

JAN NAWROCKI is a urological surgeon practising in Sussex. He has degrees in medicine, surgery and education and has held various management and leadership roles in these fields. He is currently President of the European Board of Urology and a PhD student at Birkbeck. His interests include the practical reasoning and dispositions of doctors.

Article

Methodology in the Medical Humanities

A Short Narrative of Theory and Practice

Jan Nawrocki



I WAS FIRST CONFRONTED WITH THE TERM MEDICAL HUMANITIES ABOUT TEN YEARS AGO. It appeared in a document which asked me what provision I had made for the subject in the area of postgraduate medical training for which I had responsibility. Despite many years of practice and experience at dealing with the increasingly authoritarian demands of regulatory bodies in healthcare and medical education my response was not to craft some suitably erudite and reassuring reply. My reaction wasn't even: 'Oh no! Not yet another requirement for which we have little time and resource!' It was quite simpler: 'What on earth is *medical humanities*?' Therefore, I still feel something of a fraud when asked to talk or write on the subject.

Medicine and surgery have a teleological basis; a particular purpose. Medicine and surgery are subjects which serve the practices of medicine and surgery. Students of different academic fields may study their chosen areas for a variety of reasons, perhaps in order to gain better understanding and knowledge of the relevant subjects, perhaps to grow in useful personal attributes such as creative, independent and critical thinking. Students of medicine and surgery may attain the same benefits from their studies but the purpose of their endeavours is ultimately so that they can practice medicine and surgery. In turn, their practice of medicine and surgery is concerned with

-serving the health and well-being of individuals. The modern United Kingdom equivalent of the Hippocratic Oath, the General Medical Council's *Good Medical Practice*, reflects this *telos* when it admonishes doctors, 'to make the care of [their] patients [their] first concern'.¹

The components of the practice of medicine at one level are straightforward. A patient asks for help from a doctor. The doctor establishes what is the matter, advises the patient and helps deal with the health concern, if the patient so wishes. This simple summary belies enormous underlying complexity. The subjects and practices of medicine and surgery deal with matters of profound importance for the individual patient and may touch on matters of life and death. In spite of the advances of healthcare there remain many uncertainties. The foundation of medicine and surgery is a large amount of specialist knowledge, on which are built specialist skills. Clinical judgement is the mortar of this edifice and of particular importance. Judgement is the key to the decision making and problem solving that is required in clinical practice. Without good judgement or practical reasoning the specialist knowledge and skills would be of no use in achieving the aims of medical practice. They would remain of purely abstract or academic interest. Therefore, the exercise of judgement, clinical decision making or practical reasoning occupies a place of particular importance in medical education and medical practice. It is a subject that a number of us consider worthy of scrutiny and academic study.

Undergraduate medical students find that even in the era of readily accessible information, their education and training nevertheless concentrate predominantly on acquisition of specialist knowledge and skills. This is still mirrored in postgraduate training where, for example, doctors learning to be surgeons will tend to focus on the practical specialist skills required in the performance of surgical operations. Yet sooner or later both undergraduate medical students and postgraduate surgeons-in-training will come to realize that knowledge and skills are relatively easy to acquire and that the exercise of judgement is the important and more challenging attribute to learn. Sooner or later the surgeon comes to appreciate the oft-repeated adage that it is easy to learn how to operate, rather, it is knowing when to operate and when not to operate that is more difficult.

Academic study of judgement, clinical decision making or practical reasoning could reasonably be grounded in a number of different fields, each with different theoretical frameworks and methodologies to draw upon. After all, considerations of judgement and *phronesis* are scarcely unique to medicine and have been the subject of extensive deliberation in philosophy, psychology, sociology, anthropology and education. The broad fields of medicine and medical humanities are themselves comprised of numerous different subjects and so there are a number of different related areas that might be employed. However, this multitude of disciplines creates its own difficulties.

