

Reversing the Medical Humanities¹

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ABSTRACT: The paper offers the concept of *reversing the medical humanities*. In agreement with the call from Kristeva J, Moro MR, Ødemark J, et al. (2018) to recognize the bidirectionality of the medical humanities, I propose moving beyond debates of attitude and aptitude in the application and engagement (either friendly or critical) of humanities to/in medicine, by considering a reversal of the directions of epistemic movement (a reversal of the flow of knowledge). I situate my proposal within existing articulations of the field found in the medical humanities metaliterature, pointing to a gap in the current terrain. I then develop proposal by unfolding three reasons why we might gain something from exploring a reversed knowledge flow. First, a reversed knowledge flow seems to be an inherent – but still to be articulated – possibility in medical humanities and thus provides an opportunity for more knowledge. Second, the current unidirectionality of the field is founded on an inconsistency in the depiction of the connection between medicine and humanities, which risks creating the very divide that medical humanities set out to bridge. Practicing a reversal may help avoid this divide. And third, a reversal might help rebalance the internal epistemic power, so as to motivate less external scepticism and in turn displace more external epistemic power towards medical humanities. I end the paper with a remark on precursors for a reversal, and ideas for where to go from here.

INTRODUCTION: AN(OTHER) APPEAL TO THE MEDICAL HUMANITIES

What are medical humanities? What promises do they hold and what knowledge is gained from them? These are fundamental questions, frequently posed in the field. As a relatively young field or discipline, self-reflective debates about what medical humanities are – and should be – are still numerousⁱ, and suggestions for new paths are many and varied. In this paper, I wish to propose a reversal of the way most previous literature has thought about medical humanities. I make this proposal with curiosity about where it might lead and give three reasons why I think reversing the medical humanities is worth thinking more explicitly about. The paper will develop the notion of reversal through these reasons as well as situate it among dominant articulations or schools in the field. The reversal is proposed as a new (and additional) articulation within the field, but this paper should be read only as an initial encouragement for further debate not as a final formulation, a suggestion rather than an argument.

In the theme paper for the conference behind this special issue, J Kristeva, MR Moro, J Ødemark & E Engebretsen call for “a fundamental rethinking of the medical humanities”ⁱⁱ. They set the stage for debate within medical humanities by noting that despite the recent critical turn of medical humanities, the field is still broadly organized as an application of humanities to the field of medicine – be it as supportive friend or critical tutor. Kristeva et al. see more potential in medical humanities as a bidirectional undertaking, where medicine and the humanities should be taken seriously as equal partners in medical practice. For Kristeva et al., the bidirectional

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version of medical humanities implies that we should find ways of uncovering how humanities – like biomedicine – can be materially productive in their own right (and not just supportive of the productivity of biomedicine); and they ask that researchers, funding committees and academic institutions give more material weight to the humanitiesⁱⁱⁱ.

I support the call to reinforce a bidirectionality, but my errand here is slightly different from that of Kristeva et al. While they advocate for making humanities and medicine partners in the medical enterprise, I focus instead on the inverse aspect of the issue, that is, on the cultural and humanistic productivity of medicine. By this, I do not mean the ways biomedicine and medical technologies shape our culture (as shown by historical and cultural analyses), but rather the ways in which medical practice *produces* cultural knowledge (as opposed to material effects), the partnership that medical practice may have in the ‘humanities enterprise’. I thus propose an alternative way of rehabilitating bidirectionality within medical humanities that takes medicine and particularly medical practice seriously within the field of humanities. I do this through the notion of *reversing the medical humanities*. I want to suggest that such a reversal is inherently implied in the claim that medicine is or should be more than just science: that medicine is at its core preoccupied with the human condition. If this is the case, there should be elements in medical practice that contribute to the humanities (and to medical humanities)^{iv}. That is, I suggest that the field of medical humanities might gain something from exploring the possible ways that medicine may actively contribute insights in a humanities context, and not only ways in which it passively receives knowledge from the humanities. As already stated, I will ground the proposal of reversal in three reasons: an epistemic reason, a reason from self-consistency, and a pragmatic reason, and end with some initial ideas of where to look for this reversed movement. First, however, I will give some clarifications on the way I have conceptualised the issue through the notions of ‘articulation’ and ‘movement’ in order to situate this paper within the already existing field.

REVERSING WHAT?

Proposing a reversal of the medical humanities implies a reversal of the traditional flow of knowledge within the field, that is, a change in the direction of movement. For an understanding of the traditional direction and flow of knowledge I look to the metaliterature of the field, which provides several (complicated and complex) articulations of what medical humanities are. From this I suggest the initial outline of a possible additional articulation, namely one based on a reversed flow direction. By metaliterature I refer to academic articles, chapters, and books that deal explicitly with the positioning and formulation of medical humanities as a discipline or field. These auto-reflecting self-portrayals run throughout the medical humanities publications as a continuing commentary track reflecting on the great variety of concrete work carried out between medicine and humanities, summing up and suggesting new courses in the field^v. Within the metaliterature I will rely mainly on conceptual reflections and analyses of the field (rather than those focusing on institutional historiography^{vi}). These conceptual approaches commonly work through representing subdivisions of traditions in the field; most prominently they identify a ‘classical’ pedagogical or empathy focused school^{vii}, critical medical humanities^{viii}, and more recently health humanities^{ix}. I rely on these subdivisions as what I will call ‘articulations’ of medical humanities.

TERMINOLOGY AND TERRAINE – ARTICULATIONS OF THE MEDICAL HUMANITIES

I use the notion ‘articulation’ here to make manifest the differentiation between various established representations in and of the field of medical humanities. It should be read as a notion that indicates distinguishable and somewhat well-defined conceptualisations of the field. These articulations arise out of a variety of different elements that shape and effect their articulation, and perhaps we may think of them in a similar, although figurative fashion to the notion of “body image”, i.e. the cognitive representations – explicit or implicit – we have of our body^x. In such a sense, different articulations are figuratively equivalent of the ‘body image’ for medical humanities, that is, self-conceptions or -portrayals of the field, whether explicit or implied. We find the articulations – the self-conceptions – of the field in the metaliterature of medical humanities, and correspondingly (in this metaphor or body image) they are expressions of a corpus – the body – of concrete work carried out between medicine and humanities. Importantly, body images are informed by the detailed, variable activities of the body, by its actuality, but they are not determined by it. And as with the body image and the body, we might also think there is a strong relation between the metaliterature and the concrete work in the field, but one is not determined by the other. That is, there may be elements of the corpus not represented in the metaliterature articulations, or conversely, metaliterature articulations articulating elements not present in the corpus. The suggestion developed here comes out of engagement with metalevel articulations (rather than the concrete body of work), and this article will situate itself in relation to other articles that aim at articulating the field^{xi}.

I acknowledge that concrete contributions of medical humanities (the corpus) may provide great insight into the field and its character. However, for this paper, the aim is to clarify and point out a gap in the existing terrain of articulations, that is, a gap in the metaliterature, and I will not discuss particular methods/types/fields of humanities in medicine (e.g. creative writing/narrative medicine/literature), particular settings (countries, schools, programmes etc.), specific teaching methods/curriculums, or the use of medical humanities in particular specialities/with particular patient groups (e.g. cardiology/cancer patients). These or other similar topics may, however, hold great potential for future work in developing the notion of reversal in closer dialogue with the activities and actuality of the field, through challenges or suggestions from this literature. My claim here stays neutral as to whether concrete reversal work is or is not already present in the corpus of medical humanities, and only claim that the articulation of this type of work is missing in the metaliterature terrain. This is not to say there is no link between the two, initiating the work of formulating such an articulation may hopefully both further new concrete projects along this line of thought, and/or provide already existing concrete reversed projects with a meta-articulation to discuss (whether this will be in terms of challenge or support).

I should stress that although I refer to established articulations of medical humanities, no agreed definitions or exact demarcations exist, neither of the field as such, nor of the different articulations. The richness of metaliterature articles is proof that the discipline is in ongoing debate with itself about what the better articulation is, and what the relations among different articulations are. Some papers stress that the distinction between different “positions” or articulations should not be taken too seriously, and that medical humanities should most of all stay messy^{xii}. Most papers question in some sense or another whether there is or should be any conclusive articulation and phrase their attempts of (re)defining medical humanities more in terms of broadening of the already existing ground^{xiii}, rather than replacing or settling the question. While I agree with the ideal of keeping the medical humanities open and explorative, and especially with the intent to expand rather

than replace or conclude, I rely on the differentiation between distinct articulations within the field here, in order to show the lack of bidirectionality, even if we should keep in mind that the boundaries between articulations are blurred.

A prominent debate between articulations in the metaliterature is one of inclusion and exclusion of various types of medicine-humanities/arts interactions: where do we draw the border around medical humanities. Different articulations express diverse constellations among:

- A. Arts as/in therapy
- B. Arts for health / Community Arts / Arts for environmental improvement (e.g. art used to ease the atmosphere in hospitals)
- C. Arts in health promotion (e.g. the use of artwork in national health campaigns) / art engaging with medical themes in public
- D. Humanities and arts as a source of influence on daily practice (e.g. the literarily interested nurse who draws on literary experiences in daily practice)
- E. Humanities and arts in medical education
- F. Intellectual (academic) inquiry into medicine from the perspective of humanities / doing interdisciplinary research^{xiv}

This list – like most such lists – is of course debatable, and it is set forth in a great variety of versions^{xv}. Most commonly, though, medical humanities articulations admit at least either E or F. It is not my errand here to decide which categories should or should not be included in medical humanities; this paper, however, will focus mainly on medical humanities as an *epistemic activity* (as differentiated from a therapeutic or ideological activity), that is on E and F. In doing so, it will focus on humanities as an academic discipline, more than on art^{xvi}.

Broadly – although made up from and blurred by many variations and disagreements – three major articulations of the medical humanities are present in the literature: a ‘classical’ pedagogical or empathy-focused *Medical Humanities* (also named 1st wave^{xvii}); *Critical Medical Humanities* (positioning itself as 2nd wave^{xviii}), and *Health Humanities*^{xix}.

The first ‘classical’ articulation is historically linked to a North American context^{xx}, where the development of medical humanities is framed as a reaction to the Flexner Report and its revolutionary effects on the US medical schools during the first few decades of the 20th century^{xxi}. Significantly it was developed as a pedagogical/educational tool of resistance aiming for: “a new Flexner-esque report”^{xxii} that would revolutionize medical schools again, against the strong focus on (natural) scientific education of doctors and the concept of medicine-as-biomedicine that the Flexner report brought with it. In a UK context, Bleakley tells us that medical humanities developed out of the arts as therapy/arts for health movement, but later, and funding-wise decisively, took on a narrow focus on medical humanities as an academic activity^{xxiii} (although medical humanities integration into medical teaching programmes has also been an important element here^{xxiv}). The story of the ‘classical’ medical humanities is thus complex; and illustrate that a strict division between teaching and research makes little sense, as many of the intersections between medicine and humanities have been practised simultaneously and as a result of exchange between them^{xxv}.

