This is an author’s final draft of an article accepted for publication in the Semiotics 2015

DOI: 10.5840/cpsem201524
In Search of Thure von Uexküll: Psychosomatician? Biosemiotician? or Clinical Educator?

John Tredinnick-Rowe

Abstract

Thure von Uexküll’s reputation as pioneer in biosemiotics and also in psychosomatic medicine is well documented. It is easy to see these disciplines reflected in his notable publications, both in English and in German. However when if one spares the time to filter through all of the peer-reviewed works and monographs in English and in German a notable gap arises in his English language publications; that of clinical education. This gap in the Anglophone literature may seem unimportant in of itself, but it speaks volumes when we consider the total absence of medical semiotics in the curriculum of medical schools in the English speaking world. Also in contrast to the strong traditions of psychosomatic medicine in Germany, which Thure von Uexküll largely helped to instil. Do the works of Thure von Uexküll offer an possible steps towards a resurrection of Medical Semiotics in Clinical Education? This paper attempts to explore the lesser known German literature on Clinical Education that Thure von Uexküll produced, and explore the role semiotics can play in medical education in the English speaking world. And contrast it with other existing approaches in British Medical Schools’ attempts to reintroduce Medical Humanities and reflexive thinking into clinical education.

Keywords

Thure von Uexküll, Clinical Education, Medical Semiotics,

This paper is represents tentative steps in analysis of the German and English language work of Thure von Uexküll. Predominantly the works of von Uexküll that remain untranslated in the original German. As such the premise of the paper, is to highly some of the less common themes associated with Thure’s work, namely his

1 Affiliation - Post-Doctoral Research Assistant in a Clinical Education at the Peninsula Schools of Medicine and Dentistry, University of Plymouth, UK, john.tredinnick-rowe@plymouth.ac.uk
papers and book chapters on Clinical Education. Regrettably I have not yet had the time to translate the dozens of publications that make up this body of literature, let alone to obtain. Never the less all the progress that has been made with this endeavour no matter how small, I hope will shed some new light on the work of von Uexküll. I do however acknowledge there is much left to do in this area.

Whilst I have talked about the premise of this work, I feel it is also important to disclose my intent. Semiotics and medicine in the western tradition share a common foundation, in that they both have a father in the works of Hippocrates (Kleinpaul, 1893, p103). Whilst western medicine has since the 1800’s been dominated by disputes between Empiricist and Rationalist approaches (Coulter, 1994). In the current era the dominant force in medical curricula has been the influence of biomedical science, however there have been move to append this model in the creation of a Biopsychosocial Model created by George Engel in the later part of the 1970s (Engel, 1977). Semiotics as a progeny of the Hippocratic tradition has not followed its wayward medical brother and become enamoured with rationalism, or the empiricism vs. Rationalism debate. Petrilli and Ponzio (2005, p242) go as far as to state that “Peirce’s semiotics2 is explicitly anti-Cartesian and rejects the rationalism-empiricism dichotomy as sterile and abstract.” Although some would dispute this See Stables (2014). Separate argument about Saussurean semiotics and its relationship to rationalism could be made of course (Joseph, 2014). Regardless, the subsequently development has been that semiotics, although from the same Hellenic root as medicine has not found a place in modern medical school curricula of Anglophone countries.

However, one could still find German and Russian doctors in the 1800’s writing about medical Semiotics, such as Feodorovich and Hippius (1892)’s work Semiotics and Diagnosis of Childhood Diseases (Semiotik und Diagnostik der Kinderkrankheiten). Or Hufeland (1823) in the Journal of Obstetric Practice who wrote On the value and importance of semiotics (Ueber den Werth und die Bedeutung der Semiotik), similarly Becker (1832) addressed the role of semiotics in relation to cardiology in his On the physiology and semiotics of cardiac activity (Zur 2 See PEIRCE, C. S. 1868a. Questions Concerning Certian Faculties Claimed for Man. Journal of Speculative Philosophy in CP 5.264-5.317. & PEIRCE, C. S. 1868b. Some Consequences of Four Incapacities Journal of Speculative Philosophy in CP 5.317-5.357.
Physiologie und Semiotik der Herzthätigkeit). This literature naturally, the author feels culminates in the works of Thure von Uexküll, as the one of the originators of a modern movement in medical semiotics and psychosomatic medicine (von Uexküll, 1986, Von Uexküll, 1982, von Uexküll, 1979).


