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## Medicine and the Medical Arts<sup>1</sup>



*At the beginning of the 21st Century, the achievements of medicine as well as the accomplishments of scientific and technological civilization are obvious to everyone. Today, many illnesses can be treated far more precisely than in the past. Therapies allow patients to lead a self-determined and fulfilled life again. Nevertheless there remains an uneasiness that something is being short-changed, that we are lacking something. Since the middle of the 19th century, the scientific character of medicine has been emphasized in a special way. Medicine wants to be regarded especially as one of the emerging natural sciences. Its emphasis on experimentation is becoming more important. The paper discusses the question of what is the essence of medicine actually, or what it should be, and what follows from this for how physicians should act. We are not concerned about alternatives to the scientific and technical side of medicine, but about a larger field of view. We are discussing this here in seven steps that involve systematic and historical perspectives from the history of philosophy and medicine. The patient is not just “a case” or “a number” in the hospital ward or an entry on an index card in a medical practice, not just an object. The concrete patient must be at the centre. The patient’s concerns must be heard. The guideline for medicine that is understood as medical art cannot be just a look at efficiency and feasibility. Medical art is an educational process: a spiritual forming of individuals that requires time and cannot be switched on by the touch of a button. It does not simply mean the memorization of medical study materials, but the process of human maturation to become a true companion to the patient in an existentially challenging situation.*

**Keywords:** *medicine, medical art, medical education, physician, patient, therapy.*

“What medicine is and can be  
is determined by its own intentions and its purpose”  
[Wieland 2003: 26].

### I. 1. Medicine at the beginning of the 21st Century

At the beginning of the 21st Century, the achievements of medicine as well as the accomplishments of scientific and technological civilization are obvious to everyone. Diabetics can easily be treated with appropriate insulin therapy; many cancer patients can be helped. The battle against Parkinson

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and HIV is fought with great commitment by leading experts. In the hospitals of the world, vital functions are monitored with technical equipment. Vaccinations and neurosurgical interventions are almost an integral part of our everyday life. Antibiotics can relieve or cure many illnesses. Much hope for breakthrough therapies rests on the possibilities of DNA recombination. Genetic therapies or stem cell therapies are regarded as milestones in medicine. Today, many illnesses can be treated far more precisely than in the past. Therapies allow patients to lead a self-determined and fulfilled life again.

## I. 2. An uneasiness that something might be short-changed

Nevertheless there remains an uneasiness that something is being short-changed, that we are lacking something. While past generations were worried about waking up again in the coffin without being dead [Hufeland 1791], many of our contemporaries are afraid of a cold, thoroughly economized machine medicine. Not being allowed to die and to be kept alive by tubes is a concern that quite a few people have today.

Standardized processes play a special role, while wholeness is being forgotten in medicine. Less attention is paid to the role played by physicians. Relationships between physicians and patients are seen against a background of production logistics. Categorization leads to the situation where patients as well as their physicians, nurses or therapists become depersonalized<sup>1</sup>. Responsible physicians also sometimes lose profile with regard to the institutional processes to which they are committed [Wieland 2003: 57]. The physician becomes a cog in the wheel of a manufacturing process. Efficiency is the order of the day. The faces and life stories of patients are threatened to disappear behind numbers.

Not only the Berlin physician Fritz Kahn (1888–1968) regarded the physician as the technician, and the human body as the Palace of Industry<sup>2</sup>, both of which can be completely disassembled into their components. In Kahn's representation, the individual organs – such as the stomach or the lungs – are inhabited by little workers. In the brain, little homunculi are sitting at a table. This is a functionalistic view of the organism which is very common today. Technology plays a far more predominant role in present medicine than in

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<sup>1</sup> Karl Jaspers summarizes the risks of medicine thus interpreted as follows: "The power of judgment, of the fullness of the ability to see, of personal spontaneity is being paralyzed in mechanization" [Jaspers 1986a: 9]. He says that it remains problematic if the idea of humanity is lost in the physician/patient relationship, and the patient becomes a mere object of examination [Jaspers 1986a: 20]. "Clinics, insurance companies and medical laboratories come between the physician and the patient. The result is a world that enables physicians to act much more effectively, but that works against their being practitioners. The physician becomes a function: as a general physician, as a specialist, a hospital physician, a medical technician, a laboratory physician, an X-ray physician, etc." [Jaspers 1986a: 43].

<sup>2</sup> Cf. Kahn's teaching chart attached to his series [Kahn 1926; Engel et al. 2019: 173].

Kahn's time, and physicians are even more regarded as technicians than was the case then. Since physicians repair the human machine, diseases are considered to be defects that have to be dealt with.

Our understanding of the medical profession is in transition: In present debates, contrary to the 2.500 year-old tradition of European medical ethics, physicians are expected to provide suicide assistance. Just like witchdoctors, physicians are required to deliver death. In the course of reproductive medicine, they help childless couples to have children, and it is no exaggeration to consider this a rule of technology over life. Of course, this also applies to social egg freezing, a method which originally allowed women suffering from cancer to have a child after therapy. Today, some large corporations are suggesting this to their female employees who are supposed to be economically productive before dealing with the subject of family planning. Neither is it surprising that debates about assisted suicide by physicians go hand in hand with those about social egg freezing.

Quite often, life style and the physical features of humans are changed and "improved" by means of medical interventions. But the treatment of healthy individuals is problematic when we consider the actual core responsibilities of medical care. It places medical care in another light. For example, one branch of aesthetic medicine is extremely successful economically: "The human body is nothing but a battle zone that must be constantly optimized" [Wittstock 2019]. Today, this view of the body as a work project to be constantly optimized is also shared by many men. Especially popular among both sexes are injections (with botulism toxins or hyaluronic acid): According to the *Deutsche Gesellschaft der Plastischen, Rekonstruktiven und Ästhetischen Chirurgen* (Society of Plastic, Reconstructive and Aesthetic Surgeons) 143,000 such interventions were performed in 2014. And 138,500 aesthetic-plastic operations constituted about 29% of all surgeries performed. The basic question is why people are obviously not satisfied with themselves. How free are people who in the last analysis subordinate themselves to what "they" think or should think, feel and physically appear?

Optimization programs even begin prior to birth. In the context of liberal eugenics, it is important that one's own body and the unborn body should be optimized. Patients are regarded as welcome customers. In this context, physicians are no longer concerned just with the patient's well-being, but primarily with maximizing their own earnings<sup>1</sup>. They become wish fulfillers and service providers. Everyday hospital life is also thoroughly economized.

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<sup>1</sup>Of course, physicians must have their income and must manage well. But patients must be certain that they are not being counseled and treated with regard to economic advantages. The problem is certainly an old one: Socrates asked whether physicians are primarily businessmen or caregivers for the patients entrusted to them, which would constitute a "true physician" [Plato 2012: 345c]. His answer was: All artists practice a certain art, including physicians who practice the art of acquisition as a sideline, but they are primarily caregivers for patients. That is their specific art. [Plato 2012: 346c].

In Germany, *EBM* (Establishment of Evidence-based Medicine) has changed hospital financing. For example, per diem rates have become flat-rate charges. Physicians in private practice are facing more and more regulations for their billing procedure [Maio 2014].