Inevitably, academic study in the medical humanities requires a suitable framework and theoretical basis. Yet, adopting an appropriate theoretical framework is not a straightforward proposition. By choosing a specific framework drawn from a particular field, there may be a tendency to limit any inquiry to the academic context of that field or subject. If the advantage of academic endeavour in the medical humanities is to benefit from a diversity of subjects and disciplines, then one may appreciate that a theoretical framework grounded in one particular area may be self-defeating. Therefore, for example, a research subject concerned with aspects of the practices of medicine and medical education might lean towards a theory situated in medicine. In this case, there might be a natural tendency towards a positivist

scientific paradigm or theoretical framework in which medicine is solidly and centrally placed. Yet there are ample examples of the limitations of the associated quantitative methodologies in such situations, particularly in subject areas more allied to the humanities.²

Furthermore, a natural conflict between theory and practice emerges. Much academic discourse appears to relate to matters of theory, new theories elucidated and earlier theories defended. Yet physicians and surgeons are concerned with practice, and practice and theory are so often portrayed as opposite ends of a spectrum. Foucault may state in a conversation with Deleuze that theory is practice, but Deleuze more graphically compares a useful theory to one that is like a 'well-used box of tools'.³ The doctor whose first concern is the care of the patient is likely to look and respond to a theory that assists practice and therefore is more akin to that familiar box of tools than to a theoretical framework that resembles the never-opened manual or textbook on the dusty top shelf.

Jerome Bruner's differentiation of two modes of thought provides a useful insight. Bruner describes 'paradigmatic thought' as grounded in positivism, which seeks to explain the world and establish truth through empirical means relying largely on scientific method.⁴ This, he suggests, 'seeks to transcend the particular by higher and higher reaching for abstraction, and in the end [it] disclaims in principle any explanatory value at all where the particular is concerned'.⁵ The contrasting manner of thought he terms the 'narrative mode', which opposes abstraction and is concerned with the particular, as narratives and stories describe human experience and action. The practice of medicine may be considered to be diametrically opposed to the abstraction associated with paradigmatic thought. It is concerned with the particular. Abstraction is not unimportant in medical practice. It is necessary to understand, for example, the anatomy of the kidneys in general, their physiology and the pathology that may affect them in an abstract sense. However, the practice of medicine requires, more importantly, an understanding of the individual patient and in this example an understanding of the particular patient's kidney anatomy, physiology and pathology. The need is to understand that particular person, not another person, nor an abstract group of people. Each such particular interaction between patient and doctor may be considered an individual small narrative amongst a multitude of others, which form part of a larger narrative of medical practice.

A number of authors imply that consideration of narrative in medicine has been a relatively recent phenomenon.⁶ This may appear to be so particularly in the field of medical humanities; especially where the emphasis has tended towards narrative medicine, which itself is focused on the narratives of patients.⁷ This has been seen in many forms, one of which is manifest in graphic medicine, which explores patients' experience of illness through comics and graphic novels.⁸ It appears there has been little interest in the narrative of the other half of the patient-doctor relationship, the doctor. However, that narrative is present and has always been a central part of clinical medical education and medical practice. The past narratives of doctors have been recorded in the memoirs and biographies of doctors for many years.⁹ The contemporary narratives of doctors are an ever-present and overflowing source, as known by anyone who has had the misfortune to suffer from a dose of doctors over a dinner table or in another social setting.

If narrative is to be used as a means and framework through which to view the practice of medicine and the patient-doctor interaction, then there remain a number of possible options to pursue. Narrative itself is interpreted

differently, with diverse terminology and meaning in distinct fields. Of the varied approaches to narrative research, the methodology of D. Jean Clandinin and F. Michael Connelly, *Narrative Inquiry*, has much to recommend it, as it allows for the use of diverse methods and has already been applied to a variety of fields such as law, education, medicine and psychology.¹⁰ Clandinin and Connelly develop their methodology through the concept of thinking narratively, promoted by David Morris.¹¹ They describe the tension created when working at what they term 'the boundaries'. They refer to working at the boundaries in many contexts. For example, it has resonance in many areas where there are multi- or inter-professional collaboration and concerns associated with pre-existing boundaries of preconceived thought, theory and practice. Such tensions may naturally surface within medicine, medical education and in particular within medical humanities. For Clandinin and Connelly, one particular area of tension is at the 'formalistic boundary', as they explain: 'formalists begin inquiry in theory, whereas *narrative inquirers* tend to begin with experience as expressed in lived and told stories'.¹² For *narrative inquirers* a theoretical framework might develop out of the inquiry, whereas for formalists a narrative inquiry, if undertaken, would be expected to follow agreement of a theoretical framework.

