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Medical Humanities and Medical Education

How the medical humanities can shape better doctors

Alan Bleakley

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2 What are the 'medical humanities'?

Definitions and controversies

Defining the medical humanities: 'what's in a name?'

The medical humanities are undergoing a transition from what might be termed a naïve and celebratory 'first wave' – often attracting raw enthusiasm rather than reflexive scholarship – to a 'second wave' of more critical approaches. Let us call this first wave 'medical humanities lite' and the second wave a 'critical medical humanities'. This second wave has brought both maturity and complexity to the medical humanities culture, but not necessarily coherence. Interesting fault-lines and contradictions have appeared in the culture and are the subject of this chapter. In summary, the descriptor 'medical humanities' accommodates three distinct approaches: first, the study of medicine and the medical by humanities scholars usually based in university humanities departments; second, arts and humanities interventions in medical education; and third, arts practitioners engaging the public with issues of the body and illness through literature, performance, theatre and the visual arts in particular. Such practitioners may be based in art schools or performance and humanities departments of arts universities.

In their 2008 review of the state of play of medical humanities in Canadian medical schools, Kidd and Connor described the field as 'anarchic'. Many took this as a backhanded compliment, but the authors warned that a lack of cohesion in the field merely played into the hands of sceptics towards the medical humanities who pointed to what they saw as a scattergun approach to curriculum interventions. While a frontier spirit pervades the medical humanities this has been accompanied by a lack of rigour and discrimination. For example, surprisingly little work has been done on mapping the territory of the medical humanities in the face of unquestioned assumptions about the field's interests and limits.

Johanna Shapiro and colleagues (Shapiro *et al.* 2009: 193) wrote a perceptive article in 2009 summarising 'medical humanities and their discontents'. This focused on the medical humanities as 'an intriguing sideline in the main project of medical education' (*ibid.*). The authors point to studies showing that medical students typically critiqued medical humanities content as irrelevant; teaching as untrustworthy and personally

intrusive; and curriculum design as misplaced where content was core rather than elective. The issue for these authors is a pedagogical one – simply, medicine is not taught as a process of critical thinking and reflection but one of direct, pragmatic application. The humanities bring pedagogical process as well as content, such as critical dialogue and theory as 'sense making'. Ways of learning that are more critical could be introduced, aligned with use of media such as reflective portfolios that allow for meaningful integration of clinical experiences rather than a cataloguing of activities such as clinical skills. Humanities should not be 'add-on' but integrated.

Finally, 'applied humanities scholars' without clinical experience could work collaboratively with clinicians adding a critical dimension introduced from the arts and humanities. Prior to Shapiro and colleagues' article, since introducing a core and integrated medical humanities curriculum in 2002, Peninsula Medical School (Universities of Exeter and Plymouth, UK) had successfully introduced much of what these authors suggested to the undergraduate medicine curriculum, including an 'applied humanities scholars' faculty under the directorship of myself and Dr Robert Marshall, a consultant histopathologist with a first degree from Oxford in Classics. Marshall is a passionate advocate of the arts and humanities in medical education and provided the initial impetus for considering such a high profile for the medical humanities during the first wave of curriculum planning for Peninsula Medical School. Those humanities and social science scholars at Peninsula who had no previous clinical experience underwent staff development to gain an appreciation of clinical environments through observational placements prior to working collaboratively with clinical teaching staff. Importantly, the Peninsula curriculum plan was grounded in the assumption that the biomedical sciences are intrinsically aesthetic.

Hal Cook (2010: 3), a historian, sees the medical humanities as a way of exploring the 'complexities and ambiguities of the human condition' as these relate to medical practice. He also uses the metaphor of 'borderlands' to describe the medical humanities' position in relation to established academic disciplines. Cook's view is from the humanities looking in on medicine. In contrast, Deborah Kirklin (2002, 2003, 2005), a doctor and medical ethicist, works from within the overall field of the medical and healthcare, seeing the application of the arts and humanities as a kind of fine-tuning of sensibility allowing us to develop a far more subtle and nuanced appreciation of the context within which illness is experienced and healthcare delivered. Kirklin then looks out from the practice of medicine and healthcare towards the arts and humanities. The two positions generated by Cook and Kirklin are not incompatible, but suggest differing lines of flight.

Following Cook's definition, we might see 'the medical' as one historically and culturally determined dimension of human experience. This may lead us to ask questions such as that raised by Ivan Illich (1977) of how

does a culture become so thoroughly 'medicalized'? Illich's focus is not on the rise of technical biomedicine but rather on the deskilling of the layperson, whose capability to offer everyday healthcare is put into question as health practices are professionalized. Michel Foucault (1989) asks a different set of questions, but they are still historically and culturally grounded. Using examples from French historical archives, Foucault asks how the focus of medical practice shifted from the home visit (with its bias towards the patient and family and its restrictions on the doctor as guest in another's house) to the patient attending a clinic (with its bias towards the clinician and its restrictions on the patient as a visitor to the hospital)? What conditions emerged that legitimated intimate examinations ordinarily taboo in everyday social exchanges (legitimated in the clinic but not necessarily sanctioned in the patient's house)? What is different about the way that a doctor and a layperson gaze on, or at, a body? These are questions from outside medicine looking in.

Following Deborah Kirklin's view of the medical humanities, we would pose different questions and pursue differing methods of inquiry. Looking out from medicine and healthcare to the worlds of the arts and humanities, the most pressing, and problematic, question is then how might we improve healthcare with the help of the medical humanities? Kirklin's position is ultimately embedded in pedagogy – how can medical education be designed with medical humanities in mind?