Yet pompous promises for the future in the sense of a new age of medicine seem to not quite comprehend the complexity of man and medicine. We may also suspect that such announcements can always be guided by various interests. “A typical pattern that promises success is based on the equation: Knowledge = action, although in principle they are the same thing. Yet [...] it is proving to be much more difficult to find a way from scientific knowledge to successful activities” [Wiesing 2020: 32].

All of these issues raise the question of what actually is the essence of medicine, or what it should be, and what follows from this for how physicians should act. We are discussing this here in seven steps that involve systematic and historical perspectives from the history of philosophy and medicine.

## II. 1. The Physician as artist vs. the physician as a template

Since the middle of the 19th century, the scientific character of medicine has been emphasized in a special way. Medicine wants to be regarded especially as one of the emerging natural sciences [Sigerist 1930; Diepgen 1965]. Its emphasis on experimentation is becoming more important. And indeed, medicine owes many of its achievements to the inclusion of methods and findings from the natural sciences. Findings based on the spectrum of methods in the natural sciences constitute a better knowledge about the nature of man, thus allowing a more promising treatment as well as better prevention.

However, there is a tendency to over-emphasize this facet, which was expressed by the internal specialist and professor Bernhard Naunyn, who wrote early in the 19th century: “Medicine will either be a science or not” [Naunyn 1909: 1348; Bauer 2005]. In that connection, patients are regarded in terms of their functionality. Measurements are in the foreground.

Yet this one-sided view of medicine is by no means shared by everyone. In the 1920s there was a debate about the epistemological status of medicine. Approaches that were too reductionist were criticized, and a more holistic viewpoint was demanded [Klasen 1984; Geiger 2010; Timmermann 1999]. Among the protagonists of this debate were medical historian and internal specialist Georg Honigmann (1863–1930), the three surgeons, Ferdinand Sauerbruch (1875–1951), August Bier (1861–1941) and Erwin Liek (1878–1935), the immunologist Hans Much (1880–1932) and the gynecologist Bernhard Aschner (1883–1960). For example, they pleaded for the inclusion of philosophical considerations, saying that physicians should also regard man

as an “intellectual being” [Sigerist 1930: 105]. They demanded an extension of the reductionist and mechanical view.

Victor von Weizsäcker (1886–1957) talked about “anthropological medicine”. In contrast to medicine in the 19th century, which was mostly concerned with researching causal relationships, he saw medicine in his time as being determined by a paradigm of doing. According to him, the guiding principle is not what is behind the phenomenon of an illness, but what can be done about it, and that even a statistically determined reproducibility is enough to initiate the necessary steps [Weizsäcker 1986: 48]. He pleaded for not ignoring the subjective experience of patients as well as that of physicians. The individual life story must be part of the treatment. It is not enough to look only at the known medical facts. Physicians must also be concerned about the patient’s body-and-soul condition.

Wolfgang Wieland (1933–2015), Karl-Eduard Rothschild (1908–1984) and Richard Toellner (1930–2019) referred to medical practice at the beginning of the 20th century and arrived at an appropriate epistemological determination of medicine. They analyzed medical activities and the basic terminology of medical decision making. They argued that it would be insufficient to understand medicine as an applied natural science or epistemology. They regarded it as the responsibility of medicine “to take action in individual cases by means of reasonable determination” [Wieland 1972: 529] and not to generate abstract and general knowledge [Wieland 2003: 12]. We should not understand medicine through one of its means, but through its purpose. Wieland also said that the practice of medicine can be based on different sources of knowledge, such as the experience of the physician’s trained power of judgement.

It is problematic wanting to understand medicine exclusively as an exercise in the natural sciences. The scientific side is certainly one dimension, but not its only one. Medicine also has other dimensions such as technical and practical skills. A physician must know what to do in a certain situation, what means must be applied and what strategies should be disregarded. Of course, they will have to be able to draw on experience and on what is usually called cleverness. We must also include a theoretical dimension that collects and evaluates data, exploring the patient’s physical nature. Physicians do not act “somehow”, but according to certain ideas of what it means to be sick and healthy, about the nature of therapy and prevention. Normative imagination does play a role in medical practice.

An illness is experienced as incisive and has an existential dimension. It can turn a patient’s accustomed life and that of family members upside down – from one moment to the next. That can be a great burden and a challenge, a situation when much becomes brittle and questionable, when patients must rely upon themselves again. Medical practice has to do with concrete human beings who

have become ill, not with blood counts, liver counts and temperature curves. The blood counts, liver counts and temperature curves belong to specific human beings for whom medicine has a healing mission. The aim of the physician's action is very practical: the patient's health. And health is not something abstract, but a purpose given to us by nature, which we are ourselves<sup>1</sup>.

The responsibilities of physicians include the recognition of diseases, the alleviation of illness, to be therapeutically and preventively active. Physicians must diagnose, consider and judge. In consultation with a patient it becomes clear that the physician's responsibility is not only to apply the theoretically accumulated knowledge. Physicians must also be consultants. Patients come to them with their questions about meaning, their fears and worries, their hopes as well as their ethical concerns. Let us pay attention to our language! It is still quite customary today to refer to these activities as an "art". In that sense I speak of the physician as a template vs. the physician as an artist. The distinction goes back to Ernst Schweningen (1850-1924), of which Georg Honigmann (1863-1930) reminds us in his *Introduction to Medicine*. That is why I am bringing up the above mentioned discussion in the 1920s again, from which we can learn quite a bit today. The physician as a template regards patients as research objects.<sup>2</sup> On the other hand, physicians as artists care about the patient as a whole: "He applies his acquired knowledge, his learned and experienced knowledge in a specific way to decide what is needed in every individual case" [Honigmann 1924: 274].

Honigmann emphasizes individual concern for a patient who has fallen ill. He stresses that the patient must first learn to deal with illness, to adapt to being sick<sup>3</sup>. This could be very different in two persons who have the same illness. This is also cleverly expressed by the main character in Arthur Schnitzler's *Anatol*, the 1910 one-act play: "There are so many diseases and only one health -! ... We must always have exactly the same health as others, but our illnesses can be completely different than those of others!" [Schnitzler 2004: 98]. The view seems to be quite correct that illness is something individual that concerns you or me.

<sup>1</sup> Kluxen underlines that "medical science [...] as a practical science that utilizes theoretical knowledge derives its sense of awareness from the purpose of medical practice" [Kluxen 1976: 465].

Wieland said it as follows: "The concept of the art of medicine reminds us that medicine is a practical discipline whose final goal lies not in understanding matters of facts and reasoning about them, but rather in acting reasonably or prudently" [Wieland 1993: 166].

<sup>2</sup> Cf.: "Just as he needs a diagnosis to choose from the beginning, his kind of intervention, the time for acting according to learned indications, fixed pieces of advice and memos derived from general experience, all of which he adapts to the peculiarities of an individual case" [Honigmann 1924: 273].

<sup>3</sup> Cf. [Honigmann 1928: 63]. In English there is a difference between disease and illness. In German, one equivalent relates to the sickness, the other to being sick. Disease means the organism's objectified malfunction, while illness is the patient's personal experience of being sick.

