ORIGINAL ARTICLE

Courses, content, and a student essay in medical humanities

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Two principled decisions underlay the introduction of the new compulsory medical humanities course. First, it was decided, all lecturers must be trained in the discipline; second, the course content must be relevant to medicine. This paper gives details of the content of eight selective courses. There is also an example of an essay by one of the students, Tiffany Suk. Entitled "Two patients in two rooms with two choices and two ends", it is a brief analysis and critique of Sylvia Plath's poems *Tulips* and *Contusion*. It shows how the student took what she had learned from her course in health psychology to further illuminate the poems. The essay is followed by comments from the lecturer, Anna Jackson, giving the context for the essay and her assessment of it.

In implementing a new compulsory course in medical humanities two fundamental decisions were taken. The first was the necessity for papers to be taught by lecturers trained in the basic discipline. The second was the necessity for papers to examine content related to medicine. Both decisions were contentious, with medical faculty wishing to "leave the door open" for their colleagues to teach in the new courses, and arts faculty being unsure about the extent to which the medical faculty should prescribe content.

For some, the most important decision was the one taken to invite only lecturers who were trained in the discipline. There was to be no place on the teaching staff for medical practitioners who had, for example, "always enjoyed history". Unless they had an additional *academic* qualification in the discipline of interest they would not be eligible to teach.

The argument underlying the second decision (about content) also seemed at base a simple, even moral, issue. If students, their families, their teachers and the wider community were all working towards the optimal training and development of medical practitioners, there could be little justification for offering classes that could be construed merely as hobby classes. The argument that simply producing a more rounded individual was in itself enough reason to include the humanities was seen as insufficiently persuasive to justify the introduction of a compulsory course. Hence it was deemed all courses should aim to provide content relevant to medicine and thus have, and be seen to have, the potential to result in improved patient care.

These principles, requiring close attention by lecturers planning the courses, laid the groundwork for a measure of integration. Like others we preferred to think of the medical humanities as being integrated into the medical enterprise rather than being seen as simply another add-on.²

COURSE DETAILS

In the year 2000, the following courses were offered. The list gives the discipline first, then the title of the course. This is followed by a brief description of course content and finally, in parenthesis, by an example of an essay title, some of which were student-initiated and some of which were set by the lecturer.

Art history: contemporary artists' perceptions of the body

The course introduces contemporary art by artists concerned with issues related to the body: from the "Carnal Art" of Orlan, and Stelarc's conviction that the body is "obsolete", to investigations of the medical gaze in Orshi Drozdik's work, and of the Human Genome Project by artists concerned about its implications. A discussion of such issues as the construction of gender and identity, and the fetishisation of the prosthesis in recent film and video work will be contextualised within an overview of the major shifts in art practice from the 1960s.

(Example: student essay: "Analysis of how the body is articulated in David Cronenberg's *Crash*").

Classics: Latin in medicine

This course shows why a knowledge of Latin is still very useful for medical students and practitioners. It covers the historical background to the use of Latin in medicine and will examine Latin words and roots in modern terminology (especially anatomical). In addition, in each two-hour session time is spent on an author who made an important contribution to terminology. For example, we discuss Celsus and the terminology of surface and planes, Pliny the Elder and cardiovascular terminology and Galen's terminology for the gastrointestinal system.

(Example: set student essay: "Why is the official anatomical terminology in Latin?")

English: medicine in literature

The course considers novels, short stories, poetry, and non-fiction to show how writers have treated illness, pain, disability, birth, death and dying and how the skilled

Author's note: This paper is one of a linked pair of articles about making medical humanities a core part of the medical curriculum. The other paper includes an account of the professional and academic rationale that led to this decision and the process by which it was implemented.¹

imaginative exploration of these subjects increases understanding of the human condition, especially of human suffering, and contributes to compassionate patient care. The focus is on the experience both of patients and of those who care for them.

(Example: set student essay: “Examine the relationship between mind and body in Oliver Sacks’s *The Man Who Mistook His Wife for a Hat* and Elaine Showalter’s *Hystories*”).

History: case studies in medical history

Our understanding of contemporary events needs to be informed by examining the past. Since the 1970s there has been a growing awareness that medical history provides an insight into many fundamentals of human society and development. This course offers an introduction to the social history of medicine, with an emphasis on New Zealand. Seminars provide an opportunity for discussion and interpretation of historical documents such as patient case notes, medical journals, official reports and photographic or other illustrations. Topics covered include immunisation, mental health, health education and the transfer of technology.

(Example: student essay: “To what extent did service overseas shape the future careers of New Zealand doctors?”).

