Conclusion

The increasing use of force against healthcare facilities and medical personnel is an issue that requires systematic research. The inescapable aspect of armed conflict is that there is a clear spillover of the "political" dimension into such a fundamentally critical and non-aligned arena as health provision. The fact that modern day armed groups and state actors do not conform to the standards and ethics enshrined in IHL with regard to protection of healthcare provision is echoed in the findings of an ICRC report titled *Healthcare in danger*. The report concludes that the "means to address this problem do not lie within the health-care community; they lie first and foremost in the domain of law and politics, in humanitarian dialogue, and in the adoption of proper procedures by State armed forces" (10). However, attributing the solution to the political domain is not enough, as it dissociates the issue of humanitarian healthcare from its own ethical responsibilities in conflict zones. Seen from the lens of civilian protection, the onus of the protection of healthcare facilities must not be limited to state and non-state actors. Rather, serious ethical reflection on the provision of humanitarian healthcare is required, which also takes into account the responsibility of aid agencies towards vulnerable populations.

References

1. Shahid S. Body of kidnapped ICRC official found. *Dawn* [Internet]. 2012 Apr 30[cited 2012 Jul 3]; From the newspaper:[about 4 screens].Available from: http://dawn.com/2012/04/30/body-of-kidnapped-icrc-official-found
2. MSF: Medicins Sans Frontieres [Internet]. New York: MSF; c2012. MSF closes two large medical centers in Mogadishu after killings of staff; 2012 Jan 19[cited 2012 Jul 3];[about 3 screens]. Available from: http://www.doctorswithoutborders.org/press/release.cfm?id=5733&cat=press-release
3. MSF: Medicins Sans Frontieres [Internet]. New York: MSF; c2012. Sudan: security incidents force MSF to suspend activities in Gumuruk; 2010 Jul 30 [cited 2012 Jul 3]; [about 3 screens]. Available from: http://www.doctorswithoutborders.org/news/article.cfm?id=4628&cat=field-news
4. Al Jazeera [Internet]. [place unknown]: Al Jazeera; c2009. Sri Lanka war hospital 'hit again';2009 May 13[cited 2012 Jul 3]; [about 5 screens]. Available from: http://www.aljazeera.com/news/asia/2009/05/20095131040721771.html
5. BBC News South Asia [Internet]. UK: BBC; c2012. Bagchi S. Red Cross and MSF accused of helping India Maoists;. 2011Jan 21[cited 2012 Jul 3];[about 4 screens]. Available from: http://www.bbc.co.uk/news/world-south-asia-12247693
6. Rubenstein LS. Bittle M. Responsibility for protection of medical workers and facilities in armed conflict. *Lancet* [Internet].2010 Jan 23[cited 2012 Jul 3];375:329-40. Available from: http://www.jhsph.edu/sebin/y/h/Rubenstein_ProtectionofMedicalWorkersInConflict_Lancet2010.pdf
7. ICRC: International Committee of the Red Cross [Internet]. Geneva: ICRC;c2005. *Protocol Additional to the Geneva Conventions of 12 August 1949, and relating to the Protection of Victims of Non-International Armed Conflicts (Protocol II,8 June 1977)*; 1977 Jun 8[cited 2012 Jul 3];8p. Available from: http://www.icrc.org/ihl.nsf/WebART/475-760004?OpenDocument
8. Dickinson E. How much turf does the Somali government really control? *Foreign Policy* [Internet]. 2010 Sep 23[cited 2012 Jul 3]. Available from: http://www.foreignpolicy.com/articles/2010/09/23/how_much_turf_does_the_somali_government_really_control
9. Stoddard A, Harmer A, DiDomenico V. Providing aid in insecure environments: 2009 Update trends in violence against aid workers and the operational response. *HPG Policy Brief 34*[Internet], 2009 Apr[cited 2012 May 4]. p 3.Available from: http://www.odi.org.uk/resources/docs/4243.pdf
10. ICRC: International Committee of the Red Cross[Internet]. Geneva: ICRC; c2005. *A sixteen country study: healthcare in danger*;2011 Jul 3[cited 2012 Jul 3];19p. Available from: http://www.icrc.org/eng/assets/files/reports/4073-002-16-country-study.pdf

"Medical humanities" for India

Radha Ramaswamy

Centre for Community Dialogue and Change, A-6, Grasmere Apartments, Osborne Road, Bangalore 560 042 INDIA e-mail: radharamaswamy08@gmail.com

Is there a problem?

A 21-year-old senior medical student is standing at the bedside of a patient in a general ward. The intern has been told that it is important to pick up the patient's hand, and look into his face, before asking any questions. He has seen his teacher do this. He moves his hand stiffly, watches it go towards the patient's hand, and pause, and in those few seconds, realises this is not going to work. He gives up, and asks: "Tell me what the problem is."