Honigmann believes that the physician's responsibilities include "penetrating the patient's life and empathizing it" [Honigmann 1928: 67]. He speaks of the physician's unity of thinking and doing, which he formulates concisely:

"It is not his abundance of knowledge, his scholarship or his mastery of technology that constitutes the physician, but only the ability and the means given to him by science, by his experience, his knowledge of human nature and his skills that merge together into a unified thinking and doing in which all the patient's physical and spiritual relationships find their account. It is those characteristics that raise the physician to the status of artist and that raise medicine to a real art which like all other arts explore new sources that benefit a needy mankind" [Honigmann 1928: 123].

For Ferdinand Sauerbruch (1875–1951), the art of healing was not something that anybody could learn. He brings the education of mind and heart into play, saying that healing is something special that is congruent neither with science nor with parts of religion or philosophy [Sauerbruch 1926: 1086].

In the 1890s, Martin Mendelsohn (1860–1930) published a small paper in which he analyzed that medical science was successfully advancing while medical practice had degenerated [Mendelsohn 1894: 15]. He said that without a doubt contemporary physicians were not inferior to those in earlier times with regard to their diligence and intellectual abilities. Yet regardless of their talent and the medical knowledge they had acquired, things were not well in the medical arts. "Those who have made medical science their own are hardly a step further as a physician than he would be as a sculptor who has acquired in-depth knowledge of the mineralogical and chemical properties of plaster and clay. It is just that the latter knowledge can be acquired with much less effort because the material is much simpler" [Mendelsohn 1894: 21].

## II. 2. The patient as a bodily structured person

Since the Kennedy Laboratory for Molecular Medicine saw the light of day as the first laboratory for molecular medicine in 1962, the success story of that branch of medicine has continued. Nevertheless, medicine is far more than molecular medicine<sup>1</sup>, even though its successes, its knowledge about the molecular level of the organism, about causalities and – which is connected therewith - its special power to make prognoses are undisputed. Yet from the perspective of those affected, illness does not concern the molecular level but the patient himself as a person.<sup>2</sup>

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<sup>1</sup>It has sometimes been tried to characterize medicine as "molecular medicine" [Rheinberger 1996; Kulozik, et al. 2000].

<sup>2</sup>Medicine has to do with the individual concerns of patients. The diagnosis a physician makes is all about the healing of those patients. It presumes a normative perception of why suffering individuals are seen as ill and what is the objective of their treatment. The idea of

The patient who is facing the physician is by no means the sum of his organs, but a bodily structured person who in the long run should not be reduced to the symptoms of their illness either. The medical arts consist of medical care that is focussed on the person *as a person*.

As persons, we are bodily structured. The body is not a thing among things and by no means a tool. It is part of me, it has been given to me, it has to do with me.<sup>1</sup> Where my body is, that is where I am. Where your body is, that is where you are. We encounter that person by his face. Body language plays a big role in everyday social life: Friends embrace, lovers kiss, a look can speak volumes. Pain must not be equated with the fire of neurons. It is felt bodily and is part of ourselves. We do not just face it like on a display board. The body places us into the world. It is the foundation of our being alive, but it also makes us vulnerable. It is our bodily being that makes us into relational beings that depend on relationships with others. In phases of illness and dying, people seek the physical closeness of others. Encounters are bodily. That is why eHealth programs reach their limits when the physician cannot see the patient's facial expression or feel the touch of their hands.

This is how Victor von Weizsäcker formulated the following "primal scene" of medical care:

"When the little sister sees her little brother in pain, she will find something before she knows anything: She soothes him by guiding her hand to where she wants to *touch* him: where it hurts. This is how the little Samaritan becomes the first physician. Inside her is a subconscious innate knowledge about a primal effect that guides her hand towards an effective touch. That is what the little brother will experience: the hand soothes him. The perception of being touched by the sister's hand comes between him and his pain, and the pain retreats before this new feeling" [Weizsäcker 1941: 89].

Neither tele-medicine nor the best pill in the world can replace the helping hand. Certainly, digital health care expands the treatment spectrum. But even in the future, we will not be able to do without physicians of flesh and blood. They cannot be replaced by the fastest machines because machines lack the ability to suffer themselves and to deal with contingencies [Maté 2020: 11]. Technically transmitted communication transforms what and how something

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individual is subsumed under the word general. «Primarily it is not a matter of understanding processes of disease in general, but of enabling the reasonable treatment of individual patients» [Rager 1994: 18].

<sup>1</sup> "We must learn to perceive and to take seriously the feeling of concern that is implied in every physical impulse [...] To become responsible patients, we must learn to understand that our physical impulses and also our pain not only disable our condition and reduce our performance capacity, but that they also reassure us of our bodily existence and remind us that it is now all about us." [Böhme 2019: 105].



is being said. The display screen is only a cut-out; the transmitted data are “naked” and require interpretation<sup>1</sup>.

Treatment means exploring what patients need and what will help them. Gadamer brings it to the point as follows: “To treat is *palpare* in Latin, i.e. to carefully and sensitively palpate the patient’s body with the hand (*palpa*) to detect tension and pre-tension which may perhaps confirm or correct the patient’s subjective localization which we call pain” [Gadamer 1993: 139].

The importance of physical contact between physician and patient does not only begin with palpation, but clearly sooner, as the following patient history shows:

“For example, a sixty-five-year-old man came to see me in midwinter because of troubling heart palpitations. On shaking hands I was intrigued by his warm, slightly sweating palm. It was blustery cold outside and I commented that he must have nice warm sheepskin gloves. He replied that he rarely wore gloves. I immediately suspected an overactive thyroid, which was later confirmed by appropriate laboratory tests. When the thyroid is overactive the metabolism of every organ is increased, the skin, receiving more blood flow, is warm and flushed, while the heart, beating rapidly, is predisposed to arrhythmias” [Lown 1996: 24].

### II. 3. What counts in life cannot be calculated and illustrated in tables

In his dialogue, *Idiota de staticis experimentis* (*The Layman and the Experiments done with weight-scales*), Nicholas of Cusa (1401-1564) argued in the 15th century that it is correct to measure people for humanitarian reasons [Nikolaus 1982: 631]. He called it useful to collect exact data which can be used in different ways for practical reasons. This man – cardinal and philosopher, born in Bernkastel-Kues on the Moselle – had the social life of society in mind. All subjective perceptions would have to be abstracted for that purpose. Thus, it would be practical, for example, to disregard one’s own perceptions when making a medical diagnosis. Inaccuracies would have to be eliminated by repeating measurements under conditions that are as identical as possible. Of course, this Renaissance thinker’s statement already goes in the direction of modern natural sciences, namely the separation of objective knowledge and subjective experience. Yet unlike modern natural scientists, Nicholas of Cusa realized that quantities can be measured, but not qualities. He knew that mind and soul cannot be measured using a natural-sciences approach.

Marsilio Ficino (1433-1499), another representative of the Renaissance and thinker of the 15<sup>th</sup> century, in his book about medical theory, *De Vita libri*

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<sup>1</sup>“Glorifying digitalization systematically ignores and disqualifies the special importance of medical care by physicians” [Maio 2020, 8].