- Suicide (Utriainen and Honkasalo, 1996),
- Diagnostics (Kahn, 1978),
- Clinical Medicine (Chinen, 1988)
- Gerontology (Stafford, 1988)
- Psychosomatic medicine (Langewitz, 2009),
- Homeopathy (Walach, 1991, Schemm et al., 2002), Menstruation (Mazaj, 1995),
- Anti-depressants/ Depression (Catt, 2012, Donnelly and Irvin, 1990),
- Therapy (Kozin, 2003),
- Drug Therapy (Schonauer, 1993)
- Anorexia (Prewitt, 1992),
• Prescription of medicine (Nuessel, 2002),
• Autism (Smith and Bell, 2001, Oakley and Vidanović, 2014),
• Osteopathy (Gaines and Chila, 1998),
• Nursing (Donnelly, 1987)
• The use of medical tools (McRoberts and Sears, 1998),
• Health promotion (Brookes and Harvey, 2014),
• Chronic disabilities (Connolly and Craig, 1996, Stockall and Stickels, 2000),
• William’s Syndrome (James, 2009),
• Fibromyalgia (Quintner et al., 2003),
• Immunology (Sercarz and Celada, 1988),
• Chronic pain (Priel et al., 1991, Honkasalo, 2001, Honkasalo, 2000), and

Whilst there ample literature on Medical Semiotics, with the exception of the psychiatric semiotic literature and the works of Giorgio Prodi (Prodi, 1981, Prodi, 1988a, Prodi, 1988b), most of the authors in the list above are semioticians with an interest in Medical topics, rather than clinicians with an interest in semiotic. This gives testimony to the fact that medical semiotic is no longer on the curriculum of medical schools, but has passed into the remit of semioticians proper. Which in itself is not a criticism, but it may limit the dissemination of the subject beyond those with specific training in semiotics. Hence the focus and intent of this papers, is to explore remedies to this conundrum.

Working in Clinical Education, and with medical students, I feel that the absence of medical semiotics in clinical education is a regrettable loss. As from a personal perspective as a clinical educator, it is my conjecture that (in line with Cobley (2014) ) subjects such as medical semiotics could have a beneficial effect on medical students and their praxis.
THE HUMANIZING TURN IN MEDICINE

At the turn of the 20th century in America some efforts were made to dethrone the dominant rationalist approach to medicine, who clung rigidly to a biomedical model of clinical practice in isolation of the influence of humanist or socialising principles. This challenge to the status quo was termed a ‘Humanising’ movement in medical education. And was largely driven by a sense of noblesse oblige of those privileged enough to train as physicians.

Prior to the modern allusion to a humanising turn in clinical education, which shall be addressed forthwith it is important to highlight some of it historical antecedents. For example tensions between the Abraham Flexner’s biomedical model of medical education (circa 1910), came into conflict with the Sir William Osler’s more holistic approach to medicine, who argued that a physician should be “humane and learned” Oslerians (Vinten-Johansen and Riska, 1991). And was quoted as saying that “The practice of medicine is an art based on science”3 (Silverman et al., 2003). Osler interestingly also placed emphasis on the Hippocratic corpus, and the humble and gentle manner that it recommend doctors inculcate (Silverman et al., 2003, Silverman, 2012). Consequently, the the Oslerian reform have been termed a “humanizing movement” in clinical education by Vinten-Johansen and Riska (1991). An entirely appropriate term that persists to this day, and was the basis for later reforms in medical education in the 1960 and 1970. The proponents of which terming themselves the ‘New’ Oslerians (Vinten-Johansen and Riska, 1991).