During the 2000-10s, the pedagogical/empathy-focused or ‘classical’ articulation of medical humanities was challenged by scholars who wanted more radical and critical integration of medicine and the humanities. This new suggested articulation termed itself *critical medical humanities* and divided medical humanities into a 1st and a 2nd wave (themselves being the 2nd). The critical medical humanities articulation is contrasted with the ‘classical’ medical humanities by its addition of a critical attitude towards medical practice, rather than a mere aiding medicine in achieving its goal(s). The difference between the two is described with varying terminology, but generally as the difference between the 1st wave utilitarian model of humanities that acts as a supportive friend or helper, and the 2nd wave disruptive model of humanities that acts as a critical interlocutor^{xxvi}. The 1st wave approach centres around “the three E’s” – ethics, education, and (individual) experience, with the occasional addition of a further E such as an emphasis on the role of empathy. The 2nd wave takes comprehensive *entanglement* as its baseline assumption, emphasising historical and cultural contexts of medical knowledge and practice^{xxvii}. Although 2nd wave advocates are rather critical of the 1st wave’s lack of critique, their point, much like my point of a reversal, is not to replace 1st wave medical humanities, but to add an extra layer^{xxviii}. And as already noted, the distinction between the 1st and 2nd wave should be understood as a simplification. The division between an empathy-based and a more critical version of medical humanities has precursors in the literature long before the idea of “two waves” or the notion of critical medical humanities^{xxix}.

Most recently a new articulation termed *health humanities* has become prominent within the medical humanities field. Whereas the critical medical humanities distinguish themselves from the ‘classical’ medical humanities through temporal metaphors (1st/2nd wave), the health humanities position themselves through metaphors of capacity or aptitude. Health humanities characterise medical humanities as a narrow discipline, and themselves – health humanities – as a broader, more inclusive overarching field^{xxx}; as a “more encompassing label”, looking at the intersection between humanities, arts and health through a “wider lens”^{xxxi}. Like the critical medical humanities, health humanities also stress critical theory^{xxxii}, particularly in terms of challenging hierarchies of power, drawing on notions such as intersectionality^{xxxiii}, global health^{xxxiv}, and describing themselves as an international endeavour^{xxxv}. They thus articulate themselves as different from prior articulations in terms of broadening the focus from medicine and physicians to also include other groups within the healthcare system (such as nurses, occupational therapists, and expressive therapy^{xxxvi}), and as focusing on more applied and practical goals. In this latter respect, the health humanities seem partly to align with, or share the call from Kristeva et al. to look more closely at the material productivity of humanities^{xxxvii}.

While I acknowledge a pressing critique of medical humanities as upholding some unfortunate hierarchies^{xxxviii}, and the potential gain in opening up the terminology to counter established hierarchies as proposed by health humanities, I have chosen for this paper, to stick with the terminology of *medical* humanities. This is because it is still the most established and commonly used term, and because this paper focuses on relations between humanities and medical practice, more so than on aspects of health and care. However, I do not think that the suggestion for a reversal is necessarily limited to the medical and that it could not apply to other fields in health care, but this remains to be unfolded by others. It is worth noting that Pellegrino in the opening remark of the 1971 *Institute on Human Values in Medicine: Proceedings of the first session* – typically portrayed as one of the key events for the starting points of medical humanities – does not talk of medical humanities but stresses

the movement's origin in "Society for health and human value"^{xxxix}; the term 'medical humanities' only later took on a central role.

In recent years a further critique has been raised, pointing out that medical humanities are a western phenomenon, privileging a western understanding of both medicine and culture^{xl}. This paper does not reflect on these issues and in not doing so, is perhaps complicit in them. However, I acknowledge them as important for any new movement or articulation in medical humanities, and wholeheartedly invite any alterations to the proposed reversal that may address these issues.

MOVEMENT – CHANGE OF DIRECTION

When I propose a reversal of medical humanities, I am suggesting a change of direction, that is, a change in movement rather than an attitude or aptitude related transformation. To unfold this, it will be helpful with a more explicit reflection on the current status of movement in medical humanities. One immediate thing to note about the field, is its implied dependence on the connection between two foundational fields: *medicine* and *humanities*. By that is implied that we have at least two positions between which the field of medical humanities is laid out. Within this field many types of movements and relations are possible, but schematically, particularly two directions of movement constitute or frame the field: movement from humanities to medicine, and movement from medicine to humanities (Figure 1).

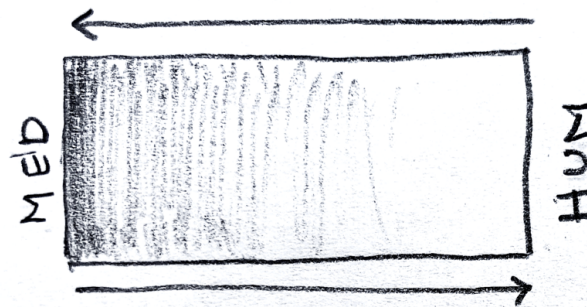


Figure 1: Medical Humanities

Very few metaliterature papers state concrete definitions of medical humanities – in fact many papers agree that the definition, boundaries and content of medical humanities should remain open and up for debate, at least at the time of their writing^{xli}. Those that do give a definition often rely on this idea of a field stretched out between several positions^{xlii}. In 1971 Pellegrino talks about this new field (not yet called medical humanities) as “a marriage between the two points of view” [biology and humanities]^{xliii}, that is, medical humanities as an inquiry into the field that extends between two positions. 30 years later, in 2001 and in the UK-based “Proposal for an academic Association for the Medical Humanities” Arnott, Bolton, Evans et al. define the field as “a sustained interdisciplinary inquiry into aspects of medical practice, education and research expressly concerned with the human side of medicine”^{xliv}. We might note that interdisciplinarity is a term widely used in the literature^{xlv}, even if there is some discussion as to whether medical humanities are interdisciplinary, or rather multidisciplinary, or even transdisciplinary, or what wither of those mean^{xlvi}. Others have defined medical humanities as an application of the humanities to “specific experiences of patients, doctors, health, illness, and suffering”^{xlvii} or as “those parts of the humanities that are of relevance to the study and practice of medicine”^{xlviii}, or formulated the goals of medical humanities as the “integration of all the human elements involved in the

understanding and practice of medicine”^{xliv}. While the first definition of medical humanities from Pellegrino stays open in the question of direction, note that the rest either stress or imply a certain direction, namely that of humanities applied to medicine and medical practice. Describing interdisciplinary collaborations in medical humanities likewise often consists in naming a specific humanities discipline (e.g. literature) and linking it to medicine as a singular category, leaving an impression that medicine is a (homogeneous) discipline, while humanities is a broader meta-discipline made up from several different perspective that can be cast on the uniform area of medicine^l.

This unidirectionality is even present in the notion of *entanglement* proposed by Viney et al. as a “new form of interdisciplinarity”^{li}, as its contributions and suggestions mainly remain on the humanities side and reflect on a difference in the type of humanities drawn on, rather than on the inter-field relation. This, despite a stated goal of contributing a conception of a more messy relation between medicine and humanities, i.e. moving away from the idea that interdisciplinarity is the collaboration and integration between two disciplines that are otherwise separable (e.g. a sub-discipline in humanities and a subdiscipline in medicine), towards an understanding of collaboration as something that is always already present: a primary entwining of all disciplines within the sphere of medical humanities that presupposes collaboration^{lii}. Kristeva et al. have criticized the 2nd wave medical humanities for not fully committing to their own concept of entanglement, in maintaining a medical humanities with “mere application of perspective from humanities on medicine”^{liii}. I think it is worth considering here whether the main element in the critical medical humanities, namely the critical, works against its notion of entanglement, given that the potential to criticise stems from a separation of positions, placing one field (the humanities) above the other (medicine) in a position of power to judge. To fully embrace the notion of entanglement and its promise of bidirectionality, Kristeva et al. argue for the need to acknowledge the material productivity of culture, that is, the importance of culture as resource in medical treatment^{liv}. I wish to second Kristeva et al. on discussing the bidirectionality of the relation between medicine and humanities but want to focus on what medicine can contribute to humanities and acknowledge medicine as productive of knowledge within the realm of culture^{lv}.

In the articulations of medical humanities, the main focus of debate has been on different qualities of the interaction, of what attitude is appropriate and of who/what should be included as legitimately part of the field (rather than the direction of interaction). The debate between ‘classical’ and critical medical humanities about whether the quality of interaction should be exclusively supportive, or also allow for critical and deconstructive work. And while critical medical humanities stress entanglement, this is mainly used to legitimize the humanities’ critique of medical notions, that is, to strengthen the movement from humanities to medicine. The challenge posed from the health humanities addresses inclusivity, i.e. whether medicine is too narrow a category and the field should be expanded in size, but still proceeds to further arguments for the movement from humanities to health/medicine. No matter if it is applied or integrative, critical supportive or reflective, all these articulations manifest a notion of medical humanities as acting mainly through pouring knowledge into medicine. While this one movement (from humanities to medicine) is enough to establish a relation between medicine and humanities and extend a field between the two, I will suggest that the field also allows for movement of knowledge in the opposite direction, and that articulations of medical humanities in terms of this movement are missing.

EPISTEMIC REASONS AND THE EPISTEMIC DOUBLE NATURE OF MEDICINE: A POSSIBILITY

While medical humanities are composite of medicine and humanities, several scholars have argued that medicine itself (that is, not just medical humanities) has an epistemic double nature, as something in-between, or a mix of humanities and science, a “scientific humanities”, if you will^{lvi}. Medical humanities rely on this idea

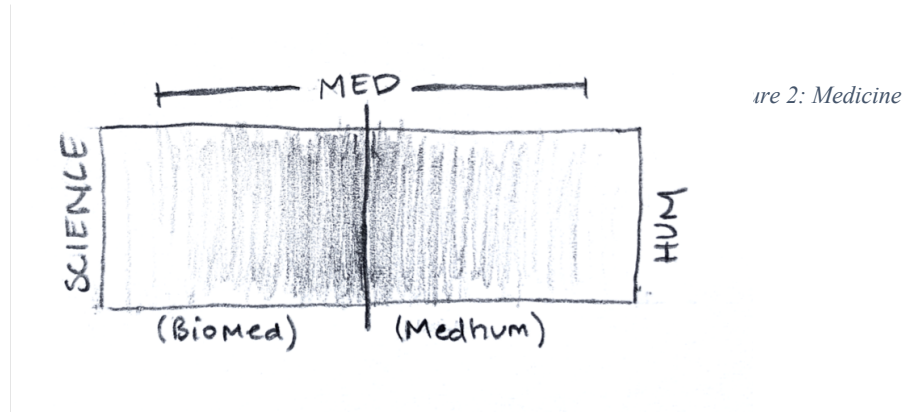


Figure 2: Medicine

of an epistemic double nature, and it is exactly this composite identity that guaranties the possibility of a reversal, which provides an opportunity for more knowledge in the field and new insights in the humanities (Figure 2).

As noted above, the medical humanities originated as a counter-action or counter-movement to the scientification of medicine that happened as a result of the Flexner-report. As such, medical humanities act as the mirror side of biomedicine in terms of the two cultures, as characterised by CP Snow^{lvii}. We might thus imagine medicine through adding an extra domain to the visualisation of medical humanities. Medicine here, is a broad field that spreads out on both sides towards humanities and science, something that encompasses both biomedicine and medical humanities.