*tres* (Three Books on Life) not only advocated a correct life style that helps to prevent diseases from the start – such as the right measure of work and leisure, good nutrition and bodily hygiene – but he also said that clerical aspects should be taken into consideration so that healing can be successful. He said that there are also questions that cannot be answered technically and practically [Ficino 2012a: 399], and that it matters how patients look upon themselves and their lives, what they are prepared to do in a situation into which they are being placed. “All medicines taken to prolong life are dead if they are taken without the light-heartedness that – so to speak – is the life of all medicines” [Ficino 2012a: 411]. In modern terms, this means that in addition to somatic aspects, the psychological and social situation should also be taken into account when looking at the origin, the progress and the overcoming of diseases.

Medical care includes measuring, such as the temperature or the HbA1c value. We all know that this is important. That is probably the reason why the Latin *medicina* includes the proto-Indo-European syllable “*med*” which means to measure. From this root derive terms in many modern languages such as the English verbs to measure, to medicate and to meditate, and the noun measurement [Schäfer 2018: 82].

Of course, medical care must include biotechnical, technical and statistical aspects. However, when we are ill, it is not enough to refer only to those aspects. Psychological, existential, social and spiritual aspects also play a role and must be taken into account. Drugs are useful, but nothing absolute by themselves. “Medical care goes beyond what is scientifically justified and explainable” [Hartmann 1975: 62].

Kant, for example, pointed out that certainty is not always available in the context of medical care [Kant 1998: A 824/B 852]. The diagnosis a physician has made in all good conscience may only be temporary and not necessarily the last word on the subject. There may be situations in which he may have to act in pragmatic faith against the given background.

Physicians are required to know more than what they may have crammed for prior to an exam. They must have certain social abilities. Trust cannot be prescribed, it can only be earned. It is desirable that physicians and patients are capable of reciprocal resonance and that they can trust each other.

“A patient’s trust is not necessarily based on the security of the physician’s knowledge or the success of medical treatment, but on the reliability of the physician’s behaviour. Patients will only entrust themselves to a physician when they are convinced that the physician is acting in all good conscience” [Toellner 1995: 5].

## II. 4. Establishing contact and the ability to listen

“The child is sick. The mother puts it to bed, sits with the child and begins to tell it some stories” [Benjamin 1971: 430]. This is what Walter Benjamin wrote. The child’s healing process begins with the closeness of the mother.

As social beings we depend to a large extent on interchange with others<sup>1</sup>. Humans require communication with others. They virtually hold a mirror to our faces<sup>2</sup>. We confirm our identity in others and are recognized as persons. Being in dialogue with someone means addressing him as a personal You<sup>3</sup>.

This basic human condition can easily be transferred to our topic; the dialogue usually begins with the anamnesis. In his 1999 inauguration speech as President of the German Medical Association, Jörg-Dietrich Hoppe referred to “talking medical care”, by which he underlined that the art of conversation belongs to the medical arts, which refers not only to the relationship between physicians and patients, but also to conversations among experts in a multi-professional team or with family members. These conversations are extremely important. It is obvious that they require a good atmosphere. Physicians and patients address each other using the personal You: “The purely functional aspect of medical care is heightened and increased by the personal kind of You which everyone uses or should use to address the other. [...] Certainly some materially functional measures will have to be taken, but they must be carried out and explained somehow by means of the mutual You relationship” [Welte 2006a: 142].

The art of medicine does not focus on objectification but on the possibility of real resonance. For example, such a resonance relationship exists in a dialogue. Seen from that aspect, medicine must not only clarify but also try to understand. Let us recall the following words by Hippocrates: “Where there is love of humanity, there is also love of art. Some patients will recover because they have good accord and satisfaction with their physician, although they are aware of the seriousness of their condition” [Lown 2004: 23]. Not much seems to have changed about that in more than two thousand years of medical history. Let us also remember the example of the caring mother presented by Benjamin. The patient is happy, and it adds to his well-being, when attention is paid to him and the physician (or the mother) can master the art of listening.

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<sup>1</sup> “Man’s first requirement will always be other human beings. We do not encounter this specialty of helplessness only at the beginning and at the end of life, but throughout life. [...] Humans need human beings to be human” [Marten 2018b: 339].

<sup>2</sup> The idea of this mirror identity is developed in [Marten 2018a].

<sup>3</sup> “Talking and listening belong together as the You and the I belong together. Not only do listening and talking belong together, but they are actually the two sides or the two poles of a single life that weaves itself and forms itself from addressing and being addressed, from saying You and knowing himself as a You of the other You” [Welte 2006b: 199].

Listening is a type of attention, of being awake, and thus not only a purely passive letting-it-happen. In German, we say “to be all ears”, meaning that someone is mastering the art of listening. This does not only involve the organ of hearing, but the entire person. There is also a superficial, unreal listening, as illustrated by this patient history:

„When I questioned one man about sex, he promptly responded ‚Sex no problem.’

At each yearly visit, we went through the same exchange.

‚Sex?’ I would ask.

‚Sex no problem,’ he replied instantly.

After he had been my patient for about five years, his wife came along for the first time. During interval history-taking, when I posed the same old question about sex, he gave the same answer. His wife appeared startled and looked quizzically at him.

I asked, ‚How, exactly, do you punctuate that sentence?’

He answered with some embarrassment, ‚Sex no. Problem!’

He defended himself by saying, ‚For five years I have been giving the same answer, but you were not paying attention” [Lown 1996: 19].

The physician had heard the words the patient had used but not the meaning, not the message he was trying to convey. He hadn’t grasped the sense of the words. It had been a prejudiced, unreal listening. In contrast, it is a matter of perceiving the sound of the words, the intonation with which a patient speaks them, to know how to help him. There must be a listening that is open, unprejudiced, leaving room for a meeting of minds.

It is important to get really involved with one’s counterpart, not to believe that we already know everything there is to know. Such a discussion must be open and cannot be planned. The physician must respond to his counterpart. He does not want to “shape” him, but must take him the way he is. The same is true for the patient who is looking for advice and help. He must be ready to be touched by the physician’s words and to be changed by them.

## II. 5. Healing cannot be done

Thomas Aquinas (1225–1274) took up a thought again that had been valid since the days of antiquity. In his treatise, *De veritate*, we read: „*Medicus in sanatione est minister naturae, quae principaliter operatur, confortando naturam et apponendo medicinas, quibus velut instrumentis natura utitur ad sanationem*” [Thomas Aquinas 1953: Qu. XI, Art. 1]. This characterizes the role of the physician to provide help so that our body, which is our nature, can become well again. Accordingly we cannot “make” or “do” health. For Thomas,

*summum bonum*, the highest asset, is not health, but God, while in current debates, the question of God seems to be pushed into the background, and health is postulated as the highest asset<sup>1</sup>.

