"The Medical Humanities," for Lack of a Better Term

Recently, I returned from addressing a conference in London, one that had been convened to discuss issues relevant to what was called somewhat vaguely "the medical humanities." Among the few hundred attendees were poets, physicians, filmmakers, nurses, sociologists, literary theorists, art therapists, ethicists, photographers, medical students, hospice workers, historians, representatives of public and private grant-making organizations, musicians, philosophers, occupational and physical therapists, dancers, and patients—many of whom, like me, owing allegiance to more than one such group. The gathering was also both international and multicultural, with Americans and Britons of various roots (Indian and Latino, Nigerian and Scottish) mixing with their Chinese, German, Cuban, Scandinavian, and Australian counterparts. The greatest paradox of the meeting, however, soon became apparent: here we were, scientists and artists from across the globe, all deeply concerned about the growing dehumanization of medical care, yet quite unsure about under which inspiring banner, exactly, we might most effectively unite to combat it. "So, what are the medical humanities, anyway?" asked a savvy medical student during a break as we nibbled on cookies, neatly summing up the vast yet unspoken problem we had posed to ourselves from the outset.

My initial reaction to his question enacts the very difficulty of even attempting to conjure up such a definition. On the one hand pour in all the emotions of knowing intuitively that the way medicine is now taught and practiced is simply *wrong*, that the humane is being supplanted by unfeeling science and uncaring economics—the incalculable distress I feel when I hear an intern refer to her patient as "the breast cancer in room 718," the ephemeral sadness in cutting short a visit before we can delve into my patient's grief at the loss of her husband because I have three others waiting. On the other hand clamors the need to articulate rationally, in language not only my physician colleagues but also the likes of health administrators and policy makers can understand, just what it is that I do—and that this work is not amorphous and merely sentimentally gratifying, but can be productively studied and harnessed.

Ironically, the more tedious difficulties of practicing medicine in a modern era increasingly dominated by economic constraints,[1-5] technological hubris,[6,7] and multicultural differences[8,9] are painstakingly described in the medical literature. "Distancing," the process whereby physicians remove themselves from the particulars of patients' experiences of illness so that they may render accurate diagnosis and treatment, has also been thoroughly addressed, albeit more theoretically, by ethicists and social scientists such as Howard Brody and Frank Davidoff—and is enacted (and sometimes poignantly interrogated) in the memoirs of physician-writers like Jerome Groopman, Perri Klass, Danielle Ofri, Richard Selzer, and Abraham Verghese. Yet all our knowledge of these invidious forces has failed to prevent them from frankly imperiling the work of doctoring in our moment, converting it from a sacred vocation borne of the desire and duty to alleviate suffering into a merely financially rewarded, technically challenging line of work. Thus, many of us find ourselves looking instinctively to the humanities as a source of renewal, reconnection, and meaning.

Alas, even "the medical humanities" as a rallying cry may ultimately provide little help in relieving such a predicament. It neither asserts the goal of educating aspiring physicians to be more empathetic, as we cannot invoke the word "medical" without automatically thinking of today's dominant, antiempathetic biomedical approach to treating patients, while "humanities" fails to stipulate just what in so far-reaching a realm is truly relevant to the ill and their care providers. It seems as a construct utterly exhausted, attenuated by decades of trying to encompass all that the invincible biomedical model of medicine actively ignores; it even risks sounding petty and adversarial, as if medicine were unremittingly inhumane. Despite some public exposure in such divergent forums as *Academic Medicine*[10] and *The New York Times Magazine*,[11] no conception of "the medical humanities" compels, caught somewhere between manifesto, mushiness, and marketing lingo.

