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Medical humanities: some uses and problems

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ABSTRACT The arts and humanities were allowed into the British medical curriculum in 1993 when the General Medical Council re-structured it in a paper entitled 'Tomorrow's Doctors'. Since then many medical schools have developed humanities modules and the broad term 'medical humanities' refers to these. They can contribute to medical education in at least three ways: as a supplement to what is already in the curriculum, especially for ethics and communication; as an outside critique of medical practice; and to personal and professional development. Nevertheless, there are practical problems concerning appropriate teachers and methods of assessment. Moreover, the dominant interest is now academic research rather than education.

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INTRODUCTION

The arts and humanities have no clear identifying criteria but most commonly they are thought to comprise histories, philosophy, literatures, drama and film, visual arts and music. Their methods are imaginative, analytical, critical, or investigative, and they provide insight into human motivation and relationships as well as enjoyment. They can have a bearing on medicine in at least three ways.

First, the oldest strand is 'arts therapy'. Degree courses in music therapy, art therapy, and so on, have existed for many years. Practitioners emerging from these courses see themselves as therapists and have their own ways of evaluating their activities. Second, there is the overlapping movement known as 'arts in health'. The artists working in this area are not trained as therapists and wish to retain their professional identity as artists, writers, musicians and so on. They use their skills in hospitals and communities to enhance people's interest, creativity and enjoyment of life – which of course affect their health. Third, there is the movement involving the arts and humanities in medical education. It is unfortunate that the term 'medical humanities' has come to be used as an umbrella term for all three movements. Indeed, as I shall suggest in the final section of this paper, it is unfortunate that the term has arisen at all, although I shall continue to use it. It is with the role of the arts and humanities in medical education that I shall be concerned, although the other areas are also important, inexpensive and successful.

EARLY HISTORY

In any new movement the question of 'who got there first' is always contentious, but a case can be made (I shall not insist on it) that the use of the humanities in medical education emerged out of the teaching of medical ethics in Glasgow University in the late 1980s. I was fortunate in being allowed to take part in joint teaching on ethics with Sir Kenneth Calman, who was then Postgraduate Dean at Glasgow University. Our discussions with students involved analysis and criticism of medical practice and human motivation. We found that students were more interested in the details of cases than general principles. Their interest led us to set up an after-hours club for discussion of these matters through literature, film, etc; these meetings were well-attended by students and consultants alike. Encouraged by this I organised five annual conferences in the early 1990s and anthologised material for discussion.[1] More importantly, in 1993 the General Medical Council changed the undergraduate curriculum making room for what were then called Special Study Modules: five weeks of intensive study of anything a medical school could offer.[2] There was encouragement for involving the humanities in some Special Study Modules. Funding bodies such as Nuffield and Wellcome became interested and national conferences developed. The present outcome is that many medical schools in the UK and elsewhere offer options in the medical humanities.

If the humanities are to be allowed into the curriculum it is reasonable to review what they can contribute to medical education or clinical practice. First, they can contribute to topics currently in the curriculum, such as

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ethics and communication. I shall call this the supplementary function of the humanities. Second, the humanities are able to offer detached, third-party scrutiny, a way of putting medical practice into a wider perspective. I shall call this the critical function. Third, the humanities can make a contribution to the personal and professional development of at least some medical practitioners. Despite these positive contributions I shall suggest that the medical humanities face some serious problems.

THE SUPPLEMENTARY FUNCTION OF THE HUMANITIES

In this section I shall be concerned with ethics, communication and the connections between them. The Hippocratic tradition in ethics has of course been re-stated in updated versions such as the Declaration of Geneva, adopted as the Code of the World Medical Association (1968). In recent times codes have been made more specific by medical law and the quasi-law issuing from the General Medical Council in the UK and similar bodies elsewhere. Ethical regulation is of central importance for a clinician but it by no means covers everything of relevance because what it offers is *medical* ethics, or ethics from a medical point of view. But 'ethics' is just a professional name for ordinary right and wrong, and right and wrong, good and bad, extend well beyond the boundaries of medicine.