Just like Thomas, the Flemish physician Stephanus Blancardus (1650–1704) still held the view that medicine is an art that serves nature (*ars naturae ministra*) [Stephanus Blancardus 1973: 308]. This can be easily continued: According to Christoph Wilhelm Hufeland (1762–1836) whose patients in Weimar included Goethe, Schiller, Herder and Wieland, and who later in Jena corresponded with Fichte and Schelling: “Medicine is *naturae ministra* and by no means *magistra*: It was always nature and not the art that heals illnesses, and medicine *non est magister, sed minister naturae* (Medicine is not the master, but the helper of nature)” [Hufeland 1811: 20]. Kant (1724–1804) was also still of the opinion that the physician is an “artist” who “directly borrows his art directly from nature” [Kant 1972: 26]. The immunologist Hans Much formulated this thought early in the 20th century in his work that has the remarkable title: *Hippokrates der Große* (Hippocrates the Great): “It is not the physician, but the body that heals” [Much 1926: 80]. And Gadamer (1900–2002) said correctly: “Medical science is a science which in the end produces nothing at all but that distinctly must deal with the wonderful ability of life to restore itself and to become attuned again and again” [Gadamer 1993: 118]. Thus, health – as the examples we have employed here show – is not a product of medical work, not goods that can be disposed of, that can be ordered and sold. Instead, we must take multi-perspective aspects into account to preserve health. Contrary to “feasibility thinking”<sup>2</sup>, where health is regarded as something that can be produced, the above shows that it is not in the realm of medicine to satisfy all physical, mental and social requirements of man and to establish paradise on earth.

Medical aids are not the “hands of God”<sup>3</sup> and medicine is not the “science of salvation”. Salvation must not be expected from medicine, and that would tax it far too much. Illnesses belong to the contingency of life.

## II. 6. Knowing our limits and not looking at everything with the eyes of “what is technically feasible”

The physician wants to heal the patient who consults him to get help. For that he needs certain skills such as technical knowhow and whatever means are available. Not everything that is technically feasible is also ethically cor-

<sup>1</sup>Juli Zeh, in her novel, *Corpus Delicti*, addresses very beautifully what may happen when health becomes the supreme duty of citizens [Zeh 2013].

<sup>2</sup>Health is not “doable”, as Heinrich Schipperges also underlines [Schipperges 1980]. Very similarly: Günther Pöltner who qualifies that at best, health can be “restored” [Pöltner 2007: 198].

<sup>3</sup>For example [Scribonius Largus 2009: 57].

rect for the actual patient. What should guide medicine as an art of healing is not whether something is in the realm of the possible, but whether it is serving the patient.

A technical and scientific side of medicine also always depends on making it available and in that respect it has to do with objects. For example, something is made available by making it visible: What is hidden becomes presentable and controllable. That is important and necessary, but not everything can be moved into the realm of the available. The art of medicine recognizes when a human becomes unavailable. It is confronted with the limits of humans, with helplessness and impotence. Patients have many expectations of their physicians, and of course some of them cannot be met. Physicians should also recognize the limits of their abilities. Regardless of their achievements, they should not forget what they can not achieve.

Organic processes can be observed and analyzed by means of the natural sciences, but the sick and suffering patient is not completely covered by the spectrum of natural science methods [Sauerbruch 1926: 1083]. Medicine that wants to be understood as an *art* must know its limits. It is specifically not only concerned with bodily functions. It regards healing as a holistic process in which internal and external factors work together.

The physician's activities in that sense include looking for a correct measure, to ask what intervention is useful in a situation and not only what is financially attractive. Orientation on the correct measure also applies to patients: They should ask themselves the question of what might promote a qualitatively good life. Not everything that is announced as new and trend-setting in medicine, sometimes even as a revolution, will actually come to pass. To quote Urban Wiesing:

“When we imagine the future in a certain way and even establish prerequisites by which the future has come to pass and has to be measured, we cannot exclude that the predictions will come to pass anyway, regardless of what happens. In other words: When someone claims that a disease can be finally cured in 20 years if only all efforts are bundled (which can hardly be checked), and then the promises are not kept, it can still be said that the efforts were not bundled” [Wiesing 2020: 20].

Again and again in the past medicine has raised expectations. In view of growing possibilities, it is even more important for medicine to know to become more aware of its limits and to search for the correct measure.

## II. 7. Enabling patients to accept their fate

Humans are vulnerable, contingent beings and not perfect body machines. A diagnosis resulting from the estrangement of the body caused by disease and by the loss of control over one's own body can be experienced as incisive

and can cause existential questions. It may even mean that independent life will be impossible for the moment or in the long run. It is also possible that patients are lacking the words, that they feel the need to isolate themselves, or that others who are healthy don't know how to deal with the situation.

Illness brings patients to a limit: This or that no longer works or has become burdensome. Hidden behind the limits caused by an illness is the limit of human finality. It can be painful to realize this, also for the physician.

Frailty and finality must be accepted and integrated into the patient's own life plan. Patients must deal with their illness and perhaps even try to gain something positive from it in the sense that they might choose different priorities in their lives.<sup>1</sup> "Illness, then, is not simply a biological event; it is also an existential transformation. One may be stripped away of one's trust in the body, reliance on the future, taken-for-granted abilities, professional and social roles, even one's place in the cosmos" [Leder 1995: 1109].

It is also possible that existential fear may have a grip on a patient who may then be unable to liberate himself. In accepting their own situation, it may be helpful to be in the presence of someone else. This is where the physician plays a special role. He may take away uncertainties and become a companion enabling the patient to accept his lot.<sup>2</sup>

The attention a physician pays to the patient should not be "domineering and controlling", but "advancing and liberating" [Heidegger 2001: 26]. It should not be a matter of restricting the other, but to show him spaces of freedom. The physician should enable the patient to learn to accept his situation. As Dirk Lanzerath emphasizes, the physician should not only "provide therapeutic help" in the narrow sense, but also hermeneutic help against any shortening by technological means" [Lanzerath 2008; 49]. Martin Mendelsohn has said that the physician "must be a willing companion who knows the way" [Mendelsohn 1894: 35]. And Jaspers (1883–1969) characterized the physician and the patient in this sense as a "companion in destiny": "The physician is neither only a technician nor only an authority, but just another existence: a transient human being just like the patient himself" [Jaspers 1986: 88]<sup>3</sup>.

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<sup>1</sup> In the Middle Ages people sometimes talked about *infirmetas salubris*, an illness that brings salvation, and *sanitas pernicioso*, a dangerous healthiness. Cf. [Engelhardt 1999: 42].

<sup>2</sup> In connection with modern medicine the question also arises how we want to handle our uncertainties and our lack of knowledge. It is quite possible that knowledge about how the patient's health situation actually is may paralyze him and negatively affect his way of life. A patient must continue to have the right to either have knowledge about their health situation or to refuse such knowledge, which is an expression of their informational self-determination. Of course, this is of particular importance when it involves a disease that is not or not yet curable. Patients must be informed about the nature, scope and meaning of medical examinations. Cf. [Chadwick 1997; Taupitz 1998; Duttge, 2015].

<sup>3</sup> Regarding the same thought, see also [Maio 2012: 25].

There is good reason not to hope for a medicine of immortality, but we do hope that physicians are experts in finality. This includes the realization that a patient at the threshold between life and death must also be allowed to leave.

### Conclusion

Today, the fact that the scientific side of medicine is of importance seems to be so certain that it actually does not require special mentioning. Insofar as the above mentioned advances of medicine are beneficial, it cannot simply be a matter of wishing the olden times back. It cannot be an option to treat patients on the operating table “the classical way”. It would even be criminal. According to law, physicians must act according to the “rules of medical art” [Fünftes 2011] as recognized today.

