Medical Humanities: new frontier or back to the past?

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In nomenclatural terms Medical Humanities is a relatively new discipline. Originating in the United States and Australia almost simultaneously, Medical Humanities is seen by many as a means of ‘making better doctors’ by adopting analytical and methodological strategies from the humanities and importing them into medical education. In the United States this remains its principal application and, as this definition from New York University’s School of Medicine suggests, it broadly encompasses the arts, humanities and social sciences:

We define the term ‘Medical Humanities’ broadly to include an interdisciplinary field of humanities (literature, philosophy, ethics, history and religion), social science (anthropology, cultural studies, psychology, sociology), and the arts (literature, theater, film, and visual arts) and their application to medical education and practice.15

Recent years have seen the discipline grow in Britain, where it has developed firmly along philosophical lines, with many of the key practitioners either based in, or drawn from, Departments of Philosophy. Notable examples include the Centre for Medical Humanities at Durham which has become a centre of excellence. There Medical Humanities is not simply seen as a ‘further humanities discipline’; instead it is viewed as ‘a field of enquiry’ with a particular emphasis on the ‘recognition that subjective experience can be a legitimate source of knowledge’.16

Progressive Medical Schools have adopted Medical Humanities as a major preparatory component of ‘work-based learning’.17 Apart from the desire to produce more rounded medical graduates by involving the humanities in their training, it is largely seen as a way of teaching empathy by developing cognitive awareness of the human condition. Several studies over the past twenty years are agreed that teaching humanistic approaches in the medical curriculum helps to develop critical thinking skills. Thus student doctors continue to learn their clinical skills, but are also taught how to read textual material, to look beyond the hard facts for soft data that will, hopefully, make them better

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17  See various contributions to Tim Swanick (ed.), Understanding Medical Education: Evidence, Theory and Practice (Chichester, 2010).
practitioners, and develop the empathetic skills that will improve the doctor/patient encounter. These skills help to prepare medical students for the practical components of their programme, when the clinical space replaces the lecture theatre as a site of teaching and learning. Doctors will be further humanized by the Humanities, and the discipline has been credited with helping to prevent burnout amongst practitioners, by encouraging them to develop the imaginative elements of their personalities. Practitioners who are members of the Association for Medical Humanities certainly confirm this interpretation, indicating that the discipline allows them to explore approaches that are necessarily excluded in their clinical work. In fact, Medical Humanities represents not a new departure but a reversion to the original form of medical education, when physicians were also classicists and historians. Historically a man would not be deemed professional with only a partial education in science, anatomy, and clinical skills. Ironically, it was the rise of evidence-based medicine, and developments in surgery, anaesthetics, antiseptics, and epidemiology that led to an exclusive focus on the disease, and not the patient. At the start of the twentieth century, major laboratory-based breakthroughs meant that student doctors were actively encouraged to treat the ailment, but not necessarily the individual who embodied it. As late as the 1970s, hospitals adhered to strict timetables and routines that tended to ignore the emotional needs of patients, even the most vulnerable groups such as the very young or the chronically ill. Clinicians agree that in everyday practices the biological approach in isolation ‘cannot address the various human phenomena that physicians encounter in their everyday practice’.

Nowadays, the notion that children would be isolated from parents and siblings for the course of their illness is repugnant to us, but the provision of beds for parents in children’s wards, and a recognition of the impact of mental stress on physical recovery, are relatively recent developments. Medical Humanities has played a key role in the reconsideration of the whole patient, to the benefit of all. The discipline has encouraged the development of additional therapeutic aids such as music therapy, art therapy, patient education, and multi-disciplinary care teams in hospitals.

The benefits to medical practitioners and clinical practice as a whole are clear. But an equally important question, that we are attempting to address through the Consortium for Medical Humanities, is what might the benefits be for scholars in the humanities? On a practical level, we have seen the positive impact that the involvement of practitioners has had upon our work. It is not merely the fact that medical practitioners can engage with medical records on a different level, offering insights into therapeutic regimes and treatments that are unavailable to historians (although the world of retrospective diagnosis
is a rather dangerous one). More importantly, clinicians bring a distinct methodological approach to medical history, and the reading of literature, that opens up a whole new world of analysis. For example, our work on mental hospital records has been enriched through an understanding of the most recent clinical findings on genetic markers for psychiatric illness. Where historians have been inclined to look exclusively at social, cultural, and political factors in explaining, for example, the rise of institutional care, the insight of medical staff allows for a rounded explanation of medical dependency. And it is not merely a jigsaw, for which these staff supply missing pieces. Medical research provokes a re-examination of historical analysis of developments that appear to have an unshakable narrative, and has an interesting ‘knock-on’ effect. To take one striking example: it was part of Irish popular culture to point to the supreme irony of Jonathan Swift succumbing to insanity, having endowed St Patrick’s Hospital to care for the Irish insane. His self-penned epitaph seems to underline the wisdom of ‘not throwing stones’:

He gave what little wealth he had,
To build a House for fools and mad;
And show’d by one satiric touch
No nation needed it so much.20

However, Swift was not in fact insane, but suffering from Menière’s disease, a condition of the inner ear that causes dizziness, hearing loss, nausea and disorientation. Poor Swift himself believed he was losing his reason, and contemporary commentators were all too willing to agree, seeing in his state a just punishment for the author’s savage satirical writings.

Since 2008 fruitful collaborations have resulted in medical humanities modules being embedded in Irish medical school curricula. Arising from a 2009 public health strand at UCC funded by the Programme for Research in Third-Level Institutions, Cycle 4, and an Irish Research Council-funded Lifecycles project (2008-2010) at UL, we pooled resources to found the Consortium of Medical Humanities in March 2010.21 This Consortium, predicated on a cooperative basis, has formed a research cluster between UCC, UL, the University of Ulster (UU), Queen’s University Belfast (QUB) and Glasgow Caledonian University; it has yielded two further IRC awards and, more recently, a three-year Arts and Humanities Research Council award.22 The Consortium is working closely with the National Archives of Ireland to develop a Medical Records policy, which

22 The Consortium also hosted the Association of Medical Humanities annual conference in July 2012 at University College Cork.
has at its core the development of historical resources as teaching and learning tools. In Ireland, historical analysis is central to the development of the field, with scope for the inclusion of a wide variety of additional approaches. One of the key developments is an emphasis upon the preservation and digitization of vulnerable medical records, which hold a wealth of detail on medical practice, epidemiology, and social, political and cultural responses to professional medicine. Interdisciplinarity in the humanities has been impeded by lack of funding or indeed match-funding for inter-faculty teaching posts. We have however an active research bid that aims to enhance our existing portfolio and in conjunction with clinicians we are currently developing exciting interdisciplinary projects in medical demography and history at Trinity College Dublin: the potential for research-led teaching in the area will naturally follow from such interdisciplinary and inter-institutional initiatives. There are areas of significant strength in Medical History in Ireland, which suggest the potential for a unique national contribution to the international field.

23 UCD established a Wellcome Trust-funded Centre for the History of Medicine in 2006. It is liaising with the National Archives and the Consortium to develop the records policy.