STRANGERS IN A STRANGE LAND: WHAT ARE THE HUMANITIES DOING IN MEDICAL EDUCATION?

SLIDE 1: Good afternoon, everyone. My name is Johanna Shapiro, I'm a professor of family medicine at your sister institution to the west. I'm a psychologist by training, and for the past 16 years have directed the Program in Medical Humanities at UCI-SOM, so I am qualified to speak on the topic of being a stranger in the strange world of medicine.

SLIDE 2: Anyone who is not an MD and who ventures into the world of medicine for teaching or research purposes finds themselves in a very strange land. Even some MDs can feel it is a bewildering place.

But for us non-MDs, our best hope for survival is to become, in the words of the famed neurologist Oliver Sacks, an anthropologist on Mars. We must become acquainted with

- **a new language – medical-speak**
- **totemic objects – stethoscopes and white coats**
- **unusual customs (such as discussing flesh-eating bacteria over lunch)**
- **and rituals (knocking on exam doors, entering before pt says come in)**
- **a still (for many academics) a strikingly hierarchical structure(in which learners, especially medical students, are at the bottom of a very tall totem-pole**
- **priorities – health care systems that sometimes seem to prioritize insurance coverage and paperwork over patient wellbeing**

SLIDE 3: Like most cultures, the culture of medicine is not monolithic or static In fact it is comprised of competing world views and priorities. Just to mention a few of medicine's creative tensions:

- **pressures for productivity and efficiency vs. patient-centered care, humanistic values**
- **reductive, linear, cause and effect model of health and illness vs. a narrative, sometimes circular, multi-determinative way of understanding health and illness**

SLIDE 4: So one of our tasks as strangers in a strange land is to try to listen rather than talk; try to be open-minded rather than judge; and try to understand rather than advise.

But today I'd like to focus on the other side of the equation, which is that, as strangers, in addition to our naivete, the humanities also come bearing gifts. Hopefully, the humanities do not represent some kind of Trojan horse that, if let in past the gates guarding the medical establishment, will seek to undermine its very essence. Rather, at their best humanities and arts can offer medicine true gifts that can support and complement the best goals of the profession.

Because I chose to paint this presentation with a broad brush, it may rightfully be accused of superficiality. I recognize that the humanities have much to offer medicine in the way of very specific skills and capacities, such as improving communication skills, visual diagnostic skills, and ethical problem-solving. But for today I want to discuss what the humanities can offer medicine in a more abstract and philosophical sense. I believe that one of the most valuable gifts which we can potentially contribute to medicine and the medical education enterprise is that of PERSPECTIVE. And one way the various perspectives of the humanities are expressed is through METAPHOR.

SLIDE 5: Now we all know that metaphors compare unlike things to find similarities; and to give us new ways of thinking about the things we think we know. Metaphors are valuable because they can give us new insights and help us discover the meaning of things. Like Emily Dickinson's injunction to "tell all the truth, but tell it slant," metaphors help us find A truth about medicine, but we will find that truth at a slant.

SLIDE 6: Of course, metaphors have limits. Metaphors themselves are reductive, and while working within the metaphor can be revealing, it can also be constraining.

For example, in thinking about what the humanities can offer medicine or medical education, we might make an analogy to the old story of the blind men and the elephant. Each humanities discipline may feel the trunk, or the tusk, or the tail of medicine, and bring insights based on its own academic traditions and perspective. The hope is that, by working together with physicians and medical educators, we end up not with some desiccated reconstruction of an elephant in a museum, but a living, breathing, vibrant animal, that trumpets and sprays water… well, you see what I mean about the limits of metaphor.

SLIDE 7: The first metaphor I'd like to mention is what remains the dominant metaphor of medicine itself – and that is the biomedical metaphor. Now many people especially many medical students and physicians would argue that biomedicine is not a metaphor, it is just how things are. Of course, there is a truth, a powerful truth, to this assertion. But in addition to being "how things are," biomedicine is also a metaphor.