Law: legal issues in medicine

The course consists of an introduction to the role of law in relation to medicine, with emphasis on the following key areas: confidentiality and privacy of information; consent to treatment; the new code of health and disability services; consumers’ rights; criminal liability of doctors; civil liability for medical malpractice, and medical discipline and legal issues in rationing health services.

(Example: student essay: “The meaning of accountability in relation to privately funded and publicly funded health care”).

Philosophy: quotidian ethics in medical settings

This paper provides the opportunity to discuss topics in everyday ethics. Topics include humour, gossip, duties to aged parents, charity and friendship, eating meat, adultery, and smoking.

(Example: set student essay: “As adults, are we obliged to look after our parents in old age?”)

Political studies: politics of health care delivery

This course examines the factors that influence the politics of health in New Zealand. We look at the key players in health policy and the institutions which shape their activities. The course also examines the politics of health sector reform, and looks at how New Zealand health policies compare with similar countries.

(Example: student essay: “The overhaul: an insight into the 1993 health reforms”).

Sociology: social issues in medicine and health care

This course focuses on understanding how and why social processes and contexts can influence medical practice, the provision of patient care, and the experience of illness. Through a case study approach, the paper examines such issues as HIV/AIDS; therapeutic drugs and the pharmaceutical industry; emerging health care technologies; physicians working in health care teams, and patient attitudes and behaviour.

(Example: set student essay: “The medicalisation of society has seen a shift of medicine into the lives of the healthy. This has had profound influences on societal norms and the basis of one’s self-identity. Discuss.”)

The final selection of disciplines included in the first compulsory year was made partly on lecturer availability. In future years we might look to include a course from the faculty of theology on the history of the church’s contribution

to the care of the sick, or a course from anthropology on cultural variations in attitudes to illness.

The integration of medical humanities into the medical curriculum was a goal that foundational staff worked towards from the beginning. Nevertheless the extent to which students themselves worked on the integration of material was a surprise. Perhaps it should not have been. As Tiffany Suk describes in her essay, books from all the different disciplines lay around her on the floor. Further, she reported, as a preclinical student she felt an urge to make some constructive use of the material from health psychology which as yet, she had not had the opportunity to use in a practical setting.

But there may have been more to it than that. This student, as well as a few others who produced comparable work in the other humanities papers, may have achieved some satisfaction in being able to integrate some of their apparently disparate material, fragmentation often being perceived as a negative quality in professional courses where there is little time to cover topics in depth. Putting the material together in a new and interesting way may have brought intrinsic rewards for the students as well as satisfaction for the staff.

THE STUDENT’S ESSAY

Two patients in two rooms with two choices and two ends

Sprawled around me, I consider the shape of my world—the practical and the abstract entangled with each other. My anatomy text lies open waiting for another study session. On top of those anatomical words, words written with a different passion have been discarded. These are the words of Plath.

Medical school seems to offer two types of papers: the obviously needed and the merely common sense. Papers such as “Lifespan development” and “Health promotion and communications” reduce half the class to playing tic-tac-toe with their neighbour and the other half to catching up on sleep they were deprived of the night before with their study of “real medicine”. Anatomy and even Biochemistry seem relevant to our training as future health professionals. But learning about people’s emotions and body language? As if we didn’t have more “time worthy” objectives to be achieved! One has only to step into the library to feel the swarthy thickness of stress descending on dwindling time. The incessant plea seems to be: “Just give me one more hour to learn the concepts of ventilating the lungs—I know I’ll be a good doctor then”.

It was in this frame of mind I began to think about my English essay. What relevance does poetry analysis have in my life now? This was surely the stuff of freer days. Somewhere between before medicine and now, I had undergone a transition. I had once scoffed at the importance of chemistry, choosing to practise handstands in the back of the classroom and devote more passion to Shakespeare and Socrates. My conception then was that real people embraced the finer arts. It surprised me, therefore, to find I no longer looked upon those volumes with such esteem—that I placed a higher importance on my new volumes of scientific mass. It seemed blasphemous for the two worlds to cross. I believed it was “all for medicine” or “all for the arts”. I chose medicine, and my disdain for any fluff increased.

However, I met two future patients in a place I would not have thought to look before. One had a contusion and the other was brought tulips, and both took my eyes away from the microscope of biochemical pathways to the telescope that revealed what health and sickness really mean. Poetry became a window to the emotions of the ill.

In both *Contusion* and *Tulips*, the patients view sickness as being vulnerable to fate. Sea imagery is used to illustrate this. The sea is volatile, unpredictable and too strong a natural force for the human will to battle with. The patient with the contusion felt the “sea suck[s] obsessively”, portraying a feeling one can imagine in a patient battling a formidable disease like

cancer. Cancer cells multiply exponentially. To feel a sense of control over rapidly increasing numbers would be hard to do. It would be easier to submit to the opposing forces for a period such as the patient in *Tulips* had done: “I have let things slip, a thirty-year-old cargo boat”.

