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Medical Humanities as Expressive of Western Culture

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Abstract
In this paper we articulate a growing awareness within the field of the ways in which medical humanities could be deemed expressive of Western cultural values. The authors suggest that medical humanities is culturally limited by a pedagogical and scholarly emphasis on Western cultural artefacts, as well as a tendency to enact an uncritical reliance upon foundational concepts (such as 'patient' and 'experience') within Western medicine. Both these tendencies within the field, we suggest, are underpinned by a humanistic emphasis on appreciative or receptive encounters with 'difference' among patients that may unwittingly contribute to the marginalisation of some patients and healthcare workers. While cultural difference should be acknowledged as a central preoccupation of medical humanities, we argue that the discipline must continue to expand its scholarly and critical engagements with processes of Othering in biomedicine. We suggest that such improvements are necessary in order to reflect the cultural diversification of medical humanities students, and the geographical expansion of the discipline within non-Western and/or non-Anglophone locations.

It is our contention that, whatever may be the excellent intentions of its founders and practitioners, medical humanities as a field has often been strongly, though not wholly, reflective of the traditions of Western (Anglo-American and European) culture, particularly what used to be referred to as 'high' culture[1]. In this essay we outline the grounds for this perhaps provocative statement, and explore some of its implications for the field. These include the possibility that what constitutes 'the medical humanities' could differ profoundly from place to place, particularly in the developing world. A second concern is that since Western cultural traditions embody certain ideas about selfhood, patienthood, illness and medical care, the dominance of these traditions may exclude important ways of knowing and being for both Western and non-Western patients and doctors.

This paper contributes to the recent communal conversations that have, of late, marked the success and expansion of the medical humanities[2-5]. The field is clearly in the process of significant change – change that is generational, pedagogical, and scholastic. Soul-searching is common to this phase of development. Our own soul-searching was initially prompted by one of us (CH) being privileged to

participate in and consult with a number of scholars and practitioners across Asia (China, Japan, Indonesia, India, Korea, and Singapore) as they have developed their own medical humanities programs, a feature of the rapid global expansion of the medical humanities during the past five years. What often emerged was a quasi-Western canon-of-medical-humanities (in history, philosophy, literature and art) in which the diversity, sophistication and richness of different cultural traditions was uncomfortably marginalised. We became increasingly aware that materials commonly used in teaching and scholarly discussion in the medical humanities often encouraged a generally uncritical reliance on foundational concepts (such as 'patient' or 'experience') expressive of Western approaches to the self in sickness and health. In this paper we argue that although the teaching of medical humanities is aimed at a humanistic decentring of various 'objectifying' knowledges deemed central to the practice of Western medicine, its correlate emphasis on teaching epistemology through Western cultural artefacts, ideas and *ideals*, can actually contribute to the marginalisation of some patients and health care workers.

This situation raises a further issue, which is the rather surprisingly small presence of the swathe of scholarship that was not only a prominent, but a even a defining feature of humanities scholarship over the past 30 odd years: namely, the structuralist and postructuralist critiques of social power relations, and related explorations of the enculturation of difference and otherness that have altered the basic assumptions and practices of most humanities disciplines. These now firmly-entrenched revisionist approaches to the pursuit of knowledge in the humanities are present in the critiques of orthodox medicine put forward within the medical humanities – but only partially, as we will show. A complicating factor in this situation is a fundamental and ongoing tension that lies at the heart of the medical humanities – a tension between appreciative and critical stances and epistemologies. This tension is reflective of, though it cannot be identically or simply mapped to, the dual commitments to practice and research that now define the field. Our suggestion is that this tension necessarily influences how difference is understood, explored and validated within the medical humanities, particularly in curricula for medical students.

