COMMENTS

Sensitising doctors: a pedagogical approach to medical humanities

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Abstract

The first part of this paper explores what we mean by the word 'sensitising' and presents an argument for conceiving of 'sensitising' in a way that respects the intellectual as well as the healing roles of medical practitioners, while taking the concept further as ' informed reflection'. It also makes a case for the importance of sensitising in medical 'praxis'. The second part of the paper describes an approach which is based partly on a module that has been taught in a medical programme.

Introduction: sensitising as informed reflection

Several arguments have been advanced for the inclusion of the humanities in medical education, primary among them being their role in 'sensitising' future doctors. Doctors are a special kind of professional for two reasons: first, their very knowledge system depends upon human beings in a way that is distinct from other scientists; second, doctors are inevitably dealing with the sick and the vulnerable, which means that sensitivity, is a necessary expectation to have of them. But what does 'sensitising' mean? Sensitising is commonly understood as making doctors sensitive or more humane in the practice of their profession. But it could also imply making them sensitive to fields, issues and discourses other than the medical one. Gender sensitising, for instance, caught the imagination of pedagogues across many disciplines since at least the 1970s, and medical education too attempted to reorient itself to a gender perspective, even in India. It is another matter that, despite such efforts, a recent analysis of textbooks used in community medicine shows the failure of such reorientation in India (1).

The general argument for medical humanities is that exposure to literature, poetry, music, art and philosophy will expose medical students to other ways of thinking and living, and this will factor into their professional lives in some way. Presumably this sensitising will enable them to become 'better' doctors, evidenced at the very least in an improved quality of doctor-patient interactions. Many times, however, this sensitisation is projected as being part of the 'soft skills' of doctors, which is unfortunate, because the focus then is on communication skills or personality development. Sensitisation is not (only) a set of soft skills including improved communication or gentle speech. Such skills will certainly influence the doctor-patient interaction and consequently patient care, but will do little to transform the fundamental problems of the medical profession.

In this paper, sensitisation is seen as being primarily concerned with thinking through issues as they impinge on our own chosen professional field. Clearly this is not a requirement only of the medical profession, but it is something particularly relevant to the profession. I use the concept of sensitisation as a form of 'informed reflection' drawing on fields such as literature, arts, social sciences, philosophy, history and music.[1] Exposure to themes in the humanities is one way of practising informed reflection.

No doubt there are several ways in which this can be done but the approach taken towards the medical humanities influences the pedagogical strategies used. This approach also has a different impact, as compared to regular medical education, on medical students and thus on the types of doctors produced in the country in the long run.

Neo-liberalism as a context for sensitising: the need for medical 'praxis'

There is also a larger purpose to this sensitisation which is not immediately apparent. It needs to be articulated, especially in the current context of neoliberalism where the market rules all sectors, including the medical one (2). Alongside the high fees that students pay in private medical colleges, the larger neoliberal context makes it appear inevitable that students think of medical education as a monetary investment from which, at some point, there should also be monetary returns. But is it possible that students can be made to become aware of the larger ecosystem of medical education and their place in it? How can we engage with doctors and medical researchers in order to make their education more relevant to the needs of the larger society in which we all live? Is it necessary for medical professionals to reflect on how their politics (or the lack thereof) affects their profession? [2] Is it possible for students to develop a politics, enabling them to make the shift from medical practice to medical 'praxis'?

Although 'praxis' is a complex concept, I am using it in a simple way to mean the energising of medical research and practice by other, more theoretical ideas and exposure to different contexts. Thus, when doctors are made socially and politically aware beings, they are enabled to develop a rationale and position from which their work stems. To make the idea clearer: earlier, some doctors used to say that they practised from a position of service, similar to what missionaries used to do while serving the poor. Other doctors may have considered

themselves to be healers, orienting themselves along with shamans of tribal communities. Both positions strengthened the medical practice of doctors who held them because they linked their medical 'work view' to a social worldview. These views, however, were held a priori to the work these doctors did and were more concerned with belief systems. When I use the concept of medical 'praxis', I mean a work view that arises from 'informed reflection' on the social worldview. It is a cultivated and reasoned position that one develops over the course of medical education. The approach described in this paper is one such attempt to cultivate medical praxis through informed reflection.[3]