Here, we might draw on the engagement of the radical arts with contemporary medicine as a response to Kirklin's prompt, noting that such an arts intervention is not located within the medical school and teaching hospital, nor within the University humanities department, but within a gallery engaging the public. In this case, it happens that the gallery space within a museum of art simulates a hospital ward. Bob Flanagan was an American performance artist who died in 1996 from cystic fibrosis. He was also a masochist who derived sexual pleasure from being dominated by his partner Sheree Rose. A film, released in 1997, about Flanagan's complex relationship with terminal illness – *Sick: The Life and Death of Bob Flanagan, Supermasochist* – won the Special Jury Prize at the Sundance Film Festival in 1997. With Sheree Rose, Flanagan made a performance piece called 'Visiting Hours' (shown at Santa Monica Museum of Art in 1992–3, the New Museum New York City in 1994 and the Museum of Fine Arts Boston in 1995) in which museum spaces were transformed into a hospital ward with waiting room and X-rays. Flanagan lay in a hospital bed at the centre of the installation.

Flanagan's performance dramatically challenges what the hospital expects of the supine and conforming patient, and what culture may expect of playing the 'sick' role, in what he termed 'fighting sickness with sickness'. The performance climaxes with Flanagan being tied by the ankles and winched out of the bed by Sheree Rose to hang upside down, literally inverting the supposedly proper and normal relationship of patient with clinic, of sick patient with medicine (see www.youtube.com/watch?v=vgWyxjjecOw).

Such radical art questions notions of what is 'healthy' and positions medical education as, potentially, a pedagogy of difference. Here, if authentic 'patient-centredness' is practised many of the conventions of medicine reinforced through a traditional medical education must be questioned.

Flanagan's work brings together the medical humanities as (i) a perspective looking in on medicine and healthcare from the outside to critically examine historically and culturally determined assumptions about the body and illness, and as (ii) a perspective looking out from within medicine and healthcare to critically examine how apprentice practitioners are socialized, gain and consolidate identities – or learn. From docile and supine 'patient' (literally 'one who suffers') to hanging, inverted above the bed – having metaphorically transcended suffering through inflicting even more pain – Flanagan points to critical positions that both look in on and look out from medicine and healthcare simultaneously. Importantly, Flanagan, an against-the-odds survivor of cystic fibrosis (he outlived medical mortality predictions by around 35 years) problematizes descriptors such as 'health', 'wellbeing' and 'quality of life'.

Paul Crawford and colleagues (Crawford *et al.* 2010) see the 'health' humanities as the 'future of medical humanities', objecting to the implied exclusion of wider healthcare when using the descriptor 'medical'. Yet Deborah Kirklin's approach to the medical humanities from 2006 is certainly inclusive, specifically referring to 'healthcare'. In the UK, this debate goes back to at least 2002, when an editorial in *Medical Humanities* by Martyn Evans and David Greaves suggested that the 'medical' in 'medical humanities' was not being used just to refer to medicine, but the term 'medical humanities' had already gained currency and traction internationally and that it was effectively too late to attempt to introduce the potentially more inclusive descriptor 'humanities in healthcare'. Evans and Greaves (2002) asked, rhetorically: '"Medical humanities" – what's in a name?' This related to the development of an Association for Medical Humanities (for which Evans twice served as president, and for which I am currently president at the time of writing).

The authors apologized for potential exclusivity in sticking with the term 'medical', both for healthcare practitioners such as nurses, and for non-medical participants in the medical humanities culture such as social sciences, arts and humanities academics and practitioners (Evans himself is a philosopher and not a clinician). But this issue really only matters to those who align the medical humanities with medical education. Here, non-clinical academics and artists will meet healthcare in general even as they work with doctors, where they see doctors working with patients and in multiprofessional clinical teams. On the other hand, for humanities scholars or artists working outside of medical schools in humanities or arts departments, 'medical' humanities is an appropriate descriptor, as these scholars engage mainly with the subject of medicine or with the roles and identities of doctors.

Certainly in Canada, with the development of the health humanities network and an associated annual conference, the health humanities is now the preferred term, displacing the medical humanities. The decision to publish a comprehensive compendium of articles on the state of the art of the medical humanities under the title *The Health Humanities Reader* (edited by Tess Jones, Delese Wear and Lester Friedman), as noted in the previous chapter, makes a significant statement: that 'health humanities' may become the preferred term in North America (Jones *et al.* 2014).

My concern with the health humanities, as indicated in the previous chapter, is the privileging of 'health', generally linked with optimism and wellbeing, now extended also to 'safety'. Artists such as Bob Flanagan – while his work was extreme even for contemporary performance art – seek to critically challenge assumptions about 'health', 'illness' and 'disease' and the role of the patient. Flanagan did not seek to challenge western biomedicine per se, but rather assumptions about the status of the human body as it encounters the cultural process of medicalization as normalizing. Ironically, medical education itself has historically offered a distinctly sado-masochistic model of apprenticeship. Combinations of punishing work schedules, learning on the job through ritual humiliation and plunging junior doctors in at the deep end at the limits of their competence have led to doctors having higher rates of suicide and burnout than the average population (Wible 2014) and medical students also showing high rates of suicide ideation and burnout (Dyrbye *et al.* 2008) and produced 'survival' guides for residents (Peterkin 2012). This is coupled with a lack of formal support structures for the psychological wellbeing of doctors who traditionally resist self-help, make poor patients and dislike treating other doctors (Garelick 2014). Further, our cultural models of 'health' and 'wellbeing' are ambiguous. On the one hand we are asked to adopt lifestyles that promote health, but on the other, we do so in ways that court danger and risk, such as extreme sports. 'Quality of life' does not necessarily equate with medical models of 'health' or healthcare models of 'wellbeing'.