The ties between medicine and science, or the importance of biomedicine in medical practice is taken as given in the medical humanities literature (and justly so), however, some effort is put into arguing for the idea that humanities also have a fundamental role to play in medicine. For example, arguments for the relevance of medical humanities are often connected to the argument that medicine should – in order to fulfil its goal(s) – (re)turn to holism or to the patient as person^{lviii}, or in newer medical humanities, the view that medicine is always already entangled with society, culture, and history^{lix}. In other places, papers rely on the notion of the human condition to tie medicine to more humanistic elements. While implicitly taking humanities to be a concern with (the specifics of) the human condition, some papers argue that it is the job of medicine to improve the human condition^{lx}, or – in line with this – that medicine is an activity based on interpreting the human condition^{lxi}, or that medicine and humanities share the human condition as their field of inquiry^{lxii}, and thus that humanities (as concerned with the human conditions) do hold a place in medicine. Some also give the argument that medical humanities are important to medicine, exactly because they provide an opportunity to gain insight into the human condition and thus implicitly, like the others, that medicine must understand the human condition^{lxiii}. Ahlzén writes “the practice of medicine integrates – intertwines, amalgamates – knowledge and experience of the human condition in the broadest possible sense”^{lxiv}. Humanities are then of particular

relevance to medicine, rather than say to physics, because medicine does not only deal with cells and biochemistry, but with human beings and operates within a cultural, social and subjective world, i.e. works with, upon and within the human condition. Medicine finds itself in-between humanities and science; it has an epistemic double nature.

If medicine and medical practice are so closely involved with the human condition, it seems that there must be an acquaintance with and knowledge – perhaps latent or implicit – of human lives or the human condition in medicine. That is, there must be knowledge in a humanistic, or perhaps more correctly put, in a humanities sense; regarding living well (ethics), living meaningfully (existential), translation between general knowledge and individual cases (epistemology), or something entirely different. For now, this potential source of knowledge has drowned in humanities scholars' eagerness to analyse, improve, and rework the medical field through medical humanities. At least this is the tendency portrayed in the meta-discussions of the medical humanities, as shown in the first section of the paper. Returning to the visualisation of the medical humanities field (figure 1), understanding this field is always already part of medical practice, we might imagine how currently the articulations of the field only envision cultural epistemic insight (let us use the metaphor of light) from the humanities side, supporting or critical. However, if medicine is in fact always already engaged in the human condition, as the medical humanities literature argues, there is the possibility to turn on the light at the other end of the field too (figure 3).

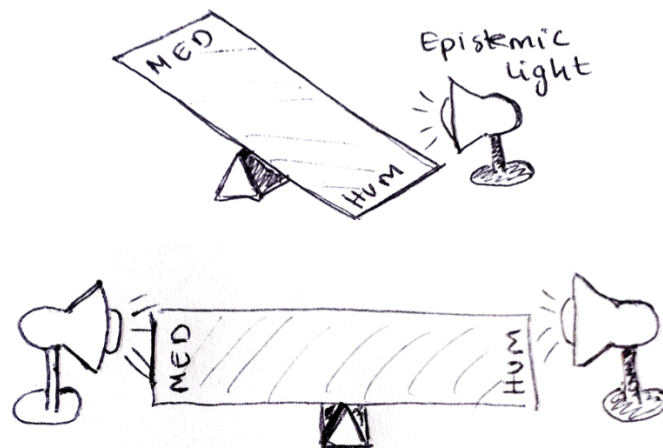


Figure 3: Epistemic light

To reiterate: the proposal to reverse (or perhaps rather add a reverse movement to) the medical humanities is the proposal to emphasise and inquire into ways in which medicine may participate in the medical humanities as medicine. Finding ways where cultural knowledge flows from medicine into humanities. This move is located as an unfulfilled promise or possibility that is inherently available in the double nature of medicine. What I call epistemic reasons for a reversal is, simply put, that there is a possibility of more knowledge or insight to be gained (more light to be turned on). Articulating a reversal of the medical humanities means exploring ways in which a largely untouched knowledge resource may contribute to the field, and such work might just give us more knowledge. The proposal to reverse the medical humanities is a proposal to look towards a positive potential in the resources of humanities knowledge already in the medical field, and make better use of these, perhaps to the benefit of both medicine and the humanities.

REASONS OF SELF-CONSISTENCY: KEEPING IT TOGETHER

Looking at the medical humanities articulations, and their portrayal of the relation between medicine and humanities, an ambiguity or lack of self-consistency shows up. On one hand, the field relies upon the argument that medicine is not only a science but rather has an epistemic double nature. That is, medicine is and must inherently be both science and humanities this is why medical humanities are relevant to medicine in the first place. On the other hand, the argument for the need of humanities (to support or critically challenge) to improve medicine, seems to place medicine outside humanities and manifests a difference between them. The second reason I give will try to show that the reversal is not just an inherent possibility in the structure of medicine and medical humanities, but that negligence of it has given rise to an inconsistency within the medical humanities.

Many of the metaliterature papers strongly emphasise the first version of the relation between medicine and humanities, namely that medicine is a field not wholly distinct from culture and meaning. In this concept of medicine, the idea of medical humanities seems self-evident, almost to the point of revealing “a redundancy in the term ‘medical humanities’”^{lxv}, since medicine – in this account – is (in part) medical humanities. However, simultaneously another version is also present, namely one that characterises medicine as biomedicine (i.e. as a natural science)^{lxvi}. Even if papers argue medicine *should* be re-humanized, many of them contrast themselves (as doing humanities) with medicine (as doing “only” biomedicine)^{lxvii}. With this reduction, existing articulations of the medical humanities insinuate a contrast between medicine and humanities, pushing – it could be argued – medicine out of the humanities area of research, reconfiguring the conception of the epistemic nature of medicine into something more like figure 4 than figure 2, and thus de-emphasizing the epistemic double nature. It is worth noting that this move of separating or creating difference is helped from the other side of this contrast with a simultaneous tendency from the medical community to push humanities away through centering around quantitative ideas of evidence and method, asking for (natural) scientific proof of the medical humanities’ effect^{lxviii}.

As already argued, many papers justify the need for medical humanities in medicine by simultaneously

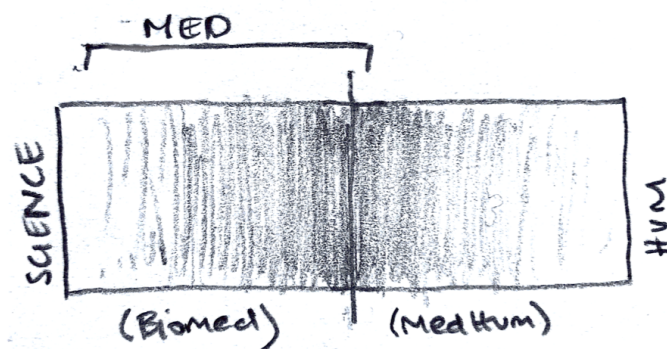


Figure 4: Medicine skewed

categorizing medicine as fundamentally an involvement with the human condition, thus inherently also humanistic, and reducing medicine to its biomedical component in need of help from the humanities. If medical humanities rely on the condition that medicine concerns the human condition, it should acknowledge medicine for its access to insight within this area, and cannot simultaneously reduce medicine to biomedicine. To address the tension between *medicine as biomedicine*, and *medicine as always also humanities*, medical humanities

might claim that the two characterisations are respectively purely descriptive (medicine *is* currently only biomedicine) and purely normative (medicine should or *ought to* be deeply involved in the human condition). To do this some papers emphasize the historical contingency of the split between medicine and the humanities, and attribute it to specific circumstances such as the formation of *studia humanitatis*^{lxxix}, to the systematization of disease categories^{lxxx}, or to the success of physiology and bacteriology in the 19th century, and later biochemistry and genetics^{lxxxi}. While there may be many important lessons to learn from the history of medicine, my errand here is with medical humanities and the articulations present in this field. Notwithstanding debates about when, where, and why medicine has developed towards a biomedical regime, claiming that there is in current medical practice no involvement with the human condition or interpretation of (concrete) experiences is a radical claim, and one I think very few scholars are interested in making. In fact, Evans argue that we cannot really imagine a physician who does not at least aspire to understand and engage with “some of the qualitative reality” of the patient experience^{lxxxii}. And Culbertson calls out the insinuation that medicine should be only biomedicine, saying that medical practice is (still) not reducible to biomedicine and that doctors make “non-scientific” (not unscientific) judgements of norms and experiences every day^{lxxxiii}.

To help avoid some of the confusion about the complex relations between humanities, medicine and science, I think there is an important case to be made for distinguishing more clearly in the literature between talk of the medical field as such, and its biomedical (also sometimes called technical) components, even if these are, for the time being, the dominant discourse. And I suggest that we become more explicit in our language by using the term *biomedicine* when talking about a kind of medicine that is in opposition to humanities. Keeping in mind, that this is more a tool for clarity than an ontological separation, and that the boundaries between humanities, medical humanities, medicine, biomedicine and science are still, and should be, both fuzzy and fluid.

The point of emphasizing this tension is that the shift between understanding medical humanities as motivated by medicine’s inherent humanities side, to viewing medical humanities as a necessary supplement to medicine, is not merely an inconsistency, but can end up as an enforcement of the very divide that medical humanities argues it is trying to bridge (figure 5). In their introduction to the *The Edinburgh Companion to the Critical Medical Humanities* Whitehead & Woods speak strongly in favour of a 2nd wave medical humanities that focuses on dissolving dichotomies (particularly that of medicine versus humanities). I think there is something very noble about this aspiration; however, I also think it is to a great extent founded in the understanding of medicine as equal to biomedicine. Insisting that humanities are missing and should be restored in medicine, and thus that medical humanities have something that medicine does not practically forces medicine into a biomedical category that can easily be argued to be incomplete. The reduction of

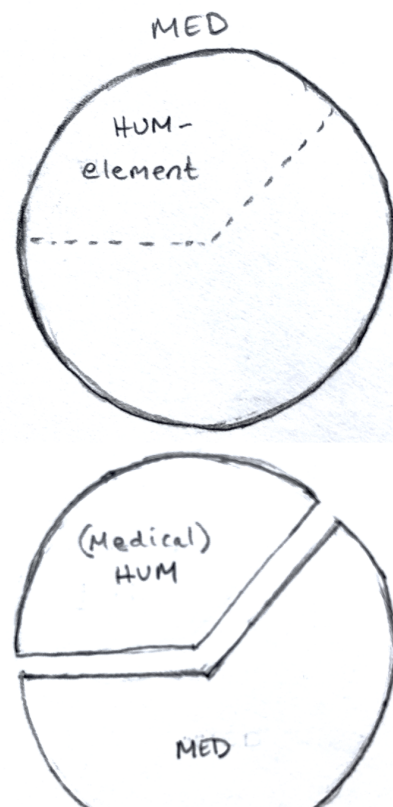


Figure 5: Dividing

human life to biology seems then not only to be a blind-spot in some characterisations of medicine, but might also be perpetuated in the view that some humanities scholars (and some medical humanities articulations) have held or imposed on medicine^{lxxiv}. A consistent argument for medical humanities must then be that we wish to strengthen something that is already present in medicine, and by denying medical practitioners epistemic value *as practitioners* within the humanities, medical humanities contradicts its very foundation.

