

How to make the most of history and literature in the teaching of medical humanities: the experience of the University of Geneva

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In this paper the authors discuss the benefits of history and literature in the teaching of medical humanities. They suggest that human sciences produce a common effect, which they call *distancing*. Distancing is the awareness that one natural way to describe a given situation does not exist and that any point of view—scientific or not—is context dependant and culturally shaped. Distancing is important to medical students, by allowing them to become aware of the specificity of their own professional point of view. The authors offer a reflection on the specificities of both historical and literary approaches and on the tools they provide for medical students. This paper assumes there is a close link between the theoretical debate on the benefits provided by human sciences and the concrete framework of a given programme. The authors describe team teaching, which has been the solution adopted in the School of Medicine at the University of Geneva to obtain the most from history and literature.

department. While setting up this programme, it became apparent that teaching humanities to medical students needed to be grounded on a specific theoretical and methodological basis. Indeed, medical students are not the same kind of audience as students in history or in literature. The Faculty context differs in many organisational aspects, but also in the objectives pursued when teaching in different fields. Consequently, it appeared that the teaching, both in its form and its content, should be adapted to the context.

DISTANCING

The subject of medical humanities requires different human sciences, each of them providing their own methodology and research material. Despite this diversity, human sciences—among them history, literature, and philosophy—are supposed to complete the biomedical point of view by stimulating alternative ways of considering issues in medical practice.

Each human science is likely to throw its own light on a particular aspect of a given medical problem. But they all produce a common effect, which we call *distancing*. Distancing reveals that a natural way to describe a situation does not exist; that a point of view—be it scientific or not—is context dependant and culturally shaped.

The distance given by an historical approach lies in the temporal gap; it appears to be a diachronic distance—that is, a gap between our present view and the one relevant to another time. Distancing provided by a literary approach lies in wording or formulation; it appears to be a synchronic distance—that is, a gap between a piece of information and the way it is expressed through language.

Our experience suggests that distancing is important to medical students, by allowing them to become aware of the specificity of their own professional point of view.

THEORETICAL ASPECTS

Historical approach and medicine

There are many different ways of writing history, and it is so with the history of medicine. Over the last 30 years, narrative history has met many challenges and known many reforms, most of them tending to reassert the value of narration.³ The focus of narrative history is based on exploring themes based on the human being, such as ordinary people, everyday life, interpersonal relationships, common things, shortly

The purpose of this paper is partly to take up the debate raised by Evans and Greaves on central disciplines contributing to Medical Humanities, and on the privileged role of philosophy.¹ We would like to discuss the respective benefits of history and literature in the teaching of medical humanities. Furthermore, we assume there is a close link between the theoretical debate on the question and the concrete framework and material conditions of a given programme.

Thus the question discussed here is not about the centrality of one discipline or another, but in which way they can be useful to medical students. Our thought runs on history and literature because we have experimented with them in our teaching at the Geneva School of Medicine.

The Geneva programme of Medical Humanities, which has been running for three years and is regularly amended, has to be understood within the context of the organisation of the medical school based on problem based learning. The course is formed of four compulsory seminars of two hours, and a one month optional course.² This programme is placed under the responsibility of a historian, with the collaboration of a member of the French literature

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speaking, on singularity rather than on generality; on the individual rather than on the group. This trend has been clearly adopted in the history of medicine, notably following Roy Porter's call in favour of a "history from below"—that is, from the patients' point of view.⁴ Many historians answered the call and focused their interest on individual experiences of sickness, pain, suffering, and dying. The concept of historicity is linked to this trend. This concept expresses the realisation through historical works that what happens now did not always happen; that what we consider as new is not, or that what we thought was permanent is quite new. It helps to define continuities and ruptures.⁵ The present discussion is rooted on this narrative approach of history.