The young men and women who enter medical colleges in India are of above average intelligence, many are exceptionally bright, and all yearn to do good. This is largely true, even though our entrance exams do not really test intelligence or aptitude, and these young people stopped looking beyond physics-chemistry-biology at the age of 13, becoming little more than marks-scoring machines. Miraculously, many of them survive these battles with their intelligence intact and clinging still to their desire to be of service. The battle scars are there -- fear lies beneath the "cool", "don't care" surface. There are countless doubts. Am I in the right place? Am I good enough? But isn't this wrong? What should I do?

Not addressing these questions can be dangerous: to the individual medical student whose doubts gradually vanish, leaving him numb, or worse, indifferent; to the patient who has to confront an emotionally stunted doctor; to the national healthcare scene dominated by people who learned to leave their humanity behind years ago.

Medical education and patient care

The deteriorating quality of medical education and patient care in the country has been the cause of much concern and discussion, both within the medical profession and outside (1-3). One of the chief causes of this is being identified as the jettisoning of all humanities and arts courses from curricula for students preparing for professional courses – our own adaptation of CP Snow's 'two cultures' phenomenon, the divide between scientists and literary intellectuals (4).

'Infuse joy into learning', say educationists, in response to this situation and 'bring genuine human interaction into the classroom' (5). Business schools are introducing managers to literary texts so that they may learn to appreciate metaphorical language and become more sensitive to hidden meanings in communication. In medicine, an increasing body of public opinion now considers the doctor's emotional, psychological, even spiritual wellbeing to be almost as important as his clinical competence.

Recognising the urgent need for reforms in medical education, the Medical Council of India has, in a recent document, proposed significant changes to the MBBS curriculum(6). Perhaps for the first time, there is a mention of medical humanities in the course components, as well as a direction to medical colleges to appoint faculty who are experts in these non-medical disciplines. In the light of this recent MCI initiative, this special issue of the *IJME* is timely. The collection of articles here represents current thinking on the subject in the country, and will help not only to focus attention on the need to introduce MH, but also to highlight critical pedagogical issues in its implementation.

Why this theme

Medical humanities (MH) is projected to be the answer to many of the serious, unresolved issues in medical practice. Before we hurry up and install it in our medical curricula, we need to see the shape of the beast more clearly.

Loosely described, MH is the name generally given to an interdisciplinary programme, drawing largely on the humanities and the arts, that aims to address the emotional, and psychological aspects of medical training not taken care of by the standard undergraduate medical curriculum (7-9). As a formal field of inquiry and as a part of the medical curriculum, MH has been around for quite a while outside India, and in a few centres scattered across India in recent years(10). Perhaps following the lead of the US, and the remarkably useful databases, MH courses have been largely focused on the use of literature and the arts, including drama.

While a wealth of literature is available on MH, the challenge for us in India will be to evolve a model that is India-specific, shaped by our socio-economic and cultural realities and the diversity of needs of our population. We hope that the writings in this issue will both guide us as we begin exploring this unfamiliar territory and help us move in fresh and new directions.

Some of the articles in this issue may contain generalisations that may appear unoriginal, even commonplace. Yes, we are all aware of the commercialisation of medical practice, the increasing dependence on technology and invisibilisation of the patient as a human being, and how the medical curriculum does not prepare the student for the dilemmas or the uncertainties built into the experience of being a doctor. The significant thing – and this is no mean significance – is that it is medical students and doctors who are saying these things, and for the first time openly, in a special issue on the theme in medical literature in India.

In this issue

We begin this issue with patient narratives. Put the patient first, says Usha Rajaram, who believes that true healing, especially in cases of serious and long term illnesses, can only happen when the doctor acknowledges the patient's need to seek emotional, and psychological support from the doctor. Sunil Pandya narrates his experiences of the shift from being a neurosurgeon to a patient, and his newfound perspective on illness, treatment, and hospitalisation.

The voices of medical students are next. The first piece by Jayesh Vira is a plea for help, underlining the undergraduate medical student's struggles to cope with the magnitude of the changes in his life as he enters medical college, and the need to revamp the curriculum before introducing MH. Anvita Pauranik testifies to how medical education actually contributes to the gradual erosion of empathy in students, and argues that a course based on the humanities will probably help, if faculty is suitably trained. Neha Dangayach muses on the contribution of teachers, friends and patients to her evolution as a resident but concludes that a formal course in the humanities can help medical students evolve into sensitive doctors.

These are voices from the ground. They need to ring in our ears as we ponder curricular changes.