Of course, the medical humanities as a field has been cultivated precisely in order to help us come to terms with certain *kinds* of difference – those that are produced within contexts of illness and/or disability. And in fact these typologies of difference, and the political commitments on which they rest, have been foundational to the medical humanities, as a way of generating an appreciative, ethical understanding of persons and bodies in socially and/or medically disadvantageous circumstances. This focus on entrenching humanistic insights 'from below'[6] may partially explain the relative absence (so far) of critical attention to the cultural normativity of the medical humanities considered *in toto*. The act of asserting disciplinarity, even interdisciplinarity, derives momentum from a certain teleological impetus to self-narrate, producing a coherent or centralising version of selfhood in relation to one's envisaged audience. But contexts and audiences change; whereas once medical humanities may have written 'up' to a body of predominately white, Western medical practitioners most interested in harnessing the humanistic insights derived from a conventional Western classical education, the composition of our cohorts has altered to reflect increasing diversity in the nature and practice of medicine, as well as the geographic (re)zoning of medical humanities itself. As the medical humanities matures, both as practice and in scholarship, we will have to communally negotiate ways of encountering difference that challenge as well as enrich audience encounters with this diverse disciplinary 'genre'.

Medical humanities as expressive of elite Western culture

Our opening contention, and consequently this article, is somewhat polemical, so we will address it first. Our argument is that the actual content of most medical humanities works and curricula has been clearly identified with 'Western' nations (such terminology is appropriate here, since part of

our argument is that the field at present unwittingly tends to reproduce such troubling locations as the 'Western' and the 'Oriental'). In our experience, curricula often make significant use of works drawn from the Western 'canon'[7]. We suspect that this more classical orientation is one of the distinctive aspects of the medical humanities with potential for renewed scholarship within the humanities themselves; but at present, it might also convey a set of elite cultural assumptions[7 8].

Our contention is based on a brief reckoning of a group of works that may be regarded as reasonably representative of what is admittedly a highly diverse field, and contemplating how they might be taken up in non-Western and developing nations. We examined several books that are explicitly published as medical humanities texts[9-15]. We also considered a range of curricula developed for medical students (e.g. those housed in the 'arts, literature and medicine' database[16], which we note was the primary resource used when constructing a medical humanities curriculum in Nepal, a project that raised concerns similar to those we express here[17 18]). We recognise that in some Universities medical students are simply given access to courses run within humanities or liberal arts degrees; our examination of curricula was restricted to courses that appeared to be designed specifically for medical students, where we could reasonably identify that this was the case, as these tend to be the models used when medical humanities programs are developed. We found that both books and curricula gave significant attention to two genres of works. Firstly, canonical works in literature, music and art, valued for their beauty and insight, were present (e.g. Shakespeare, Tolstoy, Carlos Williams, Woolf, and Eliot; Rembrandt, da Vinci, Klimt, and Picasso; Verdi, Puccini, and Mozart) (see e.g. [17 18]). The relevance of this classical tradition to the medical humanities is exemplified by the recent publication of *Osler's Bedtime Companion*, which presents the classical literary works beloved of iconic medical humanist Sir William Osler for the use of doctors and students with similar expectations of character improvement to the man himself[14]. The second genre contains 'experiential' works written by doctors and patients – poems, short stories, dramas, and pathographies of various kinds. Whilst this second category is almost endless, so expansive has been the genre of cathartic writing about 'trauma' and/or illness, particularly in recent times[19], a smaller subset of these works tend to be regularly used in the medical humanities, some well on the way to becoming classics themselves (e.g.[20-25] and, also, the ever-expanding literary descendents of *The House of God* [see e.g. Foxton[22]]). Virtually all these works are written by Western authors and reflect similar cultural values concerning the nature of care, individual autonomy and so forth. Collectively, this material establishes elite Western culture as central for the medical humanities – alongside other cultural traditions perhaps (e.g. popular cultural representations of medicine and illness) - but nonetheless normative in their scope and implementation. Certainly the absence of artefacts from developing nations and non-Anglophone cultures was noteworthy in view of the cultural diversity amongst both medical students and patient populations.

