

A PIECE OF MY MIND

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Negative Capability and the Art of Medicine

On December 21, 1817, John Keats wrote to his brothers George and Tom about a literary discussion he had recently had with the critic Charles Dilke, after which “several things dove-tailed in my mind.”¹ Keats continued, “At once it struck me what quality went to form a Man of Achievement, especially in Literature, and which Shakespeare possessed so enormously—I mean Negative Capability, that is, when a man is capable of being in uncertainties, mysteries, doubts, without any irritable searching after fact and reason.”¹

The young physician then went on to cite Samuel Taylor Coleridge as a poet whom he considered deficient in negative capability because he was “incapable of remaining content with half-knowledge.”¹ What exactly did Keats mean? That Coleridge was too curious or too intellectual to be a great poet? We’ll never know because Keats, who died of tuberculosis less than four years later, never referred to negative capability again, either in his letters or other writings.

A single mention in a private letter is not much of a pedigree. Nevertheless, Keats’ casual turn of phrase has generated many writings by others in the centuries that followed. Literary critics generally interpret negative capability to mean being open to the world without having preconceived theories, a willingness to suspend judgment, or the ability to function imaginatively in the face of incomplete knowledge. Notable psychoanalysts and philosophers have championed

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the importance of negative capability in their own fields. In fact, with the enthusiasm of a dilettante who knows little about literary criticism, I too have argued that negative capability is an important quality for clinicians to develop.²

But there’s something wrong with this picture. Physicians not “searching after fact and reason”? Doctors “remaining content with half-knowledge”? How can negative capability be a positive quality in scientific medicine?

What did John Keats have in mind when he coined the term? In 1816 Keats had successfully passed his examination for a medical license and joined the Worshipful Society of Apothecaries yet had also become increasingly ambivalent about a career in medicine. By late 1817, he and his brothers had rented a house in Hampstead, where John devoted himself to writing poetry, as well as taking care of his brother Tom, who was dying of tuberculosis. Keats had given up the idea of practicing medicine. Yet could medical training have had any influence on his concept of negative capability?

Medicine has a long tradition that attributes a special quality to the diagnostic and therapeutic thought processes of good clinicians, an attribute independent of intelligence, medical knowledge, or even logical deduction. When I was a medical student, my teachers referred to this quality as clinical intuition or clinical judgment. Yet the word *intuition* was always suspect because it smacked of mysticism, and *judgment* was co-opted in the 1970s by clinical epidemiologists, who characterized it in mathematical terms of probability and utility, which sounded good but didn’t capture the experiential quality of medical thinking.³

In an episode of *Star Trek*, when Spock questions Captain Kirk about an apparently foolhardy decision that has endangered the entire crew of the USS *Enterprise*, Kirk replies, “It’s not logical. It doesn’t make sense. It’s my gut feeling!” Kirk, as usual, had chosen the right course of action and by the end of the episode saves the day. However, even if clinical judgment can’t be reduced to an algorithm, surely it must have more going for it than gut feelings. I recently found an interesting, and I think plausible, definition: “a judgment in which visual and verbal cues are so rapidly and subliminally observed that their contributions to the final decision are virtually forgotten.”⁴

Yet visual and verbal cues can’t stand alone. They require something to integrate them, a process, a creative spin. In 1967, physician and cognitive psychologist Edward de Bono introduced the term *lateral thinking* to describe an indirect approach to problem-solving, involving ideas that might not be obtainable by using traditional step-by-step logic.⁵ De Bono’s lateral thinking seems roughly equivalent to today’s favorite metaphor for creativity: “thinking outside the box.” Alternatively, those of us who slavishly adhere to reason are doomed to remain trapped inside the box, like Schrödinger’s cat, neither dead nor alive.

Whatever you call it, there is something attractive about attributing a special openness and curiosity to the art of medicine, an openness that permits a greater variety of information to *enter* the box, rather than kicking the logical brain out of it. In his famous turn of phrase, Keats obviously chose to give “negative” a beneficial meaning. Negative in this context implies passivity, receptivity, and humility, yet it seems these qualities are precisely what made the difference between a competent poet like Coleridge and a truly creative one. Does this sense of negativity have a place in the art of medicine? Does it tell us anything about the difference between merely competent and master clinicians?

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If we as clinicians predicate our care entirely on “irritable reaching,” or abandon patients because of “uncertainties, mysteries, doubts,” we lose much of our effectiveness as healers. What if you view negative capability as intellectual and emotional openness, a willingness to be reflective and mindful about one’s practice?

I think of negative capability as the gateway to reflective practice. In self-awareness or reflective practice sessions, I often prescribe a judicious application of poetry, sometimes asking students to write a poem about a clinical experience that is particularly meaningful or upsetting. Of course, poetry is only one of many tools that can assist in developing the habit of reflectiveness, but it offers a glimpse into the paradox of the art of medicine: the ability to function at the interface between detachment and engagement, steadiness and tenderness, resilience and vulnerability, science and art. In pursuing the steadiness and detachment required to master clinical practice, it is tempting to neglect the more difficult project of nourishing engagement and tenderness in our relationships with patients—and with ourselves. In an address to medical students at McGill University, William Osler claimed, “Nothing will sustain you

more potently in your humdrum routine ... than the power to recognize the true poetry of life—the poetry of the commonplace, of the ordinary man, of the plain, toil-worn woman, with their loves and their joys, their sorrows and their griefs.”⁶

That “power to recognize the true poetry of life” is a function of negative capability. Notice that Osler speaks of sustaining the physician through the “humdrum routine” of professional life, not specifically of patient benefit. Could it be that physicians who develop negative capability are happier, more productive, less likely to burn out?

I teach a narrative medicine elective in which students are asked to keep a clinical journal. In one of her final entries, a fourth-year student, reflecting on her experience in medical school, wrote, “The practice of medicine is simply poetry in motion. The art of medicine is the validation of everything that makes the human experience. I learned more about myself than I ever imagined....”

Simply poetry in motion.

I wonder what John Keats, who rejected medicine for poetry, would have to say about that?

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