

## Medical Humanities – Serious Academic Pursuit or Doorway to Dilettantism?

Despite increasing interest in incorporating Medical Humanities in undergraduate medical education, the discipline often suffers from a lack of clear definition in terms of scope, purpose and clinician engagement<sup>1</sup>, and as yet rarely attracts the degree of postgraduate and research activity generally associated with substantive academic disciplines. This confusion is reflected by high degree of variability in the range of topics included under the rubric – one Irish university includes global health as a part of Medical Humanities, possibly to the detriment of the definition of each discipline - and there is tentative investment at best by Irish universities in the infrastructure of such courses.

Without a clearer focus, the project risks marginalization, as outlined by the critique of the American poet Raphael Campo: “no conception of ‘the medical humanities’ compels, caught somewhere between manifesto, mushiness, and marketing lingo<sup>2</sup>”. Advances in definition since then include a move beyond a mere list of relevant disciplines to consideration of issues such as how the medical humanities can act as a source of moral and aesthetic influence upon the daily praxis of organized clinical health care<sup>3</sup>, foster an understanding that medicine is a profoundly social enterprise and the practice of medicine a value-laden undertaking<sup>4</sup>, and provide an important personal support in the challenge of daily practice<sup>5</sup>. A helpful approach in understanding these aspects of medical training is Charon’s concept of the multiple dialogues inherent in the doctor-patient relationship<sup>6</sup>. That between the patient and the doctor, requiring empathic engagement, is obvious. Less apparent is that between the doctor and his peers – standards, audit, conscious and unconscious rationing –requiring the development of due professionalism. The third discourse is the doctor with him/her self –fears, prejudices, uncertainties, past experiences – mandating reflective practice. Finally, there is the dialogue with society – stigma, rationing, ethics, support/lack of support – an awareness of which is critical to the development of trust.

All of these aspects fall generally within the emerging rubric of teaching professionalism, within which is nested clinical ethics and the medical humanities<sup>7</sup>. Within this framework the medical humanities provide not only content but also helpful educational tools. Much of the practice of medicine is complicated and rich in ambiguity. Metaphors are a good medium for explaining complexity, and artists often provide the best metaphors: examples include illuminating professional etiquette<sup>8,9</sup>, dignity in disabling illness<sup>10,11</sup>, why doctors fail to treat pain<sup>12</sup>, and the challenges of ageism in health care<sup>13</sup>. Irish medical schools can also benefit from newly evolving research and academic debate on the Medical Humanities<sup>14</sup>, including reflection on its content<sup>15</sup>, who determines the curricula<sup>16</sup>, who teaches this curricula and to what ends<sup>17</sup>. This body of knowledge can facilitate curriculum design which incorporates medical student critiques of existing programmes, including content (perceived relevance and consistency), teaching (credibility of teaching staff and perceived personal intrusiveness) and positioning with related topics within the curriculum.

Careful linking with physicians in practice is absolutely critical to ensure relevance and avoid a disconnect between what is taught and what is practiced, lest students and staff become cynical about the process. A helpful model has been developed in Ireland for the teaching of medical ethics which could serve as a template<sup>18</sup>, and physician leadership is likely to be vital in the development of curricula for both professionalism and the medical humanities. A major challenge to developing a Medical Humanities programme is the persisting perception of a dichotomy between the practice of medicine and the humanities<sup>1</sup>.

Although there are clearly strong elements of the basic sciences inherent in the practice of medicine, there is an increasing awareness that medical students and doctors are not an inarticulate group of aesthetic illiterates. A number of studies have shown that a high proportion of doctors are interested in the arts and humanities<sup>19</sup>: therefore the worst possible approach is to drop in dollops of high culture, rather than seeing them as collaborators in the educational process.

Our own approach has evolved from the perspective of an evolving combined Medical Humanities/Arts and Health programme with an active research, undergraduate and postgraduate teaching programme<sup>20</sup>. Critical success factors appear to include a clearly stated mission for academic outputs, engagement with peer-reviewed funding mechanisms, the pairing of interested clinicians and artists/humanities academics (a guard against dilettantism in both directions), delineation of theoretical frameworks, and an emphasis on basing the teaching on the arts, cultural and leisure activities of the students (rather than the faculty!) to avoid the danger of losing touch with the personal relevance of the topic for the students.

This broader perspective on the humanities is important as much of the academic literature contains an over-emphasis on literature, poetry and the ‘high arts’: working with the students’ cultural and aesthetic preferences allows us to access film and television studies, popular music, photography and architecture to explore the medical humanities in a much more meaningful and personal way<sup>21</sup>. The development of medical humanities will also need investment of time and effort by those involved to ensure better integration between clinicians and academics in the humanities and arts practitioners: a successful programme requires true interdisciplinarity rather than vicarious multidisciplinary. Unresolved issues include the organizational basis of the programme within the university, the engagement of full-time academic staff with part-time staff/adjunct lecturers, and a more consistent integration with other elements of the undergraduate curriculum.

Finally, due modesty about the outcomes of medical humanities programmes is also important. The development of professionalism is a life-course process, subtle in character but of huge importance to individual doctors and the profession. It is not surprising that enthusiasts would talk up the impact of medical humanities programmes, but as drily observed, literature’s relevance to coping with people in the Monday morning surgery queue is nil – unless they happen to be very old Russians<sup>22</sup>. The medical humanities do not make you a better person and they will not immediately improve your communication skills. However, we can be heartened in our pursuit of critically informed and relevant medical humanities programmes by emerging research that doctors who pursue cultural pursuits are more likely to display vocational engagement<sup>23</sup>, a key indicator of durable professionalism.

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