This perception is reinforced by curricula in the history of medicine within medical education, which in many cases remains a Whiggish story of discoverers and discoveries. It is also reinforced by many prominent 'definitions' of the medical humanities, and by the tendency to construct a hierarchy of disciplines amenable to the medical humanities, with philosophy in pride of place[12]. Defining the field has been a scholarly pastime of late[2, 26, 4]. Many of these definitions are often closer to mission statements, in which the medical humanities aim at helping to 'develop and nurture skills of observation, analysis, empathy, and self-reflection, skills that are essential for humane medical care', to take a prominent example[27] (our own website provides a similar, if less elegant, version[28]). Such statements identify values and imply agendas, defining both areas for study – such as patient or practitioner experiences, the nature and experience of illness, the human condition – and a set of value-commitments with which to understand the pursuit of knowledge within these domains (empathy, self-reflection, and 'understanding' itself). General ideals, such as the frequently-occurring 'gaining of an understanding of culture in relation to illness and health care practice'[27] become instrumentalised through their embedding within the goals of medical education, and

articulated in terms of traits deemed central to the 'unique' disciplinary contribution of the field (i.e. empathy and self-reflection within medical practice). In this way, the cultural norms of the medical humanities itself go largely unchallenged, being subsumed within an overarching Western ideological and, to some extent, evidence-based[29] rhetoric of medical pedagogical 'value-adding'.

This deployment of Western culture in many contemporary medical humanities courses is distinctly out of step with the uses of culture that define approaches to understanding in contemporary humanities courses, and in a number of ways. In disciplines such as literature, for example, the American Modernist literary canon has, since the 1960s, been undergoing extensive revisions, to include the works of women, gay, African American, Hispanic American, Asian American, Native American and non-European authors such as the female African-American author Zora Neale Hurston, to name but one of the many names offered for inclusion[30 31]. Notably, for the majority of scholars interested in questions of revision, a dispensing with the works of canonical authors (e.g. Joyce, Eliot, Lewis and Pound) has not been a central objective – rather, scholars have advocated for an expanded canon which retains an emphasis on understanding literary 'tradition' but supplements this emphasis with recourse to the literatures of gifted women and minority writers whose contributions serve to decentre the historical notion of the male anglocentric subject as central to the experience and perception of modernity. Moreover, since Raymond Williams first penned his now-famed titular statement that "culture is ordinary,"[32] the discipline of Cultural Studies has been invested in uncovering the complex ways in which meaning and identity is both generated and disseminated via mass culture. Central to both these developments in Literary and Cultural Studies, has been an investment in undermining cultural hegemony—or to rephrase this in Foucauldian terms, in strategic acts of resistance—so as to challenge the insidious means by which power imbalances are dissimulated within our society.

Notably, the humanities has incorporated the insights of much of this scholarship into its own encounters with medicine – harnessing Foucauldian insights on the nature of power, for example, to illuminate structures of compulsory visibility within doctor-patient relations[33]. However, a question remains as to the extent to which this critique of science by humanities has been reciprocated: in allowing humanistic insights to inform and *re*form medical practice, has the medical humanities deployed scientific practice so as to extend the humanities' own self-critique? Or has it subordinated its own cultural knowledges to traditionally canonical artistic insights, thereby enforcing largely outdated humanistic paradigms?

Of course, our overview emphasises the similarities across the field of medical humanities, rather than the equally significant diversities. Medical humanities curricula were and are necessarily, varied, and many teachers could reasonably claim that they teach works and ideas of more diversity and complexity than we seem to credit here. This is especially true where humanities courses have simply welcomed, or been only slightly modified for, medical students. In particular, many would address cross cultural issues, our chief concern here. But, with the exception of one or two curricula deliberately aimed at exploring cultural knowledge[34 35] these sessions tend to remain tokenistic, thus reinforcing rather than destabilising the reliance upon Western cultural paradigms. As we show below, in these contexts 'culture' can become something that other people have—not something whose normalising aspects define the limits of our own perception.

