to work with what Keats called 'Negative Capability'. In a letter to his brothers on 21 December 1817 he said:

Browne & Dilke walked with me & back from the Christmas pantomime. I had not a dispute but a disquisition with Dilke, on various subjects; several things dovetailed in my mind, & at once it struck me, what quality went to form a Man of Achievement especially in Literature & which Shakespeare possessed so enormously - I mean Negative Capability, that is when a man is capable of being in uncertainties, Mysteries, doubts, without any irritable reaching after fact & reason (Rollins 1958, 193).

The occasion is not a formal discussion or lecture, but an informal, opportunistic conversation – a ‘professional conversation’, as we call it in KSS. In PGME, this is the process and point of transformation, the moment when the learner suddenly ‘gets it’, when the words and notes are heard together as a song – it is ‘anagogy’ as the Renaissance mind termed it, the education of the learner by sudden insight. Every experienced clinician is familiar with this experience: the case in which all the objective data, the *episteme*, clearly point in one direction, but about which a nagging uncertainty enters the mind, unwilling. These doubts and uncertainties have no rational basis – their genesis is instinctive – but if they are followed appropriately, then they lead to knowledge that can throw a new and different light on the case, to the benefit of patient and doctor. Where ‘pedagogy’ means teacher-led learning, and ‘andragogy’ means self-directed learning, ‘anagogy’ means ‘led from above’, that is, led onto an unexpected path, by a visible fact that reveals an invisible truth. Anagogy and negative capability are part of the formation and practice of doctors, as greatly powerful as they are generally unacknowledged.

It is crucial to note, however, that negative capability requires one to sit within the mysteries, doubts and uncertainties, without an irritable search for an answer. Real-life clinical practice does not operate to a technical-rational model, in which the answer arrives after a pre-ordained period of analysis, any more than the resolution of a patient’s condition occurs at a specific point in time, still less a predictable one. Rather, both are a longer-term, gradual shifting of understandings, as every Intensivist knows. In Intensive Treatment Units, patients progress from being monitored minute by minute, to being monitored hour by hour, then day by day, at an individual rate, over an unpredictable time period. Ripeness is all. A point arrives when the learner understands, when resolution has been achieved, when the patient is well, but these are not foreknown, and even in retrospect, they may be difficult to describe. As T. S. Eliot puts it in *Four Quartets* (2001,5):

I can only say, *there* we have been: but I cannot say where.
And I cannot say, how long, for that is to place it in time.

Above all, the Humanities provide – restore, really – an additional way of *seeing*. Science’s love affair with the microscope, telescope, and every other kind of scope, produced astonishing, breathtaking benefits to humanity, but it also moved medicine’s gaze from the personal standpoints and lived experience of individual people. In medicine, the scientific gaze became a Foucauldian ‘regarde’, penetrating beneath the skin, into humanity as biology and biochemistry, not into people as whole, contextualised individuals. For medicine, therefore, the present shift in science’s claims for objectivity is not so much a loss, as a restoration of a newly understood subjectivity: intersubjectivity, the co-construction of a shared narrative

about an individual's condition, treatment, and outcome. Such a narrative engages all stakeholders – doctor, patient, team, and organisation: social sciences and management sciences join biomedical sciences to become part of an essentially humanistic project, requiring humanistic insights.

These humanistic insights, and a restored way of seeing, may be learned from the complex accounts of human emotions, actions, and relationships that comprise literature; from the intensely personal possibilities, choices, and consequences depicted by drama; from the nuanced aesthetics involved in art and music's depictions of people, places, and worlds; and from the complex intertwining of mythologies, artefacts, values, and rituals, through which cultures articulate themselves. Experiencing them is to experience, *par excellence*, the 'uncertainties, Mysteries, doubts' of negative capability, and their appreciation requires patience, a slow unfolding, without 'irritable reaching after fact & reason'. It is the same discipline that is required from our Intensivist, or from any clinician faced with a complex and critical case, since the art of medicine is an entry into the world of artistry, where keen observation, alertness to possibilities, provisional judgement, a readiness to notice new information or ideas, receptiveness to ambiguity, and a deep pleasure in weaving these elements together to form many-layered interpretations, and to derive a whole understanding, is required.



Back to the Future

To return to Raphael's image of Plato and Aristotle, invoked in Chapter 2, what is required is a marriage of art and science, an overlapping, as Plato's and Aristotle's figures overlap, to produce a 'third space', a new location, where apparent contraries are reconciled. It is not a matter of 'either-or', but of 'both'.

Raphael has made this clear in his painting, with a little in-joke, painting Plato's mobile figure as barefoot, a direct reference to the *Symposium*, in which five people, including a doctor, debate the nature of the highest good, the greatest love, and the finest knowledge. In that dialogue, Socrates recounts what he was taught by his own teacher, 'Diotima of Mantinea, a woman wise in this and in many other kinds of knowledge'. Diotima teaches Socrates that in all things that appear antithetical, there is always 'a mean between the two', a third space (*Symposium* § 201-2). Raphael's visual allusion is to Diotima's personification of the lover of wisdom, who, occupying this third space, 'is always poor . . . and has no shoes, nor a house to dwell in; on the bare earth exposed he lies under the open heaven', and yet is also 'bold, enterprising, strong, a mighty hunter . . . keen in the pursuit of wisdom, fertile in resources, a philosopher at all times' (§ 203). This third space is fluid, like the painting's mobile harmonisation of movement, direction, and epistemology, which Raphael suggests by overlapping Plato's and Aristotle's figures. Diotima says, 'that which is always flowing in is always flowing out', so that the third space occupies a kind of homeostasis, since it 'is never in want and never in wealth'. Furthermore, its understandings are always provisional, since it 'is a mean between ignorance and knowledge' (§ 203-4).

