Advances in psychiatric treatment (2012), vol. 18, 369–371 doi: 10.1192/apt.bp.111.009415

Searching for real holism

COMMENTARY ON… PAYING ATTENTION†

COMMENTARY

Julian C. Hughes

SUMMARY

Robin Downie provides useful reminders of the broad basis of medical practice. This should encourage the sort of 'engaged attention' that he describes – the sort of attention needed to appreciate works of art. But what else is going on in a clinical encounter (as in a work of art)? This commentary suggests that real communication is to be understood in dramaturgical terms as occurring between actors in real time and space. It involves shared understandings, which require empathy but which depend on something ineffable to do with our standing as human beings in the world.

DECLARATION OF INTEREST

None.

In 1953, Ludwig Wittgenstein wrote: 'The work of the philosopher consists in assembling reminders for a particular purpose' (Wittgenstein 1968, §127). Downie (2012, this issue) eloquently reminds us of a variety of things: the contribution of the humanities to our understanding of the practice of medicine, the challenges that face anyone trying to teach communication skills, the potential for words such as 'empathy' to be used too glibly and that medicine has its roots in more than one pot. These reminders are, however, for a purpose, which is to commend a type of 'engaged attention' that allows the Asklepian and Hippocratic (scientific) approaches to flourish simultaneously. This is all deftly done.

But are these reminders necessary? It would seem so, because some people think of psychiatry in very biomedical terms, whereas others proffer a highly psychosocial paradigm. Alternatively, Downie is keen to establish that these dichotomies are unnecessary. Music and painting make the point nicely: our appreciation is enhanced by technical knowledge, but if we focus only on the artist's technique, we will miss the message. But should practitioners really need to be reminded to take the holistic view? Is this not the stuff of quotidian clinical experience? People are made up of more than their (causally interacting) molecules, but nonetheless – to quote Wittgenstein's pupil and friend, Drury (who became a psychiatrist) – 'Our sanity is at the mercy of a molecule' (Drury 1973, p. 134).

Perhaps this demonstrates, therefore, the truth of Fulford's (1991) suggestion that there should be two-way traffic between philosophy and psychiatry: clinicians know things that should be jolly good grist to the philosophical mill. So I shall, albeit briefly, add to or comment on some of Downie's reminders. My purpose in doing so is to point towards something more mysterious at the heart of practice.

Communication

As any examiner of the Clinical Assessment of Skills and Competencies (CASC) part of the Royal College of Psychiatrists' membership exam (the MRCPsych) knows, the rote use of some communication skills can be excruciating. But, with deference to Downie, I think that there are higher skills to be acquired that would indeed support 'engaged attention'. After all, something similar happens in the humanities. Any dullard can quickly acquire the vocabulary of architectural appreciation (e.g. flying buttresses, fan vaulting, Ionic capitals), but it is also possible to learn how to attend (to acquire the skills), so that we see or hear in a way that is more informed and more reflective. Of course, there is something else – to do with aptitude, temperament and experience – that means that some of us will always find good communication difficult and some of us will never like any music beyond Tchaikovsky. The point, it seems, is not to disparage the possibility of acquiring higher skills, but to ponder their nature and how they are acquired. It might be by example, but then, I suspect, what is acquired is not some mere skill: rather, an attitude or way of life.

Narrative

Let's say that the nature of higher communication skills can be characterised (at least partially) by reference to the ability to engage in a meaningful way, which requires that the person has really been heard and knows it. We might link this to the idea of narrative, which helps us, for instance, to see our interrelationships more clearly: we are the co-authors of our stories.

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†See pp. 363–368, this issue.

https://doi.org/10.1192/apt.bp.111.009415 Published online by Cambridge University Press

But is life actually as clear-cut and logical in its progression as the notion of literary narrative might suggest? Arguably, life is more like the theatre. There is still a story, but unexpectedly dramatic things happen, not on the page, but in the space and time in which we are situated. The tension between the actors is one that now grips us. To interrupt the silence with a cough or sneeze – as in the concert hall – would be anathema. The drama is shared in public space. Similarly, practitioners and patients can have shared understandings in the clinic. The meaning of a sentence lingers in the air, as does hope or its absence. These things are created in real time between real people, not just in the reconstructed narrative. Encounters between doctors and patients, involving shared feelings, are just as dramaturgical and they generate, at their best, shared understandings.

Empathy

'Shared feelings' hints at the vexed question of empathy or at least at sympathy. If what I have said above is correct, then there is the possibility that empathy need not involve some sort of trite attempt to stand in the shoes of the other. Instead, it could mean openness to the meaning that emerges as part of the mutual and authentic engagement of the actors concerned. Empathy was central to philosophical and psychological thought at the start of the 20th century in Germany. The very possibility of a distinction between the human sciences (*Geisteswissenschaften*) and the natural sciences (*Naturwissenschaften*) was partly predicated on the possibility of empathy (Fulford 2006).