An influential attempt to connect the ethical problems of medicine with the broader sphere of morality was made in a book entitled *The Principles of Biomedical Ethics* by Tom L. Beauchamp and James F. Childress.[3] They argued that ethical problems in medicine can be resolved by the use of four principles from ordinary morality: non-maleficence (don't harm), beneficence (do some good), autonomy (respect the patient's decisions) and justice (treat patients fairly). Their book has exerted a dominant influence on the teaching of ethics to medical students for generations. But there are problems about how to use the four principles. An influential supporter of the approach, Raanon Gillon, argues that the four principles offer a vocabulary for discussing moral problems in medicine.[4] Perhaps they do, but there is no reason to impoverish our discussions by restricting moral concepts to just four. For example, sometimes a doctor may need to stand up to a manager, or an angry relative. Qualities such as courage, equanimity, tact, honesty or patience may be needed – even humility when things go wrong. The general point is that hospitals or general practices are microcosms of society as a whole – with heightened tensions – and it is therefore necessary to have the entire range of moral concepts to understand their problems.[5] This is where novels, short stories, plays and films are helpful. They can provide condensed versions of the problems of life and confront us with the question: What would you have done? Stories can sharpen judgement.

In any case there is more to morality than principles and concepts; morality has what we might term its adverbial aspect. It matters not just what we do but how and when. In this context it is sometimes said that what is needed is compassion or empathy, and there are many advocates for the teaching of such matters in medical training.[6] But the limitations of compassion or empathy are satirised in a poem entitled *Animal Rights* by Miroslav Holub, a distinguished Czech doctor who was one of the best poets writing in Europe in the second half of the 20th century.[7] This abbreviated version gives the flavour of it:

Animal Rights

Pity for dogs that cry
(boundless pity).
Pity for mice that squirm.
Pity for earthworms that wither helplessly
(limited pity).
....

Patients with progressive amyotrophic lateral sclerosis
can just fuck off. They shouldn't have been born.
Hieronymous Bosch be with them
for ever and ever amen.

This poem can produce animated discussion! The conclusion we usually reached is that doctors, who will be faced with blood, sweat, tears and worse, should try to have a controlled, measured and calm response to ailments of all kinds - too much emotion will get in the way of the job. What is needed is quiet waiting and listening, giving concentrated attention to the patient.

At this point some medical educators will say: 'We know this, and it is taught in courses on communication and listening skills.' There is indeed a vast literature on communication skills. The assumption is that there are generalisable skills that are teachable and learnable and therefore widely applicable. Perhaps there are but their universal applicability is unlikely to extend much beyond such matters as avoiding technical terms, not speaking too quickly, and repeating the message. These things are of course of the first importance, but the attempt to have a complete reduction of communication to a set of discrete skills is bound to fail. Patients and their problems, doctors and their personalities, are too varied for any reductionist approach to communication to be entirely successful. Good communication is not a manipulative technique but is inherently creative.[8] This is where the arts and humanities, especially creative writing or drama or film, can be of help. The arts can bring out the myriad ways in which people can successfully and unsuccessfully communicate with each other.

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They can also illustrate how a human response to a patient is compatible with a technical concern. Paintings can be good examples of this. There is a painting called 'The Doctor' by Sir Luke Fildes which hangs in the Tate Gallery.[9] It presents an eloquent portrayal of what (as it seems to me) medicine is all about; the doctor, the patient (a sick child), the parents anxious in the background, and the quality of the relationship between them all. The emotional impact of the painting is enhanced by noting some of the technical details, e.g. the angle of the doctor's back, the space between his eyes and the sick child, the highlighting of the child in bed. An appreciation of technical detail in art or music can enrich emotional impact. The psychiatrist Jonathan Green argues that works of art 'carry their cultural power by being ways of embodying states of mind' and that 'inferring mental states is not only a core psychiatric skill but also one we exercise in looking at art'. In a telling image he says: 'The painting sucks in attention to itself'.[10] He is speaking of psychiatry but what he says is surely true of medicine more generally. Technical awareness and human response can enhance each other and can produce a unique mode of attention.[11] Fine art and music can bring this out.