Education and training are fundamental components of medicine. Medicine is practice; it needs to be learnt and it needs to continue to be learned. Medical education is ongoing throughout every doctor's professional life. Like medicine, medical education emphasizes particularization rather than abstraction in its practice. Although the practice of education requires a degree of abstraction and generalization in the knowledge drawn from educational theories, it ultimately involves an individual learner who has an individual social context as well as particular attributes and requirements. Such a requirement for particularization in the practice of education again inclines to Bruner's narrative mode of thought. In this there is a natural synergy with the educational philosophy of John Dewey and others who advanced experiential education.¹³ Dewey believes in an 'organic connection between education and personal experience'.¹⁴ He stresses two components of experience: continuity and interaction.¹⁵ In Dewey's words, 'every experience enacted and undergone modifies the one who acts and undergoes, while this modification affects, whether we wish it or not, the quality of subsequent experiences'.¹⁶ More memorably he illustrates the concept of experiential continuum with the words of Lord Alfred Tennyson's 'Ulysses':

I am a part of all that I have met;
Yet, all experience is an arch wherethrough
Gleams that untravelled world, whose margin fades
For ever and for ever when I move.¹⁷

The influence of the past and the contemporary contexts in the practices of medicine and medical education is ever-present; it shapes their futures and is manifest in the diverse narratives of doctors and their teachers. These narratives in turn provide a valuable means of study for the researcher in medical humanities.

Birkbeck, University of London

Notes

- ¹ General Medical Council, 'Good Medical Practice', ed. by General Medical Council (2013).
- ² See for example: David Mechanic, 'Medical Sociology: Some Tensions among Theory, Method, and Substance', *Journal of Health and Social Behavior* (1989), 147–60; Catherine Pope, Nicholas Mays, and Jennie Popay, *Synthesising Qualitative and Quantitative Health Evidence: A Guide to Methods* (Maidenhead: McGraw-Hill Education, 2007).
- ³ Michel Foucault and Gilles Deleuze, 'Intellectuals and Power', *Language, Counter-Memory, Practice*, trans. by Donald F. Bouchard and Sherry Simon (Ithaca, New York: Cornell University Press, 1977), pp. 205-217 (p. 208).
- ⁴ Jerome S. Bruner, *Actual Minds, Possible Worlds* (Cambridge, MA: Harvard University Press, 2009), p. 12.
- ⁵ *Ibid.*, p. 13.
- ⁶ Rita Charon, 'Narrative Medicine: A Model for Empathy, Reflection, Profession, and Trust', *Jama*, 286 (2001), 1897–1902; David Hatem and Elizabeth A. Rider, 'Sharing Stories: Narrative Medicine in an Evidence-Based World', *Patient Education and Counselling*, 54 (2004), 251–53. A. Scott Pearson, Michael P. McTigue and John L. Tarpley, 'Narrative Medicine in Surgical Education', *Journal of Surgical Education*, 65 (2008), 99–100.
- ⁷ Trisha Greenhalgh, 'Narrative Based Medicine in an Evidence Based World', *British Medical Journal*, 318 (1999), p. 323; Brian Hurwitz, 'Narrative and the Practice of Medicine', *The Lancet*, 356 (2000), p. 2086.
- ⁸ Ian C. M. Williams, 'Graphic Medicine: Comics as Medical Narrative', *Medical Humanities* (2012).
- ⁹ See for example: Oscar Craig, *A Life in Medicine* (Self Published: London, 2000); Henry Marsh, *Do No Harm: Stories of Life, Death and Brain Surgery* (London: Weidenfeld & Nicolson, 2014).
- ¹⁰ D. Jean Clandinin and F. Michael Connelly, *Narrative Inquiry: Experience and Story in Qualitative Research* (San Francisco: Jossey-Bass, 2000); F. Michael Connelly and D. Jean Clandinin, 'Narrative Inquiry', in *Handbook of Complementary Methods in Education Research*, ed. by Judith L. Green, Gregory Camilli and Patricia B. Elmore (Routledge, 2006), pp. 375–85.
- ¹¹ David B. Morris, 'Narrative, Ethics, and Pain: Thinking with Stories', *Narrative*, 9 (2001), 55–77.
- ¹² Clandinin and Connelly, *Narrative Inquiry*, p. 48.
- ¹³ John Dewey, *Experience and Education, The Kappa Delta Pi Lecture Series* (London: Free Press, 2015); Donald A. Schön, *The Reflective Practitioner: How Professionals Think in Action* (New York: Basic Books, 1983).
- ¹⁴ Dewey, *Experience and Education*, p. 25.
- ¹⁵ *Ibid.*, p. 33.
- ¹⁶ *Ibid.*, p. 35.
- ¹⁷ *Ibid.*, p. 35.

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