The set of artefacts and values that have been central to the medical humanities are expressive of a first generation – those practitioners and scholars whose vital insistence on the need for attention to the 'human' aspects of medicine can be credited with birthing the field, thereby installing the space from within which we are able to write this paper[36]. It is reasonable to hypothesize that medical humanities curricula are often reflective of the Oslerian educational background that many of this group may have experienced. This is an observation, not a criticism; we would argue that there is

much to value in the resurgence of a classical education within medicine. But we also want to encourage the challenges to and diversification within the medical humanities that we hope will result from the spread of the field around the world, and to cultivate the important traditions of academic critique that have been deployed against classical modes of thought over the past few decades. For this, the medical humanities will need to re-engage with the concepts of difference and otherness as they have been, and continue to be, theorised in humanities scholarship from literary theory through to sociology and cultural studies.

Encountering difference and otherness in the medical humanities

As a result of our own grappling with teaching medical humanities across diverse cultures, we feel it is worthwhile to revisit the concepts of difference and otherness in this context. 'Difference' and 'otherness' are phenomenological, philosophical, historical, and sociological concepts[37-41]. The concept of 'difference' is logically basic, yet subjectively complex. In simple terms, it is about how we make distinctions and categorisations about the world and its inhabitants. More particularly, it is about how people come to regard other people as 'different' from themselves. Without revisiting the enormous academic literature on the topic, we want to draw attention to two issues that flow from an intellectual, experiential encounter between medical humanities and conceptualisations of difference.

The first is an epistemological question: how can I know or understand someone who is not me, and to whose sensations and thoughts I have no direct access? This is the question with which the medical humanities has been most concerned, deploying humanistic insights in order to confront the mysteries and challenges of individual illness, together with its existential impacts, so as to understand, and enhance, experiences of living and dying.

The second question is also epistemological, not to mention ethical, ontological, sociological, and phenomenological: how can we understand social and cultural difference? This question is one that has been of fundamental importance to philosophers and social scientists who wish to confront racism, sexism and other forms of oppression. Sometimes, difference is valued as simple diversity (often problematically, as diversity is rarely simple and invariably occurs in a context of social power relations). But more often, difference is identified as a negative deviation from the norms of a dominant group. 'Otherness' is the extreme version of this in which a dominant group defines itself *in opposition* to a marginalised group[42]. Features that are both desired and feared are projected onto this marginalised group and assumed to be intrinsic and 'natural' to that group. Thus women and femininity have oft-times been constructed as the opposite to men and masculinity: as earth and flesh, not spirit and mind; they have been culturally defined through desires and fears of culturally dominant masculinity, as in the enduring positioning of women as either pure goddess or defiled whore, a construct still powerful in so many cultures[41].

Deploying a similar logic that recognises exclusion as central to human processes of self-affirmation, Edward Said forged a tradition of post-colonial scholarship that critiqued normative European cultural views by revealing how the 'East' or 'Orient' was a constructed series of images and references: defined as a place of both sensual indulgence and of barbaric savagery[40]. This process of defining and naturalising the features of a marginal group is also referred to as 'Othering'. Since Said, this terminology has been developed and refined through the insights of a swathe of post-colonial theorists who have worked to combat the residual effects of colonialism upon cultures, both by uncovering sites of unstable and productive cultural 'hybridity'[43] and by seeking out zones of articulation for culturally marginal(ised) views. As the prominent American feminist and cultural critic, bell hooks, identifies, this project has necessarily entailed a struggle for self-representation

and self-recognition which pushes at the imagined centre of mainstream Western epistemologies from within the powerful site of its porously fragile margins; as she exhorts:

> "This is an intervention. A message from that space in the margin that is a site of creativity and power, that inclusive space where we recover ourselves, where we meet in solidarity to erase the category colonized/colonizer. Marginality is the site of resistance. Enter that space. Let us meet there. Enter that space. We greet you as liberators."[44]

