PRIME III MAY 2012

Panel discussion: "How to Integrate Humanities and Ethics into Medical Education: A Panel of Art, Ethics, History, and Literature Educators"

Why Integrate: Purposes of literature in medical education

My assignment is to discuss the integration of literature into medical education. But before addressing the how, we have to consider the why **(slide 1 – how and why).** The role of literature in medical education is not completely self-evident, despite extensive theoretical work and on-the-ground curricula addressing this issue.

Theoretical, philosophical, and existential questions

Critical theoretical, philosophical, and existential issues regarding the nature of medicine itself are implicated in questions about the role of literature in medical education. **(slide 2)**. Is medicine fundamentally narrative or analytic in nature? Is it disease-oriented or patient-oriented? Is it a technical enterprise or a moral enterprise? Should it prioritize efficiency or humanism? (Obviously, these are posed as either/or questions for dramatic effect, but the answers to some degree will always be both/and). Still, how we answer such questions has ramifications for how we conceptualize the role of literature in medical education, how important a place it should hold, and how it should be integrated.

Narrative Medicine

As an illustration, let's look at the concept of narrative medicine **(slide 3):**
Narrative medicine has been variously defined, but at its broadest it certainly includes developing a "sense of story" in practitioners, an appreciation for and understanding of the fact that, from a certain perspective, medicine is a story-telling enterprise. Patients offer their stories to physicians, who reinterpret and try to make sense of them, and then present them back to the patient for the purpose of alleviating suffering and restoring health and wellbeing. Elements of narrative medicine include **attention** (being fully present in listening to, observing, and attending to the patient); **representation** (how the patient is portrayed - in writing and in telling – to colleagues, learners, the patient herself and her family, and to the self of the physician); and **affiliation** (commitment to adopting a position of compassionate solidarity with the patient's suffering, empathy for the patient's perspective, and advocacy for the patient's needs) – a position that offers a stark contrast to emotional detachment.

Not everyone agrees that narrative is a critical dimension of medicine; but to the extent that it is, it suggests the importance of integrating literature into the curriculum because of what we understand *medicine* to be.

Medicine as a practice profession

Despite the importance of theory, medicine is not primarily a philosophical exercise. As Donald Schon pointed out decades ago, medicine is a practice profession **(slide 4)**. It does things, it is all about how to do things, and how to do things better. Therefore it is important to consider what it is that we think literature "does" in medicine and medical

education. As most people in this room know, this is not an uncontroversial topic. I am not going to try to resolve it, but I'd like to frame some perspectives.

Physician well-being and improvement project

The value of literature in medical education has been touted on many grounds, and slammed on precisely those same grounds. For example, some understand the use of literature in medical education as primarily a physician well-being and improvement project argument (**slide 5).** In this view, literature restores the soul, and is an antidote to burn-out and disillusionment, while also having the effect of creating more broadly educated and cultured practitioners. This view implies a somewhat superficial sprinkling of literature within the curriculum – the occasional "poetry break." Such a formulation has been criticized as decorative and ornamentalist, in which the occasional exposure to literature is a palliative adornment to the real, more essential curriculum of medicine. Critics of this position lament that literature here has been subverted for the purpose of keeping medical practitioners patched together, so that they can continue to carry out the functions of the medical power structure.

Instrumentalist production of empathy and compassion

There is also the instrumental rationale, i.e., that the study of literature can somehow "make" physicians more compassionate and empathic **(slide 6).** Reading literature will encourage the cultivation of caring and other virtues toward suffering others. Since everyone wants caring doctors, this claim suggests more extensive curriculum in the humanities along with rigorous measurement that the poems we will presumably require students to read are actually accomplishing this utilitarian purpose. Criticisms of the assembly-line approach for producing nice doctors include skepticism that such an outcome is even possible, as well as critiques of simplistic formulations of empathy and compassion, noting that these constructs can be used, albeit unwittingly, to manipulate, oppress, patronize and generally support the existing status quo. Critics fear that, from this perspective, literature ends up serving an "additive" function, intended to compensate for the deficits of medical training Stempsey, for example, writes scornfully about humanities courses that attempt, futilely in his view, "remedial humanization" of learners.

Pedagogy of discomfort and resistance

There is also the position that literature in medical education can best serve learners by creating a pedagogy of discomfort and resistance **(slide 7),** in which the role of literature should be to "catalyze emancipatory insights" and to create an environment of sustained critical interrogation. Literature should not shore up the status quo in medicine, but instead should help learners question their own and more importantly the system's preconceptions and prejudgments to make transparent the values, culture, and ideology of medicine. According to this view, literature should provoke discomfort and resistance in learners, and disrupt their conventional thinking. This position may strike some as excessively confrontational or ideological.

Value in each model

Each of these formulations has something of value to offer. In the first model, understanding how studying literature can promote physician wellbeing is a goal worth

pursuing. In the second model, how literature can help physicians learn to choose nuanced and humble attitudes of empathy and caring toward patients also strikes me as a laudatory outcome. And in the third model, the use of literature to develop critical analysis and questioning of assumptions also seems meritorious.

Two essential skills

To return to narrative medicine, I believe that through understanding stories, learners can develop two specific skill-sets that contain elements relevant to these three models of integration: Specifically, these skill sets are first:

- **Critical thinking/reflective capacity** (**slide 9)**
- Self-awareness and self-understanding
- Appreciation for multiple perspectives (perspective-taking)
- Capacity to identify and interpret meaning
- Cognitive disequilibrium
    - Interrogating assumptions/values, both self and others (becoming aware of culture of medicine
    - Tolerance for emotional/intellectual ambiguity and uncertainty

- **Awareness, interrogation, cultivation of values/attitudes/emotions** (slide 10)

***** Developing emotional intelligence

*learning about/working with emotions

- Cultivating attitudes and emotions

*Empathy, Compassion

*****Altruism/service

*Establishing emotional resonance/emotional equilibrium in patient care

I believe that with these skills, future physicians will achieve improved patient care through

- greater attention: presence, respect, and witnessing toward patients
- greater representation: more respectful, nuanced, and patient-centered portrayal of patients and
- greater affiliation in the form of attitudes of humanism, empathy, and caring