Humanities in medical training and education[1]

Deborah Kirklin

Abstract: This paper explores how current developments within medical humanities might provide a way to both understand and address the origin of recent events that have left the profession branded as arrogant, out of touch and misguided[2]. The arts provide a powerful medium to improve the understanding of the experience of illness. Furthermore the understanding obtained is qualitatively different from that acquired in the traditional doctor–patient encounter. In addition medical humanities can create a space for doctors to reflect on their own practice and experiences. The benefits of using this space are illustrated with four examples of arts-based education delivered to groups of practitioners at different stages in their professional lives.

Centres for medical humanities in medical education and training now exist in the Royal Free and University College Medical School, in Durham and in Swansea, and the opportunity to provide special study modules in humanities, as a result of the recommendations in *Tomorrow's doctors*[3], has led to the development of a number of innovative and exciting courses[4,5].

Nevertheless, for many doctors not directly involved in this embryonic field, the question remains: exactly what has medical humanities to do with them and is it anything more than a nice way to spend the afternoon[6]?

Two educational objectives encompass much of what medical humanities purports to achieve. The first is to allow practitioners to reflect on their own thoughts, feelings, inclinations, practice and experience. This process of reflection offers them the opportunity to gain new insights into the strengths and weaknesses of their own practice[7]. The second objective is to allow practitioners further to appreciate the experience of illness by patients and their carers. This process is sometimes referred to as 'improving empathy'. One view of empathy as 'vicarious introspection' comes close to describing the way in which the arts can connect doctors and patients. Both objectives require practitioners to step outside their professional role and to think, feel and listen person-to-person, and not as 'professional' to their patient.

Key Points

- **The arts can help doctors to understand better the needs of their patients.**
- **The understanding obtained is qualitatively different from that acquired in the traditional doctor–patient encounter.**
- **Medical humanities can create a space for doctors to reflect on their own practice and experience.**
- **The insights gained have direct relevance to clinical practice.**

The Doer of Good

Oscar Wilde's parable 'The Doer of Good'[8] portrays an unidentified figure who walks through a beautiful city encountering the beneficiaries of his good deeds. However, the restored functions of those he encounters are not being used as he would wish: the once blind man now uses his sight to ogle women; the man once lame now leads a wild and decadent life. Finally, the Doer of Good meets a weeping man and asks him why he weeps. The answer is '*For I was dead and you made me alive. What else should I do but weep?*' I have used this piece with, amongst others, GP registrars who requested discussion of the ethical issues concerning consent. One such session took place in the week the interim Bristol report into organ retention was published[2]. Consent, duty of care and autonomy can seem rather theoretical subjects to idealistic young doctors who intend only to do good. Recent developments at Alder Hey Hospital in Liverpool and elsewhere, where childrens' organs were retained without seeking parental consent, have shown that good intentions are not enough[9]. The first reaction among registrars accustomed to being taught about practice management, the management of chronic disease and how to pass the MRCGP, was summed up by one of them who said 'It's so Oscar Wilde.' Shared delight in meeting this old friend immediately took them out of role, and enabled them to respond to the piece as individuals rather than as would-be GPs. The immediate moral message was, for them, the need to remember that there is always another side to the story, and that those who ignore alternative perspectives do so at their peril. The next chord that struck was the disappointment of the benefactor with the behaviour of those

Deborah Kirklin
MRCGP
Co-Director, Medical Humanities Unit/Lecturer in Medical Humanities, Royal Free and University College Medical School

Clin Med JRCPL 2001;**1**:25–7

he had helped. Several registrars likened it to the patient with a smoking/drinking/drug related condition who gets 'patched up' by the doctors, only to do it all over again. Like the Doer of Good, doctors can feel let down by patients. They fail to appreciate, in both senses of the word (understand and value) the perspective of the patient. This understanding, that wishing to do good isn't always the same as doing it, was then used to explore what had happened in Alder Hey. The decision to do good, that is to develop a collection of organs for educational and research purposes was, they felt, taken in good faith. However, because of the blinkered approach taken by those involved, other goods went unrecognised. Foremost amongst these was the right of parents to choose what happens to their children's bodies (in this case after autopsy). Moreover there was a failure adequately to assess the harms involved in alternative courses of action. The supposed harm inherent in seeking consent for organ storage from already distressed parents and the potential loss of organs for the collection (if consent had been refused) weighed heavily, whereas the potential for harm, now realised, of denying parents choice, was disregarded. By ignoring the *prima facie* good inherent in respecting the right of those parents to choose, the Doers of Good became vehicles of harm. This is not a simple case of good or bad doctors but rather a case of doctors who had lost sight of the bigger picture. The registrars studying Wilde's parable were able to understand what had gone wrong using a non-judgmental and balanced approach.

A funny kind of cat

Paediatric gastroenterology might at first seem an odd place to find medical humanities. It is after all a field where scientific understanding has increased remarkably in recent years and where the tools to diagnose and treat gastrointestinal disorders in children are being developed by rigorous scientific research[10]. It is also a busy, often hectic, specialty with reflective time usually spent focusing on case presentations, audit of outcome and clinical research. One recent afternoon, instead, Professor Walker-Smith and his team at our hospital studied 'A funny kind of cat', an extract from Louis de Bernières' *Captain Corelli's mandolin*[11]. It describes how Lemoni, a little girl, calls on Dr Iannis, the island doctor, to cure a funny kind of cat with a headache. Dr Iannis finds himself led by an insistent Lemoni on his knees through the thick undergrowth, only to find a pine-marten caught on barbed wire. His instinct, to end its suffering, is over-ridden by an indignant Lemoni and he successfully nurses it back to health.