The next set of four articles addresses the big question: Do we need a fundamental change in perspective or just additions to the current syllabus? Navjeevan Singh graphically describes the oppressive systems suffocating the medical student, and suggests how some of the challenges to introducing humanities-based programmes may be faced. Krishnakumar offers suggestions for remedying the tragic disconnect between the realities of the healthcare needs in the country and the professional orientation that students receive during their medical education Urging doctors to embrace the spirit of MH - of a bold inquiry into themselves and their patients - Radha Ramaswamy makes a case for a flexible and creative approach to MH. Finally, Rama Jayasundar

describes the Ayurvedic approach to patient care, which integrates, instead of fragmenting, the patient, and emphasises wellness over the cure of an illness.

In forthcoming issues

Future articles on this theme in *IJME* include: accounts of experiments in MH from four different colleges in India and Nepal that vary in approach, content and methodology, providing a rich ground for creative and fruitful discussion; doctors' narratives about coping with doubts, guilt, and feelings of incompetence; a guide to curricular issues, and the MCI's thoughts on introducing an MH programme in the undergraduate medical curriculum.

Preparing for MH

Medical education is the site where we see tremendous possibility for change. We need many and diverse voices to speak to us, so that we may see what resonates for us.

A whole range of issues will appear before us as we start our journey on the road to MH. From large and abstract questions such as 'Is a happier doctor a better doctor?', or ' Is kindness as important in a doctor as clinical competence?' to decisions about the nitty-gritty of implementation, about making MH courses voluntary or mandatory, about not overloading the already crowded curriculum, and finding suitable resource persons.

We need to draw on a wide array of disciplines outside of medicine, and identify the inputs needed to challenge students as well as excite and interest them. The courses need to be relevant to their development as medical professionals, and this relevance needs to be identified as broadly and deeply as possible.

For example, while choosing literary texts, what kinds of texts do we look for? Is it necessary to identify texts that are directly about doctors or patients or about illness? This is the more popular, instrumentalist approach to MH. But more and more medical educators are arguing that all good literature is useful because it keeps the imagination alive (11). When a doctor faces a patient, he often needs to makes an imaginative leap into the other's thoughts and feelings. The same imagination helps him examine places within himself where his attitudes and beliefs lie, hidden even from himself.

Lest we slip into the comfortable slotting of MH as 'the soft skills', there is a growing body of scholarship on India in the social sciences and humanities that MH needs to draw upon (12). This will provide a valuable perspective, provide inputs that will help medical students approach the ambiguities and dilemmas of their profession in a more informed way, and make them reflective practitioners.

MH courses can be designed so they also provide opportunities for students to learn from their peers, patients, caregivers and families. The classes need to be enjoyable, provide a friendly environment for exchange of ideas and debates, and be a safe space for students to express personal views. A large hall, empty of furniture, where everyone leaves their shoes outside, and sits on the floor in a circle, can dramatically alter the nature of the communication in the group. Small group discussions rather than lectures, workshops, projects and presentations, reflection time, and regular oral and written feedback, could be useful features of an MH course (13).

The approach, always, has to be flexible, and non judgemental. For example, imagine a formulaic communication skills course, where Step 2 is: 'Take the patient's hand in your own.' This is no doubt a profoundly meaningful ritual for patient and healer (14). Our hypothetical student in the scene described in the opening paragraph of this editorial, might however ask: "What if it doesn't come naturally to me, and I feel awkward picking up the patient's hand?" To condemn such a response as 'lack of empathy' would be as wrong as any attempt to 'teach' it as if it were a communication strategy to be picked up mechanically.

Lastly, how does one handle assessment in such courses? Even after inputs from sociology, economics, public health and ethics, is it possible for a student to give the 'correct answer' to a question on abortion? The hard part for medical educators, and students, will be to let go of the need for Yes/No answers. The standard kinds of assessments that test factual knowledge will have to be abandoned, and so will impact studies to measure the effectiveness of such programmes. Does this mean we cannot know whether these programmes are benefitting us at all? Not true. For, even though we may not be able to define or measure kindness, we all recognise it when we see it.

Through the articles in this and subsequent issues of this journal we hope to generate questions and discussions such as these, that will help us see MH for what it can truly be - beyond issues of medical and professional ethics, and beyond prosaically learnt communication skills.

What next

In August, when the new term begins, let's see colleges take those first bold steps.

Call a meeting of everyone - hear students and faculty speak their minds freely on what they struggle with, on changes they would like to see. Every voice counts.

Who's passionate about change? Who reads beyond medicine? Who has friends in the humanities departments, or hobbies they would like to bring into the classroom? Form a team.

Let ideas come from everywhere; hierarchies can kill initiative.

Draw up a programme for the year. But let nothing be frozen.

Let Imagination, Flexibility and Fun be the key words.

Announce the first module, talk, screening, workshop. Take feedback always.

Call a meeting every month, after every term, and take stock; be ready to make mid course corrections, if necessary.

Let's try something different from the standard medical education programme.

And, in July 2013, let's all meet to share our MH stories.