PRAGMATIC REASONS AND EPISTEMIC POWER: REBALANCING ON SEVERAL LEVELS

A commonly mentioned critique of medical humanities is a question of the legitimacy of medical humanities as a significant contribution to medicine. In educational contexts we might ask ourselves whether medical humanities are worth the time spent relative to “hard science”, or in research contexts: whether medical humanities are worth the money relative to developing new biomedical technology? Objections are both of a conceptual kind, arguing that the introduction of medical humanities is based on nothing more than a simple lexical association between humanism and humanities (a confusion between medical humanities and humanistic medicine) and that the idea that humanities have the ability to transform physicians into humane persons is simply flawed^{lxxv}. And of an empirical kind: That there are not enough studies of the actual empirical impacts of the medical humanities, and that those that exist, do not show significance^{lxxvi}. Often, though, these studies or calls for studies rely on ideas of evidence and measurement similar to those in EBM, a methodology strongly tied to biomedical aspects of medicine^{lxxvii}. Medical humanities scholars have answered that the humanities (and thus medical humanities) are not result-oriented and that impact is not measurable within a biomedical evaluative framework^{lxxviii}, and that it is (still) unclear and unsettled what should be measured^{lxxix}. Macnaughton nuances the argument, stating that medical humanities should neither succumb thoughtlessly to biomedical measurements, nor carelessly ignore the dominant rules of validity in the field – medicine – that they are engaging with^{lxxx.lxxxi}. Meakin emphasises the establishment of *mutual* respect as essential for a pragmatic integration of medicine and humanities that is, humility is needed from both parties^{lxxxii}.

Implicit in the movements within medical humanities is what I will call “epistemic power”, that is, the idea that some stakeholders have or lack a certain knowledge that other stakeholders may benefit from or be able to provide – the provider or knower being the one who holds the epistemic power. In fact, a lot of medical humanities literature addresses different power and hierarchy issues in medicine^{lxxxiii} and health^{lxxxiv}, particularly turning against medical paternalism. Arguably, medicine (particularly as biomedicine) generally – compared to the humanities – holds a strong power position: in funding, output measures, as well as public and political opinion, as is also implied in the paper by Kristeva et al.^{lxxxv}. This is why there is a need for medical humanities to prove their value (as instrumental to the goals of medicine) in order to gain acceptance within medicine. However, while the *external* power lies with biomedicine, that is, the general epistemic power when distributed between biomedicine and (medical) humanities as separate fields, power within medical humanities – the *internal* power dynamic – is currently heavily located with humanities. Medical humanities conceive of their task as providing knowledge from humanities to medicine. The proposal to reverse the medical humanities is a proposal to displace some of the epistemic power *within* medical humanities towards the medical practitioners, by incorporating new directions of knowledge-flow in medical humanities. This move is seen as an attempt to internally rebalance the field.

This may seem a somewhat surprising suggestion, given the dominant and significant impact of the inequality in external power. Some readers may be sceptical about the idea of rebalancing medical humanities by displacing power away from the humanities, and I will try to expand, through a pragmatic motivation, why there is some reason for this seeming converse approach. This pragmatic motive relates to the challenge met by medical humanities in getting physicians, universities and health care systems on board. As already noted, we could say that medicine generally holds a strong epistemic position (particularly in its biomedical aspects), and that in some sense, the humanities have had and still have to work rather hard to achieve the same curricular weight, for instance. Externally, then, medical humanities are working from a position of less epistemic power to rebalance a scale that is tipped strongly in favour of biomedicine. Internally, however – to medical humanities that is – the scale is tipped in favour of the humanities. By this I mean that it is the position of humanities scholars that holds the epistemic power to formulate the field (of medical humanities), the questions asked and the answers given. Perhaps it is exactly this discrepancy of the external and internal power-relations, the humanities' claim to epistemic power *within* medical humanities that become counterproductive. Internally, humanities claim power (sometimes almost to the point of patronising medicine, presenting it as ignorant of its own cultural entanglement^{lxxxvi}) and challenge normal ways of doing things in medicine. Medical humanities contest the epistemic power of medicine. At the same time medicine can – because of its external position of power – chose to overlook this challenge from humanities. That is, because medical humanities speak from a weak external position, positioning itself as the knower internally, there is a risk that such lecturing is counterproductive and comes off as unwarranted arrogance.

Instead then, of attempting to prove and impose the value of humanities from without, we may attempt to strengthen the humanities from within medicine, avoiding the sense of conflict that may otherwise arise. O'Neill et al. has in fact argued that failing to recognise medical practice as contributors will cause a constant struggle for acceptance of medical humanities^{lxxxvii}. A reversal of medical humanities drawing out ways in which medical practice produces cultural knowledge, offers the possibility of sidestepping the need to prove that humanities should be allowed *into* medicine, and rather shows that medicine is *already* (partly) humanities. That is, by reversing the knowledge-flow *not* in order to give more epistemic power to *biomedicine*, but to bring forth humanities knowledge obtained from a medical position, we place medical humanities as already at the heart of medicine, and thus, perhaps counter the resistance and distancing from the side of medicine. In other words, reversing the medical humanities is an attempt to approach a recalibration of medicine from within the field of medicine itself, by letting medical practitioners become directly engaged in and take ownership of the field as active contributors. In this recalibration, more internal power is given to medicine and medical practitioners, in the hope that the reversed knowledge-flow will reveal that medicine might also have an interest in raising the external power of humanities, as well as open up areas where medicine could prove valuable (as instrumental to the goal(s) of humanities). Importantly, this does not mean cancelling out knowledge flowing in the 'current' direction – the reversal should be an addition, not a substitution. That is, medical practitioners cannot do or replace the important job carried out by many skilled humanities scholars working in the medical humanities. Neither does it mean that medical practitioners should become hobby-humanities scholars. This would amount to displacing them to the other end of the field, rather than reversing the direction of knowledge flow. Medical

practice should take ownership in the humanities endeavour *as* medical practitioners and in terms of the insights that this practice provides.

CONCLUDING REMARKS – A WAY FORWARD

I have suggested that there is a gap in the self-portrayal of medical humanities – a lack of articulations that consider the reversed knowledge flow to that traditionally talked about in medical humanities metaliterature. That is, an account of medical humanities that recognises and considers the possible ways in which medical practice can produce cultural knowledge that will contribute to humanities questions, and which takes medical practice as an active, contributing partner rather than passive receiver. I have listed three reasons why I think this suggestion is worth pursuing. First, an epistemic reason: there is an inherent possibility of more knowledge to be gained. Second, a reason of consistency: unidirectionality in the flow of knowledge risks creating the very divide that medical humanities set out to bridge, reversing the flow of knowledge may help prevent this divide from arising. And third, a pragmatic reason: inviting medicine as active contributors in the humanities and working to articulate the ways in which medicine is already (partly) humanities may counter the request for medical humanities to prove themselves ‘useful’ in terms of medical goals, and thus, displacing some internal epistemic power towards medicine may help to rebalance and strengthen humanities in terms of the external power relation. The three reasons are of course counter-dependent. Both the consistency argument and the pragmatic reasons work to reconcile a divide, that arises out of unidirectional practice. And all relate in one way or another to the idea of medicine as having an epistemic double nature.

The idea of reversal – as most ideas – is not entirely original. Similar sentiments already exist in the medical humanities literature, and should be given due credit. However, these precursors have – in my view – not yet been taken seriously enough to become established articulations, or do not themselves succeed in following through on their implications. Two points in the literature are commonly made related to a possible reversal:

(1) That working unidirectionally might foster arrogance among both medical and humanities scholars; it “leaves open the possibility of a certain smugness on the part of humanities [as the knowers] and resentment on the part of medicine [as the supposed benefiter, that did however, not ask for advice]”^{lxxxviii}. To properly integrate the two, some papers argue or imply that medical humanities should aim to create “equal space and respect” between its partners^{lxxxix}, and demand that all parties make an effort to understand each other’s culture^{xc}. Aligning with what I have termed pragmatic reasons for a reversal. However, even if the potential for reversal is implicit in the talk of interdisciplinarity, entanglement, and in the fluidity between the concepts of medicine and humanities, and Bates & Goodman in fact mention *reciprocity* in the field several times^{xcii}, medical humanities articulations have not managed to avoid unidirectionality. As pointed out by Kristeva et al. as well as O’Neill et al. all the talk of interdisciplinarity seems to get stuck in unidirectional ideas of ways in which humanities can solve problems in medical practice^{xciii}. Prior literature thus paints a picture of medicine as *lacking* and the humanities as saviours, be it through help and support or through critical reflection (as also evident in most of the definitions of medical humanities, save Pellegrino, encountered earlier in this paper), emphasising the knowledge-flow from humanities towards medicine.

(2) That we should not think only medicine gains from medical humanities. In fact, many humanities disciplines gain from engaging with medicine. Evans talk of medicine as an opportunity for philosophy to recognise new

and wider questions^{xciii}, and in a conversation with professor Andreas Roepstorff at a medical humanities-seminar in Copenhagen he talked of medicine as holding powerful case studies for humanities to develop its ideas^{xciv}. Although I believe there is much importance in this type of benefit from interdisciplinary work, the idea of a reversal is not aimed at ways in which humanities gain knowledge from doing medical humanities by way of its own reflections and expansions. Rather the reversal should focus, like O'Neill et al., on the way medicine contributes to the collaboration and through that to humanities, as pre-empted by Evans, where he writes that aspects of medicine can be used to gain new insight into the human condition^{xcv}. However, even if O'Neill et al. point towards some of the thoughts presented in this paper, their paper talks about positive contribution from medicine in terms of medical students' spare-time interests in cultural activities, thus arguing that the positive contribution from medicine is based on physicians as hobby-humanities scholars^{xcvi}. Even if this element is important to acknowledge, it does not change the flow of knowledge and the locus of epistemic power. Rather it merely moves persons with particular interests into the existing power-position in medical humanities (that of traditional humanities interests).

Claiming relevance of the humanities in medicine as has been the foundation of medical humanities, should not only motivate humanities to supplement or critically engage with medicine, it should also invoke interest in the insights into human life and culture gained through medical practice. A reversal of the medical humanities is thus an attempt to earnestly acknowledge *medicine* as an entanglement of humanities and science, and to support the attempt of transgressing the distinction between humanities and medicine by encouraging more work done from the side of medicine to develop its humanities elements. Reversing the medical humanities is an attempt to become curious as to what an open dialogue may lead to – for both parties: Displacing some of the internal power in medical humanities towards medicine, in order to, hopefully, redistribute some of the external power towards the humanities.

I offer the notion of reversal as a suggestion, but also as an invitation to think it further than I have or in different ways. I have myself expanded and modified my view of the notion many times, and it is clear to me that the formulation of reversing the medical humanities can encompass a whole range of interesting and useful ideas, some of which are not yet clear to me. However, let me give a few indications of where I think it will make sense to look or not look for further development, and how I imagine we might move forward from here. The idea of a reversal is neither the idea of bringing biomedical methods into humanities, attempting a scientification of the humanities, nor is it of making physicians into hobby-humanities scholars. Neither is the idea of reversal a call for historical or anthropological analysis of ways that medicine, health and medical practice effects culture. The invitation to reverse the medical humanities is more of an invitation to develop a stance *in medicine* from where we can explore ways in which medical practice (as exactly itself) produces cultural knowledge and may contribute to humanities.

By saying this I find myself at an impasse. As a humanities scholar who does not do medical practice, I cannot do the work of reversing without being myself guilty of the kind of paternalism and arrogance that I have just criticized. On the other hand, in making the proposal, I am under some obligation to attempt to make clear what it is I am aiming for. Rather than attempt to imagine what a reversal may look like, I will suggest that the way forward from here is a stronger focus within medical humanities on developing articulations of and making manifest the implicit cultural or humanities type knowledge that is already in medical practice. That is, a call to

work closely with medical practitioners of all kinds to do the work of carving out a new area of discourse from their point of view^{xcvii}. By this, there is also a call to think more about experienced practitioners and everyday practice than education, to look in the places where medicine and health are immediately enveloped in human lives, rather than in curricula and text books. Perhaps asking for a reversal is asking for an activity that is still in the making – a “branch” of humanities that has yet to be developed. Whereas disciplines such as literature studies, philosophy or history have had hundreds of years to form a language and a structure to academically capture certain types of experiences or acquaintances with their subject-material, newer disciplines such as gender studies or post-humanism studies are still at work to place themselves within such a framework. Asking what a reversal is, requires, perhaps, first of all a similar type of hard and lengthy work of establishing a ground where conversations and explication of experiences and acquaintances with the human condition that are particular to medical practice, can take place. Hopefully, the notion of reversing medical humanities might call some attention to getting started on this work.