The 'medical' and 'health' descriptors in medical/ health humanities are then problematic, but I am equally concerned with the potential exclusivity of the 'humanities' descriptor in 'medical humanities', where 'humanities' are assumed to include the arts. Also, do we include the humanities-facing social sciences? In my own work in medical education, I have often used the term 'medical aesthetics' as a composite descriptor, but recognize that this must also encompass politics and ethics (Bleakley 2014). The concern of Martyn Evans and David Greaves (2002) to address 'what's in a name?' in a 'first wave' of medical humanities is far from resolved, but we cannot simply leave things to rest. The beehive must be stirred and we must be stung into action to consider that a 'name' does matter.

A multidisciplinary or interdisciplinary field?

The descriptor 'medical humanities' has been applied to the following five fields of activity:

- The humanities studying medicine (such as history of medicine or the critical evaluation of medicine in literature).
- Arts and humanities intersecting with medicine in medical education – often called 'medicine as art'.
- The arts engaging with medical themes in public engagement.
- Arts for health (for example, art in hospitals and arts activities with patients – often called 'arts as medicine').
- Arts therapies (sometimes linked with arts for health, but usually associated with mental health interventions using arts media within a psychotherapeutic framework).

While the medical humanities in the UK may have its roots in arts therapies, the arts as therapy culture now has its own academic meetings, journals and societies and has limited overlap with the other four areas above. Arts for health, like the arts therapies (with which it has resonance) also has its own networks, conferences and publications that are separate from medical humanities. Medical humanities, rather, has flourished in three places – university humanities departments, through the formal study of medicine; university medical schools, teaching hospital and community clinics, through medical education; and public galleries, museum spaces and theatres through arts engagement with medical themes.

Claire Hooker (2008: 369–70) echoes the fields described above, where the medical humanities offer:

1. 'a field of academic inquiry';
2. 'the intersection of medicine and the creative arts'; and
3. creating 'more compassionate, more capably communicative doctors' that may 'lead to better health outcomes for patients'.

Hooker's rhetoric, however, sets out to persuade that medical education (3 above) is less sexy than the field of academic inquiry into medical culture and history (1 above) where she gives an example from the University of Auckland, New Zealand: 'researchers who investigate such things as illness narratives, death and dying, mental health and incarceration, and the semiotics of disease, are primarily charged with the task of training doctors to be more likeable and trustworthy for their patients' (*ibid.*).

This is an unfair reading of the complexity of medical education as it draws on the arts and humanities, as I hope Chapter 3 will demonstrate. Democratizing and politicizing medical culture – both of which are necessary aims for the medical humanities in medical education – is a far more

onerous task than that of 'training doctors to be more likeable and trustworthy for their patients'. For example, educating doctors in teamwork in order to reduce medical error – one key strand in democratizing medicine – seems to me to be a key outcome and reason for including, say, illness narratives and the semiotics of disease in a medicine curriculum. Further, a reflexive medical education does not set out to 'train' doctors but to educate them, for example in how to deal with disgust (see the extract from Gabriel Weston's semi-autobiographical 2014 novel *Dirty Work* that opens Chapter 4), or with erotic and sexual attraction to patients and colleagues.

An evolving area in the medical humanities is how contemporary arts practitioners can engage critically with medical education to shape new practices, moving clear of the territory of arts therapies and arts in health (where the art is a medium for working with patients, and not primarily a cultural object or artefact that has independent impetus to challenge the 'health' of a culture). For example, the Scottish artist Christine Borland was appointed as Visiting Professor of Visual Art at Peninsula Medical School precisely to challenge the habitual use of artists as handmaidens to medicine (such as life drawing classes for anatomy learning or medical illustration). Borland, a Turner Prize nominee in 1997, has worked consistently in the areas of medicine and forensic science to provide critical visual commentary. She is interested in how exposure to the medical can depersonalize, where art interventions can reconstruct and personalize.

Borland reformulates issues of social justice, ethics and representation of the 'human' through complex visual art projects, often involving collaborations with scientists, doctors, anatomists and forensics experts. In making the 1994 piece 'From Life' (Borland 2006), Borland sought out a human skeleton sold through an anatomy catalogue. She imagined that skeletons would be plastic and was shocked and intrigued to find that, at the time, she could buy a real human skeleton. In the setting of the medical school's anatomy laboratory, the skeleton is simply a passive teaching object, acting not only to depersonalize the human who once inhabited this skeleton, but acting as a signifier for medicine as a whole as a depersonalizing institution. Borland aimed to reconstruct and repersonalize the human who once fleshed the skeleton. Through tracing ownership of the skeleton and through forensic reconstruction of the face Borland discovered that this was an Asian female. This forensic art process offers a model for a humane medicine that does not strip us back to anonymous skeleton but refleshes us and builds meaningful relationship layer by layer. Such a process too is transdisciplinary where it is powered by moral dilemmas. While the medical humanities in medical education may draw from several disciplines, the worry is not how we knit those disciplines together, but whether or not we can find compelling topics that act as encompassing vehicles for collaboration between differing approaches of thinking and making.

Of the five fields of activity referred to above, arts for health and arts therapies have activities, organizations and publications that are distinct

from the medical humanities, although there is overlap, particularly with the arts for health field. Of the other three approaches, two – the medical humanities in medical education and the medical humanities as the discipline-based study of medicine and the medical – are, however, in tension and not readily interdisciplinary or transdisciplinary. Both of these traditions have passed through an historical 'first wave' and are entering a 'second wave' of interest. Both claim the descriptor the 'critical medical humanities' for this second wave of activity. The passage from first to second wave in both cases can also be described as from 'celebratory' to 'critical', or from the naïve to the reflexive.