Although now found in many other institutions with medical schools and teaching hospitals, it was the University of Glasgow that first instigated a programme of medical humanities in its medical school in the 1980s (REF, 2014). The UoG describe that rationale for the programme in the following way:

“The field of medicine has become more complex and morally demanding as it faces the challenges of technological advances, changing social attitudes and financial constraints... These challenges require a profession with independent judgment and a willingness to listen to, and communicate humanely with, patients. The complex skills required for this can be developed through what have become known as the

3 Quote number 143
‘medical humanities’, or the application of philosophy and other humanities to medical education.” (Ibid, 2014)

Essentially the premise of this argument is that effective clinical judgement requires more than just a technical element, this additional element being something that humanities can teach (Downie and Macnaughton, 2000).

It was not until 1993 that under the influence of former University of Glasgow staff, that the General Medical Council (GMC) started to recommend the incorporation of medical humanities modules in its guidance for trainee doctors Tomorrows Doctors (GMC, 1993).

However these modules, were, and still are what is known as SSUs, Special Study Unit, or SSCs Student Selected Components, or something of a similar nomenclature. Which function as an additional course for medical students, that come with additional credits but are by no means a core part of the medical curriculum. With that being said, as of 2013 humanities modules are available to medical students in 30 of the UK’s 32 medical schools (REF, 2014). So even if there humanities are not a requirement for British medical students they are at least available.

By 1996, the medical humanities occupies a ‘modest spot’ in the special units courses in medical schools (Calman and Downie, 1996). This foundation of work, prompted continuing debate about the role of humanities in medical schools in the UK (Downie, 1999) and in other predominantly Anglophone countries such as Australia (Downie and Macnaughton, 1999) and New Zealand (Downie, 1998). The first appraisal of the system, looking at the outcomes of this new educational programmes was conducted in 2000 by Macnaughton (2000).
It is within this humanizing movement that perhaps, the resurrection of medical semiotics back into medical school curricula could be performed. Will the humanizing term in medicine allow the reintroduction of medical semiotics in medical curricula. And if so what lessons can we learn from Thure von Uexküll about it.

BRIDGE PARA TO DATA SECTION

DATA

The literature that forms the data set in this paper was collected from several sources during 2015. The primary sources of data were the bibliographies of Thure von Uexküll's compiled by Kull and Hoffmeyer (2005) and Koehle (2003). Additional papers were located through online literature searches and citation chasing. In total 201 academic papers and book chapters, all of which are in German were located.

These publications’ titles were translated, and then categories according to subject area. Table 1 contains the breakdown of the percentage and number of works that fall into each category.

Table 1 Germanophone Publication of Thure von Uexküll

<table>
<thead>
<tr>
<th>Areas of work</th>
<th>Number of Publications</th>
<th>% of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Biosemiotics</td>
<td>17</td>
<td>8.46</td>
</tr>
<tr>
<td>Philosophy of Science</td>
<td>12</td>
<td>5.97</td>
</tr>
<tr>
<td>Medical Philosophy</td>
<td>9</td>
<td>4.48</td>
</tr>
<tr>
<td>Medical Semiotics</td>
<td>11</td>
<td>5.47</td>
</tr>
<tr>
<td>Psychosomatic Medicine</td>
<td>90</td>
<td>44.78</td>
</tr>
<tr>
<td>Clinical Education</td>
<td>24</td>
<td>11.94</td>
</tr>
<tr>
<td>Biomedical Science</td>
<td>24</td>
<td>11.94</td>
</tr>
<tr>
<td>Medical Sociology</td>
<td>7</td>
<td>3.48</td>
</tr>
<tr>
<td>Medical Services</td>
<td>7</td>
<td>3.48</td>
</tr>
</tbody>
</table>
This data has also been represented visually in the form of a pie chart, see Figure 1. The subject areas in both Figure 1 and Table 1 will of course be quite familiar for most, or at least not a surprise: Biosemiotics, philosophy of Science, Medical Philosophy, Psychosomatic medicine. Less familiar to most, but again entirely understandably is the presence of papers on clinical education, given the medical training of Thure von Uexküll.

This in itself is perhaps not surprising, however if one is to investigate Thure von Uexküll’s works that have been written or translated in English, a quite different pattern emerges. A summation of all the English language works of von Uexküll that have currently been published can be found in Table 2.

