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'Developing the medical humanities'– report of a research colloquium, and collected abstracts of papers

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A research colloquium, sponsored jointly by the University of Wales and the Nuffield Trust, took place at Gregynog Hall, Powys, during early May 2001. The purpose of the meeting was to provide the opportunity for an intensive exploration of how the medical humanities could, as a recently emerging field of inquiry, best be developed into a worthwhile area of university-based teaching and research. The invited participants, primarily from United Kingdom universities but with a significant delegation of academics from Finland as well as individual thinkers from outside the university system, met to consider practical, methodological and theoretical or philosophical questions about the nature, scope and prospects of medical humanities as an academic undertaking.

This was the second meeting of this kind, the first having led directly to the publication of the first post-introductory volume of papers from the current medical humanities movement[1] and, indirectly, to the founding of this journal.

In this year's meeting, most research contributions concerned educational matters including whether there could be a "core curriculum" for medical humanities and whether medical humanities should be considered as belonging to the core of medical education.

Other questions included the nature of the relationship between humanities, healthy communities and the social goods supporting wellbeing; the problem of detached bureaucratic regulation of practice, and how it and its fixation with numerical measurement may best be understood and dealt with, and the nature and explanatory possibilities of the relationship between the metaphors used by patients and practitioners in the clinical consultation.

Abstracts of these presentations follow.

The Medical Humanities as part of the 'core' curriculum

JANE MACNAUGHTON

The General Medical Council's (GMC) 1993 guidance document, *Tomorrow's Doctors*, set out the principle that the undergraduate medical curriculum should include material that was either of "core" relevance to the creation of a generic doctor, or that would be of educational benefit to the developing person intending to become a doctor.[2] Currently most arts–and humanities–based teaching falls into the second category. Should we, however, consider medical humanities as a core subject? If so, what might the content of that core be?

These questions of course beg an important prior question: what do we mean when we talk of the "medical humanities". Do they constitute a core subject (or subjects)? Currently in undergraduate medical education, medical humanities comprises a range of subjects, whose inclusion in courses is justified in two main ways. First, a humanities course which has no direct relevance to medicine may be justified on the basis of general educational benefit to that individual student. Second, and more common, courses (typically literature) may be laid on by interested doctors, where students are asked to consider the application of what they are reading to medical practice and to their own developing approach to that practice. This second approach is justified on the basis that the humanities can provide understanding and insights into the experiences of individuals, either as doctors or as patients, which may be more helpful than the more conventional study of psychology. A third and more radical approach is that characterised as "integrated" by Greaves who envisages an interdisciplinary study within which students unify their scientific knowledge and understanding with humane knowledge and understanding, thus leading on to good medical practice.[3] The "discipline" of medical humanities is, therefore, defined not by the content of its knowledge-base but by its aim. Therefore one might envisage medical humanities "departments" which include a wide range of disciplinary interests, among them literature, philosophy, history, ethics, history of science, and perhaps law. Such departments might then become responsible for the delivery of a core part of the curriculum.

Tomorrow's Doctors defines the "core" curriculum in this way: " . . . the requirements that must be satisfied before a newly qualified doctor can assume the responsibilities of a pre-registration house officer".[4] Medical humanities departments or courses (within this integrated model) could deliver a number of the objectives listed by the GMC under the three domains of *knowledge*, *skills* and *attitudes*. "Knowledge" could include discovery of how knowledge is acquired, particularly that concerning human relationships and ethical and legal issues. Under "skills", philosophical training

could be important for acquiring basic clinical method. Most objectives listed under "attitudes" fall within the remit of a medical humanities approach; in particular, future doctors' development of critical self awareness. Many medical courses in the UK run core modules which tackle these objectives, often under the banner of personal and professional development. Curricula might benefit from these more difficult educational objectives being brought under the remit of a coherent, albeit multidisciplinary, group.

Philosophy for medical students–why, what and how?