In the development of the medical humanities in medical education, a first wave of interest saw the medical humanities introduced to medical students as modules in ethics and the history of medicine, while this gradually expanded to include narrative-based medicine and topics such as how looking at art may help medical students to look more closely at patients. Given that medical students gain an identity as a doctor through performing like their seniors, medicine developed an interest in drama, and this was reinforced through the widespread use of actor patients in learning clinical skills through simulation. However, in this first wave the introduction of the medical humanities was characteristically 'lite' educationally – as a supplement within the curriculum, as optional learning, as light relief from biomedical science and even conceived as 'edutainment'.

A second wave has reformulated the medical humanities as a critical educational intervention. Here, the 'critical' medical humanities can act as a counterpoint to reductive biomedical science from within the curriculum, as core and integrated provision. This extends technical interest in diagnosing and treating the chief complaint (disease) to a wider appreciation of the illness in the context of the patient's life, as the chief concern (Schleifer and Vannatta 2013). This critical role for the medical humanities is pedagogical where it educates for a more reflective and reflexive imagination than the literalism encouraged by other aspects of the curriculum.

The medical humanities are no longer supplementary or complementary but actively reformulate what clinical thinking and clinical practice – or the clinical imagination – might be. The arts and humanities are given a central role (i) politically – in democratizing medicine, where they also educate for tolerance of ambiguity, and (ii) aesthetically – in providing the necessary media for learning how to communicate professionally and sensitively through a moral imagination and learning how to engage close noticing in physical examination and diagnoses. In short, within medical education, the medical humanities have come to configure a radical and primary educational intervention, shaping practice aesthetically and politically (Bleakley 2014).

In a parallel development, a first wave of interest in humanities disciplines studying medicine, such as the history of medicine, often left medicine untouched. Medicine was a passive object studied by an active discipline.

The aim was not to *transform* medicine or indeed to trace the vicissitudes of 'the medical' but merely to *describe* and *understand* medicine. In a second wave of interest, as noted, a 'critical medical humanities' has emerged (Woods and Whitehead forthcoming). The project is now to not just engage with, but also contribute to, the medical understanding of individuals and populations in terms of potential transformation. Where the humanities once studied medical phenomena from a distance they now offer to process or remake the fabric of the medical in intimate, critical engagement.

Proponents of this kind of 'critical' medical humanities have emerged from the Wellcome-funded Centre for Medical Humanities at Durham University, UK, including Angela Woods and Corinne Saunders and Anne Whitehead at the University of Newcastle. The 2009 online manifesto describes the medical humanities as:

> the name given to a so-far rather diverse field of enquiry. Its object is medicine as a human practice and, by implication, human health and illness, and the enquirers are, basically, people working from the perspectives of humanities disciplines. Thus 'medical humanities' denotes humanities looking at medicine, looking at patients, and – crucially – looking at medicine looking at patients. At present, history, literature studies, theology, anthropology and philosophy are prominent among the disciplines that engage in medical humanities. If they act separately and in isolation from one another, then 'medical humanities' is just a list. But it becomes far more interesting when these disciplines' perspectives are combined in a genuinely interdisciplinary way.
>
> (Durham University 2009)

There is nothing here about pedagogy, or medical education as an arts- or humanities-led intervention; nor about the arts operating as 'diagnosticians of culture' (Smith 2005). The 'critical' medical humanities are described as diverging away from centres developed in medical schools to:

> a new generation of research groups emerging from humanities departments. [Where] critical social and cultural theories . . . direct and infuse our work to unpick the hidden assumptions underpinning the use of key concepts, lines of policy argument and characterisations of particular bodies or groups of bodies. . . . We have a particular interest in collaborating with the creative arts and the arts and health community in exploring the radical potential of the arts within a critical medical humanities.
>
> (Durham University undated)

As mentioned earlier, just as Foucault (1989) suggested that the movement away from doctors visiting patients at home to patients visiting doctors in clinics changed the nature of the relationship between doctors and patients, for example in legitimating the intimate examination, so the Durham manifesto suggests that a shift in location from medical schools to humanities departments can herald a revolution in medical humanities by ushering in the critical approaches common to academic study, particularly in an era of critical theory. This moves in the opposite direction to Johanna Shapiro and colleagues' idea of an 'applied medical humanities scholar', who would work alongside clinical faculty and gain knowledge of clinical environments rather than working out of humanities departments (Shapiro *et al.* 2009). The key aspect of such a role is to critically engage with clinicians, medical students and patients in clinical spaces to expand, for example, awareness of the limits to practice, or of values informing practice.

As noted above, at Peninsula Medical School, from its inception in 2002, this model of non-clinical arts, humanities and social science scholars working closely with clinical teaching faculty in clinical spaces was developed. Non-clinical faculty underwent socialization into clinical environments such as hospital wards, operating theatres, laboratories, morgues and community general practices, and teaching spaces such as simulation suites, working alongside clinicians, often in interprofessional team settings. For example, Christine Borland, mentioned above, appointed as Visiting Professor of Visual Art at Peninsula, set up a project in which she worked alongside clinicians, actor-patients, technicians and students in critically examining learning clinical skills through simulation. Critical questions were asked, for example, about the male gendering of manikins, the ready slippage of simulation into dissimulation as medical students learned roles and scripts within a structure of performance and the lack of aesthetic in simulation suites. Borland made film, installations and artefacts exploring aesthetic, ethical and pedagogic contradictions and controversies in clinical skills learning, and presented this to a public audience in a gallery context over an extended period (e.g. *With Practice*; *Sim Bodies, NoBodies and Me*; see, for example, www.gsa.ac.uk/life/gsa-events/events/c/christine-borland). The work was continued and extended with students and faculty at Glasgow medical school's 'communication suite' where professional clinical communication is first learned with actor patients in simulation.

