

Embracing the unknown: introducing medical humanities into the undergraduate medical curriculum in India

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Abstract

Medical education fails to address the medical student's many questions, doubts and anxieties about his profession and his own relation to it. Students' growing disillusionment with the profession and increasing disconnect with the realities of the healthcare scene in India have reached critical levels, resulting in a general clamour for reform of the medical curriculum. Many look towards medical humanities for the answer to the problem.

Referring to some of the available western thinking and practice of medical humanities (MH), this paper recommends the evolution of an indigenous model which will draw on the growing body of new scholarship on India in the humanities and the social sciences. Some guidelines are offered for starting an MH programme, stressing the need for a flexible and broad-based approach, and a participatory pedagogy focused on students' needs, that draws creatively on available resources. Rather than viewing the 'arts' as a discrete addition to our personalities, an MH programme needs to show us how to integrate the multiple facets of our personalities.

I am certain of nothing but the holiness of the heart's affections, and the truth of imagination.

— John Keats

Background

In September 2010, about 100 people, medical teachers and students, administrators and policy makers gathered in Mumbai (1) to discuss reforms to the medical curriculum. The round table revealed a fundamental and glaring feature of medical education in the country: students who enter medical colleges with a desire to be good doctors seem to lose belief in this possibility *in the course of their education*.

That may seem like a deliberately provocative statement to make, but that is not the intention. From what students at this round table shared, and based on formal and informal interactions with medical students and faculty over the last year and a half (2), it would appear that the definition of 'a good doctor' undergoes drastic reshaping in the course of medical education, mostly resulting in a whittling down of the comprehensive original image. Often this happens in deference to what is loosely referred to as 'the demands of the time'- which includes the strong influence of available role models, the prevailing medical culture, and the inability of the curriculum or medical teachers to satisfactorily address students' experiences of anxiety, disillusionment or doubts

about their profession and about their own relationship to it.

The need for curricular reforms, long overdue, is felt across the board by all stakeholders, even if the nature of the needs, and their articulations from different quarters, might vary. As we try to address this urgent demand for change, and look hopefully towards 'medical humanities' as the shape this change might come in, it is important that we carefully examine some of the debates around it, and try to create a model appropriate to our own context.

Rather than outline a one-size-fits-all blueprint for an MH programme, this paper will suggest some essential features for a course that can address some of the deficiencies in the undergraduate medical curriculum. Suggestions will be offered on how a college might go about starting an MH programme. Understanding and articulation of the approach is emphasised, rather than valorising specific disciplines over others, or listing syllabus items. At this prenatal stage in the life of the MH programme in India, it seems vital to get the approach right, rather than work out details of the course content.

Medical humanities – a definition?

First, what MH is *not*: MH is not a syllabus to be covered in a certain number of weeks or months. It is not a set of communication strategies a medical student can pick up, to make a patient feel cared for – 'Greet a patient with a smile, introduce yourself, sit down on his bed, do not appear to be in a hurry'.

MH is a bold and continuous search for connections between medical practice and the realities of our world. It is an attempt to challenge one's own assumptions about 'how things have to be'. It is an enrichment of the mind and the soul through exposure to diverse knowledge systems, learning to see with the imagination, and feel what you dare not feel. It is an education in confronting contradictions within oneself. It is an encouragement to rest in the unknown, without fear or the urge to seek immediate resolutions.

Can doctors have doubt? If a doctor makes a mistake, can he acknowledge it? Is it possible to build a patient-doctor relationship in a non-adversarial mode, in a climate of non-fear? How can doctors in the making deal with their doubts and fears about their own inadequacies, about competition, about the 'industry' that the medical profession has become, about the fading idealism?

An MH programme can address these and similar questions.

We in India are latecomers to the field of MH, or at least to the formal introduction of the discipline in the medical curriculum, and thus have an opportunity to learn from the pioneers.

The Centre for Medical Humanities in London offers the following definition: "Medical humanities is an interdisciplinary and increasingly international endeavour that draws on the creative and intellectual strengths of diverse disciplines, including literature, art, creative writing, drama, film, music, philosophy, ethical decision making, anthropology, and history in pursuit of medical educational goals." (3)

The definition emphasises that the arts and the humanities, if introduced in the medical curriculum, are to serve the 'pursuit of medical educational goals'. The need to show a direct relation between the introduction of the arts and humanities and professional benefits for the medical student is thus emphasised. For example, if residents are asked to discuss a poem, the purpose of the activity is not to improve their literary analytical skills (though that may also happen incidentally) but primarily to fulfil the goals of their medical education.

Such an instrumentalist definition and approach is followed in most colleges offering MH. But many ask: Isn't an introduction to the arts and humanities 'good in itself'? Isn't it demeaning to the arts and humanities to attempt to make them serve the purposes of medical education? And how is it possible to *prove* their benefits to the medical profession?

All the available writing on the subject corroborates the view that an introduction to the humanities (taken broadly to refer to all the subjects mentioned in our definition above) has multiple benefits — immediate and long range — impacting the student-doctor both as individual human being, and as professional (4-6). For example, working with complex literary texts enhances students' ability to understand the complex nature of communication, and impacts their interactions with patients, their families and their colleagues. It also sensitises them to the role of social and cultural factors on patient behaviour and that of caregivers.