According to Jaspers, phenomenology involves 'understanding, empathic representation', or a type of non-sensory seeing what the other person is experiencing (Walker 1995). Empathic understanding (Verstehen) of psychic life is contrasted with causal explanation (Erklären). Such explanation is required by both natural and human sciences, but empathy supplies the phenomenological account. The specific account to be given of empathic understanding does not, it seems to me, have to be reduced to the idea of seeing the meaning of the person's narrative. It is more dramaturgical. Not only is it captured by Buber's 1923 account of 'I–Thou' and 'I–It' relationships (Buber 1937), but also by the possibility of both 'being with' and 'doing to'. It is something that emerges between people as human beings-in-the-world; it uniquely reflects the human-person perspective (Hughes 2011). Downie usefully reminds us that the dichotomies must be discarded to capture the whole picture. I would add that there is more to the picture than meets the eye. It presupposes or points to something else.

Conclusions

What do these reminders drawn from clinical experience add up to? What does the picture, the drama or the music point to? I think it is something mysterious: real but difficult to pin down. It is this mysterious element, I suggest, that runs through good communication, understanding of narratives, true aesthetic appreciation, as well as genuine empathic encounters, and is that which clinicians simply know as raw experience. Downie points out that Buber's account of the tree does not end with a soul, but this seems to overlook the overall thrust of Buber's work, which is theological: 'The extended lines of relations meet in the eternal Thou' (Buber 1937).

The translation of *Geisteswissenschaften* as 'human sciences' ignores the true meaning of *Geist* as 'spirit'. Some will be keen to avoid the spiritual spin, but the ineffability that emerges as seemingly central to good-quality clinical encounters (reflecting the human 'spirit', even) points to something mysterious. Similarly, music can be explained in multifarious ways; but there is something shared and understood, yet that cannot be said. This understanding may be inevitably tacit because it could be to do with a shared background which has to be taken for granted to get things going in our encounters, but which reflects our unique being-in-the-world as the creatures that we are (e.g. see Fulford 2006: pp. 402–3).

Downie is correct to commend 'engaged attention'. Our day-to-day experience of this is, I think, more than an experience of both the human and scientific sides of medicine. It is an experience of the mundane, but the mundane, the everyday, presupposes shared commitments – meanings, values, intuitions, emotions and so forth – that can never be fully specified; nonetheless, they are implicit in clinical practice.

Maintaining the holistic view is, as Downie suggests, an important perspective. Maybe, however, this is to be thought of in terms of neither a searchlight, nor nightclub lights. What is required is the full glare of the sun. Practitioners need every perspective possible (biological, psychological, social and spiritual) and there will still, perhaps, be aspects of the encounter, immanent in the mundane, that cannot be pinned down.

Acknowledgements

I am very grateful to an anonymous reviewer for comments on this article, which have been wholly helpful.

References

Buber M (1937) *I and Thou* (trans RG Smith). Continuum.

Downie R (2012) Paying attention: Hippocratic and Asklepian approaches. *Advances in Psychiatric Treatment* **18**: 363–8.

Drury MO'C (1973) *The Danger of Words*. Routledge and Kegan Paul.

Fulford KWM (1991) The potential of medicine as a resource for philosophy. *Theoretical Medicine* **12**: 81–5.

Fulford KWM, Thornton T, Graham G (2006) *Oxford Textbook of Philosophy and Psychiatry*. Oxford University Press.

Hughes JC (2011) *Thinking Through Dementia*. Oxford University Press.

Walker C (1995) Karl Jaspers and Edmund Husserl IV: Phenomenology as empathic understanding. *Philosophy, Psychiatry, & Psychology* **2**: 247–66.

Wittgenstein L (1968) *Philosophical Investigations* (eds GEM Anscombe and R Rhees, trans GEM Anscombe). Blackwell.

Melancholia: from *Hamlet*, by William Shakespeare

IN OTHER WORDS

Selected by Femi Oyebode

I have of late – but wherefore I know not – lost all my mirth, forgone all custom of exercises; and, indeed, it goes so heavily with my disposition that this goodly frame, the earth, seems to me a sterile promontory; this most excellent canopy, the air, look you, this brave o'erhanging firmament, this majestical roof fretted with golden fire, why, it appears no other thing to me than a foul and pestilent congregation of vapours. What a piece of work is a man! how noble in reason! how infinite in faculty! in form and moving how express and admirable! in action how like an angel! in apprehension how like a god! the beauty of the world! the paragon of animals! And yet, to me, what is this quintessence of dust? man delights not me; no, nor woman neither, though by your smiling you seem to say so.

(*Hamlet*, II. ii. 291–308)

William Shakespeare (1564–1616) wrote the play *Hamlet* around 1600. Shown here is Hamlet's description of anhedonia, the inability to experience joy, indeed to draw any emotion, from experiences that would normally cause delight. From *Madness at the Theatre*, by Femi Oyebode (RCPsych Publications, 2012: p. 40).

doi: 10.1192/apt.18.5.371