The final line from the Durham Centre website quoted above shows confused thinking and is rhetorical. It persuades us into thinking that a second wave critical medical humanities engages with the avant-garde in the arts, but in the same sentence adds the 'arts and health' community into the mix. The latter certainly does not have a track record of 'exploring the radical potential of the arts' in the way as, say, the Peninsula Medical School experience with Christine Borland as faculty (along with Visiting Professor of Music and Medicine Paul Robertson and Visiting Professor of Medical History Helen King).

Importantly, the approach of the humanities as applied to medicine in this second wave does position the medical humanities not as additive, as

handmaiden, or supportive friend to medicine but as a constructively critical intervention that sets a climate for medicine's reformulation of its aims including how it configures embodiment. This role of interlocutor is vital to the development of medical practice and knowledge, but also to how policymakers frame their social interventions (for example in public health education).

Proponents of this 'second wave' of medical humanities have suggested that the first wave was the application of the medical humanities to medical education, but this is misconceived and historically inaccurate. As I suggest above, there are two streams at work. These two streams of the critical medical humanities – one situated in medical education and the other in the humanities engaging with medical understanding – do, however, have common concerns. For example, from within the humanities-based critical medical humanities 'second wave' have emerged sophisticated interrogations of taken for granted notions such as 'empathy' (Macnaughton 2009) and 'narrative' (Woods 2011). In the second wave of medical humanities within medical education, critiques of the unquestioned notions of 'empathy' (Marshall and Bleakley 2009) and 'narrative' (Bleakley 2005) have also emerged, but these have had explicitly educational aims, those of improving patient care and safety through medical education.

I suggest that while a first wave of the medical humanities promised to counter medicine's scientific conservatism (appearing in practice as the dehumanizing of patients), and authoritarianism (appearing in practice as the depowering of healthcare colleagues), this wave is already being absorbed into the mainstream of medicine, where its revolutionary potential is being sublimated. Such sublimation is readily achieved where the *kinds* of arts and humanities that this first wave draws on are conservative, pointedly avoiding the liberal avant-garde. Further, this wave of medical humanities aligns with the dominant discourse of medicine as homeostasis (health and wellbeing, or human flourishing) grounded in utilitarianism.

Paul Macneill (2011) is one of the few commentators in the field of the medical humanities who has engaged with this problem of avoidance of the avant-garde. Macneill calls for a more 'muscular' approach to the medical humanities – perhaps an unfortunate metaphor in light of the other major issue in the medical humanities being one of ignorance of gender issues. Macneill sees the arts and humanities as pressed into service by medical humanities and remaining as 'benign' and 'servile' in relation to medicine and the health professions. While humanities interventions may critically address the limits of the biomedical model of medicine, it may also 'challenge quiescent notions of the arts'. Macneill considers the work of performance artists such as Stelarc (see http://stelarc.org/?catID=20247) and Orlan (see www.orlan.eu), who have subjected their bodies to modifications and extensions. Such work questions assumptions about the normative medical model of the body and extensions to this in what is considered a normal appearance. For Macneill, it is difficult to simply graft on the more radical arts to medical education without medicine questioning its foundational assumptions about what constitutes a 'normal' body.

Carrying the burden of the medical humanities

The development of the critical medical humanities within academic humanities departments does carry a danger – of distancing itself from the clinical coalface and of passing the responsibility for evidence of impact of medical humanities interventions to those still working within medical school medical education, humanities and ethics departments. Some of the ghosts from the more 'anarchic' days of medical humanities experimentation still linger. Geoffrey Rees (2010: 267) speaks for many in the medical humanities community when he talks of the 'slights endured by persons who labor under the rubric of the medical humanities'. This aligns with the assumption by sceptics towards the medical humanities that burden of proof of impact rests with those who support the medical humanities. And, of course, such proof must be provided under the terms set out by sceptics as evidence gained from empirical studies following a scientific or quasi-scientific experimental paradigm. In Chapter 9, I address this demand in detail and suggest that 'proof' cannot be reduced to an 'either it exists or it does not' scenario. Further, as Neville Chiavaroli and Constance Ellwood (2012) note, Ousager and Johannessen's (2010) review of the impact of research in the medical humanities suggests that 30 per cent of studies are justifications or 'pleading the case' for the inclusion of the medical humanities in the undergraduate medicine curriculum – again with backs to the wall.

Rees notes that the quality of a humanities intervention in medicine is more likely to be judged by those who make the intervention on the basis that it is ethically important – the intervention makes for a more caring medicine. This, however, may apply to medical humanities more oriented to the wider critical engagement with the goals of biomedicine and the medicalizing of the body. It does not so readily apply to medical humanities engaged primarily with pedagogy in medical education. Here, some pragmatic value is expected from medical humanities interventions, even if this is paradoxical, such as adding value to sensibility (for example, educating for close noticing, such as Chapter 6 details).

Jeffrey Bishop (2008, 2011) bemoans the fact that the medical humanities are commonly reduced to a medical 'humanism' that is an anaemic, technical version of the complex historical project of the arts and humanities. For example, proponents of the medical humanities may find themselves justifying curriculum models that set out to include medical humanities on the weakest of platforms that turns out to be the best understood by medical school pedagogical cultures. Here, instead of being able to celebrate the patent richness, complexity and critical challenge of the arts and humanities in the life of humanity as a starting point for a (usually

minor) curriculum reform, champions of the medical humanities find themselves arguing, for example, from the platform of a functional 'professionalism', the arts and humanities running away like sand through their fingers as they speak. Bishop warns of getting into divisive debate about separating 'fact' (science in medical education) and 'value' (ethics and humanities in medical education) and then trying to stitch them together through medical education, when they are inseparable at root and should be considered as such – the medical humanities in principle cannot then be separated from learning biomedical science. This returns us to the argument we made when developing the curriculum at Peninsula Medical School – that the 'medical humanities' issue does not start with a battle between science and the arts but rather with a recognition that good science is intrinsically aesthetic, ethical, complex and necessarily ambiguous, where science's 'truth' claims are historically and culturally determined.