Research has shown, however, that people who develop “learned helplessness” or sense no control are more prone to illness and recover more slowly.³ The contusion patient reaches this point. She accepts the “doom mark” that “crawls down the wall”, and like the wall, this state entraps her. The clipped shortness of the lines in this poem conveys a weaning of energy as the patient accepts impending death. Acceptance is seen as one of the last stages of dying.⁴

In contrast, the rhythm and verses in *Tulips*, although slow and laboured with commas and regular full-stops, is still continuous. It is as if the heart is continuously struggling to beat. The patient with the tulips is restored to health when her “stupid pupils” see the “dangerous animals” in the flowers, reminding her of the potential power in a healthy life. So as the tulips’ “redness talks to [her] wound” and her heart corresponds, a decision to possess the will to become healthy manifests itself. The words used in this poem are more optimistic than in *Contusion*. For example, where the “heart shuts” in *Contusion*, the “heart opens and closes” in *Tulips*. It is as if finality in the *Contusion* patient were already decided. It made me realise that my practical training may amend physical ailments, but the emotions and the mentality of the patient will often push the verdict in one way alone. Two patients lay in two rooms with two choices and two ends.

I felt that medical school had almost drilled the patient as a person out of sight and replaced it with floating organ systems and mechanisms occurring in cells without faces. It became more understandable to me how this sense of lost identity could spiral in a patient. To be healthy is to have an identity. The “husband and the child smiling out of the family photo” had faces, as they were healthy people. However, sickness in the patient with the tulips forces her to give her “name and ... day-clothes up to the nurses”. She states: “I have lost myself ... I have no face”. The sense of lost identity is also seen in the contusion patient as “the mirrors are sheeted” and can therefore no longer reflect a person’s face. When identity is lost, the confusion from being ill is compounded. Confusion over identity can hamper a person’s sense of wellbeing, making existing problems more magnified in a person’s mind.⁵ This state is not conducive to health or to self esteem which often builds health. “I see myself, flat, ridiculous, a cut-paper shadow”. There is no strength in paper shadows, and strength can often be lacking in patients.

This feeling was further developed in the patient with the tulips as she became an object having things done to her. “I have given ... my history to the anaesthetist and my body to surgeons.” Being in this position could heighten the vulnerability felt by patients, as the doctor-patient power balance becomes more distinct. It reminded me of something a surgeon once told our class. He said something along the lines of: “Sometimes, there is not much a doctor can do for his patient. And the patient will be afraid. All you can do is offer your friendship to the patient, and give them the reassurance that you are accessible to them at anytime.” (P Alley, personal communication, September 1999) Had this principle been applied in the hospital of the *Tulips* patient, the sense of such detachment of the patient as a person from the medical world may not have been present.

Loneliness is not a far away feeling in illness. David Elkind called this the “personal fable” stage, where people feel their circumstances and emotions are beyond others’ understanding.⁶ The contusion patient feels this sense of isolation. Plath illustrates this with images of pits of rocks, accessible to nothing but the enemy forces such as the obsessively sucking sea. The loneliness in the *Tulips* patient seems to be sought, as she “only wanted to lie with ... Hands turned up

and be utterly empty”. And yet she did seemingly have social support in the form of her family. Although insignificant in the recovery of this patient, social support, none the less, is beneficial in handling illness.⁷

Running recurrently through both poems is the theme of “purification”. White is symbolic of purity, and this colour is associated with sickness and death: “Look how white everything is ... I have never been so pure”. The body of the contused patient is the “color of pearl”. This idea that illness could be synonymous with purity seems counterintuitive, as the earlier centuries viewed sickness as a form of punishment for wickedness and the medical world today sees attacks from antigens (foreign substances) as being responsible for disruption to health. However, in the mentality of a patient, illness could be seen as an avenue to a new person. The patients rely on doctors to make them better, to make them different from their old selves. In *Tulips*, the patient sees her sickness as freedom from her life, and finds peacefulness because death seems to “ask nothing” compared to life. Plath draws on the religious symbolism of cleansing as she states: “It is what the dead close on, finally; I imagine them shutting their mouths on it, like a Communion tablet”.

It is this idea of death of the old bringing a nun-like purity that may draw patients who are weary of fighting the struggles of life to allow illness and eventually death to ravage its course. Jesus told Nicodemus that he must be born again in order to be pure and live.⁸ As *Tulips* pivots into concentration of life and health after the Communion tablet, the image of “an awful baby” in “white swaddlings” is brought into view. It is as if the transformation is complete. Like the broken body of Jesus represented by the Communion tablet bringing life, this patient’s broken body from illness had made regaining life possible for her.