SLIDE 8: If we deconstruct this metaphor, we discover that, despite our talk of patient-centered medicine, the primary focus of medical education is still on disease, especially on the differential diagnosis, treatment and prognosis.

SLIDE 9: In this metaphor, the patient becomes equated with the disease. Dr. Lyons mentioned yesterday the importance of referring to patients by their names, not by their diseases. But in reality, their names are often much less important in this metaphor than their disease. The Methods used to make this metaphor "work" include dispassionate observation, increasingly abetted by diagnostic and evaluative lab tests and imaging studies, and clinical reasoning.

The Skills required in this metaphor are mastery of large quantities of scientific information preferably encapsulated in randomized control clinical trials; ability to generate differential diagnoses; versatility with relevant technologies and pharmacotherapies; and for certain medical specialties, comfort with and knowledge of surgical interventions.

The role of the physician is first as Arthur Conan Doyle realized in the 19th c. that of master Detective, and of course we all know that Sherlock Holmes was based on the physician Dr. Joseph Bell, for whom Doyle clerked; and then, once the diagnostic mystery has been solved, the physician becomes the Fixer and Curer-in-chief. Arthur Frank has described this as a restitution model, in which the doctor identifies the problem, prescribes the solution, and restores the patient to pre-illness status.

SLIDE 10: The humanities bring different metaphors to the study of medicine. Since efforts to understand medicine through studying literature have perhaps the oldest pedigree, dating back to the 1970s, I will start here, with what more recently has been called NARRATIVE MEDICINE.

Here are two doctors debating the putative value of a literary complement to the study of medicine: VIDEO

SLIDE 11: In a literary view of medicine, the dominant metaphor is the patient as text; the Method emphasizes close reading. The Skills emphasized are critical thinking, empathic perspective-taking, and emotional awareness and resonance with the condition of various characters. The role of the physician is that of Close Reader, Interpreter, and perhaps Co-Editor as she works with the patient to co-construct a healthier, more hopeful story.

SLIDE 12: Doctor as close reader.

SLIDE 12 A AND B: Twisted Smile
What does this story has to say about medicine that might not be learned on a surgery clerkship?
Inverts classic role of physician as hero and primary protagonist
Emphasizes the social determinants of healing and the resiliency of patients and families
Shows the importance of humility in medicine

SLIDE 13: Another metaphor comes from the study of art. In this approach, a painting becomes a metaphor for the patient.

SLIDE 14: Here the Method is close visual observation, as expressed through the Skill of Visual Thinking Strategies, organized around the questions: What do you

see? What's going on? Why do you think that? – an approach that in itself closely parallels the method of close reading of literature.
BACK TO SLIDE 13: So to practice In this metaphvisual thinking strategies for a moment, what do you see? What's going on? Why do you think that?

SLIDE 14: In this metaphor, the doctor is similar to an art historian, bringing expert knowledge and finely honed interpretive skills to bear on the patient.

SLIDE 15: This approach, like others in the humanities and arts, can bring new insights. For example, here are two pictures of chairs. Which one do you like best? Show of hands – chair 1 or chair 2? When an art professor asked this of a group of about 30 medical students, the large majority indicated they preferred chair 2 because it "looked like a chair." The other chair was confusing, a mess. The art professor said she liked chair 1 precisely because of its unpredictability and creativity. This led to a discussion of the ways in which a "difficult" patient is like chair 1.

SLIDE 16: Doctoring as Performance. There are those in performative studies who argue that metaphors of text and painting are too static and place too much power in the hands of the physician. They argue that doctoring is a performance.

SLIDE 17: Some, like Randall Longnecker and Paul Haidet, have compared the interaction of doctor and patient to jazz, in which the patient is a musician in an ensemble, the Method is Improvisational music-making, the Skills are listening, blending, and the capacity to take creative initiative. The physician's role is both that of another musician, but also the band leader.