Delese Wear and Julie Aultman (2005: 1056) describe a course for fourth-year medical students called 'Family Values' in which they used a range of required reading and written response to critically engage 'with violence, illness and end-of-life matters, and issues related to race, social class, gender and sexual identity'. The class, they report, 'fell flat'. In trying to understand why, Wear and Aultman suggest that the reading matter was not contextualized and too challenging. Where fictional characters fell out of the compass of tradition and normative values, students found difficulty in engaging with the issues that these characterizations brought up. Students then resisted the text. The authors suggest that the focus should be shifted away from individuals (representing types of patients that medical students may meet as future doctors) towards structural issues of the social, political, economic and cultural conditions that may affect health.

In defence of their original method, Wear and Aultman wished to apply Megan Boler's 'pedagogy of discomfort' in challenging preconceptions of medical students about wider cultural practices that deprive persons of 'their full humanity' to help doctors to 'reduce the social causes of suffering' (*ibid.*) – hence the choice of challenging texts such as Alice Walker's *The Color Purple*. Resistance took three main forms: blaming individuals for not achieving or failing to work hard enough (recognized as an American cultural trait); discounting content as irrelevant (for example, equality of treatment is ingrained in medical oaths, so why learn about inequalities?); and distancing – social issues are beyond our control, we treat disease on a patient-by-patient basis. Boler makes a distinction between 'passive empathy' and a 'semiotics of identity'. Medical students may read a text and empathise with an 'other' through a passive identification. However, how will students recognize that they may be part of the oppressive forces that alienate, marginalize or impoverish others, who remain 'different' and beyond interpersonal empathy? Students must recognize complicity in a status quo that maintains inequalities of opportunity and inequities.

It may be that these American medical students are also resistant to university medical school classes that appear to be similar to University humanities classes they attended (but also resisted) as compulsory in their undergraduate careers, such as a liberal arts 'great books' course. An alternative pedagogical approach is to always aim for relevance in teaching while incorporating meaning. In Chapter 8, I provide a case study illustration of a way that I introduced, collaborating with medical colleagues, study of contemporary fiction to analyse 'prescription culture' or the way that prescription drugs have now become part of the fabric of everyday life in North American cultural contexts. The students had no difficulty in engaging with the idea of an 'alternative' drug formulary that considered a small group of anti-depressants and anti-anxiety drugs as having 'character' when linked with case studies of real patients observed through their publicly accessible YouTube confessional videos.

Casey White, Arno Kumagai and colleagues (White *et al.* 2009) looked at the concept of patient-centred care with medical students through experiences of these students on clinical clerkships. Students reported that supervisors modelled behaviours antithetical to patient-centred care and this confused them. A programme was launched in 2003 at the University of Michigan medical school called 'the Family Centred Experience' that facilitated longitudinal placements and followed these up with small group class discussions (10–12 students) to integrate experiences. In 2002 at Peninsula Medical School, UK, 'jigsaw groups' were first developed for students to integrate clinical placement experiences and reflect on these in small group discussions with clinical tutors. The point about these pedagogical innovations is that structural issues such as social justice and equality are taught through reflection upon clinical experiential or work-based learning. Arts, humanities and social science scholars can readily be integrated into these reflections, for example through co-facilitation of reflective small groups. But, for these collaborative medical humanities opportunities to be successful, all participants must have first-hand experience of an issue such as 'patient-centredness' and 'patient-centred practice'. This again invites development of faculty along the lines of Johanna Shapiro's 'applied medical humanities scholars'.

At the heart of Arno Kumagai's (2009) 'Family Centered Experience Program', inaugurated for first-year medical students, is social justice. This shifts the frame of reference for medical humanities away from what can be read as more abstract notions, such as empathy and humanism, to the concrete acts of treating patients as complex and rich human beings whatever their social circumstances. Students work in pairs on a longitudinal placement with a patient volunteer suffering from a chronic or serious medical condition. The focus is then primarily political – setting medicine as a resource or capital to be fairly distributed across a community within a democratic framework. This framework is reinforced through fostering non-authoritarian faculty-student relationships. The primary method of

inquiry is narrative – there is a focus upon stories told and heard and subsequent assimilation and reflection. Key to the process is recognition and appreciation of difference.

Kumagai's brave medical education innovation runs against the grain of the typical processes of rendering medical students insensible through power structures. Inviting students into a democratic space of participation with their patients and their teaching faculty resists the traditional medical educational processes of marginalization and impoverishment that makes them – temporarily – the poor and dispossessed in the medical hierarchy. Such temporary conditions of marginalization are part of apprenticeships with quasi-militaristic training including the law and learning to be an airline pilot. But, while apprentices are held in this state of relative contempt, can they not engage more readily in acts of resistance? Will they not, when their false consciousness is revealed, be more willing to reflexively consider their part in later oppression of others such as patients and healthcare colleagues? As Wear and Aultman (2005) suggest, this is an invitation for medical students to engage not just with patients as allies, but with the historical, cultural and social structures that position individuals as marginal.

The first wave of the medical humanities can be seen to have subscribed to the same value system as orthodox medicine, presenting a 'tame' (Macneill 2011: 86) approach offering students 'soft' relaxation, celebratory supplement, or diversion from the 'hard' stuff of biomedical science and evidence-based clinical practice. For example, Geoffrey Rees (2010) notes that the medical humanities can be employed non-critically, serving medical dominance rather than used in an interventionist manner. Where the functional limit of the arts and humanities has been to nuance medical practice, rather than fundamentally critiquing such practice, the form of the arts and humanities drawn upon has, as noted, avoided the critical, and political, (liberal) avant-garde that Felix Guattari (1995: 106) describes as 'the incessant clash of the movement of art against established boundaries'.