We are not concerned about alternatives to the scientific and technical side of medicine, but about a larger field of view. In seven steps, we have outlined what medical care as the art of medicine can and must achieve.

In the centre of the physician’s work must be the patient as a bodily structured unique person for whom the illness is of existential importance and who is connected with other persons.<sup>1</sup> The patient is not just “a case” or “a number” in the hospital ward or an entry on an index card in a medical practice, not just an object. The concrete patient must be at the centre. The patient’s concerns must be heard. The guideline for medicine that is understood as medical art cannot be just a look at efficiency and feasibility. Instead it is the question of what serves the patient and his well-being.

Medical art is an educational process: a spiritual forming of individuals that requires time and cannot be switched on by the touch of a button. It does not simply mean the memorization of medical study materials, but the process of human maturation to become a true companion to the patient in an existentially challenging situation.

Thus, the analysis by Martin Mendelsohn remains true and current: We do require a reform today. Not a reform based on the scientific and technical dimension of medicine, but one concerning medicine as an art [Mendelsohn 1894: 43].

### References:

- Bauer, A.W. (2005). Gerabek, W. E., Haage, B. D., Keil, K., & Wegner, W. (Ed.) *Enzyklopädie Medizingeschichte (Encyclopedia of Medical History)*. [In German]. Berlin / New York: de Gruyter, 1028.
- Benjamin, W. (1971). *Denkbilder (Thinking Images)*. [In German]. Tiedemann, R., & Schweppenhäuser, H. (Ed.). Benjamin, W. *Gesammelte Werke*, B. IV, 1, Frankfurt a. M.: Suhrkamp, 305–438.

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<sup>1</sup>“Medicine between physician and patient must become a personal or existential relationship”, as Dietrich von Engelhardt once formulated programmatically [Engelhardt 2002: 33].



- Böhme, G. (2019). *Leib. Die Natur, die wir selbst sind (Body. The Nature we are Ourselves)*. [In German]. Berlin: Suhrkamp.
- Chadwick, R. (1997). The right to know and the right not to know, from a philosophical point of view. Petermann, F., Wiedebusch, S., & Quante, M. (Ed.): *Perspektiven der Humangenetik*, Paderborn: Schöningh, 195–208.
- Diepgen, P. (1965). *Geschichte der Medizin. Die historische Entwicklung der Heilkunde und des ärztlichen Lebens*. (History of Medicine. The Historical Development of the Medical Arts and the Life of Physicians). [In German]. B. 2, 2. Auflage. Berlin, de Gruyter.
- Duttge, G. (2015). Rechtlich-Normative Implikationen des Rechts auf Nichtwissen in der Medizin (Legal and Normative Implications of the Right Not to Know in Medicine). [In German]. Wehling, P. (Hg.) *Vom Nutzen des Nichtwissens. Sozial- und kulturwissenschaftliche Perspektiven*. Bielefeld: Transcript, 75–91.
- Ficino, M. (2012a). Apologia quaedam, in qua de medicina, astrologia, vita mundi; item de Magis qui Christum statim natum. Boenke, M. (Ed.). Marsilio Ficino. *De vita libri tres / Drei Bücher über das Leben*. Herausgegeben, übersetzt, eingeleitet und mit Anmerkungen versehen. (Three Books on Life, Edited, Translated, Introduction and Annotated). [In German]. München: Coincidentia.
- Ficino, M. (2012b). Quod necessaria sit ad vitam securitas et tranquillitas animi. Boenke, M. (Ed.). Marsilio Ficino. *De vita libri tres / Drei Bücher über das Leben*. Herausgegeben, übersetzt, eingeleitet und mit Anmerkungen versehen. (Three Books on Life, Edited, Translated, Introduction and Annotated). [In German]. München: Coincidentia.
- Fünftes Buch Sozialgesetzbuch. (2011). – Gesetzliche Krankenversicherung – (Artikel 1 des Gesetzes vom 20. Dezember 1988, BGBl. I S. 2477), das zuletzt durch Artikel 9 des Gesetzes vom 28. April 2011 (BGBl. I S. 687) geändert worden ist. (Social Code V, section 28, subsection 1). [In German]. <https://www.ilo.org/dyn/natlex/docs/ELECTRONIC/43202/98544/F37565229/DEU43202.pdf>
- Engel, N., Fricke, A., & Krezdorn, A. (Red.). Museum Folkwang (Ed.). (2019). *Der montierte Mensch*. (The assembled human). [In German]. Bielefeld: Kerber.
- Engelhardt, D. von. (2002). *Aufklärung in der Medizin zwischen diagnostischer Information und Wahrheit am Krankenbett* (Enlightenment in medicine between diagnostic information and truth at the patient's bedside). [In German]. *Was soll der Mensch wissen? Ethik im Zeitalter der Technologie. Veröffentlichungen des Japanisch-Deutschen Zentrums Berlin* 48, 31–41.
- Engelhardt, D. von. (1999). *Krankheit, Schmerz und Lebenskunst. Eine Kulturgeschichte der Körpererfahrung*. (Illness, Pain and the Art of Living. A cultural history of bodily experience). München: Beck.
- Gadamer, H.-G. (1993). *Über die Verborgenheit der Gesundheit*. (On the concealment of health). [In German]. Frankfurt a. M.: Suhrkamp.
- Geiger, K. (2010). „Krise“ – zwischen Schlüsselbegriff und Schlagwort. Zum Diskurs über eine „Krise in der Medizin“ in der Weimarer Republik. (“Crisis” – between key term and catchphrase. On the discourse on a “crisis in medicine” in the Weimar Republic). [In German]. *Medizinhistorisches Journal* 45, 368–410.
- Hartmann, F. (1975). In der Heilkunde wirksame Begriffe von Wissenschaft und die Frage nach einem möglichen Wissenschaftsbegriff der Medizin (Scientific Terms Effective in Medicine and the Question About a Possible Scientific Concept of Medical Care). Müller, K., Schepers, H., & Totok, W. (Ed.): *Der Wissenschaftsbegriff der Natur- und Geisteswissenschaften*. Symposium of the Gottfried-Wilhelm-Leibniz-Gesellschaft, 1973, Wiesbaden: Steiner, 57–84.