Description of the pedagogical approach

The topic of the day at the module, chosen by the students themselves, was 'abortion'. For a doctor, abortion is a 'medical termination of pregnancy' (MTP). Elicitation of associated words and responses to this topic from the students brought out a range of ideas from 'sex' to 'gift of God' to 'choice', 'taking life', 'responsibility', 'teenage sex', 'unplanned pregnancy', as well as 'rape'. A pure humanities approach was used to look at specific underpinnings of the word 'abortion' to draw out or 'unpack' its meaning. It thus focused more on the individual and the discussion revolved around concepts like the nature of choice, life, responsibility, autonomy and what these imply. For example, students were able to see the varying responses among themselves about what each considered as 'life'. Was it from the time of conception or at eight weeks or 16 weeks or only at the time of birth? Was the conceived foetus part of the body in the way that other organs were? Was there a difference? Would you remove the foetus as you would a kidney? When we, students and facilitators, discussed 'responsibility', we spoke about the nature of responsibility and what it meant to be a responsible human being. How did the students understand the word 'protection'? What did it mean to 'take care' of someone?

In none of these discussions was there any attempt to come to a conclusion, either in terms of defining the concept, or in terms of saying one response was right and the other wrong. This was the part medical students felt most uncomfortable with since they were more familiar with definitive knowledge. Elicitation of student responses and the subsequent discussion are an important part of such pedagogy for two reasons: it directly makes youngsters confront the world as it is and will be, in all its diversity, and helps them negotiate through this diversity by bringing in some simple concepts. Second, it continually opens them up to ambiguity and ambivalence, and helps 'loosen' their thinking from one which is very linear, causative and definitional to other equally legitimate ways of thinking.

The second level of discussion moved away from the individual as the locus of discussion and brought in ideas of institutions, such as religion and the State, and how these could influence abortion rights and therefore choice. We brought up questions such as: What could happen to choice when the State stepped in? In our short experience, we found that many of these students were politically unconscious and, like other youngsters of that age, took their rights and freedom for granted. We wanted them to observe and experience a time when it had not been so and chose the family planning programme during the Emergency as an illustration. We screened the documentary film *Something like a war* which documented the State programme on sterilisation in India during the Emergency (3). Students got to watch footage of how female sterilisation had been done, under what conditions, and how some doctors and the entire State machinery had handled (largely poor) women's bodies. This footage was intercut with footage of women talking about how they experience their bodies in their various roles as girls, lovers, wives, mothers and old women. Many students were able to empathise with the women's experiences as women; they were also horrified by the way pregnant women were treated. Although the conditions of the laparoscopy were clearly not as sterile as one would wish as a doctor, the horror was more at the way the women were 'handled'. Thus, a simple, scientific, medical procedure became a social phenomenon in front of their eyes, filled with its ambiguity, conflict, hope, messiness, and pain.

Since the film did draw responses about the lack of sterility surrounding the procedure (done in an assembly line fashion), we brought in the concept of hygiene to show how abortion was linked to other such issues around the woman's body. We discussed how hygiene, for instance, was not just a medical and health concept concerning only germs but was also socially constructed through rituals of pollution. Thus, 'dirt' was not about germs; it was about what women were not allowed to do when they were considered 'impure' or 'polluted'. We spoke about the prohibitions and proscriptions at the time of menstruation and pregnancy and post-delivery -- not to touch this or that, not to go here or there. Women lack control over many things such as resources but crucial among these is the lack of control over their own bodies (1, 4). We spoke about how the woman's body seldom belonged to herself but was always 'co-owned' by others: from her parents to her mother-in-law and her husband. A woman's identity thus was never only individually and personally mediated; it was also socially controlled and negotiated. In such a case, she was only one among several people who controlled her own body.