To be cynical, examples of this uncritical first wave can be seen time after time as medical schools advertise their medical humanities wares with great gusto and pride, for this to be an elective programme attracting few students who write some (often bad) poetry or make some music as a diversion from core studies. This is then self-evaluated through a satisfaction score while self-selected students are still on a high. This is some way from the kind of hard-won, self-taught pedagogy of resistance that the 15-year-old adolescents model in Peter Weiss's (2005) novel *The Aesthetics of Resistance* as they grow up in the face of the Nazi regime committed to aesthetics as the framework for democracy.

What does the future hold for the medical humanities?

Where medicine aims for homeostasis or relief from symptom, it also aims to reduce uncertainty or is intolerant of ambiguity. However, medical practice is laced with uncertainty. Art, however, is tolerant of ambiguity. Indeed, the liberal avant-garde in particular aims to generate ambiguity and uncertainty in order to questions certainties, habits and conventions, or to promote social critique. Good medical practice implies not simply tolerance, but also connoisseurship, of conditions of uncertainty (Luther and Crandall 2011) and the arts are where expertise in such connoisseurship rests. Medicine must collaborate with the arts and humanities if only to reap the rewards of learning about tolerance of uncertainty and ambiguity, such as awareness of the cultural habit to repress or deny uncertainty that is also a symptom of the high rate of medical error.

The 1998 Windsor Conference (Phillip *et al.* 1999: 26), discussed in the previous chapter as a landmark occasion for the development of the medical humanities in the UK, linked a classic definition of the humanities, as 'the study of human nature and the practice of compassionate concern for the advancement of mankind's welfare', with 'the WHO definition of health' that described 'a balanced relationship of the body and mind and complete adjustment to the external environment'. 'Balanced' and 'complete adjustment' echo the utilitarian rhetoric of normative, idealistic wellbeing, failing to see that by denying and repressing the potential of illness things may get worse, where, as Freud suggested, the repressed returns in a distorted form.

Utilitarianism sees life's purpose as the pursuit of happiness and the greatest good for the greatest number of people. 'Life, liberty and the pursuit of happiness' are ideals embedded in the American Constitution and Declaration of Independence. That happiness is preferable to misery is held to be 'self evident'. The empiricist John Locke in 1693 wrote that 'the highest perfection of intellectual nature lies in a careful and constant pursuit of true and solid happiness' (Locke 1975: 2.21.51). Modern medicine, with its central notion of homeostasis, follows this philosophical position, but the arts and humanities in general tend to diverge, often wildly, from such a philosophy.

That the pursuit of happiness is always preferred to misery must be qualified as relative. Utilitarians describe the best possible state of happiness for the greatest number of people, but again, whose 'happiness' are we describing? One person's happiness – say, misogynist hip-hop, 'death metal' music or radical performance art, is another's pain or disgust. Masochists and sadists gain pleasure from receiving and inflicting pain. Himalayan mountaineering affords huge risks, but still attracts its devotees, including doctors. Giving birth and parenting are mixtures of pain and pleasure. Love may be the most beautiful pleasure but is always close to the pain of loss. Importantly, illness is a way into rich experiences that health denies. Further, notions of pain and pleasure change historically and culturally (Elias 2000).

Voltaire, Nietzsche and other philosophers of 'pessimism' disagree with utilitarianism and the optimism of philosophers such as Leibniz who see life as the 'best of all possible worlds'. This is not simply because they are

realists and accept the inevitability of human suffering, but because they recognize value in such suffering. Nietzsche (1984) articulated a philosophy of life from within his own illness, suggesting that suffering artists make sensitive diagnosticians of a suffering culture, a notion expanded by the philosopher Gilles Deleuze (1993; see also Smith 2005). Could Beethoven have composed the sublime late quartets without his deafness, or Chekhov have written such insightful literature without contracting tuberculosis that afforded empathy for the suffering of his patients? Importantly, Nietzsche, Beethoven and Chekhov did not invite or cultivate suffering, but turned misfortune into opportunity.

This philosophy of 'pathologizing' (Hillman 1992) does not square with Ken Calman's desire to set up a 'Department for Health and Happiness', where the function of art is to please and to heal rather than to challenge homeostasis for transgression, instability and education into tolerance of ambiguity and paradox as a permanent revolution, thus refreshing culture. The potential implications of this run deep – art can be anti-fascist in its desire to educate for tolerance of ambiguity, where intolerance of ambiguity is the mark of the authoritarian personality (Adorno *et al.* 1950), again combining the aesthetic with the political.

Where 'hospital' and 'hospitality' have the same root, Jacques Derrida (2000) notes the aporia, or puzzle, of hospitality – that those who provide hospitality must at the same time exert control over their household, thus providing a challenge as well as a welcome to visitors who cross the threshold. A hospital is an aporia, where healing and hospital-induced illness, such as 'avoidable' medical error and hospital-acquired infections, go hand in hand. Richard Cork's (2012) history of art in hospitals reveals a similar conundrum. While contemporary art in hospitals tends to be decorative and bland, certainly not challenging or upsetting, Cork shows that since the Renaissance art in hospitals had traditionally been shocking and challenging. It is only relatively recently that such art has become mundane. Art hung in hospitals, up to the time of Hogarth in eighteenth-century England, often included challenging motifs such as displaying symptoms suffered by patients, who would have to cathartically confront the reality of their conditions rather than be distracted or comforted by palliative images.