The historical distance

In order to have as precise an idea as possible of an historical object, the historian strives to recreate the context in which it happens (see p 141 of Stone³ and p 232 of Temkin⁶). This reconstruction requires a broad knowledge of secondary literature about the object, and a deep investigation of primary sources of various kinds to increase the array of points of view, to bring to light the specificities of the context, and thus to have a better understanding of the object. This process of depicting with details the general conditions of the context is necessary to sharpen the interpretation of the object studied and to achieve the required distance. If one were to ignore this step, the analysis of the object would lose its historical acuteness and relevance; the narrative would become anachronistic by being incomplete, and would be influenced by one's contemporary representations or projections. This influence is perhaps still more definite when historical objects are related to medical topics, such as the body, the patient, the healer, the suffering. Indeed, these topics are present in our lives, and we all have an idea, an experience, or at least a representation about them. Subjectivity is an integral part of the historical approach. Historians should be aware of being subjective, capable of defining their own subjectivity's contents, able to take it into account, and possibly strive to reduce its importance. Consequently, in order to interpret such historical objects, it is important to put aside or to suspend our contemporary view of the object.⁷ The specification of the framework, not only by defining two historical dates, but above all by setting the object in relation with the other conditions of its time, will contribute to reduce the influence of our subjectivity. This is the cost of the "distancing process", but it is also the precondition of its success.

The importance of historical approach for medical students

When teaching medical humanities, the question is why is it important to introduce this notion of historical distance to medical students? They are not required to become historians; however, we think that the result of historical studies can help them in various ways. Firstly, to consider the same object in two different contexts distant in time helps to assess their usual framework and point of view, to make explicit the conditions in which we are operating nowadays. "History helps to decipher the landscape in which we are living" (Winock, p 21⁵), and history contributes "to know ourselves by contrasts and similarities" (Temkin, p 99⁸). For example, looking at elements shared by both the present and Ancien Régime consultations—such as the place of illness narratives, the role of the body, the expression of symptoms—elucidates the way we now consider those same elements. Secondly, questioning is usually part of the intellectual process, and each field builds its own way of investigating. If one considers the same object in two different contexts, one observes that questioning does not unfold in the same way,

precisely because the contexts differ. History allows us to move away from everyday questions, and thus reorients the contemporary debate. Thirdly, the historical approach introduces the key notion of interpretation, a notion that is at the core of the historical discipline, as the results of any historical research are but extractions of meanings through an interpretation of the archives. The historian knows he cannot grasp the whole reality of his object. As direct observation of what happened in the past is not available, interpretation is the only clue to get a clearer picture and finally an explanation of historical events.

Tools provided by history

In concrete terms the historical approach, through its process and its results, offers valuable tools to medical students. It may foster their skills in analysis and observation, by reading and questioning archives and trying to give further meaning to the content of the text. Those skills can be enhanced by paying attention to the details which constitute the specificities of the context. It will increase their awareness to the role of interpretation, a notion also important in medical practice. Reading, questioning, and interpreting are also part of medical practice. Cassell noted that, "historians might have something special to contribute to teaching how to obtain, understand, and use the illness history" (see page 28).⁹ It will also draw students' attention to the part of subjectivity in their practice. In the same way that historians try to put aside their subjectivity or at least to take the measure of it, physicians should also be aware of its influence, whether they choose to take it into account or not.

As mentioned above, distancing is not the prerogative of history, but is shared by other fields of humanities, among them literature.

Literary approach and medicine

Distancing by literature

In order to explain the singularities of a narrative and give a coherent interpretation of it, literary criticism usually works on two textual levels, namely content and form. Both levels have to be analysed in connection with each other so as to catch the meaning of any particular literary work.

A literary approach thus focuses on the way ideas get shaped through a specific form—the basic postulate being that content cannot be understood on its own because its form actively contributes to its original meaning.

Being aware of the solidarity of both content and form paradoxically leads to the literary distance because it draws attention to the semantic construction every discourse undergoes and, if need be, it enables control of the influence the wording has on the message one wants to transmit. The formulation of a message is of great importance for its general signification: the expressive choices one makes are not neutral. The literary distance enables appreciation of the implicit sense conveyed by the message's form.

The importance of a literary approach for medical students

The techniques of literary criticism offer close scrutiny of the uses of language. They give the language a predominant role and help decipher the way in which it informs (that is, gives form to) thoughts. In what way may that kind of approach constitute a benefit to medical students?

Firstly, it brings to the physician the opportunity to consider a patient's account in a new way—that is to say, a different *reading* of it and therefore a wider understanding. The physician is the person who transforms the patient's history into a medical case. Under his clinical gaze, the patient becomes an object (see Kleinman, p 130¹⁰). This transformation means interpretation. As Hunter¹¹ wrote, "clinical knowing is interpretive, a matter of making sense

of what is going on at a particular place and time" (p 310). If one considers that interpretation is important in medicine, interpretive skills may be trained through literary approach.