Another concept we used to discuss abortion was the 'objectification' of the human body. We started by talking about advertisements and showed the sexual objectification of women and what this implied. We explained how the relationship based on objectification is created between two people, one being active (the doctor), the other passive (the patient), one always acting upon, and the other always being acted upon. Distance is then brought into this relationship in an attempt to be 'neutral' and 'scientific' as well as protect the doctor in the face of continual disease and suffering. We spoke about the subsequent objectification of the patient's body in a further attempt to be 'efficient'. For instance, names and personal pronouns are left out (*the* heart as opposed to 'your'

heart) even while talking to the patient. But we also made them reflect on what implications this distancing had for the patient and how it could interfere with the healing process from the patient's point of view. We then could discuss the connection of objectification with medical ethics (5).

Finally, we linked the idea of control over a woman's body to the phenomenon of sex-selection in the form of selective abortion and female infanticide. While the medical profession would like to distance itself from this phenomenon and the consequent sex ratio figures at birth in India by putting it on the shoulders of both medical technologists and quacks sitting in rural areas, it is quite clear that they too are implicated in it. We thought it appropriate for us to complete the cycle on abortion by discussing this aspect. We showed figures for sex ratio at birth in India over time and discussed what the implications were when people in a society wanted a child of a particular sex. Issues such as dowry inevitably entered the discussion but our attempt was always to nudge the discussion towards creating an awareness that MTPs are not just a medical procedure but are practised within a larger social history and context where the status of women is low. We then discussed whether it was possible or even necessary to factor these aspects within medical practice and research.

Student learning and responses

What was the response from the students? Is this style of pedagogy different from what is taught as part of mainstream medical education? As far as we are aware, raising open-ended questions is not the usual pedagogy; the responses of students suggested this as well. Students were silent at first because they were trying to figure out the 'right' answers to the questions we raised. It took them time to get used to the idea that there are no 'right' answers but rather that they would have to listen to each other's answers, set them against larger themes and issues and come to conclusions of their own. For instance, women students of different religious backgrounds were more vocal about their opposition to the State taking decisions about their bodies as it had under the Emergency in India. Men were less articulate about this aspect. When we opened up discussion on the control of the woman's body by religion, community and family, we heard many more diverse views across sexes and religions about what the students considered 'right' and 'wrong'. It was an eye opener for many students to hear each other speak about their experiences as part of a family, community or religious group. Thus, from our point of view understanding that abortion was linked to the (lack of) control of a woman's body as well as larger issues in a woman's life was a major achievement for students. It also sensitised medical students to the larger social meaning inherent in every act, even if they are about the body and health. The most important aspect of this pedagogy in the eyes of the faculty and students was that it was designed to make the students think – thinking itself became the focus of teaching, and it was recognised that this was a skill that must be developed and cultivated over the period of a student's education.

Conclusion

The module described above was oriented towards three things for medical students. The first objective was to make students more sensitive to the larger context they live in, even when they may choose to work in urban, corporate hospitals where none of this appears to matter since their patients are drawn from a more homogenous group. Second, it aimed to expose students to ways of being, thinking, and living that are vastly different from their own, enabling them to take more reasoned decisions by taking into account differing points of view. Third, it tried to make medical education more relevant and responsive to the larger society in which students live by helping them develop a medical 'praxis'. Whether this module succeeds in making more 'sensitive' doctors or not remains to be seen. Yet, cultivating perspectives from the medical humanities is critical to achieving this. The hope is that this approach will result in more compassionate doctors and indeed, more relevant medical education and research.

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Notes

[1] The use of the concept of 'informed reflection' in the context of this paper is acknowledged to Sundar Sarukkai in a discussion with the author. It has however been used by many philosophers in disciplines other than the medical humanities as far as this author was able to ascertain.

[2] 'Politics' does not refer to the saffronisation or otherwise of education, nor does it suggest any other radical formations of students. These may be important issues to deal with but are outside the purview of this paper.

[3] This was co-facilitated by four faculty of Manipal University, Manipal: Sundar Sarukkai, Meera Baindur and Nikhil Govind (all from the Manipal Centre for Philosophy and Humanities) and myself for first year medical students in a large medical programme in Southern India. Some of the strategies used have been analysed in this paper in order to make the module more comprehensive and theoretically connected.

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