These insights surrounding the problems and potentials of negotiating cultural difference within Western society are not new to medical humanities practitioners. Critiques of how various socially marginalised groups, particularly women, those with disabilities, and those from non-Western cultures, have been understood, labelled, diagnosed, pathologised, and disempowered have been the stuff of medical history, sociology, anthropology, and public health for several decades (e.g.[45-49]) and have been strongly and centrally incorporated into medical humanities as a field of research. Insights garnered via the incorporation of these perspectives within the medical humanities include analyses of the many ways in which biomedical knowledges have defined categories of people as deviant or diseased; the ways in which the primacy of biomedical definitions of disease have supplanted the subjective experience of illness; and of how, at times, biomedicine has been a fundamental mechanism of social inequality and exclusion. A pre-eminent example of this cross-disciplinary exchange is the fertile pedagogical relation between medical humanities and the long-established area of disability studies and advocacy. In the medical humanities classroom, the presentation of narratives and creative artwork concerning ability require students to confront all the ways in which biomedicine defines identity and capacity, and hence marks people as 'different' in ways that are socially negative. Appreciating these works requires one to join their producers in resisting social norms and the social disempowerment attached to possessing certain types of bodies. Many medical humanities courses – like those that encounter 'patient, doctor and society'[16] – either are the main mode in which such critical engagements with biomedicine are presented to medical students or offer tangible, imaginative, and stimulating ways for medical students to come to grips with them. Many such courses have the cultivation of critical skills as a major aim.

The prioritisation of cross-disciplinary interventions into conventional biomedicine, within the field of medical humanities, indicates the centrality of difference as scholarly concern. Nonetheless, the discourses of recognition and expansive ways of seeing that such cross-pollination promotes is not, as we have elaborated, tending to be reflected within the Westernised content of medical humanities syllabi. Although the medical humanities has been good at incorporating humanistic insight so as to enhance health service delivery, this incorporation of complex gestures towards recognising 'otherness' has not often laid specific, curricular emphasis on obtaining a rigorous, *analytic* awareness of how greatly both our bodies and ideas are Western cultural constructions, by its choice of, or approach to, the content of medical humanities courses. Central to this limitation, as we will explain, is a classroom emphasis on 'receptive' as opposed to critical encounters with difference – an emphasis which is sustained by the objective of 'cultivating empathy' that is promulgated by the field.

Understanding difference: patient experience

The primary way in which the medical humanities explore difference is through appreciating the diversity of patient experiences. The medical humanities have been very good at incorporating the insights of cultural relativism and subjective difference, recognising that it is very difficult – in fact, close to impossible – to truly understand someone else's experience of illness from the outside, or at least without undergoing a similar physical experience yourself [50]. Just think about how different it is to cognitively understand how to fix a broken leg, versus actually *having* a broken leg. Each patient's

reaction to illness is unique. Various existential matters, such as the meanings attached to illness and the way a person's identity changes as a result of illness, are often as important to patients as their physical experience of pathology and recovery. The medical humanities are often used in medical schools to cultivate empathy in student doctors, meaning an ability to imaginatively appreciate some part of what their patients endure[51 52]. It does this very well; a few images in class, for example, may give us more insight into the actual experience of Alzheimer's – for few of us can draw from our own experience as to what this feels like – than any numbers of textbooks listing symptoms and progression[53]. In such a way, patient experience is assumed to be brought closer to, and perhaps even understood, by the medical practitioner.

It is important to acknowledge, here, that whilst the insights into patient experience obtained from art-inspired exercises in cultivating empathy can be both stunning and unique, the assumed transferability of affect and understanding, within these contexts, can hinder, as well as enhance student encounters with difference. Because of the tendency within the medical humanities to approach difference within the aforementioned contexts of 'appreciative' and 'receptive' encounters - devoted to 'drawing close', 'connecting with', 'bearing witness' or 'active listening'[10], 'experience' can frequently disguise itself as empirical fact. Consequently, difference can become reified, dissolving into the uniquely denatured and decontextualised perspective of the individual patient.