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ⁱⁱ Julia Kristeva et al., ‘Cultural Crossings of Care: An Appeal to the Medical Humanities’, *Medical Humanities* 44, no. 1 (March 2018): 55–58, <https://doi.org/10.1136/medhum-2017-011263>.

ⁱⁱⁱ *Materially productive* and *material weight* should be understood here as linked to the nature-culture dichotomy. That is, typically humanities are conceived as contributing (mainly) to culture, or at the cultural level of analysis, as a meaning-making and meaning-analysing practice. On the other hand, science/biomedicine is typically seen as intervening (mainly) at the material level of nature, as a manipulation and control of materiality. This distinction between nature-culture has been challenged by many science studies scholars (e.g. Haraway and Latour), and this challenge seems to be in agreement with what Kristeva et al.’s claim of bidirectionality aims to show. That is, that meaning-making analysis also intervenes in and manipulates materiality, and that manipulation of material also produces meaningd (Bruno Latour, *We Have Never Been Modern* (Cambridge, Mass: Harvard University Press, 1993); Donna Jeanne Haraway, *Manifestly Haraway*, *Posthumanities* 37 (Minneapolis: University of Minnesota Press, 2016).)

^{iv} This claim is *not* about bringing biomedicine into humanities, neither in content (e.g. explaining van Gogh's works through reference to a biological visual defect etc.), nor in methods (e.g. introducing a medical measurement technique as a replacement for humanities methods, e.g. neuro-aesthetics), although those are valuable cross-overs in their own right.

^v I acknowledge that this is a simplification. Each paper might be somewhere on a sliding scale between metaliterature and concrete contribution, and the relation may be more like a symbiotic entanglement than two parallel tracks. However, for the sake of this paper I wish to keep a clear distinction between metaliterature *about* medical humanities (what they are and should be), and concrete medical humanities literature.

^{vi} For a thorough treatment and critical reflections, see Harold J. Cook, 'Borderlands: A Historian's Perspective on Medical Humanities in the US and the UK', *Medical Humanities* 36, no. 1 (1 June 2010): 3–4, <https://doi.org/10.1136/jmh.2009.002626>; Alan Bleakley, 'Towards a "Critical Medical Humanities"', in *Medicine, Health and the Arts: Approaches to the Medical Humanities*, ed. Alan Bleakley, Victoria Bates, and Sam Goodman, Routledge Advances in the Medical Humanities (London; New York: Routledge, 2014), 17–26; Shafer, 'Medical Humanities'. For varying mentions, comments, and reflections see: Eric J Cassell, *The Place of the Humanities in Medicine* (Hastings-on-Hudson, N.Y: The Hastings Center, Institute of Society, Ethics, and Life Sciences, 1984); T. J. Murray, 'Why the Medical Humanities?', *Dalhousie Medical Journal* 26, no. 1 (18 February 1998), <https://doi.org/10.15273/dmj.Vol26No1.4424>; Martyn Evans and David Greaves, 'Exploring the Medical Humanities: A New Journal Will Explore a New Conception of Medicine', *BMJ: British Medical Journal* 319, no. 7219 (1999): 1216–1216; Delese Wear, 'The Medical Humanities: Toward a Renewed Praxis', *Journal of Medical Humanities* 30, no. 4 (December 2009): 209–20, <https://doi.org/10.1007/s10912-009-9091-7>; Martyn Evans and David Greaves, 'Ten Years of Medical Humanities: A Decade in the Life of a Journal and a Discipline', *Medical Humanities* 36, no. 2 (30 November 2010): 66–68, <https://doi.org/10.1136/jmh.2010.005603>; Jane Macnaughton, 'Medical Humanities' Challenge to Medicine', *Journal of Evaluation in Clinical Practice* 17, no. 5 (October 2011): 927–32, <https://doi.org/10.1111/j.1365-2753.2011.01728.x>; Brian Hurwitz, 'Medical Humanities: Lineage, Excursionary Sketch and Rationale', *Journal of Medical Ethics* 39, no. 11 (November 2013): 672–74, <https://doi.org/10.1136/medethics-2013-101815>; Victoria Bates and Sam Goodman, 'Critical Conversations - Establishing Dialogue in the Medical Humanities.', in *Medicine, Health and the Arts: Approaches to the Medical Humanities*, ed. Victoria Bates, Alan Bleakley, and Sam Goodman, Routledge Advances in the Medical Humanities (London; New York: Routledge, 2014), 3–13; Robin S Downie, 'Medical Humanities: A Vision and Some Cautionary Notes', *Medical Humanities* 29, no. 1 (1 June 2003): 37–38, <https://doi.org/10.1136/mh.29.1.37>; Therese Jones et al., 'The Almost Right Word: The Move From Medical to Health Humanities', *Academic Medicine* 92, no. 7 (July 2017): 932–35, <https://doi.org/10.1097/ACM.0000000000001518>. For a historical overview, see Alan Bleakley and Victoria Bates, 'Timeline', in *Medicine, Health and the Arts: Approaches to the Medical Humanities*, ed. Victoria Bates, Alan Bleakley, and Sam Goodman, Routledge Advances in the Medical Humanities (London; New York: Routledge, 2014).

Some texts in the field also figure as institutional documents themselves, e.g. Edmund D Pellegrino, 'Welcoming Remarks', in *Institute on Human Values in Medicine: Proceedings of the First Session* (Adren House, Harriman, New York: Society for Health and Human Values, 1971), 3–9; General Medical Council Education Committee, 'Tomorrow's Doctors. Recommendations on Undergraduate Medical Education' (London: General Medical Council, 1993); Evans and Greaves, 'Exploring the Medical Humanities: A New Journal Will Explore a New Conception of Medicine'; Raanan Gillon, 'Welcome to Medical Humanities – and Why', *Journal of Medical Ethics* 26, no. 3 (1 June 2000): 155–56, <https://doi.org/10.1136/jme.26.3.155>; David Greaves and Martyn Evans, 'Medical Humanities', *Medical Humanities* 26, no. 1 (1 June 2000): 1–2, <https://doi.org/10.1136/mh.26.1.1>; Robert Arnott et al., 'Proposal for an Academic Association for Medical Humanities', *Medical Humanities* 27, no. 2 (1 December 2001): 104–5, <https://doi.org/10.1136/mh.27.2.104>.

^{vii} For example: Martyn Evans, 'Affirming the Existential within Medicine: Medical Humanities, Governance, and Imaginative Understanding', *Journal of Medical Humanities* 29, no. 1 (March 2008): 55–59, <https://doi.org/10.1007/s10912-007-9051-z>; S Pattison, 'Medical Humanities: A Vision and Some Cautionary Notes', *Medical Humanities* 29, no. 1 (1 June 2003): 33, <https://doi.org/10.1136/mh.29.1.33>; Deborah Kirklín, 'The Centre for Medical Humanities, Royal Free and University College Medical School, London, England', *Academic Medicine* 78, no. 10 (2003): 1048–53.

^{viii} For example: William Viney, Felicity Callard, and Angela Woods, 'Critical Medical Humanities: Embracing Entanglement, Taking Risks', *Medical Humanities* 41, no. 1 (June 2015): 2–7, <https://doi.org/10.1136/medhum-2015-010692>; Des Fitzgerald and Felicity Callard, 'Entangling the Medical Humanities', in *The Edinburgh Companion to the Critical Medical Humanities*, ed. Angela Woods and Anne Whitehead, Wellcome Trust–Funded Monographs and Book Chapters (Edinburgh (UK): Edinburgh University Press, 2016), 35–49, <http://www.ncbi.nlm.nih.gov/books/NBK379264/>.

^{ix} For example: Jones et al., 'The Almost Right Word'; Paul Crawford et al., 'Health Humanities: The Future of Medical Humanities?', *Mental Health Review Journal* 15, no. 3 (17 November 2010): 4–10, <https://doi.org/10.5042/mhrj.2010.0654>; Paul Crawford et al., 'Health Humanities', in *Health Humanities* (Palgrave Macmillan UK, 2015), https://nls.ldls.org.uk/welcome.html?ark:/81055/vdc_100059902978.0x000001; Therese Jones, Delese Wear, and Lester D. Friedman, 'Introduction: The Why, the What, and the How of the Medical/Health Humanities', in *Health Humanities Reader*, ed. Therese Jones et al. (New Brunswick, New Jersey; London: Rutgers University Press, 2014).

^x Peter David Slade, 'What Is Body Image?', *Behaviour Research and Therapy* 32, no. 5 (June 1994): 497–502, [https://doi.org/10.1016/0005-7967\(94\)90136-8](https://doi.org/10.1016/0005-7967(94)90136-8); Shaun Gallagher, 'Body Image and Body Schema: A Conceptual Clarification', *The Journal of Mind and Behavior* 7, no. 4 (1986): 541–54.

^{xi} The “articulations” that I present in this paper are based on focused analysis of approximately 100 key papers that fall within the metaliterature category, and vary in time of publication from 1972-2018 with the majority being post-2000. A full list can be provided by the author upon request but many are referenced here. A mix of snowballing and database searches on Google Scholar and PubMed was employed to locate these articles, going through approximately 1000 abstracts, although, not to a degree that provide systematic methodology. (for snowballing: Jane Webster and Richard T. Watson, ‘Analyzing the Past to Prepare for the Future: Writing a Literature Review’, *MIS Quarterly* 26, no. 2 (2002): xiii–xxiii.)

^{xii} Viney, Callard, and Woods, ‘Critical Medical Humanities’.

^{xiii} Deborah Bowman, ‘New Perspectives in Medical Humanities’, *Medical Humanities* 41, no. 1 (June 2015): 1–1, <https://doi.org/10.1136/medhum-2015-010730>.