PEKKA LOUHIALA

Philosophers do not agree about the nature of philosophy and–perhaps surprisingly–it is not wholly obvious what medicine itself is. One of the aims of medical education is of course to produce good practitioners. However, since medical schools are situated in universities the curriculum should also concern some elements of critical thinking, of which one source has traditionally been philosophy. This paper presents one view concerning the role of philosophy in medical education, based on personal experiences as both a student and a teacher of philosophy within a faculty of medicine.

Why should philosophy be included at all, and what should its taught content be? Obviously these questions are interdependent. Not only can philosophy provide tools for critical evaluation of a discipline; it can also work on the personal level, helping the student to live with uncertainty, itself a crucial element of medicine in both theory and practice.

The role of philosophy is to ask questions where, often, no obvious answers are available; yet the questions remain important. The role of philosophy in medical education may therefore be described as "asking questions about the questions medicine itself asks". Or, in slightly different terms: "The main purpose of philosophy is the critical evaluation of assumptions and arguments". Thus it could be said that a philosophical *attitude* is more important than a philosophical theory.

How should such an attitude be cultivated? It is clear that traditional lectures on traditional questions in philosophy is not the right way. Whatever form the teaching takes, the content must be linked to medicine. Academic "philosophy of medicine" is often too theoretical to be included as such in a compulsory curriculum, since complex discussions on concepts of health and disease may not motivate students. This paper argues for starting from the clinical experience of the students themselves. For example, students may be asked: "What is held in common by the diagnoses of pneumonia, hypertension, fibromyalgia, depresssion, hypomania and schizophrenia". That there is no simple right answer to the question illustrates how philosophical questions arise in daily medical practice.

Ideally philosophy would not be taught separately, but would be fully integrated into the medical curriculum. Since multiple philosophical issues arise directly and simultaneously from typical medical practice, the ideal time and place to encounter them is within that same daily practice. Problem-based learning (PBL) is also a natural way to locate not only the strictly "medical" but also the philosophical questions the cases themselves generate. Technically such a fully integrated approach is very difficult to create and sustain, and would require the constant availability of teachers with expertise on philosophical issues in medicine.

The role of history in the medical humanities

ANNE BORSAY

Though medicine and history sit on opposite sides of the science/arts divide, this paper argues that they have much in common. Both disciplines are indebted to the rationalism of the Enlightenment which, from the seventeenth century, underpinned Britain's evolution into a modern society. Only in the 1970s was there a loss of confidence in the rational society planned by experts such as health care practitioners. Postmodernism celebrated the collapse of reason and advocated moral relativism in place of objective truth. In a liberal democracy, there are ways out of this intellectual bankruptcy that respect divergent opinions framed with reference to rational rules of engagement. But this pluralist ethos suggests that traditional notions of medical authority are difficult to sustain.

Medical history has an important part to play in adapting to this new professional environment. Doctors have long used the past as a recreational activity. During the 1960s, however, a critical historiography emerged, in which the social history of medicine was urged to derive its agenda from contemporary problems. There are occasions when medical history is of direct relevance to medical practice, but history never repeats itself and so the past is better consulted to enhance understandings of the present than trawled for answers to its dilemmas. Since the mid-1970s, the conceptual apparatus for this more ambitious utility has been promoted, relating medicine to political and economic conditions, social structures, and cultural systems.

The professional reflexivity that this societal context nurtures enables individuals to build their own personae as ascribed roots of identity weaken. History's contribution to this process is illustrated by the diary of an eighteenth-century general practitioner called Richard Kay, in which he described performing a mastectomy on a patient called Mrs Driver without conveying to the reader of the diary that anaesthetic was unavailable.[5] We should not construe Kay as callously indifferent to pain, nor ridicule his techniques. Rather, we should use his words to demonstrate the transitory nature of medicine and the necessity of its contextualisation. Mrs Driver was not a passive object of clinical intervention living in a vacuum; she sought the surgeon's knife. Her decision may have been influenced by family and friends, by socioeconomic sta-

tus, by the treatments available. But in requesting Richard Kay's services she exercised power. The exclusion of her pain from his narrative highlights the psychological distance that may emerge in all professional relationships. And by drawing attention to such issues, history can encourage productive reflection about today's practice.

