**Medical Humanities & Arts to Address Emotion in Medical Training and Beyond**

I discuss how the humanities and arts can be integrated into medical education with the purpose of developing more emotional awareness and skill through the cultivation of both emotional intelligence and emotional regulation. Specifically, I explore how exposure to the humanities and arts combined with guided discussion can help students use critical self-reflection to first, to excavate and examine their own and others' emotions; then to recognize how such emotions are differentially reinforced or suppressed within the culture of medicine; and finally, to evoke alternative emotional responses, including witnessing, solidarity, and connection, that offer different meaning possibilities in terms of student-patient relationships.

**Medical humanities was originally linked to humanistic medicine.** Historically, medical humanities was often linked with the liberal project to (re)humanize medicine, which in the post-Flexnerian era, was perceived to have lost compassion and caring for patients. **Recent criticisms focus on: a) theoretically inaccurate pairing humanities and humanism b) utilitarian approach to "producing" empathy, humanistic qualities c) limitations of empathy, humanistic qualities themselves d) humanities wrongly being seen as "soft" (dealing with feelings) as opposed to "hard" (dealing with critical thinking, rigorous analysis).** In recent decades, scholars have expressed concern both at the confounding of humanities and humanism; and at the utilitarian assumption that studying humanities can "produce" compassion, empathy, or caring. Further, several scholars have questioned conventional wisdom about constructs such as empathy and trust, revealing that such emotional connections between doctor and patient can be put in the service of control and manipulation. As well, there has been alarm that the humanities in the medical context will inevitably be perceived as "soft," lacking rigor (Belling). This latter view has culminated in the AM article proposing an emphasis on the "hard" intellectualism of philosophy and a diminished emphasis on narrative.

**Need to establish link between humanistic qualities and emotion** Humanistic qualities are often expressed behaviorally, verbally and nonverbally, but they are underpinned by emotions/attitudes (and associated cognitions) such as sympathetic joy, caring, compassion, empathy, and self-awareness.

**Medical education ignores trainee, physician, and patient emotions.** These critiques, which have considerable merit, dovetail with longstanding trends to ignore emotion in the medical education context. Emotion is seen as unregulated, unpredictable, dangerous, and perhaps feminine in a negative sense of the word. Researchers in empathy in medical

contexts have gone to great lengths to pare away the “emotional” overlay of the term, reducing its definition to a purely cognitive, therefore controllable, construct.

**As a result, learners are left to their own devices to develop skills in identifying and working with emotion in clinical practice. Yet this is an essential need.**

These trends all coalesce to discourage engaging the humanities as a way to experience, analyze, probe, and examine emotions in medical training and practice.

**Medical humanities and arts offer an effective way to address emotions in clinical practice.**

## How the Medical Humanities/Arts Can Cultivate Critical Appraisal of Emotional Reactions and Attitudes toward Patients

Since learning to recognize and work with emotions cannot be a purely academic exercise, innovative pedagogical approaches need to be employed. Presenting theoretical constructs such as emotional regulation and mindfulness in a didactic lecture is important in order to give learners cognitive frameworks for analyzing the complex range of emotions triggered in response to clinical exposure and in particular to vulnerable populations. In addition, however, it is important to identify teaching strategies that enable students to examine professionally-related emotions in a particularistic and humanistic fashion.

Distance and connection and all the points on the continuum between these two endpoints are emotional positions that can be accessed particularly well through study of the humanities and arts, especially those with an orientation toward medically relevant themes (*medical* humanities/arts [Campo, 1009]). The source material of literature (prose and poetry), as well as of relevant visual and performing arts, such as painting, theater, and dance, is intended to engage the emotions as well as the intellect (Levy, 72; Montello, 185-197). When one recites a poem, gazes at a painting, or watches a play, if the work of art is successful, that person experiences an emotional response triggered by

the reactions of the characters portrayed to their own life circumstances. Thus, this aspect of the humanities can provide fertile ground for subsequent analysis and examination of emotions in both oneself and others (specifically, those of the characters represented in the work of art) (Bleakeley, Marshall, and Bromer, 205, 210-211).