Perhaps the most significant departure from this originally 'western' thinking about MH is summed up in the following words. Addressing "...the mismatch between the claims of medical science and the broader effects of ... the culture of medicine in India today," the authors ask "whether 'better' educational practices, 'updated' curricula, 'better' management, and raising awareness about 'gender sensitivity' were adequate strategies ... [or] coming to grips with these questions would require inputs from new scholarship on India in the social sciences and humanities, an in-depth assessment of the current deficits in the practice of medicine, and careful reflection on the specifics of responsive and responsible practice." (7)

While we should be wary of getting bogged down in debates about definitions, they will assume great significance for curriculum planners, faculty and administrators as they begin implementing an MH programme in their institutions.

Some guidelines for the introduction of an MH programme

An MH programme seeks to address the needs of medical students not addressed by the regular MBBS curriculum in India. These relate to an individual's emotional responses to the experience of becoming a doctor, of gearing up to practise medicine in a world that challenges many of the assumptions underlying medical education, of learning to be a professional with a clear sense of social purpose. Although individual medical colleges will deal with these issues based on their stated mission and vision, the administration, the faculty, and the profile of their students, and therefore, should design MH programmes to suit their particular needs, it is possible to set down some broad guidelines (8).

The preparation

Some suggestions as we prepare ourselves for this unfamiliar task:

1. A meeting of *all* students (not just those who will be in the programme) and interested faculty to brainstorm the question: Who is a good doctor? Compile a list of qualities prioritised by the group. This will help give direction to the process of framing the syllabus.
2. Identify major areas for study. Each person narrates a real incident from their time in medical college that posed a conflict, raised questions or created doubts. Generate a list of unresolved questions and conflicts that plague medical students through their years of training. This will help identify issues that an MH programme can address.
3. Set down the objectives of the MH programme, first broadly, and then more specifically as they will be addressed in a particular institution. These could include:
 - a. helping learners to become aware of, and understand the impact of class, caste, gender, language and other socioeconomic and cultural factors on illness, how patients and their families respond to illness, and how they, as doctors, interact with patients and their families.
 - b. enhancing learners' ability to recognise, understand and respond sensitively to the multiple perspectives and different value systems as they operate in interactions with their patients, patients' families, and their colleagues.
 - c. sensitising learners to the complex nature of communication, and developing the skills of listening to and interpreting narratives by patients, their families and their own colleagues.
 - d. encouraging and developing skills in learners to become reflective practitioners.

A. Planning the programme

Ideally, the MH programme should be mandatory for all

students, and I would argue for the inclusion of some elements of MH in the curriculum every year of the undergraduate medical programme. But initially, institutions might face several challenges and constraints. Therefore, I urge colleges to start the programme, with whichever of the following models works for them, keeping in mind the essential principles of the programme. After all, flexibility is at the heart of the subject.

- Regular and mandatory weekly classes for students in the first two years of medical education.
- A voluntary programme based on the arts and humanities with a choice of electives.
- A series of seminars, conferences, and talks on issues both medical and 'non medical', ranging from euthanasia to genetics to ethnicity, illness, gender and violence.
- Short-term courses based on any one of the arts

One university that conducted a voluntary programme spread over six months, with weekly sessions of two hours each, records that the feedback was truly remarkable for a course that occupied so little of the participants' time (4).

B. Methodology: learners, faculty, and course content

To fulfil the goals of the programme, irrespective of the model adopted, the methodology needs to bring into alignment three key components of the course - the learners, the faculty and the course content - in order.

1. *The learners:* To achieve its goals, the MH class has to be a safe space, allowing free sharing of ideas and opinions. Small groups of five or six encourage all learners to participate. If this is impractical, a facilitator can introduce an activity to a large group, split them into small groups for discussions, and have each group report to the class when the task is completed.

The programme needs to be learner-centred, and learner-friendly. Identifying learner needs has to be a continuing process throughout the course, mandating learner feedback throughout.

2. *Identifying faculty:* The chief purpose of the MH course is to provide inputs not provided by the regular medical curriculum. Therefore the *more diverse the team teaching the MH course the better*. If there are faculty interested in some of the arts, or having a deep knowledge of non-medical disciplines such as sociology or philosophy or literature or drama, it would be an excellent idea to let them develop course material from their areas of interest. As we are injecting something new and unfamiliar, an orientation for the regular medical college faculty is essential, and this can come from a person from a humanities background. In the initial years such a person needs to be full time, in order to be available for on-site support. Faculty and students may be guided through new teaching methodologies, small group dynamics, and discovering creative and individual

ways of adapting real life material for teaching purposes.

3. *Course content:* A broad structure or framework with clearly articulated objectives is essential, within which there is plenty of room for facilitators and students to be creative and improvise. The idea is to make the course enjoyable, through not only different content, but also different methods of delivery, the element of surprise and suspense, and, above all, participatory learning. The faculty and students explore and learn together in an atmosphere of democratic sharing.

The element of enjoyment is important, especially in voluntary courses. Small groups and activity-based courses can ensure that students stay motivated. In India, where we are likely to have multiple languages in a classroom, and also differential abilities in English, nonverbal media such as music and painting can be explored for their power to evoke strong feelings without words.

Conclusion

Sir William Osler, one of the greatest medical teachers of all time, said: "The whole art of medicine is in observation ... to educate the eye to see, the ear to hear and the finger to feel..." (9) The kinaesthetic feel of that statement says it all.

It is high time we learned to integrate the different dimensions of our personalities. Let us try to be whole, again, as we are meant to be.

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