Edgelands

The view from the edgelands

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Medical humanities is characterised as occupying the “edgelands” between science and the humanities

In a discussion of the built landscape, Shoard has coined the expression “the edgelands” to describe that interesting area to be found on the outskirts of towns, between rural and urban areas. This area is:

“an interfacial rim...characterised by rubbish tips and warehouses, superstores and derelict industrial plant, office parks and gypsy encampments, golf courses, allotments and fragmented, frequently scruffy farmland”.

The edgeland passes largely unnoticed although it is “a vaguely menacing frontier land hinting that here the normal rules governing human behaviour cannot altogether be relied upon”. However, Shoard argues, “if we fail to attend to the activity of the interface we forfeit the chance not only to shape that change but also to influence the effects of it on other parts of the environment”.¹

If we take the urban environment as a metaphor for the natural sciences, with their hard edges and their objectivity, and if the rural landscape could be said to represent the humanities, softer, pastoral, more relaxed and more subjective, we could characterise the medical humanities as occupying the kind of “interfacial rim” that Shoard describes. Those working in the field might not appreciate their workplaces being compared to rubbish tips or gypsy encampments, but they might respond positively to the idea that there is something dangerous or romantic about being at home in an area described as “vaguely menacing”, a place where “the normal rules governing human behaviour cannot be altogether relied upon”.

Since its first edition, this journal has addressed the interface between science and the arts, working in the interstitial space between them and seeking to blur the boundaries and achieve some reintegration of the two. This is perhaps the only territory in which writers can explore topics as diverse as the instrumental use of poetry in medical education,² or the relationship between

creative writing and wellbeing,³ or the relationship between Franz Kafka and his country doctor uncle.⁴

Country dwellers object to arrogant assumptions on the part of townies about rural life. A central concern of the medical humanities has been the critique of biomedicine and the inability of the natural sciences to say anything about the human experience of sickness, illness or suffering. As Midgley argues, this is not to be anti-science but to acknowledge the limitations of science. There are areas of activity in which science has been highly successful but, by its own self imposed terms of reference, there are areas about which it can and should have nothing to say. Midgley says:

What is called “anti-science” feeling is not usually an objection to the actual discovery of facts about the world...Instead, it is a protest against this imperialism—a revulsion against the way of thinking which deliberately extends the impersonal, reductive, atomistic methods that are appropriate to physical science into social and psychological enquiries where they work badly. That they do work badly there has often been pointed out. Yet these methods are still often promoted as being the only rational way to understand such topics.⁵

Health care professionals claim to understand how to help people with health related problems, and Boyd⁶ suggests that this involves engaging with concepts such as disease, illness, and sickness. Commonly, disease represents pathology, the variation from the biological norm. Illness represents the patient’s experience of ill health, and sickness is the role negotiated with society. Boyd goes on to give a more critical account of these and other concepts. This representation fits, however, with popular understanding, among professionals and patients alike.

As consumers of health services we hope that professionals will be able and willing to help us in all three areas, and

to do so, professionals need knowledge on which to base their practice. Clinicians need explanations of the clinical syndrome and its outcome and evidence of effective treatments to control that outcome. Scientists have taken seriously Bacon’s aphorisms, that “Man...can do and understand so much and so much only as he has observed in fact or in thought of the course of nature: beyond this he neither knows anything nor can do anything” and that “Human knowledge and power meet in one; for where the cause is not known the effect cannot be produced”.⁷ If, however, bioscience can know the cause and bring about the effect in the treatment of disease, what can scientists say about illness and sickness? The difficulty here is that, as Midgley points out, “the natural sciences are wholly dedicated to talking about objects.” Science “cannot, therefore, provide a language for discussing the relations between subjects and objects”. Our experience of illness and our negotiation of our social role are products of our consciousness but for science:

The problem then arises: how can we fit [consciousness] into conceptual schemes that were never meant to accommodate it? How are we to talk about ourselves as subjects? How, in particular, should we talk about the relation between ourselves as subjects and as objects—between the first and third person aspects of ourselves? (Midgley,⁵ pp 8 and 9)

However, just as the urban dwellers should have no dominance over the country people, neither should the pastoral ideal hold sway over the towns folk. Neither landscape alone gives an adequate account of the country as a whole. The “additive” view of medical humanities, in which we have the contrasting perspectives of science and the arts but “without either side impinging on the other”,⁸ is at best a modest improvement.