- Heidegger, M. (2001). *Sein und Zeit*. (Being and Time). [In German]. Tübingen: Niemeyer.
- Honigmann, G. (1924). *Das Wesen der Heilkunde. Historisch-genetische Einführung in die Medizin für Studenten und Ärzte*. (The essence of medicine. Historical-genetic introduction to medicine for students and physicians). [In German]. Leipzig: Felix Meiner.
- Honigmann, G. (1928). *Krankheitserkenntnis und Krankheitsbehandlung*. (Recognition and Treatment of Diseases). [In German]. Berlin.
- Hufeland, C.W. (1811). Rechenschaft an das Publikum über mein Verhältniss zum Brownianismus (Accounting for the Public about my Relationship with Brownianism). [In German]. *Journal der practischen Heilkunde* 32, 3–29.
- Hufeland, C.W. (1791). *Über die Ungewissheit des Todes und das einzige untrügliche Mittel, sich von seiner Wirklichkeit zu überzeugen und das Lebendig begraben unmöglich zu machen, nebst der Nachricht von der Errichtung eines Leichenhauses in Weimar* (On the uncertainty of death and the only safe means to ensure its certainty and to make it impossible to be buried alive, and news about the construction of a morgue in Weimar). [In German]. Weimar: C. J. L. Glüsing.
- Jaspers, K. (1986a). *Der Arzt im technischen Zeitalter*. (The Physician in the Age of Technology). [In German]. München: Piper.
- Jaspers, K. (1986b). Wesen und Kritik der Psychotherapie (*The Nature of Psychotherapy*). [In German]. Jaspers, K.: *Der Arzt im technischen Zeitalter*. München: Piper, 69–122.
- Kahn, F. (1926). *Das Leben des Menschen* (The Life of Man). [In German]. Stuttgart: Frankh'sche Verlagshandlung, 1923–1931. In 5 Bänden. B. 3.
- Kant, I. (1972). Der Streit der Fakultäten. (The Conflict of the Faculties). [In German]. Kant, I. *Werke. Akademie-Textausgabe*, Bd.7. Berlin: De Gruyter.
- Kant, I. (1998). Critique of Pure Reason edited and trans. in English by P. Guyer, & A. W. Wood. Cambridge University Press.
- Klasen, E. M. (1984). *Die Diskussion um eine „Krise“ der Medizin in Deutschland zwischen 1925 und 1935*. (The Discussion About a “Crisis” of Medicine). [In German]. Mainz: Diss.
- Kluxen W. (1976). Dauer und Wandel im ärztlichen Ethos (Duration and Change in the Physician's Ethos). [In German]. Langenbeck's *Archiv für Chirurgie* 342, 457–470.
- Kulozik, A. E., Hentze, M. W., Hagemeyer, C., et al. (2000). *Molekulare Medizin: Grundlagen, Pathomechanismen, Klinik* (Molecular Medicine: Basis, Pathomechanisms, Clinic). [In German]. Berlin: De Gruyter.
- Lanzerath, D. (2008). Was ist medizinische Indikation? Eine medizinethische Überlegung. (What is medical indication? A medical ethics consideration). [In German]. Charbonnier, R., Dörner, K., & Simon, S. (Ed.). *Medizinische Indikation und Patientenwille. Behandlungsentscheidungen in der Intensivmedizin am Lebensende*, Stuttgart: Schattauer, 35–52.
- Leder, D. (1995). Health and Disease. The Experience of Health and Illness. Reich, W.T. (Ed.). *Encyclopedia of Bioethics*. Vol. 3. New York: Macmillan, 1106–1113.
- Lown, B. (2004). *Die verlorene Kunst des Heilens. Anleitung zum Umdenken*. (The Lost Art of Healing. A Guide to Rethinking). [In German]. Stuttgart: F. K. Schattauer Verlag.
- Lown, B. (1996). *The Lost Art of Healing: Practicing Compassion in Medicine*. Boston-New York: Houghton Mifflin.
- Maior, G. (2020). Einführende Gedanken zur Bedeutung des direkten Kontaktes in einer Ära der Digitalisierung. (Introductory thoughts on the importance of direct contact

- in an era of digitization). [In German]. Maio, G. (Ed.). *Von Angesicht zu Angesicht. Zur Bedeutung der persönlichen Begegnung in der Medizin*. Freiburg: Herder, 7–9.
- Maio, G. (2014). *Geschäftsmodell Gesundheit. Wie der Markt die Heilkunst abschafft*. (Health as a Business Model. How the Market is Abolishing the Medical Arts). [In German]. Berlin: Suhrkamp.
- Maio, G. (2012). Wenn Prozesse wichtiger sind als Worte : zur Gefährdung einer personalen Medizin durch die Übermacht von Naturwissenschaft und Ökonomie. (When Processes are More Important Than Words. On the endangerment of personal medicine by the dominance of natural sciences and economics). Maio, G. (Ed.): *Macht und Ohnmacht des Wortes. Ethische Grundfragen einer personalen Medizin*. Göttingen: Wallstein, 13–32.
- Marten, R. (2018a). *Der menschliche Mensch. Abschied vom utopischen Denken* (The Human Man: Farewell to Utopian Thinking). [In German]. Freiburg / Munich: Herber.
- Marten, R. (2018b). *Nachdenken über uns. Philosophische Texte*. (Thinking about us. Philosophical texts). [In German]. Freiburg / Munich: Herber.
- Maté, C. (2020). *Medizin ohne Ärzte. Ersetzt künstliche Intelligenz die menschliche Heilkunst?* (Medicine without Physicians. Is Artificial Intelligence Replacing the Human Art of Healing?). [In German]. Salzburg / Vienna: Residenz.
- Mendelsohn, M. (1894). *Ärztliche Kunst und medizinische Wissenschaft. Eine Untersuchung über die Ursachen der „ärztlichen Misere“*. (The Medical Arts and Medical Science. An investigation into the causes of “medical misery”). [In German]. 2nd rev. ed., Wiesbaden: Bergmann.
- Much, H. (1926). *Hippokrates der Große (Hippocrates the Great)*. [In German]. Stuttgart / Berlin: Hippokrates.
- Naunyn, B. (1909). *Ärzte und Laien. (Physicians and Laymen)*. [In German]. Naunyn, B. *Gesammelte Abhandlungen*. Würzburg: Stürzt, 1327–1355.
- Nikolaus von Kues (1982). *Der Laie und die Experimente mit der Waage*. (The layman and experiments with the scales). [In German]. Gabriel, L. (Ed.). Nikolaus von Kues. *Philosophisch-Theologische Schriften. Studien- und Jubiläumsausgabe*. In 3 Bänden. Vienna: Herder, B. 3, 611–647.
- Plato. (2012). *Republic* / transl. by Rowe, C. London: Penguin.
- Pöltner, G. (2007). *Ärztliche Verantwortung im Spannungsfeld von Heilkunst und Technik* (The Physician's Responsibility in the Conflict Area of Medicine and Technology). [In German]. *Wiener Medizinische Wochenschrift* 157(9–10), 196–200.
- Rager, G. (1994). *Medizin als Wissenschaft und ärztliches Handeln*. (Medical care as Science and as Treatment by Physicians). [In German]. Honnefelder, L., & Rager, G. (Ed.). *Ärztliches Urteilen und Handeln. Zur Grundlegung einer medizinischen Ethik*. Frankfurt a. M. / Leipzig: Insel, 15–52.
- Rheinberger, H.-J. (1996). *Molekulare Medizin als Paradigma? Gentechnologie im Blick von Wissenschaftstheorie und medizinischer Ethik* (Molecular Medicine as a Paradigm? Gene Technology in the Sense of the Theory of Science and Medical Ethics). [In German]. Schott, H. (Ed.): *Meilensteine der Medizin*. Dortmund: Harenberg, 555–561.
- Sauerbruch, F. (1926). *Heilkunst und Naturwissenschaft*. (The Art of Healing and Natural Science). [In German]. *Die Naturwissenschaften. Organ der Gesellschaft Deutscher Naturforscher und Ärzte, Organ der Helmholtz-Gemeinschaft Deutscher Forschungszentren* 48/49, 1082–1090.
- Schäfer, D. (2018). *Grenzen der Medizin? Kontinuität und Wandel der Heilkunde am Beispiel des historischen Umgangs mit Unheilbarkeit und Tod* (Limits of Medical