THE CRITICAL FUNCTION

The origins of modern scientific medicine are to be found in the school of Hippocrates (around 460 BC). The central doctrine of the Hippocratic School is that every disease has a cause which can be discovered and is curable, and that this knowledge is generalisable. His scientific approach ignores the individuality of patients and concentrates on what diseases have in common. For example, Hippocrates writes: 'Every phenomenon will be found to have some cause' or 'Each disease has a natural cause and nothing happens without a natural cause'.[12] Medicine has been profoundly influenced by this tradition, to the extent that it is sometimes seen as an applied science. As an example of the critical function of the humanities I shall examine this position.

It can be claimed that science is relevant to medicine in four different ways. First, from the Greeks to the present day there have been investigations into the normal and pathological workings of the body, carried out by sciences such as anatomy, physiology and biochemistry. Second, there are observational studies which report such matters as changes in birthweight over a period. Third, there are qualitative studies which might be concerned, for example, with the interaction between doctors and patients. Finally, there are randomised clinical trials. Are these different sorts of research equally scientific?

The subjects in the first group – anatomy, physiology, biochemistry – are clearly sciences. They satisfy the usual criteria for science in that they are observational, reductionist to the factors being researched, and experimental. Their results are quantifiable, generalisable, and frequently offer causal explanations. They are therefore objective in the sense of being independent of personal bias. The second category is more doubtfully scientific. Observational studies may record quantitative changes but such studies belong more to the category of natural history than to science. This of course is in no way to denigrate their importance: facts must be known before causal explanations are attempted. Regarding the third category, qualitative studies are even more doubtfully scientific, being based very much on the interpretation and value judgments of the observing researcher. They are certainly observational but attempts to generalise them by making the qualitative quantitative will actually reduce their value. If something is quantitative, or measurable, there must obviously be factors to be measured. But in measuring, say, 'patient-centredness' the factors selected for measuring, such as the making of eye-contact or the angle of the chair, are quite arbitrary. Some patients do not want to be looked at. The reductionism necessary for quantification makes such studies misleading. The fourth sort of research, randomised trials, is regarded as the 'gold-standard' of medical research and is the kind of research most often reported in the press. But is this the 'gold-standard' of science? Are randomised trials observational, reductionist, experimental, quantifiable, generalisable and objective or independent of personal bias?

They are certainly observational and quantifiable, and they are reductionist in that they set out to test discrete factors, such as the efficacy of a given drug. But they cannot fully satisfy the generalisability criterion in that they are concerned only with statistical probabilities. Moreover, there may sometimes be questions about how the volunteers for the trials are chosen, how the trials are financed and how their results are evaluated and promoted. In other words, there may be doubts raised about the objectivity criterion. More importantly they have two other limitations: one affecting their credentials as science and the other their position in clinical practice.

It could be argued that, even if we ignore their possible failings in objectivity and generalisability, randomised trials do not contribute to the primary purpose of science, which is to offer an understanding of nature. Scientific understanding is usually provided by causal explanations or theoretical models or by providing the connecting principles of nature. If science is seen in this way, randomised trials are really natural history rather than science in the full sense. Of course, there are other views of science. For example, the 17th century philosopher Francis Bacon expresses an alternative view when he says that: 'Truth and utility are here the very same thing'.[13] Without going as far as that the aim of

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funding bodies generally is to promote what they regard as useful knowledge. Perhaps, then, it does not matter whether randomised trials are truly scientific provided they produce useful knowledge. But, secondly, there are limitations to that useful knowledge in clinical practice: limitations which stem from their statistical nature. It does not follow from the fact that a drug has been efficacious in 65% of cases that it will be efficacious with a given patient. Indeed, it might be harmful, or the patient, upon being told the side-effects, might refuse consent. In other words, randomised trials are not the be-all-and-end-all of clinical medicine. Clinical medicine claims to be 'evidence-based', but the evidence of randomised trials compares unfavourably with that of laboratory science or that of a court of law.