<table>
<thead>
<tr>
<th>Areas of work</th>
<th>Number of Publications</th>
<th>% of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>201</td>
<td>100.00</td>
</tr>
<tr>
<td>Biosemiotics</td>
<td>15</td>
<td>21.74</td>
</tr>
<tr>
<td>Philosophy of Science</td>
<td>3</td>
<td>4.35</td>
</tr>
<tr>
<td>Medical Philosophy</td>
<td>1</td>
<td>1.45</td>
</tr>
<tr>
<td>Medical Semiotics</td>
<td>9</td>
<td>13.04</td>
</tr>
<tr>
<td>General Semiotics</td>
<td>9</td>
<td>13.04</td>
</tr>
<tr>
<td>Psychosomatic Medicine</td>
<td>22</td>
<td>31.88</td>
</tr>
<tr>
<td>Clinical Education</td>
<td>0</td>
<td>0.00</td>
</tr>
<tr>
<td>Biomedical Science</td>
<td>0</td>
<td>0.00</td>
</tr>
<tr>
<td>Medical Sociology</td>
<td>1</td>
<td>1.45</td>
</tr>
<tr>
<td>Prefaces and Forewords</td>
<td>5</td>
<td>7.25</td>
</tr>
<tr>
<td>Medical Services</td>
<td>0</td>
<td>0.00</td>
</tr>
<tr>
<td>Misc.</td>
<td>4</td>
<td>5.80</td>
</tr>
<tr>
<td>Total</td>
<td>69</td>
<td>100.00</td>
</tr>
</tbody>
</table>
Once more the data in Table 2 has been converted into a visual format - See Figure 2. Both Figure and Table 2 show the clear absence of Clinical Education literature in Thure von Uexküll's English publications.

DATE RANGE OF PUBLICATIONS!!!
Thure von Uexküll's Germanophone Publications

- Psychosomatic Medicine: 45%
- Clinical Education: 12%
- Biomedical Science: 12%
- Biosemiotics: 8%
- Medical Sociology: 4%
- Medical Services: 4%
- Medical Philosophy: 4%
- Medical Semiotics: 5%
- Philosophy of Science: 6%
- Other: 8%
Figure 2
DISCUSSION

To the author’s knowledge clinical education is part of the cannon of Thure von Uexküll’s is yet to be explored in any semiotic related context, perhaps owing to it being available solely in German. And with the founding of Edusemiotics (REFS) in recent years, it seemed time to explore this undercurrent of Uexküllian literature.

In addition to the stated intent of this paper, to explore this set of literature can provide inferences on how semiotics can play a role in medical education.

Perhaps the works that were written or translated into English simply reflect the priorities of the authors at the time.

And up until this point Clinical Education, was not (and still probably is not) a priority. However with semiotics moving into the realms of education philosophy,

Perhaps now is an opportune moment to revisit the existing semiotic literature, in an attempt to fuse Edusemiotics and Medical semiotics under a similar mission

NOTE EDUSEMIOTIICS WAS BASED ON BIOSEMIOTICS !!! (REF)

An explanation of the variety of approaches to medical education is given by (Brosnan, 2009, p63)

“In the UK…the medical schools with the highest research profiles have tended to retain largely traditional medical curricula, while the newest medical schools, which generally have lower research income and prestige, typically claim to have ‘innovative’ curricula which integrate science with clinical practice. This may represent attempts on the part of the new schools to symbolically differentiate
themselves from the dominant players in the field, rather than to attempt to compete on the same terms”

It’s basically positional innovation! INSERT BESSANT REFERENCE?

You can (still following Bourdieu) trace the trajectory of influence of senior figures in clinical education as the move between institutions. That is to say, currently Cardiff Medical School’s syllabus and Peninsula Medical Schools syllabus have a striking similarly ethos in their exposition for medical humanities and ‘humanising’ subjects due to the labour movement of senior Clinical educators and directors of assessment. Who naturally take with their own conception of distinction (BOURDIEU REF) with them as the change institutions. What is surprising about this, is that in the recent past, Cardiff was considered a ‘traditional’ medical school (Roath et al., 1977). Similar results have been found in American medical schools (Maheux et al., 1989).

