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# Comprehending and explaining in clinical and healthcare practice

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**Abstract.** In medical education, humanities contribution can help to consider in a proper manner the complexity and the totality that characterize care relationship subjects, in order to avoid the reductionism, often encountered in medical practice. The active observation of art seems to be particularly significant in the support of healthcare professionals' well-being and the development of their specific competencies.

**Keywords:** medical, education, humanities, art.

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Regarding the discussion concerning which role may the art have in medical education, my intention is to give just an introduction, considering the competencies which healthcare professionals should possess because of the skills which characterise a care relationship.

Firstly, it will be necessary to define who are the subjects in a therapeutic relationship. Thus, patient and healthcare professional, both humans, individuals, who, however, feel often uncomfortable with their relationship. This one is a result of that phenomenon which may we consider as “a soul haemorrhage” [1] that recently characterises the medical science and the clinical practice and that, in other terms, is related to numerous and complex features that determine the uppermost in our era, in which relevant are technique and profit.

To try to figure out why this uncomfortable care relationship is rooted in the medical science epistemology, it will be useful to refer to Karl Jaspers' thought, German philosopher and doctor, who, in his work entitled “Der Arzt im technischen Zeitalter” (translated: The physician in the technological age) [2], analyses the healthcare professional transformation in a contemporary context, in a massive growth and dominance of technique.

The focus is immediately on a clinical eye, which in our era practice, according to Jaspers, leaves increasingly the “humanitarian” element based on an “understanding” communication between doctor and patient, in order to keep to the objectivity of clinical data which are given by the technique. However, the author states that a physician is characterised, on one hand, by the scientific knowledge and technical ability and on the other hand by the humane ethos. These two features refer to two different scenarios and because of that, they are not easy to see unified with each other in the individual caregiver’s personality.

Considering that humans are not things, the way in which they are in the world, alive, and the world meaning assumed by them depend on the sickness no less than by physicochemical elements identified by a clinical eye as only causes, according to the rules imposed by the scientific method. But through this method only facts are possible to ascertain, not meanings, the casual sequence and not the sense production, explanation order and not the one of the comprehension, whereby scientific knowledge and technical ability are always in a position to explain something without understanding anything, unless we consider as understood that phenomenon for the sole reason that it has been associated with a name.

Therefore, if the human status is not equal to the thing’s one, if its “attitude” is not a “movement” analogous to that of natural things, if medicine brought human together to positive methods of natural science – states Jaspers – it would explain facts, but it would not understand meanings, human would remain out of the reach of it, since a fact, deprived of its meaning, is actually inhuman. Until medicine regards the body as thing in isolation, as organic body (Körper) and not as a living body in the world (Leib), until it confines itself to get facts, instead of interrogating phenomena, namely subjective backgrounds as far as they are significant, medicine will be able just to link a set of “insignificant” data, resulting therefore as inhuman.

In view of these considerations, it is understandable that medicine, to be considered as “human”, – not intended consequently as exact science, but rather as activity based on scientific conditions, which operates in a world of values and differs from other techniques because its object is actually a subject [3] – it is called upon to be exercised necessarily when it manifests itself in the complexity. From this perspective, input from human sciences and that from humanities, namely medical humanities, results to be essential to medical science.

Consequently, it appears that also the sickness can only be considered as a complex phenomenon which is not possible to reduce as sole clinical data.

In this regard, the most preeminent mentors of medical anthropology, Arthur Kleinman and Byron J. Good [4] invite us to consider medicine as cultural system, namely as a set of symbolic meanings which models both clinical reality and the experience which makes sick a subject, elaborating a definition of sickness that distinguishes three meanings associated with it. They are provided by three words:

-*disease*, namely that understood, in biomedical sense, as organic wound or attack from external actors, a measurable event through a set of organic parameters naturally physicochemical (body temperature, etc.);

-*illness*, it corresponds to a subjective experience of feeling bad, lived by the sick subject based on his perception of malaise, usually culturally mediated;

*-sickness*, this term refers to the “social” meaning of feeling bad.