Colours are used symbolically to contrast life and death. The patient watches for the “dull purple” in *Contusions* and “red” for life in *Tulips*. The medical world, too, watches for these colours. The dull purple shows a patient to be haemorrhaging and the blue it is associated with indicates the border of death through cyanosis. Doctors look for red to indicate a healthy circulation in a baby and wait upon red to replace the pallor of shocked patients. Red is the colour of blood, which circulates through the heart. The heart “opens and closes / Its bowl of red blooms out of sheer love of me” in *Tulips*. This shows that the colours of emotions associated with wellbeing are not far from the scientific world. I can imagine the excitement a doctor must feel as signs of returning life appear, but *Tulips* has also reminded me that health does not come in one miraculous leap. It comes “from a country far away”, and I believe it must be our responsibility as future doctors to help patients taste the “water ... warm and salt” and wait for their arrival in that country.

I still place great importance in physiology and knowing the course of nerves in the body. But as I lay down the poems this time, the thought begins to dawn on me that perhaps poetry and medicine are not such disparate worlds. That in order to be a good doctor, in order to be a real doctor fulfilling the missions of the Hippocratic oath, one has to look as one does in poetry to discover the patient who lies in front of you. It is only when we see the patient as a person with fears and emotions that health goes beyond the definition of a lack of physical ailments to the “complete wellbeing” defined by the *Ottawa Charter*.⁹ Some patients will die, as in *Contusions* and some will slowly recover as in *Tulips*, but what a tragedy it is if doctors do not care enough to try and understand. Hard science had become empathy at last.

THE LECTURER’S PERSPECTIVE

Teaching the English selective in the medical humanities curriculum, I was adamant that the students shouldn’t simply look *through* the discipline, and through the texts, to the

“understanding of the human condition” or the “critical analysis of ideas” or even through to a more subjective, more poetic understanding of the viewpoint of the patient as a human being. I wanted English to be recognised by the students as a discipline, and for them to learn to work within the discipline.

The course focused on six writers, two each from the genres of poetry, fiction, and non-fiction, all concerned in one way or another with writing about the body, about illness and health, the relationship between the body and the mind, between the patient and practitioner. Before we examined these themes, however, I wanted the students to have a grounding in the practice of close analysis, both of poetry and prose poetics, as a basis for thematic interpretation. I introduced them too to the history of new criticism, the development of English as a discipline, and the historical basis of the discipline as it is practised and taught today.

The medical students turned out to have their own interests, which also affected the direction of the course. As a class they shared a strong interest in theoretical issues, in particular in issues of authorship, interpretation and authority, so I adapted the course to allow us to explore some of these issues together. By the time students came to write about the kind of themes that would allow them to explore issues about the body and the doctor/patient relationship, they were approaching the texts with a critical sophistication and understanding of the text as text. I hope this will continue to inflect their “critical analysis of ideas” not only in the literary texts they read for the course but in a range of texts they will encounter as doctors, and as readers.

One of the questions I set for the students’ main assignment was to consider the relationship between sickness and health, patient and medical practitioner, in the poetry of Sylvia Plath. When, as a class, we had looked at various theoretical approaches to issues of authorship and authority, Tiffany Suk had been particularly interested in some of the examples of autobiographical criticism, in which critics theorise from the basis of—and about—their own reading experiences. Now she asked whether she could use this autobiographical criticism as a model for her own writing. I agreed, but I had reservations; I was worried she might tell me more about herself than about the poetry she was supposed to discuss.

Of course, I needn’t have worried. Tiffany Suk’s essay, *Two Patients in Two Rooms with Two Choices and Two Ends*, succeeds in illuminating Plath’s poetry through her close attention to the nuances of individual words and the cadences of phrases, and

her attention to Plath’s sea imagery builds on the close analysis work practised in class. It is in placing this textual work alongside her discussion of research with which she is familiar from her medical studies, such as the research on “learned helplessness”, however, that lifts the essay beyond the class exercises. Both Plath’s poetry and the concept of “learned helplessness” come sharply into focus as a result.

Tiffany has in fact succeeded in integrating the kind of range of approaches and materials that I hoped only to place in front of the students for consideration, through her decision to write from an autobiographical perspective. Moreover, the personal context in which she sets her analysis gives essay a real freshness, as well as adding to the richness of analysis. It adds to my own understanding of Plath’s work, to have this very precisely articulated sense of what it means to one reader, in relation to her study programme as a medical student.

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T Suk, T Suk was a second-year medical student in 2000 when she wrote her essay, “Two Patients in Two Rooms with Two Choices and Two Ends”.

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