The limitations of overly 'receptive' encounters with difference, in the medical humanities, are arguably extended by uncritical engagements with the *location* of culture in social, class-based and geographic terms. Frequently, the works of art, literature, music, philosophy, and history that dominate in the medical humanities and illustrate aspects of illness, health, loss, grief, dying and so forth often come unaccompanied by analyses that identify them as expressive of a hegemonic culture, question the epistemological assumptions they make, deconstruct their representations of class, gender, race and other social characteristics and understand how they silence or devalue the views, texts and thought styles of marginalised groups[8]. This means that the medical humanities can unwittingly cement forms of social and cultural elitism through the unexamined assumptions of shared feelings, reactions, and imaginative referencing – cognitive style or 'getting it' that emerges between individuals who participate in a shared culture[1]. Thus the medical humanities tends to construct and perpetuate an implied ideal of doctoring and/or patienthood that is self-governing, responsive, and reflective in ways treasured by the writers of 'illness narratives' and process journals – and potentially rather excluding for medical students from non- Western or Anglophone backgrounds who find Tolstoy and Chekov confusing, tedious or both. On a related note, the scope of 'culture' itself, even in Western terms, could do with some expansion. While certain individuals, for example Brian Glasser in his course 'From Kafka to *Casualty*', are considering the role of popular culture (i.e. the British television show *Casualty*) in "fostering lay views of doctors and medicine"[54], this move remains innovative, rather than the rule. Moreover, it has not, to our knowledge, been extended towards cross-cultural understandings of the 'lay-person' that medical professionals may encounter in an increasingly globalised world—for example, comparing the Western 'medical soap' with the many depictions of medical professionals proffered in the extremely popular East-Asian genre of the television soap.

Finally, in the medical humanities there is also a tendency to treat the 'identity' and 'experience' of sufferers and carers purely as phenomena intrinsic to the individual, and to which they have privileged access, rather than as *also* constructed by and reflective of the social relations in which they are located[55]. The mass of pathographies – not to mention fictional or autobiographical writings by physicians – similarly tend to naturalise certain features as part of the *experience* of illness and healing, instead of understanding these as *constructed* and expected features of a genre[56]. One troubling consequence of these cultural and epistemological exclusions is that the medical

humanities can perpetuate social disadvantage in spite of the strong traditions of critique that often drive it. In fact, it is easy to perpetuate the norms of white middle class masculinity precisely by treating a disadvantaged group as a special case needing attention, for example, people from other cultures. The key word in this is 'other', an Other that implies a shared norm that goes more or less unexamined when attention is turned away from social disadvantage and towards 'illness experience', 'existential reactions to illness', 'cancer journeys', 'being a patient', 'medical professionalism', 'being an intern' and so on.

An example

We would like to offer an illustrative example relating to the challenges of medical practice in a multicultural society. In a multicultural society, the ideal (frequently unrealised, and subjected to valid modes of social and political critique) is to celebrate social difference rather than to denigrate it or to impose a dominant cultural perspective. Yet numerous studies have established that in Western nations, minority communities typically suffer from greater levels of ill health and have poorer health outcomes than patients identifiable with(in) dominant cultural norms. The reason for these outcomes is debated, but is believed to arise in part from a lack of access to appropriate medical care, and in part as a result of experiencing discrimination and prejudice. Considerable research effort – though often much less than is needed – is expended on understanding the experiences and views of members of minority communities. One such study (from Canada) explored the views and experiences of 'Southeast Asian' women patients and of the health care providers who service this population[42]. The study showed divergent perceptions of health care interactions. Whilst health care providers, some of whom were in fact members of the Southeast Asian community themselves, felt they went to some lengths to ensure that they treated all patients equally, the patients felt that they perpetually encountered racism and discrimination in health care. In the study author's view, this resulted from a subtle process of 'Othering'. All the health care workers were frustrated with their patients' choices and behaviour, including a lack of compliance with treatment regimens or with recommendations for self surveillance and screening. And all such frustrating non-compliance with the norms of medical care was viewed as arising from 'cultural differences', a label that allowed this very diverse population to be treated as a group and, as the authors point out, to stereotype women in ways they clearly found degrading and to bypass these patients as partners in decision making. In fact, a commitment to respecting cultural difference, in this situation, *became* a form of Othering, as experienced by patients. It was, in fact, a way of *not* understanding why women might act in ways so apparently 'not in their best interests', and of labelling anything non-compliant with normative medical practice as 'culture'. This is a form of approaching cultural difference that is congruent with tokenistic and uncritical inclusions of minority 'cultural' works in a medical humanities curriculum.