WHY HAS THIS WORK REMAINED UNTRANSLATED?

THEORETICAL AND RESOURCE CONSTRAINTS WITH THE WORK

Resource constraints

Whilst the titles of the Germanophone literature of Thure von Uexküll are available to those who wish to translate them. As with much historical work, in areas of academia considered less fashionable (and Clinical Education is surely one of these!) acquiring copies the works themselves proved challenging.

For example, the publication Der praktische Arzt – The Medical Practitioner – is the name of two quite separate Austria and German journals.

As is the nature of the field, some of the journals Thure published in had ceased to publish long ago. The remaining copies of the journals only being accessible in person in German archives. Other papers defied all attempt at location.
The line of thinking set out in this paper suffers from several deficiencies. Some of which are a consequence of the pre-eminence of economic capital in the field of medical schools due to the devalued nature of social and cultural capital in these institutions (Bourdieu, 1984). Also the intent of the paper is perhaps overly structuralist in its wish that doctors can be humanised simply by greater exposure to semiotic thought.

The medical education has a clear division between the biomedical scientists and clinical practitioner (Brosnan, 2009, p62). Attempts at curricula reform have generally thought to have failed because these two groups have opposing forms of capital – essentially the ‘hard’ science of medicine vs the art of surgery and other medical practices – that do not view each other as legitimate. Hence the introduction of integrative curricula that combines a humanities element runs a risk of failure due to the inherent struggle for dominance in the clinical educational system (Bonner, 1995).

Hypothetically if medical semiotics was introduced into a medical curriculum, it does not follow that we would see its processes replicated in the practice of medical students. Other humanities

This is basically you admitting that you’ve taken (as semiotics has!) an overly structuralist assumption that if you change the structure you change the people.

You’ve ignored the entire medical habitus (i.e. socialisation) in medicine that will close ranks against the ideas of something new – with the exception of the new medical schools.

Some such as Bloom (1988) have suggested such reforms in medical education only ever were construed as *panem et circenses* delivered down from the medical hierarchy, to occupy idealistic juniors intent on change, in his own words:

“medical education’s manifest humanistic mission is little more than a screen for the research mission which is the major concern of the institutions social structure.”

The research mission here referring to the economic benefits generated from research grants.
The medical habitus (Brosnan, 2009, Luke, 2003, Sinclair and Toulis, 1997, Lempp, 2012) will have to continue to undergo a slow moving change before we will see medical semiotics return to the medical school curricula. As a result of ‘widening participation activities’ that are employed in British medical schools, since the 1970s there has been great increases in the numbers of female, ethnic and minority students as well older student BMA reference. !! P7

But no significant change in the economic background of the students admitted - expand

But all really boils down to economic capital and UK medical school entrance SES data has not altered since the 1970s

The best hope is perhaps the newer British medical school whose curricula position in the medical field not entrenched solely in reductionist biomedical science.

CONCLUSIONS

STATE THAT YOU REGRET NOT BEING THERE IS PERSON AND WOULD BE VERY HAPPY TO RECEIVE AN FEEDBACK THAT YOU MAY HAVE BY EMAIL

ACKNOWLEDGEMENTS

I owe a great debt to Prof Kalevi Kull for point me in this direction, and kicking starting my interest about Thure von Uexküll. Also the extensive database of Thure’s work that have been created by Dr Karl Koehle & Prof Kull that were the platform for this work have been invaluable.


DOWNIE, ROBIN. 1999. The role of literature in medical education. A commentary on the poem: Roswell, Hanger 84. Journal of Medical Ethics. 25, 6, pp. 529-31


PEIRCE, C. S. 1868b. Some Consequences of Four Incapacities *Journal of Speculative Philosophy in CP 5.317-5.357.*


SCALVINI, M. 2010. Glamorizing sick bodies: how commercial advertising has changed the representation of HIV/AIDS. *Social Semiotics,* 20, 219-231.