Secondly, the literary distance may help the physician to take into account the polyphony in the patient's history.^{12 13} In other words, it helps to identify the implicit voices—family, friends, other physicians, social educators, and so on—that the patient unconsciously echoes when speaking about herself. A physician trying to transform a patient's story into a medical case may encounter trouble due to implicit influences or even to unsaid pressure undergone by the patient. Being aware of these multiple influences may help to solve apparent paradoxes in the patient's account and improve the communication between physician and patient.

Thirdly, the literary approach allows the physicians to distance themselves from their own professional wording, from the way they express themselves. Being aware that the medical discourse is a cultural construction can help physicians to control the effects of their own speech when communication with a patient is difficult. Literary distance certainly also helps pointing out to what extent biomedical discourse is standardised. For instance, already in their academic curriculum, medical students are confronted with an evaluation practice that is non-existent in the arts, namely the multiple choice questionnaire. They have to reply to questions without the possibility of choosing either their own terms or syntax. Getting medical knowledge is thus based on preformed expressions. Another example is provided by the actual trends to standardise and computerise medical files, trends which also lead to another kind of medical formalisation. Knowing that thoughts are shaped by language, trends towards hyper-specialisation are an impoverishment, even if subjectivity is never totally erased.¹⁴ The literary approach aims to provide students with a series of questions¹⁵ that should help point out difficulties caused by unshared language and formulation. On the other hand, it may help the physician to recover a more common (or at least less specialised) way of speaking.

Tools provided by the literary approach

From a medical humanities perspective, literature is used to enhance understanding because it has the power to "flesh out" situations relevant to medical practice.¹⁵ Narratives are thus considered as a reservoir of examples or existential situations. They are used as illustrations of features that are usually not taken into account by the scientific point of view—for instance, the scope of human emotions. In short, narratives are supposed to give readers an immediate access to experience.¹⁶

Resorting to literature in such a way may be very fruitful for the physicians. Nevertheless it remains fairly passive as an approach, because literature is considered as a kind of database containing various experiences. Basically, it means that one first has a specific idea or an educative aim and will then find an adequate illustration of it in literature. What is more, it does not imply any specific narrative competences.¹⁷

Reservoir

Narrative competences: who is speaking?

Narratology teaches that the author and the narrator of a story do not strictly share the same qualities, even if they refer to the same person. The narrator is part of the plot, as are (for example) the scenery and the other characters; the role he is playing in the story is never transparent or neutral but it contributes to the story's general cohesion, although it can appear incoherent. Thus it is important to consider how a narrator presents himself throughout the narrative in order to build a global interpretation of it. To be more precise one may for instance wonder if the narrator seems detached or

implied in the events he relates. In order to work this out, attention may be drawn to the verbal structure: does the narrator use past tenses to relate actual events?

Semantic field

Focus can also be put on the use of specific semantic fields: is the narrative dominated by a group of words all referring to the same register (for example anxiety, religious faith, aggressiveness, moral physical suffering, and so on)? What does it reveal about the narrator's point of view and beliefs? Paying attention to the semantic fields present in the patient's language may help the physician to find out which beliefs underlying the patient's story may be confusing its coherence.

For example, a patient expressing his illness through words of guilt, shame, and punishment is probably influenced by a strong moral background. That may explain why some parts of his story relating to the body or to intimate behaviour remain obscure. Being aware of that dimension allows physicians to adapt their questions and attitude, and thus meet in a more appropriate way the patient's expectations.

Wording

The words are important, as are the way they appear. For instance, one may speak about one's illness in a rather descriptive way, saying: "I have a cancer"; one may use a comparison: "I have an illness like a animal gnawing me from the inside"; or one may use a metaphor: "I have a crab". These different kinds of wording, if coupled with other information excerpted from the patient's story, attest to the patient's attitude towards her condition. A priori, the first formulation is less passionate than the second, and the comparison term "like" keeps a gap that is abolished through the metaphor (illness *is* a crab). One expression is not necessarily more or less expressive than another, but where the first may indicate a certain hindsight, the third works on total assimilation. That kind of difference should influence the physician's interpretation. It may help to level the information and sort out what is most significant in the patient's eyes. The three formulations may also reflect the patient's attempt to gain the physician's attention on a specific aspect of her story.