SLIDE 18: In this model, the physician must learn to create "communicative space" (something Miles Davis was known for); not be afraid to develop a fresh and original sound (in other words, to let her personality infuse her doctoring); and to know how to create an ensemble, referring especially to the medical team, in which people must know how to solo and how to blend together in creative harmony.

SLIDE 19: A variation of the improvisational metaphor is found in theater. In this metaphor, the patient is an Actor; the Method is Improvisational Theater techniques; the Skills have to do with delivering a convincing performance, knowing how to respond to rapidly changing circumstances; and the doctor is both an Actor and at times the Director.

SLIDE 20: I would like to very briefly allude to a couple of other humanities disciplines that offer different metaphors. For example, one way – and I stress it is only one way - of thinking about the History of Medicine is that it situates doctoring within the framework of Time. You know, it's a strange irony that a profession so preoccupied in some sense with time can also be so unaware of itself as a chronological phenomenon.

SLIDE 21: Not only do we live in an ahistorical society, but, medicine with some notable exceptions, tends to ignore its own history. For example, few medical schools require the study of the history of their own profession. When medical students think of the history of medicine at all, they tend to see it as an unblemished upward trajectory, culminating in the perfection of the present moment. The study of the actual history of medicine can complicate this view and teach much-needed humility when we learn that, in addition to its triumphs, medicine has often been wrong and misguided. The study of history can also help situate current medical practices within historical contexts of race, class, and gender. For example, it is instructive to recall that at one point in our history attempting to escape slavery was considered a mental illness, drapetomania.

SLIDE 21A: In the historical metaphor, the patient is once again a text, but an historical one. The Methods used are historical inquiry including Skills of critical thinking and attention to context. Here the physician's role is that of an historian, paying special attention to the patient's familial, social, and cultural history.

SLIDE 22: Finally, although bioethics is well-established in its own right, I will just mention that philosophy and ethics present the metaphor of medicine as a moral enterprise, rather than a primarily scientific and technological one.

SLIDE 23: For example, philosophy offers the idea that every patient interaction can be understood, in Martin Buber's terms, as an I-Thou rather than an I-It encounter. Philosophy encourages us to ask, as did the philosopher Emmanuel Levinas, what is our moral obligation to the alien other, who in the medical context often presents as homeless, substance-addicted, or mentally ill.

SLIDE 23A: The philosophical metaphor emphasizes the patient as a moral other; the Methods used involve variously principalism, casuistry, relational ethics, virtue-based ethics. The Skills include moral reasoning and cognitive analysis, and the physician is understood as a moral agent, both toward individual patients and toward society as a whole.

SLIDE 24: In thinking about the metaphors offered by these various humanities disciplines, each has its limits, each describes only one facet of the elephant, but each can make a significant contribution in helping medical students better understand what it is they are learning how to do. Each metaphor offers a slightly different perspective; each generates a slightly different dimension of reflection, and each offers slightly different skills.

Medicine is a practice profession. In general, it eschews the navel-gazing of the academy in favor of action, hopefully action that reduces distress, improves health, and sometimes saves lives. But even in such an action-oriented profession, its practitioners must sometimes pause, step back from the seemingly unending daily tasks, and think more broadly about themselves and about healthcare in general. No one metaphor can adequately prepare physicians for the extraordinary challenges of

clinical medicine. Learning to think from different disciplinary perspectives about their profession through reading texts, viewing paintings, even listening to music, or enacting skits, and of course interacting with real patients eventually will result in self and other aware doctors who can think in creative, out-of-the-box ways about both specific clinical situations and about the nature of medicine itself.

SLIDE 26. To return to my opening remarks, we non-physicians are strangers – and guests – in the world of medicine. We do bring gifts, complementary understanding and perspectives being one of the more important ones. We must remember that gifts of insight and different ways of seeing should be extended with humility, care, and respect. We should remember that it is only by working together that we can reconstruct a living, breathing elephant.