In response to this example, we may consider the relative shortage of sources depicting patient perspectives, and the extent of any scope for compensating with literary accounts. We must also note the methodological difficulties of reaching general conclusions from fragmentary evidence of any kind, together with the need to avoid heroic stories of progress when assessing past practices. Interdisciplinarity–and the creative synergy that it, as opposed to multidisciplinarity, released–should be recognised as a defence against such easy assumptions in all the medical humanities. Finally we should acknowledge that both history and medicine are inextricably linked to the political values of their practitioners.

Reverence and the dissecting room

BERNARD MOXHAM

In recent years, significant changes in medical education have particularly affected the teaching of human topographical anatomy. From all available experience and from the published literature it seems clear that, for the acquisition of the requisite and clinically relevant anatomical facts, there is no preferred method of teaching and student learning. However, it is also clear that many skills are developed through teaching in the dissecting room. In particular, it is easier to develop student-directed learning, to provide project-based learning, to acquire the skills of teamwork and of following complicated, medically related instructions; moreover it provides the oft-quoted opportunity for developing aspects of manual dexterity, pattern recognition (via an appreciation of the 3-D understanding of human anatomy), and an appreciation of biological/anatomical variation.

Increasingly, it is being recognised that the opportunity exists also to use the dissecting room experience to introduce medical students to issues relating to mortality. For many of today's students, the acquaintance with human cadavers will be their first experience of death. This experience, if mishandled, could be dehumanising. However, it is possible to develop strategies to make this a positive experience. Beyond the anatomy course, it might be advantageous to provide appropriate classes in sociology, psychology, ethics, or medical humanities on the subject of death just before, or at the same time as, the introduction to anatomy. Much can also be accomplished within the anatomy course itself. For example, lectures on the issues (introduced via the history of anatomy and through medicolegal matters relating to body bequest), the use of questionnaires to assess the reactions of students to the dissection room and to death, project-based learning that emphasises through the history of disease found in the cadaver that this was a living human being, and participation by students in a memorial service where they might give expression to their feelings, can all contribute positively for many students.

That this is of fundamental importance relates not just to the provision of discipline and good behaviour in the dissecting room, to the encouragement of reverence for the cadaver and for the person who bequeathed his/her body, and to the understanding that medicine frequently deals with the dying but also, by enabling the student to come to terms with his/her own mortality, to helping the development of the student into a mature and caring professional.

Social capital and health in rural Wales.

VICTORIA MORGAN AND RAY PAHL

The importance of "social capital" for health is recognised by government but there is disagreement among academics as to how it should be put into operation. Studies funded by the erstwhile Health Education Authority provide a useful start. One study suggested that the "civic engagement" approach of Putnam and others is less significant than a focus on small, informal groups of friends and relatives.[6] The importance of friends in particular seems to have been underestimated in the analysis of social support and health.

This paper reports Pahl's recently completed project concerning the importance and significance of personal communities and how they might be classified in terms of fragility or robustness. It recalls the classic study by Alwyn Rees, carried out in north Montgomeryshire over 50 years ago, which provided a bench-mark for rural change.[7] A repeat study of the same village is planned for publication, and has led to the formation of a group focusing more directly on health, and incorporating new thinking about social capital.

The paper goes on to outline a scheme being developed at the Rural Health Institute under the heading of New Rural Futures for Wales. The foot-and-mouth disease epidemic has given a new urgency to issues of social cohesion, social support and health, particularly, perhaps, mental health. Rees's study made much of "a sense of belonging" in his *Epilogue to Life in a Welsh Countryside*, but indicated that much of the strength of rural community life was then in decline.[7] How far, then, do social support and robust personal communities vary between rural communities, differentiated according to economic, geographical, demographic and other criteria? The paper proposes an interinstitutional and interdisciplinary programme of study combining geographers, sociologists and health specialists. There is no agreement as to the dominant distinctive qualities in Welsh rural life: those which promote good health and wellbeing, must be considered in the light of an emerging fatalism in the male farming community. The current crisis in the rural community could, however, lead to an empowering of rural women in farming areas. In summary the paper asks: can the example

of rural Wales provide help in understanding the nature and significance of "social glue".