Practical framework

In the first part of this article, we have discussed the theoretical benefits of history and literature for medical students. When implementing a programme of medical humanities in a given school of medicine, new questions arise: how to create the appropriate pedagogical framework to render those benefits relevant and useful for medical students? Which conditions are necessary to achieve that programme? There is no universal answer to these questions, nor an appropriate method which could be implemented in any medical school. We are convinced that medical humanities programmes should be flexible enough to be suited to the structure of the medical school they belong to, in order to fit in with the pedagogical format in use.

Possible misunderstandings

This adaptation can facilitate the integration of a teacher coming from an arts faculty to medical school. Indeed, the teaching frame is often very different between faculties of art and medicine—variations being in the pedagogical conceptions, methods, objectives, timing, and evaluation. The mere importation of the pedagogical framework of one faculty into the teaching of the other is not always efficient. In the context of the medical humanities, it is wise to postulate that medical students will not adapt to a different pedagogical culture, especially if available time is short; consequently, it is more reasonable for the teacher to insert his teaching into the

existing structure, at least for the compulsory seminars. Even with such flexibility, it remains difficult for humanities scholars to communicate their knowledge, thoughts, and competences. Their studies, research experience, and reading habits have contributed to shape their mind. Thus the organisation of the discourse, the vocabulary, the investigation of an object, the degree of abstraction, and the aims of the teaching, all constitute possible gaps in communication and thus possible misunderstandings.

Furthermore, humanities scholars do not usually have a precise idea about the everyday reality of medical practice. Rather, they tend to understand it through their experience as a patient, their representations, and the collective perception of medicine which is often the focus of the media's attention. This part of subjectivity induces a discrepancy between their view of medical practice and that of physicians. To spend some weeks in a hospital or any place where medicine is practiced tends to reduce this discrepancy. This does not mean that the humanities scholar's view has to be the same than the physician's, rather that the idea they have about it relies on observation of practice rather than on an abstract and subjective construction.

Team teaching

To reduce possible gaps between physicians and humanities scholars, we have decided to adopt team teaching for the mandatory seminars. This implies that both a physician and a humanities scholar are in charge of the preparation and teaching of the seminar. In actual practice, the humanities scholar chooses the theme and texts for the seminar, and the physician selects what he considers as important knowledge for the medical student. This team teaching entails numerous discussions and negotiations. It is a time consuming process, but quite exciting because it is the result of a dynamic process and of a constructive confrontation rather than a mere juxtaposition of expertise. Moreover, among the countless important inputs offered by the humanities, this solution aims to select some of the relevant ones for medical students.

This solution does however carry the risk that the humanities scholar will lose her sense of belonging to her original culture. Medical culture is quite strong and restrictive, and the necessary adaptation to its contingency, and the time it takes, may push humanities scholars to distance themselves from their usual way of thinking and working. It is this very fact that should encourage them to keep in touch, even institutionally speaking, with their own field.

In order to keep the interaction balanced and lively, each teacher should be linked to the research of his own field, since research and reading are the best way to keep knowledge and skills alive. Furthermore, as noticed by Pellegrino, this double belonging both to medicine and one's own discipline avoids humanities scholars' isolation and maintains the authenticity of the course (see p 28¹⁸).

CONCLUSION

Generally speaking, distancing is the main objective of applied human sciences. In this paper, we have shown the tools provided by and the distinctive features relevant to history and literature. It is an attempt to formalise the role and the function of these disciplines in the teaching of

medical students. We are aware that our propositions are not exclusive and that contextualisation can be provided by literature, and that history draws attention to importance in wording. However, we believed it important to clarify the specificities of the inputs of our disciplines to define our role as humanities scholars in a medical school. It would be interesting to broaden the topic in order to encompass other disciplines belonging to the field of medical humanities.

Team teaching has been the solution we have adopted to obtain the most from history and literature in the face of the very short time allotted to the compulsory seminars. It helps to reduce possible misunderstandings between humanist and medical cultures, to find topics shared by both of them, and discover the way to tackle these topics in a satisfying way for both teachers and students.

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