

Humanising doctors: what can the medical humanities offer?

J Jill Gordon

The humanities offer tools for wise application of biomedical knowledge and promotion of humane medical care

Writing in the *New York Times*, columnist David Brooks recently described a “distinct brand of social misfits” in “fields like law, medicine or politics, where a person’s identity is defined by career rank”.¹ He fears that their childhoods may have been spent in domestic “achievatrons” that ensured their academic success but compromised their interpersonal skills. Brooks believes that American society produces a disproportionate number of people with a “rank-link imbalance”, which he described as “the social skills required to improve their social rank, but none of the social skills that lead to genuine bonding”. These people have opinions about everything and “treat their conversational partners the way the Nazis treated Poland. They crush initial resistance, and the onslaught of accumulated narcissism is finally too much to bear”.¹

It is hard to know whether Australia has a disproportionate number of “misfits” in law, medicine or politics, but if this is the case, Brooks suggests that they are the people most likely to force their way to the top of their career ladder and make life miserable for the rest of us.

One way of producing doctors (or lawyers or politicians) with a capacity for genuine bonding might be to broaden their education.² However, physician and writer Rafael Campo argues that “no one has proven that injecting the humanities in any form into medical settings translates to more humane physicians or better cared-for patients”.³ Campo’s use of the word “injecting” is telling; it conveys a sense of the humanities as something foreign to medicine.

To appreciate whether the humanities are indeed foreign to medicine, try to imagine a health care facility in which no ethical issues are explored, no lessons have been learnt from the past, no cultural awareness is displayed, no written words (other than technical communications) appear, and no books, films, television programs, plays or concerts are discussed by patients or staff. Imagine that there are no artworks, no music and no other aesthetically pleasing elements. Although some of our hospitals are admittedly run down, the products of the arts and humanities are nevertheless all around us.

Two recent Australian examples illustrate why we need to draw on the humanities in health care. The first is the front cover of the 19 May 2008 issue of this Journal, which depicts the phrase “Sorry, the first step” spelt out in candles in front of Parliament House.⁴ Many doctors are indeed sorry that biomedical solutions to Indigenous health problems have been confounded by ignorance concerning Indigenous history and culture.⁵ Fortunately, the Indigenous Health Curriculum Framework prepared for the Committee of Deans of Australian Medical Schools gives priority to topics such as culture, self and diversity, Indigenous history and society, and models of health service delivery.⁶ All of these areas draw on knowledge and insights from the humanities.

The arts also offer teaching resources that provide for better cultural understanding. Recent examples include the film *Ten canoes*, which imaginatively recreates the world of the Yolngu people; Kate Grenville’s novel *The secret river*, and Doris (Garimara) Pilkington’s

book *Follow the rabbit-proof fence* and its subsequent film adaptation; and plays *Murras*, *Coordah* and *The keepers*, which explore the impact of government policies of forced removal. Such resources communicate and educate by being emotionally engaging.

The second example relates to quality and safety in health care. Among the competencies outlined in the National Patient Safety Education Framework are communication skills, teamwork, leadership, honesty and respect.⁷ The intellectual foundations for these competencies lie in the medical humanities, in particular psychology, sociology, philosophy and ethics as applied to medical practice. Biomedicine puts at our disposal the tools for safe, effective health care; the humanities explore their wise application in practice.