Friends in Low Places

JAMES WILLIS

The fact that medicine and humanity are intimately linked is axiomatic, yet it seems that one must discuss "medical *humanity*" as though it were a new idea. By contrast, medical in humanity–the mechanisation, systematisation and regulation of medicine–has become so established that the idea of holding a conference to justify it would seem absurd.

Yet the people required to implement that mechanisation and systematisation, the people in "Low Places", of whom individual medical practitioners are one example, have daily, incessant difficulty with the validity of the inhuman approach. The difficulty, however, is that they can also can see the other side. When circumstances are right they, too, feel the pull of the measurable, the attraction of the absolute, the safety and certainty of scientific evidence, as strongly as anybody else. We all operate as if in "High Places" at times, and we all operate as if in "Low Places" at others. We all live in the two worlds, and struggle to reconcile the two views, which regard each other as incomprehensible.

This paper, developing a theme in *Friends in Low Places*,[8] describes a sabbatical from general practice spent trying to explain this mystery of the relationship between structure and freedom, itself leading to that between reality and artificial models of reality, and in turn to that between artificial models of reality and mental models of reality. The conclusion is radical; the difference in each case is not quantitative but qualitative.

Not all good things in life can be reconciled. Life is not a simultaneous equation with a single solution. It consists of indefinitely many incompatible truths. The mainstream, which ordains the mechanisms and systems of practice, must confront this; those of us in "Low Places" must no longer appease the mechanistic illusion.

We can no more measure medical humanities than we can a sunrise, but without both, the most evidence-based medicine in the world will never be sufficient.

Medicine and the humanities–theoretical and methodological issues

RAIMO PUUSTINEN, MIKAEL LEIMAN AND ANNA-MARIA VILJANEN

The central theoretical demarcation in modern medicine seems to lie in the issue between reductionism and holism. The reductionist approach in medicine attempts to explain human illness through physiochemical concepts, whereas the advocates of holism have tried to include social and cultural issues as well as personal experience in medical theory. Perhaps the theoretically most ambitious and influential attempts to develop current medical theory to correspond better to human experience are Engel's biopsychosocial model,[9] Cassel's introduction of the concept, "person", into medical theory[10] and Pellegrino's proposal that philosophy of medicine be seen as a form of human activity.[11]

Engel's biopsychosocial model suggests that we need to increase the number of variables which should be taken into account in medical practice. For Cassel the core of medicine resides in the doctor-patient interaction, where the physician should approach the patient as a person instead of merely a biological phenomenon. Pellegrino has proposed that medicine needs to be seen as a form of human activity in which cure may take place. A philosophy of medicine should, therefore, be developed *from* the practice of medicine itself.

A common feature for all three approaches is their aim of widening medical theory from its current biological basis to incorporate humanistic and sociocultural issues into medical thinking. To achieve this goal they propose that humanities and social sciences need to be included in medical education. Humanities are seen as the tool by which the physician is able to enlarge his or her understanding of the human condition and the personal uniqueness of the patient. The authors choose to be eclectic in their philosophy and they draw their notions mainly from empiricism and phenomenology.

If medicine is seen as a form of human activity, as Pellegrino suggests, we may ask (1) how can medicine been examined *as an activity*, (2) what consequences does this have for medical theory, and (3) what is the role of the humanities in this approach.

Viewing medicine as an activity requires our joint consideration of subject, tools, target and the sociocultural context, asking: who is doing what to whom, and where? This analysis benefits from using historical, linguistic, anthropological and semiotic tools. Literature studies and anthropological writings provide material for analysing the various forms of medical, as well as other, healing practices. Humanities are, therefore, both theoretically and methodologically intrinsic to the analysis itself.