In concluding this aspect of the critical function of the humanities I must stress two points. First, the material is offered only by way of a very brief illustration of what a humanity such as philosophy can provide for discussion. Jane Macnaughton and I have developed the argument in detail elsewhere.[14] Many readers may wish to disagree with some or all of it, but in disagreeing they will themselves be engaged in the philosophical enterprise. Second, criticisms of the kind outlined can arise within medicine itself. A philosophical critique of some aspects of medical practice is not exclusive to professional philosophers.

Medical history also can offer a critique of what is considered the 'gold standard' of research in the sense that it can offer a wider historical perspective on research. For example, Sir James Mackenzie, working as a GP in the first half of the 20th century, regarded general practice as the proper place for clinical research. He carried out pioneering work in cardiology in Burnley, London and in the St Andrews Institute for Clinical Research. A study of his work – its successes and failures – can suggest new ways of looking at medical research.[15]

Drama can also place the narrow focus of medicine in a wider perspective. In Ibsen's play *An Enemy of the People,* Dr Stockman is first depicted as immensely popular and his report on the water contamination of proposed baths is acclaimed as scientifically accurate. But many other considerations emerge, involving tourism, jobs and so on, and he finishes up an 'enemy of the people'. The main point is well-made by the play's newspaper editor: 'You're a doctor and a man of science, and to you this business of the water is to be considered in isolation. I think you don't perhaps realise how far it's tied up with a lot of other things.'[16] The humanities, or some of them, can bring out sharply how medical issues, such as public health, are tied in with 'a lot of other things'.

Doctors have a high status in society and are highly respected for the work they do. It is therefore not surprising that occasionally some doctors are seen as pompous and self-important. But literature can provide an antidote, can hold up a mirror for self-reflection. It is true that some doctors in literature come out well, such as the doctor in Macbeth who sees limits to what medicine can do,[17] or Dr Lydgate in George Eliot's *Middlemarch*. Eliot is '…the first English novelist to delineate with historical precision the emergence of a new kind of doctor', one who is devoted both to research and to his patients.[18] But there is also a long tradition which depicts doctors in a satirical way, as figures of fun, for example the Doctour of Physique in Chaucer's *Canterbury Tales*.[19] In opera doctors hardly ever come out well.[20] Most shaming of all, the demigod of medicine, Asclepius, came to a bad end. There are various accounts of him, but he over-stepped the mark when a patient, whom Zeus had decreed should die, was brought back from death by Asclepius. According to the Greek poet Pindar 'Gold glittered in his hand' (same old story) and Zeus destroyed both with a thunderbolt.[21] The myth does not make it clear whether Zeus was annoyed at the introduction of private medicine, or whether it was a punishment for hubris – the attempt by Asclepius to continue life beyond its ordained length. Either way the myth can produce good discussion about the limits, if any, to what medicine should attempt. The humanities can offer a gentler and perhaps more effective critique of the medicalisation of life than the 'in-your-face' arguments of, say, Ivan Illich.[22]