Certain educational approaches accommodate the humanities better than others.⁸ Problem-based learning and its variants engage students’ emotions by giving each patient a story. However, problem-based learning is easily subverted by ignoring or parodying the human, experiential features of clinical problems. Privileging biomedical subjects over the humanities quickly alerts students to what counts as knowledge.³ A good medical curriculum provides time and resources for emotional engagement, reflection, and independent, self-directed learning — qualities that characterise what is best about the study of the humanities.⁹ The human experience of illness is most powerfully conveyed to students by those who have first-hand knowledge. It can be supplemented by poems, novels and films that faithfully represent that experience: *Iris*, *A beautiful mind* and *The sea inside* (which explore dementia, schizophrenia and quadriplegia, respectively) are recent examples. The Medical Humanities website of New York University provides an extensive database of resources on literature, arts and medicine.¹⁰

In the United States, the Accreditation Council for Graduate Medical Education has identified compassionate patient care and professionalism among six required competencies for residents, which training programs must assess.¹¹ It has been suggested that the humanities, and specifically bioethics, could contribute to resident education.¹² However, it has been argued that time and effort would be better spent in humanising the US health care system itself.¹³

The humanities cannot make people behave well. The late John Eisenberg, Director of the Agency for Healthcare Research and Quality in the US, has shown that doctors respond to many different influences.¹⁴ Well intentioned educational interventions will not produce more humane doctors if their role models’ behaviour suggests that it is better to do well than to do good. Medical facilities are moral worlds¹⁵ in which humane behaviour is elicited by being treated humanely,¹⁶ both in medical schools and in clinical settings.¹⁷ The humanities provide insight into why people (including patients, doctors and politicians) behave as they do and have done in the past. Equipping students with such insight is a necessary but not a sufficient strategy in the never-ending battle with the rank-link misfits.

Author details

J Jill Gordon, MPsychMed, PhD, FRACGP, Associate Professor
Centre for Values, Ethics and the Law in Medicine, University of Sydney,
Sydney, NSW.
Correspondence: jillg@med.usyd.edu.au

References

- 1 Brooks D. The rank-link imbalance. *New York Times* 2008; 14 Mar. <http://www.nytimes.com/2008/03/14/opinion/14brooks.html> (accessed Aug 2008).
- 2 Friedman LD. The precarious position of the medical humanities in the medical school curriculum. *Acad Med* 2002; 77: 320-322.
- 3 Campo R. A piece of my mind. "The medical humanities," for lack of a better term. *JAMA* 2005; 294: 1009-1011.
- 4 *Med J Aust* 2008; 188 (10) [front cover].
- 5 Brown A, Brown NJ. The Northern Territory intervention: voices from the centre of the fringe. *Med J Aust* 2007; 187: 621-623.
- 6 Phillips G. CDAMS Indigenous health curriculum framework. Melbourne: University of Melbourne, 2004.
- 7 Walton M. Teaching patient safety to clinicians and medical students. *Clin Teacher* 2007; 4: 224-231.
- 8 Gordon J. Fostering students' personal and professional development in medicine: a new framework for PPD. *Med Educ* 2003; 37: 341-349.
- 9 Gordon JJ, Evans HM. Learning medicine from the humanities. Edinburgh: Association for the Study of Medical Education, 2007.
- 10 Literature, Arts, and Medicine Database. New York: New York University School of Medicine, 2008. <http://medhum.med.nyu.edu> (accessed Sep 2008).
- 11 Accreditation Council for Graduate Medical Education. Advancing education in medical professionalism: an educational resource from the ACGME Outcome Project. Chicago: ACGME, 2006. http://www.acgme.org/outcome/implement/Profm_resource.pdf (accessed Mar 2008).
- 12 Doukas DJ. Where is the virtue in professionalism? *Camb Q Healthc Ethics* 2003; 12: 147-154.
- 13 Leeder SR. Achieving equity in the Australian healthcare system. *Med J Aust* 2003; 179: 475-478.
- 14 Eisenberg JM. Doctors' decisions and the cost of medical care. Ann Arbor, Mich: Health Administration Press, 1986.
- 15 Turner L. Medical facilities as moral worlds. *Med Humanit* 2002; 28: 19-22.
- 16 Moodie R. The way we treat each other. *Med J Aust* 2008; 188: 477-480.
- 17 Williams G, Deci E. The importance of supporting autonomy in medical education. *Ann Intern Med* 1998; 129: 303-308. □