Different medical specialties tend to differ regarding their understanding of the agency involved in the process. For instance, for a surgeon the target may be the patient's herniated intervertebral disc, while for a psychiatrist the target may be the patient's anxiety and depression which complicates his/her recovery from low-back pain. Thus the structure of the medical alliance appears quite different, depending on the understanding of the target and of the tools applied in the healing process.

Approaching medicine as a form of human activity in a certain sociocultural context may offer us new possibilities of developing a philosophy of medicine where medicine stands as a discipline in its own right.

Integrative medical humanities teaching in the medical curriculum: a proposal

MARTYN EVANS

This paper presents the rationale for, and an outline of, a proposed two-year core module in medical humanities, to be pursued as an integral part of a

medical curriculum. It is formed in terms of contributing to the first two years of a four-year graduate entry medical curriculum, but it could be adapted to other forms of medical curriculum.

The integrative approach to the medical humanities indicates a number of educational aims, of which some are explicitly or implicitly anticipated in the General Medical Council's 1993 paper *Tomorrow's Doctors*.[2] The proposed module and its syllabus are designed to support a set of "learning outcomes" which express these aims as follows: an appreciation of the human dimension of medical practice, especially seen in the experiences of patients and practitioners; a sensitive awareness of the ethical issues arising in medical practice and research; the identification, exploration and sustaining of the student's own personal values, bringing them to bear on the student's conception of his or her own clinical practice, and–perhaps most distinctively–the recognition and appreciation of both the scientific and the experiential "mystery" of embodied human nature. Further consideration remains to be given to how such learning outcomes could best be assured. There is widespread current agreement that neither medicine nor the medical humanities will be served by imposing inappropriate further assessment burdens upon an already crowded curriculum. Project and "journal" work may be an appropriate medium for amplifying participation and discussion assessments.

The proposed module would *not* be distributed among discrete "contributor" humanites disciplines, and emphatically would not attempt exhaustive coverage of any of them. Rather the syllabus would bring a primarily interdisciplinary set of perspectives to bear on a range of experiences and phenomena within scientific clinical medicine. Having said this, it is still possible to identify disciplinary perspectives which would be represented in, and would drive the conception of, the proposed syllabus. These perspectives would include studies of a range of literary forms; history of medicine; philosophy and ethics; medical anthropology and sociology; psychology, and theology.

The resulting syllabus is proposed in the form of broad topic groups, which are centred around groups of questions and ideas, as follows. "*The embodied human*" seeks to describe and understand embodied human nature from scientific, ethical and other humanities perspectives on human nature and experience. "*Situating science*" concerns features of scientific explanation, appreciating that scientific perspectives take their place among other legitimate and valuable ways of attending to human nature and the human body. "*Ways of seeing*" attends to the relation between disciplinary perspectives upon the world and the nature and identity of the objects a perspective discloses. "*The patient as object and subject*" takes seriously the phenomenon of a scientific "object" with its own point of view, and the theoretical, practical and ethical challenges to which this "object" necessarily gives rise (as for instance in defining the relationship between quantitative and qualitative research). Finally "*Human stories*" considers the way that the range of human values is expressed in stories, recognising the range of sources of what have come to be termed "narratives", and how they are said to be used diagnostically and therapeutically.

Medical humanities and cautionary tales

STEPHEN PATTISON

This paper provides a normative vision of medical humanities (MH). It then examines some of the problems into which MH may fall if they define themselves too narrowly, using health care ethics as a foil for analysis of the evolution of new movements in medical education. Medical humanities should be a loose coalition of concerns, people, disciplines, approaches and methods that are engaged in a fairly open-ended dialogue and exploration of where humanities approaches can be illuminative (or even obstructive) to, and in, health and health care. A humane contribution to the humanisation of health and health care in the broadest sense, it should enhance and affirm human existence and remain relevant and accountable to humanity.