The medical humanities could play a very important role here, both by using the creative arts to explore the dilemmas of health care providers in these situations in ways that resist the application of simple labels, and by challenging the ways in which our experiences of our bodies and selves, in illness and health, are not simply given but are constructed and reflect a number of assumed norms (including, as anthropologists point out, the assumption that illness and suffering occurs in a single individual body[57]). But this will only be possible if we in the medical humanities cultivate a critical attitude for humanistic medicine, alongside an appreciative and/or receptive one. Notably, this needn't be done through explicit recourse to the structuralist and poststructuralist philosophy that we have explored in this paper. As teachers, we understand that the medical humanities classroom is subject to time constraints. Moreover, we are aware of the dangers of substituting an often equally elite and culturally inaccessible continental philosophical canon for the classical Western cultural canon. We suggest that the medical humanities practitioner can foster productive encounters with cultural difference by practical and inclusive measures. Firstly, one can increase and diversify one's use of non-Western creative works in the classroom, engaging in cross-cultural

comparison where appropriate (e.g. why not compare *Casualty* with Korean *and* Indian soaps depicting medical practitioners?). Secondly, one can lead-by-example, fostering discussion that moves beyond mere appreciation of difference towards an explicit questioning of this term; we can ask our students, not only *what* difference means but *how* it means i.e. how it functions to reproduce, not only undermine, existing power relations by Othering the subjects to which it is applied. Such difficult problems can be quite simply introduced through questions such as: "does an awareness of cultural difference *always* bring us closer to our patients?" Medical humanities students are most often capable and interested scholars and, in our experience, these opportunities for insight rarely pass unrecognised.

Concluding thoughts

Medical humanities must of necessity be a global endeavour. Many universities in 'Western' nations already find that a fairly high percentage of their medical students are either from non-English speaking backgrounds or are 'overseas' students studying abroad. Many medical students from western medical schools will spend a period of time experiencing health care in a developing nation – another task intended precisely to give students the experience of difference, but which, without adequate preparation, can easily become a means of reproducing Otherness. The medical workforce and the patient population will always be diverse, and include members of minority groups. Becoming skilled at encountering difference is of key importance for us all.

Medical humanities programs approach this agenda in different ways. Some put advocacy, community development and social justice at the centre of their curriculum. Some Western and non-Western programs make the cultivation of spiritually-informed styles of relating (e.g. 'mindfulness') central to both making sense of illness and to professional care—an approach which itself can be problematic if local commitments and values are not introduced under the auspices of a thoroughly self-reflexive, 'critical pedagogical' process[58 59]. Other programs encounter difference solely through placing primary pedagogical emphasis upon the scholastic humanities – and here we confess to being a little unsettled when Western versions of these dominate in teaching programs. We do not desire that such rich, sophisticated and ancient cultures as those in China, India, Korea and so forth should privilege Galen (in history), Rubens (in art) and Charon (in narrative), over their local equivalents.

As Fredrik Svenaeus has articulated, "medicine is not only science, but primarily dialogue and understanding"[60]. This paper has been one step, we hope, towards forging the types of intercultural dialogues that might facilitate the transformation of medical humanities scholarship so as to complement its increasingly transnational field of practice. We look forward, not just to adding Chinese poetry or the history of meridian lines to our own curricula, but to having the framework behind the medical humanities completely altered by questioning ideas about patienthood, identity, suffering, relating, autonomy and empathising, as a result. We aspire towards having our concepts of sensation queried, and welcome the troubling of our views on what constitutes 'healthy behaviour' or 'dying a good death'. In this way, we hope, we might come to celebrate and question culture, and difference, together.

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