This deficiency is magnified by the concomitant realization that medicine, in so losing sight of how the arts and humanities inform and elevate the work of healing, is only following in the footsteps of larger societal trends. The view of any kind of work as simply a means to the all-important paycheck is widespread nowadays, and distancing pervades most human interactions, from telemarketing to televangelism. Anti-intellectualism is the order of the day, and we are told culture has been "hijacked" by elitists. What high-powered, busy professional—lawyer, banker, architect, or business executive—has the time, the imaginative wherewithal, or even the inclination to integrate an appreciation of Bach or O'Keeffe amidst his or her onerous daily tasks? Perhaps it is expedient to blame the shortcomings of modern biomedicine on the stereotypically bespectacled, heartless philistine hiding behind his bleeping machines in his white coat, rather than to look more critically at the economic pressures that have so harshly changed medical practice; perhaps we only heighten the perceived antagonism between science and the humani-

©2005 American Medical Association. All rights reserved.

Downloaded from jama.ama-assn.org at DURHAM UNIVERSITY on January 4, 2012

ties by convening "medical humanities" conferences in the first place. Can we really expect beleaguered clinicians and medical educators to teach ethical thinking or to nurture compassion in trainees who come to their prospective profession lacking these fundamental personal virtues that more appropriately ought to have been instilled in them by their parents, or by immersion in what should be a healthier, more universally humane society?

Amplifying these concerns is an even thornier one: can we even be sure that teaching humanities in a medical context might in fact humanize medical care? While it is true that such groundbreaking clinicians as Rita Charon and James Pennebaker have begun to study the impact of human creative self-expression on medicine—from potential effects of understanding narrative on medical education, to the possible therapeutic action of writing or painting on the afflicted—to date, no one has proven that injecting the humanities in any form into medical settings translates to more humane physicians or better cared-for patients. Such proof, coming as it ostensibly must in the form of *P* values and χ^2 tables, might present its own difficulties, as most true humanists resist the notion that such unquantifiables as empathy and suffering could ever be explicated by the scientific method in the first place. (Unlike a new chemotherapeutic agent or even acupuncture, the unwieldy, ever-complicating humanities do not lend themselves to neat randomization in a clinical trial—not to mention remuneration according to *CPT* coding.) Thus, the very language needed to convince the most hardcore medical scientists of the utility of humanistic approaches becomes distasteful, if not downright unworkable, to those who would rather speak through the peerless eloquence of a poem by Dickinson or the hair-raising awe of viewing Michelangelo's *Pietá*.

With no solid premise upon which to build, there quickly next arises the equally daunting and yet more urgent task of distinguishing and then choosing between competing programmatic views of the medical humanities to put into practice. A sense that some kind of change is afoot in medicine, fueled by the burgeoning dissatisfaction both patients and clinicians express for the field, insists that we act now. Real reform never waits for fully rational justification, anyway—the most impatient humanists among us could point to the tempestuous changes of the Renaissance or even the French Revolution for their historical precedents—and indeed, it is passion (and not more pretest probabilities) that the profession so sorely lacks. Delegates to the conference seemed far more readily disposed to assign themselves as members of one of two entrenched camps as regards how to implement change—the pragmatic act of self-classification perhaps having been born of necessity, in the effort to survive at all amidst prevailing biomedicine's highly quantitative and compartmentalizing culture.

A first and perhaps more philosophical outlook demands a fundamental "sea change" in the approach to teaching medicine and delivering medical care, such that every course during medical school and every rotation during residency training (and even every CME course) be rethought and revised through the lens of humanities discourses; while at another extreme, a more nuts-and-bolts view seeks to establish the medical humanities as an independent academic discipline on par with biochemistry or cardiology or any other, with its own faculty members, academic journals, curricular offerings, and clear-cut institutional support. (I have myself, for an even longer time and well before attending any conference on "the medical humanities," reflected on a personal version of these stances: Do I really belong in a Department of Internal Medicine, a busy clinician who also happens to teach an elective called "Literature, Arts and Healing" at my affiliated medical school and a few sessions on "Literature and Medicine" during the ambulatory medicine curriculum for internal medicine house staff? Or as a published poet and essayist, might I be of better service in a Department of Medical Humanities, or even a Department of English, where I could focus on literary and pedagogical pursuits—with my clinical work kept to the side?)