Biomedicine solves problems by the experimental method. But such is the power of scientific imperialism that we assume that if the randomised controlled trial is the best way to evaluate a new drug, it must be the best way to evaluate anything else. Not all research has fallen victim to the spread of experimental method. Qualitative methodologies have been developed, to tackle questions that depend on the values, beliefs, and attitudes of participants rather than that which can only be observed in fact. Qualitative researchers attempt to explore human experience, denying that their work can be value

free, or that causes and effects can be distinguished. They gather data about feelings, behaviour, thoughts, and actions as experienced or witnessed, seek meaningfulness in research findings, and judge quality by reference to relevance, plausibility, or responsiveness to subjects' experiences.

Nevertheless, at least in the context of qualitative research as it has been taken up by medicine, there is evidence of scientific imperialism at work. It seems that bioscience tolerates qualitative research as long as there is some acknowledgement of the principles of scientific method. Thus we must have rigour and replicability. We may accept that knowledge may not be universal or generalisable, but at the very least it should be dependable, credible and transferable. Qualitative researchers dispute the relevance of validity and reliability but none the less adopt such measures as "member checking", triangulation, and "insider/outsider articulation" of concepts (using both people involved and uninvolved within an analytic framework). Such approaches have, however, been criticised as limiting the depth of inquiry,⁹ undermining researcher responsibility¹⁰ and diverting attention from the strengths of an individual's views.⁹

Having criticised biomedicine and the natural sciences for their inability to express the human experience, the same can be said of qualitative research paradigms that fail to recognise the importance of balancing the humanistic with the bioscientific in health and illness. As with the natural sciences, human sciences that work alone to clarify issues of healing, illness, and wellness may be accused of overlooking aspects of the relationship between subjects and objects. For greater insight into the healing process, we must consider not only the human aspect of suffering and endurance, but the biological, physiological, and restorative technical aspects of health care that together may bring into focus a person's wholeness. Only through an appreciation of the integration between human experience and bioscientific treatments of disease, be it within historical, sociological, medical or ethical genres, can we hope to reach clarity of understanding that befits the problem.

This journal has published examples of empirical research, using methods such as questionnaires¹¹ and focus groups¹² but it has also published accounts of the visual arts, prose and poetry as methods of exploring the human condition and the experience of health and illness.¹³ What is not apparent is how, or whether, such investigations are to be located in some account

of methodology; it is clearly important to take these debates further to understand where they fit in methodological terms. If they belong in the areas of literary theory, art criticism or the social history of medicine, they might be thought to have little direct application to clinical practice, as these disciplines presumably have little to offer by way of evidence of effectiveness. And what are we to make of research that interprets the creative work of ordinary people? Sparkes,¹⁴ working in autoethnography, writes accounts of his experiences of illness that are more akin to short stories than to narratives collected by a researcher through an interview. He uses his skill as a writer to conjure the intensity of feeling and emotion that goes with disabling injuries and surgery and then offers his own reflexive interpretation of these first person accounts. Tombs¹⁵ has written a philosophical analysis of her own experience of multiple sclerosis. Are such accounts no more than self indulgence, or are they as entitled to be taken as seriously as any (member checked, double coded) analysis of data from a focus group involving a purposeful sample of individuals? Is a fictional account of illness and therapy in a tuberculosis sanatorium as credible as an ethnographic study of a real sanatorium?

Writing about the Cartesian division of mind from body, Midgley argues that "neither apartheid nor conquest will work" (Midgley,⁵ p 10). Rigid divisions between town and country are generally unproductive. Usually it is the urban landscape that spreads outwards, encroaching into the countryside, but few people would welcome the obliteration of the rural landscape or the ploughing up of cities. Peter Blake rejected London as a place of "silly cliché and cynical marketing"¹⁶ and went in search of rural solitude where he could "paint about love, beauty, joy, sentiment and magic" (Rudd,¹⁵ p 67) but the first exhibition of the Brotherhood of Ruralists work led to accusations of "self satisfied exclusivity and a regressive, mawkish, conservatism".²⁰ It is perhaps more comfortable to live in one place, a city dweller or committed to country life. Few of us choose to live in the edgelands. But arguably the dynamic of life in these areas, the tensions, frictions, and loneliness of life at the margins, can generate creativity and innovation. In such places gather people with different backgrounds, values and ideas. The area may look untidy and offend sensibilities but as Shoard observes, "if we fail to attend to the activity of the interface we forfeit the chance not only to shape that change but also to influence the effects

of it on other parts of the environment".¹ If we are to achieve the aim sketched out in the editorial of the first edition of this journal, "to refocus the whole of medicine in relation to an understanding of what it is to be fully human; the reuniting of technical and humanistic knowledge and practice",⁸ the metaphorical edgelands is probably the place to do it.

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