PERSONAL AND PROFESSIONAL DEVELOPMENT

It could be argued that professional development is a matter of attending courses to update medical knowledge and skills, whereas personal development is a matter for the private life of a doctor and is of no concern to medical educators. In some spheres, such as accountancy or plumbing, it may be correct that there is no continuity between professional or public and private life. But this is not the case in clinical medicine. Patients can easily tell whether they are dealing with a genuinely concerned and educated doctor or someone who has been on a training course and has learned what the compassionate doctor is meant to do or say. John Stuart Mill puts the point well when he writes: 'It is important not only what men do, but also what manner of men they are that do it.'[23] Indeed, it can be argued that personal development is a moral duty. Morality is often considered as a matter of checks and balances, ensuring our duties to others. But this is a recent view. Historically speaking, many accounts of the nature of morality give a large role to becoming a particular type of person. The Greeks for instance stress this. Even Kant's maxim of respect for persons as ends is rarely quoted in full, in which he says 'Respect human nature, whether in your own person or in that of another'.[24] In other words, he is stressing that we have duties to ourselves, to develop our own human

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natures. The personal development of the doctor matters both for him/herself and for patients and also, as I shall suggest, for life outside medicine and in retirement.

Personal development can be furthered by the arts but it should be noted that it can also be furthered by an interest in pure science. Science as taught in medical training necessarily has goals internal to medicine, but pure science has goals internal to itself – as a way of understanding the universe and its creatures. In that way it is educative. As simple illustrations of science depicted as a broadening or educative pursuit I point to the television programmes of Sir David Attenborough, Professor Brian Cox or Professor Jim Al-Khalili. If asked, 'What use is your science?' they would be puzzled (although no doubt they would think quickly if a grant application were involved!). What shines through their presentations is their belief that the sciences they enthusiastically explain and expound are among the glories of the human mind. It is also worth issuing the warning that the humanities themselves are not necessarily humanistic or educative. For example, a historian of the French Revolution if asked what it taught about social equality or democracy might well reply, 'I am not interested in that kind of question. I am just interested in the documents and facts'.[25] A historian with that approach is trained rather than educated. The sad truth is that many arts subjects have become infested with jargon and are inward-looking, and consequently fail in their basic humanising function.

Nevertheless, the arts can make a contribution to personal development and via that to professional development. Their contribution can be stated controversially: they provide an antidote to medical training and the whole ethos of medicine. There are two aspects to this, one specific and one more general.

The more specific contribution which the arts can make to personal and professional development is best expressed by the term introduced by Edward de Bono – a former lecturer in medicine at Oxford University - 'lateral thinking'.[26] His main point is that we tend to see the world in terms of certain patterns or groupings. The person with a disposition to lateral thinking is the person who can break away from familiar patterns and discover new ways of looking at things. Intellectually, lateral thinking may emerge as a sceptical disposition towards received opinion and routine. There is a fair amount of both in medical training and practice, but the arts can sometimes suggest alternative ways of approaching problems. More generally, many doctors see medical solutions to all the problems of life, and have encouraged the public and governments to do likewise. Thus, mental illness, disability and drug addiction are usually understood by doctors and the public as medical problems when in fact there may be other approaches to them. Perhaps organising festivals, pageants and firework displays may improve the health in a deprived area more than funding another GP. It has been said that if your only tool is a hammer all your problems become nails.[27] A doctor who can look beyond his prescription pad might be able to suggest other remedies. For example, singing has been shown to lead to improvements in chronic obstructive pulmonary disease and to the enhancing of mental health and wellbeing.[28]

Moving to the more general aspect of an arts contribution to medicine we can note that the most noticeable feature of medical training and practice is that it is highly focused and clearly useful to society. Every code of ethics stresses that the doctor must above all provide a service to others, and every aspect of medical training is practical and goal-directed. One consequence is that medicine tends to colonise the whole personality of doctors. There is said to be a tombstone which bears the inscription: 'Here lies John Smith who was born a man and died a grocer'. Whatever can be said about grocers there is a moral here which doctors should consider. The demanding and prolonged nature of medical training coupled with the tiring and often emotionally draining nature of patient care may leave time for little else, resulting in the diminishing of a doctor's personality. This is where the arts and humanities can offer a remedy.