^{xiv} Some examples, listed with reference to categories they include (or explicitly exclude) in the medical humanities: Pattison, ‘Medical Humanities: A Vision and Some Cautionary Notes’ (BDF); Downie, ‘Medical Humanities’, 1 June 2003 (ABE = broad sense / E = narrow sense); Kirklin, ‘The Centre for Medical Humanities, Royal Free and University College Medical School, London, England’ (E, excluding AB); Brian Hurwitz, ‘Medicine, the Arts and Humanities’, *Clinical Medicine* 3, no. 6 (1 November 2003): 497–98, <https://doi.org/10.7861/clinmedicine.3-6-497> (ABCF); Martyn Evans, ‘Medical Humanities: An Overview’, in *Principles of Health Care Ethics*, ed. Richard E. Ashcroft et al. (Chichester, UK: John Wiley & Sons, Ltd, 2007), 199–206, <https://doi.org/10.1002/9780470510544> (F, excluding A); Martyn Evans, ‘Medical Humanities: Stranger at the Gate, or Long-Lost Friend?’, *Medicine, Health Care and Philosophy* 10, no. 4 (December 2007): 363–72, <https://doi.org/10.1007/s11019-007-9079-x> (AEF); Evans, ‘Affirming the Existential within Medicine’ (DEF, excluding A); Claire Hooker, ‘The Medical Humanities - a Brief Introduction’, *Australian Family Physician* 37, no. 5 (May 2008): 369–70 (CEF); Luca Chiapperino and Giovanni Boniolo, ‘Rethinking Medical Humanities’, *Journal of Medical Humanities* 35, no. 4 (December 2014): 377–87, <https://doi.org/10.1007/s10912-014-9269-5> (EF); Bleakley, ‘Towards a “Critical Medical Humanities”’ (ABEF); Alan Bleakley, *Medical Humanities and Medical Education: How the Medical Humanities Can Shape Better Doctors*, Routledge Advances in the Medical Humanities (London; New York: Routledge, Taylor & Francis Group, 2015) (ABCEF); Robin S Downie, ‘Medical Humanities: Some Uses and Problems’, *Journal of the Royal College of Physicians of Edinburgh* 46, no. 4 (2016): 288–94, <https://doi.org/10.4997/JRCPE.2016.416> (ABEF). Evans further makes a short comparative note on medical humanities and other “medical something”-fields (medical physics, medical anthropology, medical statistics, and medical ethics) (Evans, ‘Medical Humanities: An Overview’).

^{xv} Some categories overlap, for example D and E might, in some versions, be almost identical in content and argument. We might think of D as related to A, in cases where humanities and arts are used for their “therapeutic effects” on personnel dealing with illness, death and sorrow in their daily work. Some categories might be split into further categories.

^{xvi} This however should not be taken to mean that art and artistic practices within medical humanities do not carry epistemic value.

^{xvii} Anne Whitehead and Angela Woods, ‘Introduction’, in *The Edinburgh Companion to the Critical Medical Humanities*, ed. Anne Whitehead and Angela Woods, Edinburgh Companions to Literature (Edinburgh: Edinburgh University Press, 2016), 1–31.

^{xviii} Whitehead and Woods; Viney, Callard, and Woods, ‘Critical Medical Humanities’.

^{xix} Crawford et al., ‘Health Humanities’; Sarah Atkinson et al., “‘The Medical’ and ‘Health’ in a Critical Medical Humanities”, *Journal of Medical Humanities* 36, no. 1 (March 2015): 71–81, <https://doi.org/10.1007/s10912-014-9314-4>; Jones, Wear, and Friedman, ‘Introduction: The Why, the What, and the How of the Medical/Health Humanities’; Jones et al., ‘The Almost Right Word’.

^{xx} In tracing a conceptual history of the field, the temporal and geographical divide between its establishment in the US during the 60ies and 70ies and its arrival in the UK during the 90ies, is ascribed some significance. The divide is widely mentioned, and to some extent becomes associated with different types of medical humanities. See for example Stanley J. M. Goulston, ‘Medical Education in 2001: The Place of the Medical Humanities’, *Internal Medicine Journal* 31, no. 2 (March 2001): 123–27, <https://doi.org/10.1046/j.1445-5994.2001.00027.x>; Bleakley, ‘Towards a “Critical Medical Humanities”’; Bleakley, *Medical Humanities and Medical Education*.

^{xxi} For references to Flexner report see Sam A. Banks, ‘The Newcomers: Humanities and Social Sciences in Medical Education’, in *Special Issue: The Humanities and Medicine*, ed. Chester R. Burns and H Tristram Engelhardt, vol. 32, Texas Reports on Biology and Medicine 1 (Galveston: University of Texas, Medical Branch, 1974); Cassell, *The Place of the Humanities in Medicine*; Murray, ‘Why the Medical Humanities?’; C. M. Stolt, ‘[What is the humanistic medicine?]’, *Tidsskrift for Den Norske Laegeforening: Tidsskrift for Praktisk Medicin, Ny Raekke* 120, no. 30 (10 December 2000): 3736–37; Cook, ‘Borderlands’; Samyukta Mullangi, ‘Presenting the Case for the Medical Humanities’, *The Virtual Mentor: VM* 16, no. 8 (1 August 2014): 592–94, <https://doi.org/10.1001/virtualmentor.2014.16.08.fred1-1408>; Bleakley, ‘Towards a “Critical Medical Humanities”’.

^{xxii} Mullangi, ‘Presenting the Case for the Medical Humanities’.

xxiii Bleakley, 'Towards a "Critical Medical Humanities"'; Arnott et al., 'Proposal for an Academic Association for Medical Humanities'. The 2001 proposal even stresses *inquiry* as the main activity of Medical humanities, i.e. research.

xxiv As is also evident by the number of references to the GMC *Tomorrow's Doctor: General Medical Council Education Committee, 'Tomorrow's Doctors. Recommendations on Undergraduate Medical Education'*; Goulston, 'Medical Education in 2001'; Jane Macnaughton, 'Research in Medical Humanities: Is It Time for a New Paradigm?', *Medical Education* 36, no. 6 (June 2002): 500–501, <https://doi.org/10.1046/j.1365-2923.2002.01238.x>; Martyn Evans and David Greaves, "'Medical Humanities" - What's in a Name?', *Medical Humanities* 28, no. 1 (1 June 2002): 1–2, <https://doi.org/10.1136/mh.28.1.1>; Martyn Evans, 'Reflections on the Humanities in Medical Education', *Medical Education* 36, no. 6 (June 2002): 508–13, <https://doi.org/10.1046/j.1365-2923.2002.01225.x>; Kirklin, 'The Centre for Medical Humanities, Royal Free and University College Medical School, London, England'; Martyn Evans and David Greaves, 'Looking for Emerging Themes in Medical Humanities - Some Invitations to Our Readers', *Medical Humanities* 29, no. 1 (1 June 2003): 1–3, <https://doi.org/10.1136/mh.29.1.1>; Alan Petersen et al., 'The Medical Humanities Today: Humane Health Care or Tool of Governance?', *Journal of Medical Humanities* 29, no. 1 (March 2008): 1–4, <https://doi.org/10.1007/s10912-007-9044-y>; Evans, 'Medical Humanities: An Overview'; Crawford et al., 'Health Humanities'; Hurwitz, 'Medical Humanities'; Bleakley, *Medical Humanities and Medical Education*; Downie, 'Medical Humanities', 2016.

xxv Medical humanities have of course proliferated outside these two countries and has increasingly become a global issue. For an overview of the global scene Bleakley, *Medical Humanities and Medical Education*; Therese Jones, "'Oh, the Humanit(ies)!": Dissent, Democracy, and Danger.', in *Medicine, Health and the Arts: Approaches to the Medical Humanities*, ed. Victoria Bates, Alan Bleakley, and Sam Goodman, Routledge Advances in the Medical Humanities (London ; New York: Routledge, 2014), 27–38.

xxvi Macnaughton is credited by Atkinson et al. and Viney et al. for describing a medical humanities in this style under the term "disruptive teenager", even if she does not herself talk of waves. (Macnaughton, 'Medical Humanities' Challenge to Medicine'; Atkinson et al., "'The Medical" and "Health" in a Critical Medical Humanities'; Viney, Callard, and Woods, 'Critical Medical Humanities'.)

xxvii Atkinson et al., "'The Medical" and "Health" in a Critical Medical Humanities'; Viney, Callard, and Woods, 'Critical Medical Humanities'; Bleakley, *Medical Humanities and Medical Education*; Whitehead and Woods, 'Introduction'; Downie, 'Medical Humanities', 2016; Uffe Juul Jensen, 'Humaniora som sundhedsvidenskab [Humanities as Health Science]', in *Humaniora & sundhedsvidenskab*, ed. Uffe Juul Jensen, Hans Fink, and Christian T Lystbæk (Århus: Philosophia, 2002), 9–39.

xxviii Whitehead and Woods, 'Introduction'.

xxix McManus distinguishes an *affective* (empathy, communication, emotional management) from a *cognitive* (reflective, critical) element of medical humanities, arguing that the conflation between humanities and humanism only really covers the affective dimension. Ahlén divides understandings gained in humanities/medical humanities in *aesthetic imagination* and *analytic reflection*, respectively. Chiapperino & Boniolo argue that medical humanities contain both work with the *existential* and the *conceptual* framework of medicine. The same is the case for the division between the helper and the interlocutor that is pre-empted in Evans and Greaves' divide between an *additive* and an *integrated* medical humanities. In one paper Evans, drawing on Merleau-Ponty, even talks about entwining. Or as the difference pointed out by Ahlén, between a *compensatory* model tied to the educational approach, and an *integrated* model tied to the pervasiveness of value judgements in medical practice. It is also debated by Evans et al., Gillon, Macnaughton, Evans & Greaves, Bolton, Downie, Pattison, and Chiapperino & Boniolo whether humanities should be considered either *instrumental* or *intrinsic* to medicine. (I.C. McManus, 'Humanity and the Medical Humanities', *The Lancet* 346, no. 8983 (October 1995): 1143–45, [https://doi.org/10.1016/S0140-6736\(95\)91806-X](https://doi.org/10.1016/S0140-6736(95)91806-X); Rolf Ahlén, 'Medical Humanities – Arts and Humanistic Science', *Medicine, Health Care and Philosophy* 10, no. 4 (December 2007): 385–93, <https://doi.org/10.1007/s11019-007-9081-3>; Chiapperino and Boniolo, 'Rethinking Medical Humanities'; Evans and Greaves, 'Exploring the Medical Humanities: A New Journal Will Explore a New Conception of Medicine'; Greaves and Evans, 'Medical Humanities'; Evans, 'Medical Humanities: An Overview'; Ahlén, 'Medical Humanities – Arts and Humanistic Science'; Evans, 'Reflections on the Humanities in Medical Education'; Ahlén, 'Medical Humanities – Arts and Humanistic Science'; Martyn Evans, David Greaves, and Neil Pickering, 'Medicine, the Arts and Imagination', *Journal of Medical Ethics* 23, no. 4 (August 1997): 254; Gillon, 'Welcome to Medical Humanities – and Why'; Jane Macnaughton, 'The Humanities in Medical Education: Context, Outcomes and Structures', *Medical Humanities* 26, no. 1 (1 June 2000): 23–30, <https://doi.org/10.1136/mh.26.1.23>; Evans and Greaves, "'Medical Humanities" - What's in a Name?'; Gillie Bolton, 'Boundaries of Humanities: Writing Medical Humanities', *Arts and Humanities in Higher Education* 7, no. 2 (1 June 2008): 131–48, <https://doi.org/10.1177/1474022208088643>; Downie, 'Medical Humanities', 1 June 2003; Pattison, 'Medical Humanities: A Vision and Some Cautionary Notes'; Chiapperino and Boniolo, 'Rethinking Medical Humanities'.)

xxx Crawford et al., 'Health Humanities'.

xxxi Jones et al., 'The Almost Right Word'.

xxxii Crawford et al., 'Health Humanities'.

xxxiii Jones et al., 'The Almost Right Word'.

^{xxxiv} Jones, Wear, and Friedman, 'Introduction: The Why, the What, and the How of the Medical/Health Humanities'.

^{xxxv} Crawford et al., 'Health Humanities'.

^{xxxvi} Crawford et al., 'Health Humanities'.

^{xxxvii} In Crawford there is explicit reference to Judith Butler's *Bodies that matter*, thematising ways in which culture affects and shapes nature. (Crawford et al., 'Health Humanities').