Belling (2010) refers to the more radical stream of thinking within the medical humanities exemplified by Wear and Aultman (2005), who show that exposing medical students to narrative approaches can produce discomfort, defensiveness and resistance to confronting political issues such as inequality and oppression. Students readily tolerate benign plots and characters in literature, where transgressive and challenging plots and characters at first produce resistance rather than empathy. This again offers a reminder of what is, arguably, the central purpose of art, certainly of the avant-garde – consciousness-raising through creating discomfort, challenge or ambiguity.

Such consciousness-raising is a three-step process: first, producing disruption through challenging habit; second, allowing typical patterns of resistance to emerge; and third, analysing such resistance to develop new awareness, as one suffers the uncertainty produced – as a resource rather than a hindrance. Belling concludes:

> Wear and Aultman articulate the limitations of treating [medical] humanities merely as a palatable reprieve from 'hard' work. They argue instead that we must attend to resistance, *even provoke it*, if [medical] humanities teaching is to promote critical inquiry as well as neutral reflection, where rigorous humanities teaching can develop an orientation toward uncertainty, knowledge, and action that characterizes the best physicians.
>
> (Belling 2010: 939; emphasis added)

Further, Alan Petersen and colleagues (2008) do not see the medical humanities as necessarily benign or liberating, but as affording an unintended form of governance, where the invitation to be 'humane' becomes a paradoxical imperative – 'you will be humane!', as in 'have a nice day!'

Some of the purported benefits of teaching medical humanities include: the promotion of patient-centred approaches to medical care; counteracting professional burnout; and equipping doctors to meet moral challenges not covered by biomedicine. In other words, the medical humanities are conventionally seen to redress a *deficit* in medicine: to act as a counterbalance to the relentless reductionism of the biomedical sciences – this, rather than reminding scientists of the aesthetic riches in their worlds. By contributing to the creation of a reflective practitioner who will exhibit empathic understanding of the patient, it is claimed (or simply assumed) that the medical humanities are necessarily good for doctors. While this sounds like good news, there is a dark side, an unintended consequence to the development of the medical humanities, where they may come to serve as a tool of governance. 'Governance' has multiple meanings with positive and negative connotations, but broadly refers to the process of steering or guiding others' or one's own conduct – in Foucault's succinct description 'the conduct of conduct'. Several questions arise from a more sceptical approach to the value of the medical humanities. For example:

1. Who is asking whom to be 'humane'?
2. What kinds of subjectivity are assumed and formed through the teaching of the medical humanities and are these welcome identity constructions?
3. What kinds of thinking and knowledge are produced by the medical humanities and how may these serve to guide action? For example, if the medical humanities are driven by the desire to 'humanize' individual practitioners, will this take our eye away from systemic failures

caused for example by poor management? Will we end up compensating structurally induced overwork and poor management with the arts and humanities?

4 How will unintended negative consequences of medical humanities interventions be noted, or indeed measured and evaluated?

The new subculture of resistance within the medical humanities culture briefly outlined above has several other foci, questioning assumptions of conventional and benign medical humanities approaches. For example, Johanna Shapiro (2011) warns against narrative medicine becoming inflated through smart textual approaches that question the authenticity or reliability of patients' stories. Shapiro then calls for 'narrative humility' from researchers. As noted in the close to the previous chapter, Claire Hooker and Estelle Noonan (2011) point to the medical humanities' largely unexamined western imperialistic tendencies, an observation that has been made about medical education in general (Bleakley *et al.* 2011). Again, Paul Macneill (2011) suggests that the arts and humanities employed in medical education are in danger of being brought into the service of a more powerful biomedical science and then tamed, as pleasant diversions for students rather than industrial strength tools for learning involving critique of reductive biomedical models.

However, what needs to be further developed is a focus upon a radical political project – that of democratizing medical culture. Democracy itself of course is a complex project. For example, Derrida *et al.* (2004) again points to the inherent paradoxes, aporias, contradictions, and ambiguities in the practices of democracy, preferring to imagine a 'democracy to come'. 'Shaping' such a horizon democracy is both an aesthetic and an ethical project (Weiss 2005). For Martha Nussbaum (2010) and Mark Slouka (2010), democracy generally is impossible without the arts and humanities, for these are the media that imaginatively allow us to educate for, and develop, the necessary and sufficient conditions for empathy, or tolerance of 'otherness', as a foundation to debate. As Slouka (*ibid.*) argues, 'the humanities are a superb delivery mechanism for what we might call democratic values'. The humanities diagnose social ills, such as unproductive authoritarian behaviour grounded in intolerance of ambiguity; and suggest cures, such as tolerance of difference through open debate and collaborative activities.

Following the detention of the internationally celebrated Chinese artist Ai Weiwei by Beijing police in April 2011, ostensibly for tax evasion but more likely as a consequence of persistent political dissidence through his art, *The Times* newspaper in London published responses from high-profile public figures as a collective open letter of protest to the Chinese government (O'Connell 2011). Sir Nicholas Serota, the Director of the Tate Gallery, observed in his response (*ibid.*) that:

> The health of a society is indicated, in part, by the freedom of its artists and writers to express their views without fear of suppression. Diversity of view generates creativity and occurs through meeting of opposing ideas, a respect for differing viewpoints and the expression of distinctive visions. A society that tolerates difference will remain creative as its values are challenged. A society that cannot accommodate points of view will stagnate and become an empty husk.

The first part of what Serota suggests – that the mark of 'health of a society' is its level of democracy – is familiar to proponents of 'open' societies (Popper 2002). The second part, however, is more radical – that it is particularly the work of artists that protects a liberal democracy. The philosopher Gilles Deleuze (1997), in his last work before his death – *Essays Critical and Clinical* – developed Nietzsche's cultural analysis to suggest that artists are physicians in another realm, as 'diagnosticians' and 'symptomatologists' of the body of culture (Smith 2005). Thus, perhaps artists are closer to doctors than we think.