As the contemporary French philosopher, Luce Irigaray, points out, Diotima's teaching provides a particular kind of dialectic, since 'it doesn't use opposition to make the first term pass into the second in order to achieve a synthesis of the two . . . she presents, uncovers, unveils the insistence of a third term that is already there and that permits progression: from poverty to wealth, from ignorance to wisdom' (Irigaray 1993, 20). There is, therefore, no requirement for science to exist at the expense of art, or vice versa, where both are oppositional cultures: they are not a battle between competing interests, as writers such as C. P. Snow (1960) suggest. Rather, they are a conversation informed by two perspectives, which are inextricably intertwined at the level of patient care and practice, and together called professionalism.



Such a reconciliation of art and science is ever-present but not automatically accessible: it must be sought, as a particular vision. Diotima calls this vision 'daemoniac', that is, 'intermediate between the divine and the mortal' (§ 202), since 'daemon' means, literally, 'guardian spirit', which in the context of professionalism we might call 'insight' or 'compassion', or 'conscience', or 'ethical awareness'. Elsewhere, Plato reminds us of the importance to the individual of exercising this 'daemoniac' faculty, with a word-play on the Greek for 'happy': 'because he has always looked after the divine element in himself and kept his guardian spirit (*daemon*) in good order he must be happy (*eudaimon*) above all men' (*Timaeus*, 121). For Irigaray (1993, 27), the daemoniac is 'a perpetual journey, a perpetual transvaluation, a permanent becoming', that is, it is provisional, highly contextualised, dependent on individual factors, rooted in radical uncertainty, and thus in PGME, co-constructed, patient by patient.

These kinds of epistemologies are being rediscovered by the contemporary Western mind, but for many Indigenous peoples they have never been lost. As Battiste and Henderson (2000, 35) point out, 'most Indigenous scholars choose to view every way of life from two different but complementary perspectives: first as a manifestation of human knowledge, heritage and consciousness, and second as a mode of ecological order'. They enlarge on this to say (2000, 45):

The traditional ecological knowledge of Indigenous peoples is scientific, in the sense that it is empirical, experimental, and systematic. It differs in two important respects from Western science, however: traditional ecological knowledge is highly localized and it is social. Its focus is the web of relationships between humans, animals, plants, natural forces, spirits, and land forms in a particular locality, as opposed to the discovery of universal "laws." It is the original knowledge of Indigenous peoples. Indigenous peoples have accumulated extraordinarily complex models of species interactions over centuries within very small geographical areas, and they are reluctant to generalize beyond their direct fields of experience. Western scientists, by contrast, concentrate on speculating about and then testing global generalizations, with the result that they know relatively little about the complexities of specific, local ecosystems.

Indigenous knowledge focuses, therefore, on the individual and on the particular, the complex, the uncertain, and the provisional, and on the relationships – we might say, the *gnosis* – that binds these things together, in a particular way, at a particular point in time. Within that 'web of relationships', precision and certainty are generated by empirical observations 'over centuries', but this Indigenous *episteme* is to be understood only within the context of *gnosis*, and not generalised beyond that field of experience. For Battiste and Henderson (2000, 43), Indigenous thought admits 'no separation of science, art, religion, philosophy, or aesthetics'. I suggest that, similarly, recognising the interpenetration of art and science is a precondition to teaching insight and professionalism in PGME.

In real-life practice, each patient arrives with their own story and identity that, as Balint (1957) puts it, they 'offer' to their doctor. To achieve 'sensitivity to people's cultures and beliefs', requires doctor and patient to work from their own personal understanding of

the world and to create between them a third space, occupied by *gnosis*, the knowledge formed by relationship. Otherwise, the patient is dehumanised and, instantly, the doctor is deprofessionalised: both become 'cyborgs' (Haraway 1991), both are degraded. The role in social justice, that lies at medicine's heart, is lost: all quality is gone, and doctors are reduced to competent technicians, and patients to raw material, on a production-line NHS. At the level of individual doctor and patient, therefore, good medical practice, and best patient experience, require a humanistic approach.

Further, the Crisp Report on *Global Health Partnerships* (2007) expresses a strong concern that 'Northern' scientific medicine, as it is presently conceived, is not sufficient to create effective partnerships with non-European cultures. This concern is supported by Battiste and Henderson's description of an epistemology that is different from the contemporary 'Eurocentric' approach of biomedicine, providing a different kind of science – more thoughtful, more specific, strongly culturally situated, holistic in the widest sense. At the level of nation, and of the NHS, therefore, there is an increasing discomfort with competing epistemologies.

The purpose of this chapter is to indicate a third space, in which a fuller sense of professionalism may be developed. Deprofessionalisation, degradation, and conflict are not inevitable, neither for individual practitioners and patients, nor for the NHS. Medicine's inheritance is a humanistic tradition, two and a half thousand years old at least, and, although it may have been somewhat overlooked in the remarkable flurry made by science in the two hundred years since Jenner, it is still present. It is a tradition which is still vital and living in Indigenous epistemologies, and its principles are still crucial to defining good medical practice. Called 'professionalism', taught sometimes as 'bedside manner', 'the patient encounter', or 'the consultation', it is what is meant by the 'art of medicine': the disciplines, inquiries and waymarks studied as Medical Humanities. Exploring this re-discovered stream of professional artistry opens up, for the medical profession, wider and deeper understandings of their work, and waymarks a route to creating a more nuanced and richer sense of medical professionalism.

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