^{xxxviii} Joanna Rogers, 'Being Skeptical about the Medical Humanities', *The Journal of Medical Humanities* 16, no. 4 (December 1995): 265–77, <https://doi.org/10.1007/BF02276583>. This paper particularly argue that this reinforces power structures already negatively effecting health care.

^{xxxix} Pellegrino, 'Welcoming Remarks'.

^{xi} Claire Hooker and Estelle Noonan, 'Medical Humanities as Expressive of Western Culture', *Medical Humanities* 37, no. 2 (1 December 2011): 79–84, <https://doi.org/10.1136/medhum-2011-010120>.

^{xli} Rafael Campo, "'The Medical Humanities,' for Lack of a Better Term', *JAMA* 294, no. 9 (7 September 2005): 1009, <https://doi.org/10.1001/jama.294.9.1009>; Shafer, 'Medical Humanities'; Johanna Shapiro et al., 'Medical Humanities and Their Discontents: Definitions, Critiques, and Implications', *Academic Medicine* 84, no. 2 (February 2009): 192–98, <https://doi.org/10.1097/ACM.0b013e3181938bca>; Kirklin, 'Medical Humanities and the On-Going Search for Reliability, Authenticity and Humility'; Bowman, 'On Identity in (the) *Medical Humanities*'; Julie Kutac, Rimma Osipov, and Andrew Childress, 'Innovation Through Tradition: Rediscovering the "Humanist" in the Medical Humanities', *Journal of Medical Humanities* 37, no. 4 (December 2016): 371–87, <https://doi.org/10.1007/s10912-015-9364-2>; Pattison, 'Medical Humanities: A Vision and Some Cautionary Notes'; Evans, 'Medical Humanities: An Overview'; Bates and Goodman, 'Critical Conversations - Establishing Dialogue in the Medical Humanities.' In Evans, this sentiment appears in suggestions for basic principles within medical humanities such as the "principle of openness", and in Bates & Goodman as the idea that "medical humanities should be studied in a broad and inclusive way".

^{xlii} For a summary of definitions in the field see Howard Brody, 'Defining the Medical Humanities: Three Conceptions and Three Narratives', *Journal of Medical Humanities* 32, no. 1 (March 2011): 1–7, <https://doi.org/10.1007/s10912-009-9094-4>.

^{xliii} Pellegrino, 'Welcoming Remarks'. This formulation is strangely close to ways in which other scholars have categorized medicine as such. We will return to this (see endnote *lvi*). This only highlights the fluidity and potential overlaps of the fundamental concepts in the field.

^{xliv} Arnott et al., 'Proposal for an Academic Association for Medical Humanities'.

^{xlv} See for example David Greaves and Martyn Evans, 'Conceptions of Medical Humanities', *Medical Humanities* 26, no. 2 (1 December 2000): 65, <https://doi.org/10.1136/mh.26.2.65>; Martyn Evans, 'Medicine, Philosophy, and the Medical Humanities', *The British Journal of General Practice: The Journal of the Royal College of General Practitioners* 52, no. 479 (June 2002): 447–49; Evans and Greaves, "'Medical Humanities' - What's in a Name?"; Pattison, 'Medical Humanities: A Vision and Some Cautionary Notes'; Shafer, 'Medical Humanities'; Desmond O'Neill et al., 'Rethinking the Medical in the Medical Humanities', *Medical Humanities* 42, no. 2 (June 2016): 109–14, <https://doi.org/10.1136/medhum-2015-010831>.

^{xlvi} Most prominently Martyn Evans and Jane Macnaughton, 'Should Medical Humanities Be a Multidisciplinary or an Interdisciplinary Study?', *Medical Humanities* 30, no. 1 (1 June 2004): 1–4, <https://doi.org/10.1136/jmh.2004.000143>; William E. Stempsey, 'Medical Humanities and Philosophy: Is the Universe Expanding or Contracting?', *Medicine, Health Care and Philosophy* 10, no. 4 (December 2007): 373–83, <https://doi.org/10.1007/s11019-007-9080-4>; Evans, 'Medical Humanities: An Overview'; Evans, 'Medical Humanities'; Atkinson et al., "'The Medical" and "Health" in a Critical Medical Humanities'; Chiapperino and Boniolo, 'Rethinking Medical Humanities'; Fitzgerald and Callard, 'Entangling the Medical Humanities'; Crawford et al., 'Health Humanities'.

^{xlvii} Evans and Greaves, 'Exploring the Medical Humanities: A New Journal Will Explore a New Conception of Medicine'; Evans, 'Reflections on the Humanities in Medical Education'; Evans and Greaves, 'Looking for Emerging Themes in Medical Humanities - Some Invitations to Our Readers'; Evans, 'Medical Humanities: An Overview'.

^{xlviii} Ahlžén, 'Medical Humanities – Arts and Humanistic Science'.

^{xlix} William E. Stempsey, 'Medical Humanities: Introduction to the Theme', *Medicine, Health Care and Philosophy* 10, no. 4 (December 2007): 359–61, <https://doi.org/10.1007/s11019-007-9078-y>.

¹ This point is only valid in terms of the metaliterature. As already hinted, concrete work in the medical humanities look at specific medical subspecialties. It would be my hope that by paying greater attention to the complexities of medicine through a reversal, we may uncover and begin to articulate more clearly the multitude of experiences and approaches within the medical field, to show that, like humanities, medicine is a meta-discipline. Related to this is the question whether medical humanities itself is a discipline, a subdiscipline, or a field? Much like the resistance against concrete definitions, many papers resist the idea that medical humanities should be a distinct discipline, and stick to calling it a field (E.g. Greaves & Evans, Evans & Greaves, and Pattison gives a down-right warning against becoming a discipline). Greaves & Evans also declare a wish to avoid division of the medical humanities into subdisciplines with each

humanities/arts discipline for itself, but later (in their 10-year overview) point out that medical humanities as such has, as a field, in some cases turned into a subdiscipline of medicine. Stempsey – using more voluminous metaphors – describes medical humanities as a meta-multiverse, that is, a meta-frame, or a meta-field in which many multiverses, or fields, each with many possible disciplinary relations exist. (Greaves and Evans, ‘Medical Humanities’; Evans and Greaves, “‘Medical Humanities’ - What’s in a Name?”; Pattison, ‘Medical Humanities: A Vision and Some Cautionary Notes’; Greaves and Evans, ‘Medical Humanities’; Evans and Greaves, ‘Ten Years of Medical Humanities’; Stempsey, ‘Medical Humanities and Philosophy’.)

^{li} Viney, Callard, and Woods, ‘Critical Medical Humanities’.

^{lii} Whitehead and Woods, ‘Introduction’; Fitzgerald and Callard, ‘Entangling the Medical Humanities’.

^{liii} Kristeva et al., ‘Cultural Crossings of Care’.

^{liv} At the theme conference Ødemark expanded on this in a comment, remarking that the paper was partly motivated by a wish to argue that medical humanities should not “just” be considered icing on the medical cake but a fundamental ingredient, and that there is a need for humanities *basic research* within medicine (Personal correspondence, October 27, 2019, Cultural Crossing of Care, Oslo).

^{lv} See endnote *iii* for clarification of what is implied by ‘realm of culture’.

^{lvi} McManus quotes Jonathan Miller saying that medicine “spans the two ends of the [art-science] spectrum”, Murray argues that both humanities and sciences are integral to medicine, Ahlzén says, quoting Toulmin, that medicine is both application of scientific knowledge and value judgements, Evans argues that medicine must intervene both in natural fabric and in lived experience in order to help human beings, and Chiapperino & Boniolo write that medicine is grounded in keeping material and experiential natures fused. In a talk on the medical concept of evidence Engebretsen draws out that even Archie Cochrane’s text *Effectiveness and Efficacy* (1972) acknowledges the doubleness of medicine as both *cure* (measured in EBM) and *care* (something else). (McManus, ‘Humanity and the Medical Humanities’; Murray, ‘Why the Medical Humanities?’; Ahlzén, ‘Medical Humanities – Arts and Humanistic Science’; Evans, ‘Medicine, Philosophy, and the Medical Humanities’; Evans, ‘Reflections on the Humanities in Medical Education’; Chiapperino and Boniolo, ‘Rethinking Medical Humanities’; Eivind Engebretsen, ‘The Medical Concept of Evidence and the Irreducible Singularity of Being’ (Kristeva Circle, Stockholm, Sweden, 2016), <http://kristeva.fr/eivind-engebretsen-the-medical-concept-of-evidence.html>.)

^{lvii} References to the two cultures and CP Snow occur several places in the literature, e.g. Harvey Mandell, ‘Humanities and Medicine (a Slightly Dissident View)’, *The Yale Journal of Biology and Medicine* 65, no. 3 (June 1992): 183–87; Gillon, ‘Welcome to Medical Humanities – and Why’; Cook, ‘Borderlands’; Arnott et al., ‘Proposal for an Academic Association for Medical Humanities’; Hurwitz, ‘Medical Humanities’; Igor J. Polianski and Heiner Fangerau, ‘Toward “Harder” Medical Humanities: Moving Beyond the “Two Cultures” Dichotomy.’, *Academic Medicine* 87, no. 1 (January 2012): 121–26, <https://doi.org/10.1097/ACM.0b013e31823ad204>; Jones, Wear, and Friedman, ‘Introduction: The Why, the What, and the How of the Medical/Health Humanities’; J. Donald Boudreau and Abraham Fuks, ‘The Humanities in Medical Education: Ways of Knowing, Doing and Being’, *Journal of Medical Humanities* 36, no. 4 (December 2015): 321–36, <https://doi.org/10.1007/s10912-014-9285-5>.

^{lviii} Richard C Reynolds and Ronald A Carson, ‘Editorial: The Place of Humanities in Medical Education’, *Academic Medicine* 51, no. 2 (1976), https://journals.lww.com/academicmedicine/Fulltext/1976/02000/Editorial__The_place_of_humanities_in_medical.16.aspx; Murray, ‘Why the Medical Humanities?’; Raimo Puustinen, M Leiman, and A M Viljanen, ‘Medicine and the Humanities—Theoretical and Methodological Issues’, *Medical Humanities* 29, no. 2 (1 December 2003): 77, <https://doi.org/10.1136/mh.29.2.77>; Macnaughton, ‘Medical Humanities’ Challenge to Medicine’; P. Ravi Shankar, ‘Medical Humanities’, *Journal of Medical & Allied Sciences* 2, no. 1 (31 January 2012): 26–28; Boudreau and Fuks, ‘The Humanities in Medical Education’.

^{lix} Whitehead and Woods, ‘Introduction’; Fitzgerald and Callard, ‘Entangling the Medical Humanities’; Kristeva et al., ‘Cultural Crossings of Care’.

^{lx} Marco Annoni et al., ‘Constructing the Medical Humanities Gaze’, *Critical Reviews in Oncology/Hematology* 84 (December 2012): 5–10, [https://doi.org/10.1016/S1040-8428\(13\)70003-9](https://doi.org/10.1016/S1040-8428(13)70003-9); Jeffrey P. Bishop, ‘Rejecting Medical Humanism: Medical Humanities and the Metaphysics of Medicine’, *Journal of Medical Humanities* 29, no. 1 (March 2008): 15–25, <https://doi.org/10.1007/s10912-007-9048-7>.