The nature of the remedy emerges when I admit that many practitioners of the arts and humanities would be uncomfortable with my attempt in this paper to suggest how they may be useful in medical education. For them the arts and humanities are simply worthwhile for their own sake. One of Aristotle's criteria for the highest good is that it must be completely useless.[29] This sounds comic to modern ears. But Aristotle is surely right. Whatever is useful is useful for a given end, which itself may become a means to a further end. Hence, there will be a never-ending chain of means and ends unless we find activities which are worth pursuing just for their own sake. The arts and humanities can be included with pure science among these worthwhile activities. Simply by being worthwhile for their own sake, the arts and humanities can broaden the outlook and enrich the personality of a doctor. This is important throughout a career but also in retirement. Having retired from an absorbing career, many doctors think: what now? Seeds sown in medical education may finally mature and new interests can develop.

SOME PROBLEMS

The medical humanities are currently faced with at least three types of problem: of administration, of content and of dominant aim. Administratively it is not easy to find appropriate teachers. Ideally, medical students who have chosen an area of the humanities of interest to them

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should take part in the relevant humanities classes. But this is difficult to timetable. Another good solution is joint teaching by someone from the humanities and someone from the medical school. Again, there are problems of finding colleagues willing to co-operate. Commonly, a volunteer may be someone from the humanities with an interest in making his/her subject interesting to medical students, or someone from the medical school with an interest in a humanity. Some universities are training specialists in the medical humanities, but there is not likely to be funding to employ them in medical schools, and they may have credibility problems with students. Moreover, however they are taught, the humanities in medical education have problems concerning levels of attainment and methods of assessment.[30]

In terms of their content, the medical humanities are often identified with literature. But many other humanities are equally of interest to students and, as I have tried to show, of relevance to medical education. One consequence of this narrowing of the medical humanities to literature has been an obsession with certain words, especially 'narrative'. The word has become to the humanities movement what 'evidence-based medicine' is to clinicians; a term which encapsulates important truths but is now obscuring other factors of clinical relevance. The importance of the word 'narrative' lies in its stress on listening to patients' accounts of what they think has gone wrong. The term has arisen as part of an attempt to move clinical attention away from an exclusive concentration on laboratory tests and other measurements and to redirect it to the patient. Clinicians of course have always listened to the patient's story. It was called 'taking a case history' and one of the relevant skills is surely being able to ask the questions which elicit helpful information. In a sense then an emphasis on 'narrative' is simply an attempt to alter the clinical balance in that direction, to make the patient feel part of the treatment rather than just an object of scientific interest. While this is admirable it hardly warrants the extensive literature devoted to the analysis of the term 'narrative'.[31] In any case, in contemporary healthcare there is not enough time to listen to anything so grand as a 'narrative'.

The dominant aim of the medical humanities seems now to be research rather than teaching. I commented at the start that the introduction of the term 'medical humanities' has been unfortunate. The reason is that it has suggested that the 'medical humanities' comprise an academic subject. Now if something is to be an academic subject there must be research, and funding bodies such as Wellcome have given millions of pounds for research into this alleged subject. But the more 'academic' the practitioners of the medical humanities become the more they will drift away from their original educational purpose. The danger is that researchers in the medical humanities will finish up speaking only to similar researchers rather than to the medical students and clinicians we originally hoped to interest.[32]

CONCLUSION

An excellent description of the educational role we originally envisaged is captured in the name of the centre in Durham, set up by Sir Kenneth Calman. It was called the Centre for the Arts and Humanities in Health and Medicine (CAHHM). This acronym brings out that there are many arts and humanities, and they may contribute in different practical ways to different areas of medicine. They can offer historical or philosophical perspectives and suggest new or alternative approaches to existing courses. Above all they can encourage creative thinking and a humane and balanced approach to patients. It will be unfortunate if this outward-looking aim is turned into an inward-looking purely academic activity.

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