Such polarized sets of considerations are at once potentially helpful, but also divisive; each side can more persuasively imagine a medical world transformed by its presence, while at the same time risking the alienation of potential allies who envision the arrival of the new health care system transformed by their preferred means. Proponents of the "sea change" model contend that every interaction with a patient, whether it be with the nameless cadaver in gross anatomy or the young multip in L&D, is imbued with complex issues of culture, representation, narrative, and art—thus, gross anatomy should always be co-taught with "embedded" medical historians to discuss, say, the disturbing genre of photographs documenting over the past century medical students in the act of dissection, and with visiting poets to engage the students in creative writing that helps them give voice to the silenced body into which they are given the great privilege of seeing; while the student rotating on the OB service should also attend Lamaze classes conducted by midwives, and also be shown representations of fertility, birth, and mothering in visual artworks made by diverse artists such as Mary Cassatt, Frida Kahlo, and anonymous New Guinean tribeswomen. Only then, with omnipresent and immediately accessible humanities resources for ourselves and our trainees, can we nourish in our profession "the art of medicine" from which we have become so estranged. The once-yearly grand rounds medical humanities lecture, or the scarcely noticed artwork hung along the ward's long corridors, together with their dispiriting implication that the humanities are an adornment to the real work of medical care, would disappear; all physicians, regardless of specialty or research versus clinical orientation, would become truly interdisciplinary, with a rich and always growing knowledge base relating to this core medical competency.

Those who see medical humanities as a free-standing discipline may imagine instead a specific faculty, specialists themselves in their own fields (literature, drama, visual arts, anthropology, etc), who would offer a curriculum of distinct

 ©2005 American Medical Association. All rights reserved.

Downloaded from jama.ama-assn.org at DURHAM UNIVERSITY on January 4, 2012

medical humanities courses. Like any other medical school's or hospital department's, its faculty would be expected to publish scholarly work in order to achieve academic promotion, and some of its courses would be required and others elective, some introductory and others more advanced—so, for the hypothetical trainees above, courses like "Silence, Voice, and the Body" (required) or "Cross-cultural Representations of Women in Visual Art" (elective). Under its auspices, critical thinking about the socialization of physicians and the construct of distancing could be fostered. Students and residents could choose to major or to specialize in this field, just as they might choose to become geneticists or pulmonologists. Though the impact of such a formalization of the medical humanities might be initially less direct, and might allow more students, house officers, and full-fledged physicians to avoid it entirely, it would prevent against a fly-by-night approach to education in this area—by not relying on part-time adjuncts, or physicians who just happen to be accomplished as, say, musicians or art historians—and it would facilitate collaborations among scholars in different areas who might otherwise not connect. The notion of a well-defined yet multidisciplinary medical humanities, while sacrificing some sense of the central importance of medical humanities concerns to any and all medical encounters, nonetheless may provide more obvious developmental guideposts for a field too long held in abeyance and thus still institutionally in its infancy.

After much wrangling about such issues in settings that ranged from idealistically headlined "interdisciplinary workshops" to what seemed to become their opposing, more cynical "special interest groups"—with no resolution in sight—came a short presentation to the entire conference by an art therapist working with people at the end of life. She described her work with two women with end-stage neurodegenerative disease, whose experiences of their illness had been effectively muzzled by their neurologists and other health care providers; she had asked them to write a play dramatizing their experiences, to illustrate the disconnection between their view of themselves and their needs and what the health care system had prescribed them. All of us were made speechless by the videotape of the production she then showed, staged originally for the women's family, friends, and care providers, feeling intensely the irony of all our debating and posturing, in the face of the much more insidious and nearly insurmountable obstacles faced by these two women as they tried, hands trembling, simply to sip from a teacup without the help of their understaffed nurses, or to raise their fears of dying with their harried physicians. Immediately apparent was that elusive proof, the shared space for meaningful healing that "the medical humanities," for lack of a better term, abets in educating physicians and treating patients. More than that, what was perhaps intended as one example of the practical utility of a nominal medical humanities approach to patient care became a potent metaphor for the tremendous struggle that lay ahead for us as a discipline in whatever name or shape we might give it.