- Care? Continuity and Change in the Medical Arts, Using the Historical Handling of Incurability and Death as an Example). [In German]. Ringkamp, D., & Wittwer, H. (Ed.): *Was ist Medizin? Der Begriff der Medizin und seine ethischen Implikationen*. Freiburg / Munich: Karl Alber, 81–93.
- Schipperges, H. (1980). Zum Verständnis von Gesundheit in der Geschichte der Medizin (On the Understanding of Health in the History of Medicine). [In German]. Schaefer H. (Ed.) *Der gesunde kranke Mensch. Gesundheit ein Wert – Krankheit ein Unwert*, Düsseldorf: Patmos, 9–36.
- Schnitzler, A. (2004). Anatol. (Anatol). [In German]. Schnitzler, A.: *Anatol. Dramen, 1889–1891*, Frankfurt a. M.: Fischer Taschenbuch Verlag.
- Scribonius Largus (2009). Rezeptzusammenstellungen (Recipe Compositions). Kollesch, J., & Nickel, D. (Ed.): *Antike Heilkunst. Ausgewählte Texte aus den medizinischen Schriften der Griechen und Römer*. Stuttgart: Reclam, 57–62.
- Sigerist, H. E. (1930). Das Bild des Menschen in der modernen Medizin (The Image of Man in Modern Medicine). [In German]. *Neue Blätter für den Sozialismus* 1, 97–106.
- Stephanus Blancardus. (1973). *Lexicon medicum*, with a foreword by K.-H. Weimann, Hildesheim-New York: Olms (reprint of the Jena edition of 1683).
- Taupitz, J. (1998). *Das Recht auf Nichtwissen* (The Right of not Knowing). [In German]. Hanau, P., Lorenz, E., & Matthes, H.-C. (Ed.): *Festschrift für Günther Wiese zum 70. Geburtstag* (Commemorative...), Neuwied, 538–602.
- Thomas Aquinas (1953). De veritate. Q. 14, a. 1. Trans. by J. V. McGlynn, S. J. Chicago: Henry Regnery Company.
- Timmermann, C. (1999). *Weimar Medical Culture. Doctors, Healers, and the Crisis of Medicine in Interwar Germany, 1918-1933*. Manchester: Diss. [https://www.research.manchester.ac.uk/portal/files/31959613/FULL\\_TEXT.PDF](https://www.research.manchester.ac.uk/portal/files/31959613/FULL_TEXT.PDF).
- Toellner, R. (1995). *Einführung in das Tagungsthema* (Introduction to the Conference Topic). [In German]. Toellner, R., & Wiesing, U. (Ed.): *Wissen – Handeln – Ethik. Strukturen ärztlichen Handelns und ihre ethische Relevanz*. Stuttgart: Fischer, 3–9.
- Weizsäcker, V. von. (1986). Natur und Geist (Nature and Spirit). [In German]. Achilles, P., Janz, D., Schrenk, M., & Weizsäcker, C.F. von (Ed.) *Gesammelte Schriften*. B. 1, Frankfurt a. M.: Suhrkamp, 9–190.
- Weizsäcker, V. von. (1941). Die Schmerzen. (The Pain). [In German]. Weizsäcker, V.v. *Arzt und Kranker*. Leipzig: Koehler & Amelang, 89-119.
- Welte, B. (2006a). Die Grenze im ärztlichen Handeln (The Limit of Medical Care). [In German]. Welte, B.: *Gesammelte Schriften I/3: Leiblichkeit, Endlichkeit und Unendlichkeit*. Freiburg: Herder, 141-147.
- Welte, B. (2006b). Vom rechten Hören (About Urge Right Kind of Listening). [In German]. Welte, B. *Gesammelte Schriften, I/3: Leiblichkeit, Endlichkeit und Unendlichkeit*. Freiburg: Herder, 198-210.
- Wieland, W. (2003). *Diagnose. Überlegungen zur Medizintheorie*. (Considerations regarding the theory of medicine). [In German]. Warendorf: Hoof.
- Wieland, W. (1972). *Praktische Philosophie und Wissenschaftstheorie* (Practical Philosophy and the Theory of Science). [In German]. Riedel, M. (Ed.): *Rehabilitierung der praktischen Philosophie*. B. 1: Geschichte – Probleme – Aufgaben. Freiburg: Rombach, 505–534.
- Wieland, W. (1993). The Concept of the Art of Medicine. Delkeskamp-Hayes, C., & Gardell Cutter, M. A. (Ed.). *Science, Technology, and the Art of Medicine*. Dordrecht: Springer Netherlands, 165–181.

- Wiesing, U. (2020). *Heilswissenschaft. Über Verheißungen der modernen Medizin.* (The Science of Healing. Promises of Modern Medicine). [In German]. Frankfurt a. M.: S. Fischer.
- Wittstock, B. (2019). Eine Frau ist eine Frau ist eine Frau. (A Woman is a Woman is a Woman) [In German]. *Falter* 33/2019, 37.
- Zeh, J. (2013). *Corpus Delicti: ein Prozess.* (Corpus delicti: a trial). [In German]. München: Btb Verlag, 8. Auflage.

### **Маркус Кнауф. Медицина та медичне мистецтво**

На початку 21 століття досягнення медицини, а також досягнення науково-технічної цивілізації очевидні кожному. Сьогодні багато захворювань можна лікувати набагато точніше, ніж у минулому. Терапія дозволяє пацієнтам знову вести самостійне та повноцінне життя. Проте залишається тривога, що щось міняється, що нам чогось не вистачає. З середини 19 століття особливим чином підкреслюється науковий характер медицини. Медицина хоче, щоб її розглядали особливо як одну з природничих наук, що формуються. Її акцент на експериментуванні стає все більш важливим. У статті розглянуто питання про те, що насправді є сутністю медицини або якою вона має бути, і що з цього випливає, як повинні діяти лікарі. Нас турбують не альтернативи науково-технічній стороні медицини, а більш широке поле зору. Ми обговорюємо це тут у сім кроків, які включають систематичні та історичні точки зору з історії філософії та медицини. Пацієнт – це не просто «випадок» чи «номер» у лікарняній палаті чи запис на індексній картці в медичній практиці, не просто предмет обстеження чи лікування. Конкретний пацієнт повинен бути в центрі уваги. Необхідно вислухати занепокоєння пацієнта. Керівництво для медицини, яку розуміють як медичне мистецтво, не може бути лише поглядом на ефективність та здійсненність. Медичне мистецтво – це виховний процес: духовне становлення особистості, що вимагає часу і не вмикається натисканням кнопки. Це не просто запам'ятовування медичних навчальних матеріалів, а процес дорослішання людини, щоб стати справжнім супутником пацієнта в екзистенційно складній ситуації.

**Ключові слова:** медицина, медичне мистецтво, медична освіта, лікар, пацієнт, терапія.

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