In this context, difference and plurality should be privileged–whereas homogenisation and regularisation of thought, method and practice should be resisted. This might:

- promote the affirmation of common, if pluralistic, humanity, help people to take their own experiences and perceptions more seriously, and aid people in expressing their experiences and perceptions more clearly
- build channels of communication; break down barriers between "us" (the professionals or the users) and "them"
- enhance interdisciplinary working; create critical and imaginative space for all
- enhance inclusive teamwork
- enrich critical reflection upon practice
- help to realise the rhetoric of partnership
- engage positively with the necessary passion and risk that allows creativity to take place and the "transfiguration of the commonplace" to occur in "everyday epiphanies".

Medical humanities should add value and values to life at a number of different levels. To realise this vision, MH must avoid becoming exclusive and elitist, disaffirming of what people are already doing, dismissive of non-intellectuals and non-professionals, or indeed dismissive of professionals. It must avoid both becoming "expert" dominated, narrowly academic, burdensome in its expectations and demands, and imposing an extra compulsory part on an already overcrowded health care syllabus for professionals. It must not be self serving or self perpetuating to justify the existence of some academic groups, or form another repository of quasiprofessionalised Esperanto, headed by medically qualified professors of medical humanities who communicate in esoteric jargon.

The fate of the discipline of health care ethics (HCE) that arose in Britain in the 1960s and 1970s may provide a cautionary example of the difficulties

in trying to maintain breadth of vision and participation. Health care ethics has become a recognised academic specialty, subordinate to medicine. It has, however, followed a "death course" that started with enthusiastic amateurs from many disciplines identifying a gap in health care thinking; thereafter champions took the discipline forward, getting it discussed in medical circles, and HCE has now coalesced to develop its own professional experts teaching a well-defined, compulsory part of the medical curriculum. Establishment, definition and maturity have, however, brought narrowness and exclusion, engendering boredom and frustration amongst the newly created health care ethics "laity".

If MH is not to become narrowed and professionalised, its enthusiastic proponents need to think now about the means by which it can retain its width of vision, practice and practitioners.

Metaphorical analysis of significant events in general practice consultations

KIERAN SWEENEY

The consultation is the central forum for delivering health care in general practice. Historically, analyses of the consultation have taken either a strategic or semantic approach. This paper reports research in which we focus on the language used by patients and doctors in significant consultations, captured on videotape (work in progress, funded by the NHS Executive Southwest region). The unit of analysis is the metaphor, and the research considers how the use of metaphor reflects the epistemological standpoint of the speaker.

General practitioners from three practices are recruited to the study, agreeing to video record their surgeries, noting *significant* consultations. Significant consultations are defined as consultations in which the health status of the patient alters, a new diagnosis is made, a new treatment offered or a significant change in prognosis is recognised and discussed.

The researcher then interviews the patient and the doctor separately, having seen the video recording of the consultation. During these in-depth interviews, the aim is to explore both what the person says, and more importantly what her or she understands by the disease, treatment or diagnosis under discussion.

The person's utterances are recorded, coded and categorised *verbatim*, before the researcher offers any interpretive comments, in an attempt to retain the meaning of the statements as they are represented and understood by the speaker.

Eighty consultations were recorded, and twelve identified as significant. The topic of congestive heart failure, as discussed by a patient and his doctor, proves an illustrative source of divergent metaphors.

The early results suggest emerging differences in the explanatory models used by patients and doctors. This could be regarded as an indication of differing epistemologies, and as a model one could draw on Piaget's distinction between operational and figurative forms of knowledge. Operational knowledge implies the ability to link notions logically, is theory driven, and allows for prediction. We argue that for patients figurative knowledge is drawn from the lived knowledge of everyday experience. The doctor's adherence to a biomedical positivist model is consistent across all the early interviews. The patients can at times use operational knowledge, but this is usually acquired in the context of their *lived* rather than their *learned* experience.

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