Taking the first step, without knowing exactly what awaits us, is perhaps the most difficult. Maybe the real challenge is that medicine is being asked to open itself to an 'outsider' gaze.

But is there really an 'outsider' here? Are we not united by a common purpose, beyond disciplinary boundaries? MH simply asks that we reclaim the vision we once had, listen to the voice that whispers in our ears.

As the founder of the Centre for Community Dialogue and Change, I conduct workshops in Theatre of the Oppressed, a popular community education tool, as part of the medical humanities programme in colleges.

Acknowledgements *I am deeply grateful to Dr Amar Jesani and Dr Sunil Pandya for giving me an opportunity to guest edit this special issue of IJME on Medical Humanities. It has been an amazing and invaluable journey. I am grateful to all the authors who so readily responded to my request for articles, to all the reviewers, and to Meenakshi D'Cruz and Sandhya Srinivasan at the IJME for their friendship and editorial support. I am grateful to my family, who greeted this new madness with their usual nonchalance, to the many friends who gave generously of their time and ideas, and finally, to all the wonderful people out there 'doing' MH, and writing about it, from whom I have learnt and continue to learn so much.*

References

1. Medical Council of India. *Vision 2015* [Internet]. New Delhi: MCI; 2011 Mar [cited 2012 Jun 27]. Available from: http://www.mciindia.org/tools/announcement/MCI_booklet.pdf
2. Supe AN, Burdick W. Challenges in medical education in India. *Acad Med*. 2006 Dec;81(12): 1076-80.
3. Zachariah P. Rethinking medical education in India. *The Hindu* [Internet]. 2009 Sep 9[cited 2012 Jun 27];Opinion: [about 3 screens]. Available from: http://www.hindu.com/2009/09/09/stories/2009090954430900.htm
4. Snow CP. The Rede Lecture1959 [Internet]. New York: Cambridge University Press;1961 [cited 2012 Jul 4]. Available from: http://s-f-walker.org.uk/pubsebooks/2cultures/Rede-lecture-2-cultures.pdf
5. Robinson K. Imagination and empathy. Dalai Lama Center's Speakers series event, Educating the heart and mind [Internet]. 2011 Nov 21[cited 2012 Jun 27]. Available from: http://www.youtube.com/watch?v=Yu2zcmb3yAQ&feature=relmfu
6. Medical Council of India. *Regulations on Graduate Medical Education 2012* - Medical Council of India [Internet]. New Delhi: MCI; 2012[cited 2012 Jul 7] Available from: http://www.mciindia.org/tools/announcement/Revised_GME_2012.pdf
7. Shapiro J. A sampling of the medical humanities. *J Learning Arts* [Internet]. 2006[cited 2012 Jun 27];2(1):Article 1. Available from: http://escholarship.org/uc/item/58b5h3h9#page-10
8. Shapiro J. Walking a mile in their patients' shoes: empathy and othering in medical students' education. *Philos Ethics Humanit Med*. 2008 Mar;3:10.
9. Kirklin D. The Centre for Medical Humanities, Royal Free and University College Medical School, London, England. *Acad Med*. 2003 Oct;78(10):1048-53.
10. Gupta R, Singh S, Kotru M. Reaching people through medical humanities-an initiative. *J Educ Eval Health Prof*. 2011;8:5. Epub 2011 May 20. Published online 2011 May 20. http://dx.doi.org/10.3352/jeehp.2011.8.5 [cited 2012 Jun 27]. Available from: http://jeehp.org/Synapse/Data/PDFData/0144JEEHP/jeehp-8-5.pdf
11. Verghese A. The Centre for Medical Humanities and Ethics: Q and A with Abraham Verghese [Internet].[date unknown] [cited 2012 Jun 27]. Available from: http://www.abrahamverghese.com/images/Q-A%20Humanities%20in%20Medical%20Education.pdf
12. Zachariah A, Srivatsan R, Tharu S for CMC-Anveshi Collective *Towards a critical medical practice: reflections on the dilemmas of medical culture today*. Hyderabad: Orient Blackswan; 2010.
13. Shankar PR, Piryani RM, Thapa TP, Karki BMS. Our experiences with 'Sparshanam', a medical humanities module for medical students at KIST Medical College, Nepal. *J Clin Diag Res* [Internet]. 2010 Feb[cited 2012 Jun 27];4(1): 2158-62. Available from: http://www.jcdr.net/article_abstract.asp?issn=0973-709x&year=2010&month=February&volume=4&issue=1&page=2158-2162&id=642
14. Ted- Ideas worth spreading [Internet]. [place unknown]: Ted; c2012. Abraham Verghese- A doctor's touch; 2011 Sep [cited 2012 Jun 27]. Available from: www.ted.com/talks/abraham_verghese_a_doctor_s_touch.html