In the end, any model of "the medical humanities" suffers perhaps most egregiously from an inability to pay for itself within medical centers. (The video production of the women's play was paid for by a small grant from a local British arts council that was not renewed—and one wonders, at the same time, how much more money might be saved by incorporating such efforts in providing ultimately more patient-centered, and thus more attentive and probably effective, care. A recent randomized controlled trial of expressive writing,[12] while showing a significant clinical benefit in symptom reduction in patients with rheumatoid arthritis and asthma, did not consider the possibly large cost savings of this approach.) Yet there remains much reason for hope—as I heard said many times at the conference, no one has yet proposed eliminating money-losing but critically needed clinical specialties such as internal medicine, pediatrics, and psychiatry from medical education at either the medical school or academic hospital level (despite what may be occurring at some for-profit hospital corporations)—while that same sharp medical student, who first pressed me for a definition of medical humanities, also pointedly asked later whether it was really necessary for his home institution to spend millions of dollars of endowment money on a new research building, going up right beside an equally opulent structure that will house a large pharmaceutical company's researchers. "I mean, think of all the ethical issues there. To me, that's even more reason we need a strong medical humanities program," he said wistfully, "if only someone would pay for it."

Rafael Campo, MA, MD, DLitt(Hon)
Boston, Mass
rcampo@bidmc.harvard.edu

Acknowledgment: The author acknowledges Drs Jorge G. Arroyo II, Michael Marmor, and Russell Phillips for their helpful comments on earlier drafts of this essay.

1. Mechanic D, Schlesinger M. The impact of managed care on patients' trust in medical care and their physicians. *JAMA*. 1996;275:1693-1697.
2. Cykert S, Hansen C, Layson R, Joines J. Primary care physicians and capitated reimbursement: experience, attitudes, and predictors. *J Gen Intern Med*. 1997;12:192-194.
3. Feldman DS, Novack DH, Gracely E. Effects of managed care on physician-patient relationships, quality of care, and the ethical practice of medicine: a physician survey. *Arch Intern Med*. 1998;158:1626-1632.
4. Grumbach K, Osmond D, Vranizan K, Jaffe D, Bindman AB. Primary care physicians' experience of financial incentives in managed-care systems. *N Engl J Med*. 1998;339:1516-1521.
5. Simon SR, Pan RJ, Sullivan AM, et al. Views of managed care—a survey of students, residents, faculty, and deans at medical schools in the United States. *N Engl J Med*. 1999;340:928-936.
6. Behrman RE. Some unchanging values of pediatric education during a time of changing technology and practice. *Pediatrics*. 1996;98:1249-1254.
7. Howell JD. The physician's role in a world of technology. *Acad Med*. 1999;74:244-247.
8. Pachter LM. Culture and clinical care: folk illness beliefs and behaviors and their implications for health care delivery. *JAMA*. 1994;271:690-694.
9. Rothschild SK. Cross-cultural issues in primary care medicine. *Dis Mon*. 1998;44:293-319.
10. Dittrich LR, Farmakidis AL, eds. The humanities and medicine: reports of 41 U.S., Canadian, and international programs. *Acad Med*. 2003;78:951-1074.
11. Thernstrom M. Is medicine a narrative art? *New York Times Magazine*. April 18, 2004:44.
12. Smyth JM, Stone AA, Hurewitz A, Kaell A. Effects of writing about stressful experiences on symptom reduction in patients with asthma or rheumatoid arthritis: a randomized trial. *JAMA*. 1999;281:1304-1309.

©2005 American Medical Association. All rights reserved.

Downloaded from jama.ama-assn.org at DURHAM UNIVERSITY on January 4, 2012