Reading through this delightful piece the group became quietly animated with many smiles and chuckles and they had little difficulty talking about Lemoni's expectations of Dr Iannis, how he felt about children and the conflicts of interest he faced. They found Lemoni determined, confident and single-minded, expecting Dr Iannis to fulfil his role as healer without question. A negotiating dialogue rapidly replaces the doctor's initially benevolent but patronising attitude towards Lemoni as he attempts to balance his appraisal of the situation with her demands. Dr Iannis describes childhood as '*the only time in your life when madness is not only allowed but also obligatory*' and acknowledges that '*children see things that adults don't*' in recognition of Lemoni's greater initial humanity when faced with the animal's suffering. Dr Iannis, asked to take responsibility for the funny kind of cat, faces several conflicts of interest. Instead of winning praise for a political argument he intends to put at his club he is faced with the indignity of crawling on hands and knees through undergrowth. Instead of a welcome cup of coffee, trouble is in store at home because his trousers are torn and filthy. Despite all this Dr Iannis, initially irritated and confused by Lemoni's request, finds himself satisfied and happy with the results of his labour. Paediatric gastroenterologists are presented with all sorts of funny kinds of cat, and indeed they confided there were several on the ward that day. These doctors acknowledged their own confusion and irritation when asked to take responsibility in such cases, and the conflicts of interest inherent in medical practice were familiar to them. They also recognised that, once past the confusion and irritation about what they are being asked to do, they have often found that their patients see things which they haven't. Responding to the needs of these 'funny kinds of cat' can provide the sort of deep satisfaction that keeps most of us going.

All this and more came out of a discussion of this short piece of literature. Those involved gained an insight into their own practice, which they found both enjoyable and enlightening. They valued the opportunity to step back from the day-to-day pressures of their work and to think about what they do, and what it is patients hope they will do. Stepping outside their own role for an hour allowed these doctors room to begin to explore the richness as well as the frustrations of the doctor's calling.

Adding the colour

My third example describes teaching that makes the qualitative difference between stories of illness and case histories central to the learning experience. It involves a purposeful, albeit temporary, abandonment of the editing and ordering skills which medical training provides. At the end of the first clinical year, students at the Royal Free campus can choose between three arts based special study modules. One of these, '*The human impact of the genetics revolution*' involves, in addition to art, literature, film and drama, a visit to a volunteer's home. The volunteer is either an individual or a family member of someone suffering from a genetic disorder. The student visits not as a medic but in a journalistic role, complete with tape recorder. Both students and volunteers understand this role change. The volunteers are asked to tell their story, and not to give an account of their medical history. They are asked to tell the story in any way they like, and to emphasise the parts of the story they wish. The students then return to the study group to re-tell the stories they have been told. Students returning to the group are excited and enthusiastic as they recount 'their' tales. The accounts are chequered with personal details that serve to explain important aspects of how families deal with or don't deal with the consequences of a genetic diagnosis. Asked what makes listening to a person's story so different from taking the history, one student

remarked, 'Taking a history is black and white. Listening to the patient's story adds the colour'. Traditional medical training conveys understanding through rigorous scientific and clinical training. The power of the arts is to add the colour to that understanding. The arts can provide students with the vicarious introspection that will enable them better to understand not only their patients but also themselves.

Even within this deliberately patient-centred approach to defining the boundaries of patients' stories, medical editing can occur. This was revealed by analysis of the differences between the stories told by the patients and those relayed by the students to the group. In one case, for example, when asked by a student about the worst effect of her child's genetic illness, a mother answered 'sleep deprivation'. This key fact was however edited out when the student recounted the mother's story to the group. This act occurred sub-consciously and only became apparent to the shocked student when editing in general was subsequently discussed. Further analysis made it highly likely that addressing the sleep deprivation, perhaps through provision of respite care, should be a high priority for this woman's doctor.

The Alchemist

The Alchemist by Paolo Coehlo[12], a superficially simplistic fable of a young boy seeking his destiny, forms a core text in a literature and medicine SSM available to Royal Free and University College first year medical students. The boy's journey takes him in search of treasure, but he discovers along the way that it is the journey itself wherein his destiny lies. Study of this text creates a space for students to reflect, right at the beginning of their training, what it is that they see as their destiny, what kind of journey they anticipate and are prepared for and how this journey of theirs has corollaries in everyone else's lives too. Other texts are used to expand and elaborate on these ideas and in addition the students produce a piece of creative writing, in the form of a fable, inspired by something they have read or discussed on the course, or elsewhere in their training. This reflection, coming as it does at a time when they are first entering into their new roles both as independent adults and fledgling doctors, aims to be both provocative and supportive. The question of exactly what happens when you take a bright young person and turn him or her into a doctor is clearly important. The challenge for educators is to ensure that it is the elixir of life and the philosopher's stone that remain at the end of this process, and not just a tarry mess. Preliminary results from this course will be available shortly[13].

Conclusion

The last few years have seen growing recognition within medical circles of the important role of the arts in health. In addition there has been increasing enthusiasm for establishing a role for the arts in both undergraduate and postgraduate medical education, and in continuing professional development. At a time when the medical profession finds its culture, traditions and systems of self-regulation under increasing scrutiny, medical humanities can create a welcome and necessary space to acknowledge the conflicting demands and stresses that are part and parcel of our working lives, to examine the driving force behind our practice and to connect through our shared humanity with the individuals who entrust their care to us.

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Address for correspondence: Dr Deborah Kirklin, Lecturer in Medical Humanities, Medical Humanities Unit, Department of Primary Care & Population Sciences, Royal Free Campus, Rowland Hill Street, London NW3 2PF. E-mail d.kirklin@pcps.ucl.ac.uk