The medical humanities and arts have shown theoretical (Charon, "Narrative Evidence-Based Medicine," 296; Greenhalgh, 247-265), anecdotal, and some empirical promise (Foster and Freeman, 297-300; Hurwitz, Greenhalgh, and Skultans, 12; Shapiro et al., 102-105; Shapiro, "Can Poetry Be Data?",174) in terms of helping students to become more aware of emotions and their role in medicine; learn how to critically question the role of emotions in clinical practice; and, as a result, to express multidimensional empathy. In writing about narrative permeability, for example, Heiserman and Spiegel (472-473) argue that film facilitates a dynamic, yet safe, engagement with difficult emotions such as fear, dread, longing, and shame. It has also been suggested that narrative approaches, by integrating experience into cognitive frameworks, can facilitate the down-regulation of disturbing emotions (Hill, 9-10). The relevant premise behind such humanities-based teaching strategies is that, by engaging with and encouraging reflection on the emotions, the humanities/arts create familiarity with emotional landscapes as well as an awareness of how the interplay of emotions in clinical settings affects both patients and physicians. Such familiarity is the first step in learning how to modulate emotional reactions to enhance their appropriateness to the particular setting and circumstances in which they occur.

The integration of the humanities and arts in medical education can also be a powerful aid in helping learners to cultivate emotional intelligence and regulation. For

example, the reading a medically-themed poem, attending a reading of the play *Wit*, or viewing the performance of a dance troupe of individuals with and without disabilities can encourage emotional intelligence in learners by helping them to develop an awareness of the existence of emotions; improve their ability to discriminate different emotional states; learn how characters portrayed act on or respond to different emotions; and examine the consequences that result. Follow-up discussion of such encounters can afford the opportunity to practice the expression of different types and levels of emotion, in an effort to gauge appropriate and meaningful ways of engaging with patients and their emotions.

This type of humanities-based, emotion-focused teaching typically occurs in small groups of 10-15 students, in which the faculty facilitator is committed to creating an atmosphere of safety and nonjudgmentalness, so that students feel secure in admitting "negative" emotions they may perceive as inappropriate or unprofessional (Berman, 235-245; Shapiro, Kasman, and Shafer, 235). Ideally, teaching that explores the emotions is guided by an interdisciplinary faculty team (e.g., physician, psychologist, medical humanities scholar), so that the investigation and expression of different emotional perspectives can be modeled. This approach is designed to validate the emotional world of the learners (Browning et al., 909-910).

The use of humanities and/or arts as an emotional prompt has the advantage that the source material is removed from direct patient care. As has been pointed out elsewhere the humanities are valuable precisely because they are works of the imagination. In studying and responding to them, the student does not have the pressure of interacting with an actual, living, suffering patient (Shapiro, "Using Literature and

Arts…", 473-494). The fear of "making a mistake" is thus reduced. Further, the focus is shifted (initially) from the patient to what the student is experiencing in response to the scene described or portrayed. Emotional excavation can expand, of course, to include the characters or voices represented in the selection, but here too distance works in favor of authentic self- and other examination. Students are free to speculate, to *imagine*, the emotional perspectives of those described without fear that they will not do justice to, misrepresent, or even insult a living, breathing human being. A poem, story, skit, or canvas is a place to practice interpretation, to learn to support those interpretations with evidence, to make corrections as needed.

Once such analysis occurs, students can then begin to explore different ways of working with the emotions created by the particular situation. If the patient is afraid and mistrusting, how might she be approached? If the student is defensive and angry, how might this affect the interaction? How can the student work with emotions to soften more negative responses to patients or supervisors, and to develop emotions of fellow feeling, compassion, and caring that might facilitate a more productive outcome? These and many other questions can be addressed through a series of mini-roleplays, in which students can empirically access, then enact different emotional responses, to consider where they might lead. One especially promising approach for developing this type of emotional skill is through forum theater (Sullivan and Lloyd, 632-633), in which dramas are interrupted to allow all participants to experiment with more supportive and useful interactions (Malchy, Johnson, and McBride, 61-72).

**Humanities-based teaching can utilize a three step process that teaches a critical engagement of the emotions: 1) Learning to accept rather than smooth out difference; and accepting that understanding of the other is always incomplete. This stance addresses emotional issues of "no-difference," dealing with fear or**

**helplessness by explaining them away. In this case, the fundamental aspect of "alterity" outside of self is accepted, and uncomfortable emotions surrounding this reality are examined and queried. 2) Learning to see self in others, both in terms of woundedness and wholeness (empathic identification). This process emphasizes seeing all aspects of the other – and of self - clearly, including strengths and weaknesses, frustrations and rewards. As this occurs, students learn, not that they are "the same" as their patient, but that they indeed share a common and flawed humanity. They are able to accept that, in this respect, both doctors and patients have vulnerability and imperfection in common. 3) Learning to be open to mutuality in the physician-patient relationship, for example to see the vulnerable other as healer and teacher, as well as sufferer and patient. This way of understanding the vulnerable patient acknowledges a bidirectionality to the relationship, recognizing what the patient gives to the doctor, as well as what the doctor provides the patient (Rabow, Wrubel, and Remen, 1426 ).**