^{lxi} Chester R. Burns and H Tristram Engelhardt, ‘Introduction’, in *Special Issue: The Humanities and Medicine*, ed. Chester R. Burns and H Tristram Engelhardt, vol. 32, Texas Reports on Biology and Medicine 1 (Galveston: University of Texas, Medical Branch, 1974); Evans and Greaves, “‘Medical Humanities’ - What’s in a Name?”; Shafer, ‘Medical Humanities’; Ahlzén, ‘Medical Humanities – Arts and Humanistic Science’; Cook, ‘Borderlands’; Mark Vonnegut, ‘Foreword: Too Long Too Short’, in *Health Humanities Reader*, ed. Therese Jones et al. (New Brunswick, New Jersey ;L London: Rutgers University Press, 2014).

- ^{lxii} Joseph Herman, 'Medicine: The Science and the Art', *Medical Humanities* 27, no. 1 (1 June 2001): 42, <https://doi.org/10.1136/mh.27.1.42>; Evans, 'Medicine, Philosophy, and the Medical Humanities'; Evans, 'Reflections on the Humanities in Medical Education'; Mandell, 'Humanities and Medicine (a Slightly Dissident View)'.
- ^{lxiii} Cassell, *The Place of the Humanities in Medicine*; P Anne Scott, 'The Relationship between the Arts and Medicine', *Medical Humanities* 26, no. 1 (1 June 2000): 3–8, <https://doi.org/10.1136/mh.26.1.3>; Arnott et al., 'Proposal for an Academic Association for Medical Humanities'; Pattison, 'Medical Humanities: A Vision and Some Cautionary Notes'; Puustinen, Leiman, and Viljanen, 'Medicine and the Humanities—Theoretical and Methodological Issues'; Bolton, 'Boundaries of Humanities'; Stempsey, 'Medical Humanities'; Evans, 'Medical Humanities: An Overview'; Shapiro et al., 'Medical Humanities and Their Discontents'; Brian Dolan, 'History, Medical Humanities and Medical Education', *Social History of Medicine* 23, no. 2 (1 August 2010): 393–405, <https://doi.org/10.1093/shm/hkq005>; Cook, 'Borderlands'.
- ^{lxiv} Ahlzén, 'Medical Humanities – Arts and Humanistic Science'.
- ^{lxv} Burns and Engelhardt, 'Introduction'.
- ^{lxvi} Greaves and Evans, 'Medical Humanities'; Herman, 'Medicine: The Science and the Art'; Puustinen, Leiman, and Viljanen, 'Medicine and the Humanities—Theoretical and Methodological Issues'; Macnaughton, 'Medical Humanities' Challenge to Medicine'; Mullangi, 'Presenting the Case for the Medical Humanities'; Downie, 'Medical Humanities', 2016.
- ^{lxvii} For examples: Macnaughton refers to Medical humanities as a "counter-culture" to medicine. Atkinsons et al equate clinical medicine to biomedicine (in a distinction between clinical and political medicine, i.e. public health). Saunders, although arguing that medicine is partially art, does so by stating "medicine as we practice it today is applied science". Dror puts the medical and scientific mind (/students) on the same footing, and opposes them to the humanities. (Macnaughton, 'The Humanities in Medical Education'; Atkinson et al., "'The Medical" and "Health" in a Critical Medical Humanities'; John Saunders, 'The Practice of Clinical Medicine as an Art and as a Science', *Medical Humanities* 26, no. 1 (1 June 2000): 18–22, <https://doi.org/10.1136/mh.26.1.18>; Otniel E. Dror, 'De-Medicalizing the Medical Humanities', *The European Legacy* 16, no. 3 (June 2011): 317–26, <https://doi.org/10.1080/10848770.2011.575595>.)
- ^{lxviii} McManus, 'Humanity and the Medical Humanities'; Andrea Wershof Schwartz et al., 'Evaluating the Impact of the Humanities in Medical Education', *Mount Sinai Journal of Medicine: A Journal of Translational and Personalized Medicine* 76, no. 4 (1 August 2009): 372–80, <https://doi.org/10.1002/msj.20126>; Jakob Ousager and Helle Johannessen, 'Humanities in Undergraduate Medical Education: A Literature Review', *Academic Medicine* 85, no. 6 (June 2010): 988–98, <https://doi.org/10.1097/ACM.0b013e3181dd226b>.
- ^{lxix} Boudreau and Fuks, 'The Humanities in Medical Education'.
- ^{lxx} Juul Jensen, 'Humaniora som sundhedsvidenskab [Humanities as Health Science]'.
- ^{lxxi} Viviane Quirke and Jean-Paul Gaudillière, 'The Era of Biomedicine: Science, Medicine, and Public Health in Britain and France after the Second World War', *Medical History (Pre-2012)* 52, no. 4 (2008): 441–52.
- ^{lxxii} Evans, 'Medical Humanities: An Overview'.
- ^{lxxiii} Carolyn Culbertson, 'Losing the Measure of Health: Phenomenological Reflections on the Role of Techne in Health Care Today', in *Existential Medicine - Essays on Health and Illness*, ed. Kevin Aho, New Heidegger Research (Lanham: Rowman & Littlefield International, 2018), 179–90.
- ^{lxxiv} In fact, Boudreau & Fuks argue that medicine was originally separated from humanities because it was excluded from the *Studia Humanitatis* tradition, that is, it was excluded from humanities before it became majorly scientific. (Boudreau and Fuks, 'The Humanities in Medical Education'.)
- ^{lxxv} There are further questions (posed by McManus, Mandell, Shapiro et al., and Mullangi) about whether it is even achievable to change personality in adulthood, whether it should be the educational system's responsibility to make students and physicians good human beings, and if so, who decides what that means. There is also the issue pointed out by Downie that it does not follow that because someone is a humanities scholar they are necessarily more human than the general population. Or the objection from Kirklin that humane practice of medicine does not rely on humanities, since humanities is a rather new concept compared to practicing humanistic medicine. (McManus, 'Humanity and the Medical Humanities'; Mandell, 'Humanities and Medicine (a Slightly Dissident View)'; Shapiro et al., 'Medical Humanities and Their Discontents'; Mullangi, 'Presenting the Case for the Medical Humanities'; Downie, 'Medical Humanities', 1 June 2003; Deborah Kirklin, 'Medical Humanities: A Personal View', *Medical Humanities* 32, no. 2 (1 December 2006): 117–18, <https://doi.org/10.1136/jmh.2006.236>.)
- ^{lxxvi} McManus, 'Humanity and the Medical Humanities'; Schwartz et al., 'Evaluating the Impact of the Humanities in Medical Education'; Ousager and Johannessen, 'Humanities in Undergraduate Medical Education'.
- ^{lxxvii} Shapiro et al., 'Medical Humanities and Their Discontents'.
- ^{lxxviii} Mandell, 'Humanities and Medicine (a Slightly Dissident View)'; Pattison, 'Medical Humanities: A Vision and Some Cautionary Notes'; Downie, 'Medical Humanities', 1 June 2003; Campo, "'The Medical Humanities," for Lack of a Better Term'; Christina M. Gillis, 'Medicine and Humanities: Voicing Connections', *Journal of Medical Humanities* 29,

no. 1 (March 2008): 5–14, <https://doi.org/10.1007/s10912-007-9045-x>; Catherine Belling, ‘Commentary: Sharper Instruments: On Defending the Humanities in Undergraduate Medical Education’, *Academic Medicine* 85, no. 6 (June 2010): 938–40, <https://doi.org/10.1097/ACM.0b013e3181dc1820>.

^{lxxix} Polianski and Fangerau, ‘Toward “Harder” Medical Humanities’.

^{lxxx} Macnaughton, ‘Research in Medical Humanities’; Rita Charon, ‘Commentary: Calculating the Contributions of Humanities to Medical Practice—Motives, Methods, and Metrics’, *Academic Medicine* 85, no. 6 (June 2010): 935–37, <https://doi.org/10.1097/ACM.0b013e3181dc1ead>.

^{lxxxi} Related to this is the concern that whereas medical humanities can be thought of as a counter-movement to the scientification of medicine (i.e. biomedicine), it stays within managerial medicine and risks becoming a “tool of governance”, that is, yet another way to measure and optimize output in healthcare, and thus does not succeed in creating genuine re-humanisation/contact between individual patient and health worker. (Alan Petersen, ‘Governmentality, Critical Scholarship, and the Medical Humanities’, *Journal of Medical Humanities* 24, no. 3 (1 December 2003): 187–201, <https://doi.org/10.1023/A:1026002202396>; Bishop, ‘Rejecting Medical Humanism’; Petersen et al., ‘The Medical Humanities Today’; Evans, ‘Affirming the Existential within Medicine’.)

^{lxxxii} Richard Meakin, ‘The Humanities in Medicine - Distancing and the Distance between Us’, *Medical Humanities* 31, no. 1 (1 June 2005): 50–50, <https://doi.org/10.1136/jme.200X.000210>.

^{lxxxiii} Rogers, ‘Being Skeptical about the Medical Humanities’.

^{lxxxiv} Jones et al., ‘The Almost Right Word’.

^{lxxxv} Kristeva et al., ‘Cultural Crossings of Care’.

^{lxxxvi} See for example Miles: “Having become seduced by the power of science and overestimating its significance in the care of the individual as a result, [...] doctors now no longer consider it their role to provide the person-centred, relationship-based, holistic model of care that was viewed essential by their predecessors and held as a natural inclination of the vocation to medicine.” (this particular example found through O’Neill et al.), or Dror: “The large majority of physicians do not have a true understanding of the humanities; they have no clue regarding what we are about”. (Andrew Miles, ‘On a *Medicine of the Whole Person* : Away from Scientistic Reductionism and towards the Embrace of the Complex in Clinical Practice*: On a *Medicine of the Whole Person*’, *Journal of Evaluation in Clinical Practice* 15, no. 6 (December 2009): 941–49, <https://doi.org/10.1111/j.1365-2753.2009.01354.x>; O’Neill et al., ‘Rethinking the Medical in the Medical Humanities’; Dror, ‘De-Medicalizing the Medical Humanities’.)

^{lxxxvii} O’Neill et al., ‘Rethinking the Medical in the Medical Humanities’.

^{lxxxviii} Evans, ‘Medical Humanities: An Overview’.

^{lxxxix} Pattison, ‘Medical Humanities: A Vision and Some Cautionary Notes’.

^{xc} Meakin, ‘The Humanities in Medicine - Distancing and the Distance between Us’.

^{xci} Bates and Goodman, ‘Critical Conversations - Establishing Dialogue in the Medical Humanities.’

^{xcii} Kristeva et al., ‘Cultural Crossings of Care’.

^{xciii} Evans, ‘Medicine, Philosophy, and the Medical Humanities’.

^{xciv} Personal correspondence, Copenhagen, May 2, 2019. See also Stempsey, ‘Medical Humanities’; Gillie Bolton, ‘Medicine, the Arts, and the Humanities’, *The Lancet* 362, no. 9378 (July 2003): 93–94, [https://doi.org/10.1016/S0140-6736\(03\)13894-9](https://doi.org/10.1016/S0140-6736(03)13894-9).

^{xcv} Evans, ‘Medical Humanities: An Overview’.

^{xcvi} O’Neill et al., ‘Rethinking the Medical in the Medical Humanities’.

^{xcvii} Inspiration for approaching this collaboration may be found in the ‘philosophy of science in practice’ movement where boundaries between philosopher and scientists are often blurred, and scholars collaborate closely in order to find better articulations of theories of science that fit the actual practice and experience of scientists. Lena Soler et al., eds., *Science after the Practice Turn in the Philosophy, History, and Social Studies of Science*. (New York: Routledge, 2017).