Indeed, from a purely biological, physiological, point of view, every one of us does not differ from another, from an historic, biographic, point of view, every one of us is unique [5] and unrepeatably, original and, precisely, irreducible because of our singularity and uniqueness, also from a clinical point of view.

There is something that makes “unique” each clinical case and this inter-individual variability, which is linked to the patient’s vital conditions, affects the forms in which pathological signs are manifested in the different clinical cases and also the patients’ reaction to care interventions.

Considering the thought about medical practice, then arises the problem of how we can relate the uniqueness of a single clinical case to the prerogatives, those of evidence-based medicine, namely to statistical data, guidelines and standardized procedures. The point is that when too much attention has been paid to quantitative aspects, then there is a risk of losing sight of the essence of that phenomenon which we observe and that we want to investigate, reaching as consequence inadequate solutions in clinical practice and in the diagnostic process.

Taking a cue this time from a Susan Sontag’s work [6], it is useful to restate that illness is something which has symbolic features for us. Indeed, the author invite us to consider this kind of malaise as a metaphor. That is to say that if illness is also a symbol, and it has more than one sense, which is a set of meanings that makes it much more significant than the signs that represent it.

To avoid the risk to practice an inhuman and inadequate medicine to manage our complexity, which we have as persons, it is essential that in clinical methodology will be recognised equal dignity of competencies both semiological and hermeneutic.

The hermeneutic awareness is that which allows taking account of the fact that not only doctor’s basic knowledges could change (disease), but also those of the patient, who gives a different sense to his symptoms, depending on his background (illness) and his context (sickness).

Indeed, at medicine and medic is required not only to explain diseases and to fix (as much as possible) patients until a full recovery, but also to understand their backgrounds to take care of them appropriately. The goal is to integrate an objective vision with a subjective one, to keep together quantitative and qualitative aspects.

Apparently, everything that is already said could be confused as something about “the look”, but, actually, perception studies show us the same thing, depending on how it is seen, it creates so many different descriptions to become then descriptions of different things. And physicians, nurses, how do they see patients and illnesses?

It is necessary to educate the future healthcare professionals’ “look” so that it becomes a look intent on expressing, in itself, a careful presence. Considering the attention as one of the crucial movements inside the relationship and essential precondition of the movement concerning comprehension and explanation. Indeed, according to the philosopher Maria Zambrano, attention “is receptiveness taken to its extreme, namely it is headed for a determined area of perception or thought: headed for the external world or, reflex, for its own world” [7].

As result, it can be seen that the art may have utility in medical education. A careful clinical eye, which is able not only to explain but also to understand, can actually be developed through the use and observation of art; taking into account the double efficacy that it can obtain, both considering the

healthcare professionals' well-being (by reducing stress job-related and burnout risk) and competencies concerning them (by developing a clinical eye and by strengthening the empathy ability).

This disposal is linked to the artefact very essence: the artwork can be defined as a "text" that is open to multiple levels of reading and information it offers can be related to each other even if they have a different meaning, representing conceptual nodes of a hypertext. And all because artistic production is closely linked to our identity and conscience. "The art languages can accept, transform and make intelligible the original and unconscious emotional magma. They offer themselves as a mirror that facilitates a more conscious interiorization of primitive mental contents and their access to thought and language" [8].

Therefore, if we want an authentically human medicine, and hence, since we cannot disregard to face in a practical way the complexity of understanding the patient as well as that of explaining the illness, the use of art, as already said, can be particularly useful in healthcare professionals' training. In conclusion, it seems nice to consider the possibility of contemplating a particularly eloquent testimony of the beauty contained in a truly careful and deeply empathic look, taking into account how often images and especially experiences are much more eloquent than any discourse or explanation for the purpose of understanding.

The testimony, which I would like to refer, is an artistic product conceived and acted by Marina Abramovic. In 2010 the artist gave a performance at the MOMA in New York "The artist is present". For 3 months, 6 days a week, 7 hours straight, the artist sat in the museum with a chair in front of her, eyes in the eye with the people sitting in front of her. Look intended as the door of the soul. A communication channel, silent and prelinguistic, opened through the ritual of the look, despite the confusion and the distractions, a channel from which flowed emotion.

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