

Medical Humanities Pedagogy: Beyond Ethics, Towards Empathy

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Most medical humanities curriculums focus on students going into healthcare fields, with the intent of training more empathic practitioners and helping students learn about systemic issues like healthcare disparities and bias in medical research. Although these goals are vital, I argue that medical humanities curriculums benefit *all students*, regardless of majors and career goals. In this piece, I explore how a medical humanities focus in undergraduate humanities classes can increase medical literacy and help students become better advocates for themselves in healthcare settings. Furthermore, I examine how medical humanities topics, beyond ethics, can be a powerful pedagogical tool. Several years ago, I had the pleasure of reviewing Mita Banerjee's 2018 *Medical Humanities in American Studies: Life Writing, Narrative Medicine, and the Power of Autobiography*. In the book, she asks us to reconsider the relationship between medicine and the humanities, writing that we must think about “not only what the humanities can do for medicine but also what medicine can do for the humanities” (Banerjee 33). I’ve been thinking about that line ever since.

As an English professor trained in the medical humanities, I’m aware that the humanities is often seen as a service discipline. At my small liberal arts university, I often hear talk about how English classes can support other disciplines. How can my literature classes help a business major? How can I tailor my writing classes for engineering majors? Since I fully believe that a robust liberal arts education can serve students their entire life, regardless of their career path, I am open to these conversations with my colleagues on how best to support their students in my classes. I believe future accountants need an art class the same way that future doctors need humanities training—belief in a well-rounded liberal arts education remains the foundation of many universities. But I always wonder: what can the other departments do for my humanities majors? Why is this conversation usually a one-way street? I have never been asked by a biology professor, as an example, how they can best serve humanities majors. As Banerjee aptly points out, understanding the relationship between medicine and the humanities needs to be central to medical humanities research moving forward.

At my university, I only occasionally teach a medical humanities class, and when I do, the class is usually for nursing or biology majors who need to fulfil their humanities core requirement. However, in the past few years, I have started incorporating medical

humanities topics into my writing and literature classes. My thought process was simple; even if students are not going to be healthcare professionals one day, couldn't they benefit from better health literacy? All my students, even in the occasional online class I teach, are presumably corporeal and need to be educated about how to exist as a human with a body. Students who are too shy to voice their opinions about "political" topics will often find their voice when we discuss medicine and medical care. Maybe they've been treated poorly by a medical professional or are coming to terms with a loved one's serious diagnosis. I've found that even the quietest student has something to say about healthcare.

From my teaching in the past few years—usually core curriculum writing and literature classes—I've come to a new conclusion: the medical humanities is not just for students going into healthcare fields. It is not just for science students. The medical humanities is for everyone and is a valuable tool for undergraduate education, regardless of a student's major. Everyone needs basic medical literacy, an understanding of the healthcare system, insight into how issues of medical bias and healthcare disparities affect society, and a more complex understanding of issues with ability, disability, and chronic illness. The medical humanities is vital for medical professionals, but these lessons have broader application in many different classrooms. By extending the medical humanities beyond the medical classroom, we can improve health and medicine on a larger scale. Equally important, the medical humanities provide students of all majors with a sense of empathy for those around them—a skill we value highly for medical practitioners, but one that is useful for everyone. Furthermore, by acknowledging and expanding the need for medical humanities curriculum outside of medical schools and programs, we can foster a more egalitarian relationship between medical education and the humanities. Although this is not a comprehensive guide on how to introduce these topics into undergraduate general education classes, I share my experience and several practical tips for incorporating the medical humanities into a wider variety of classrooms.

The term "medical humanities" was coined after World War II and by the 1990s reached a transatlantic audience. It is a diverse field with scholars in medical and scientific fields, as well as in various humanities disciplines. However, this disciplinary diversity can make it hard to pinpoint the status of the field at any given time. In fact, the very definition of the medical humanities is difficult to locate and reveals tensions between humanities scholars and medical professionals. As Banerjee argues in her book, the medical and science fields often focus on how the humanities can enrich medical education, whereas humanities scholars see the medical humanities as an interdisciplinary field (33). For example, the American Association of Medical College's (AAMC) definition of the medical humanities is solely limited to pedagogy:

Content or pedagogy derived from arts and humanities and integrated into the teaching and learning of medical students, trainees, and practicing physicians. The approaches and experiences with this education are often interprofessional, interdisciplinary, and co-designed to teach and sustain diverse competencies for better health outcomes for patients, communities, and populations (qtd. in Health Humanities Consortium).

Meanwhile, the Health Humanities Consortium does not explicitly mention pedagogy:

The Health Humanities is the study of the intersection of health and humanistic disciplines (such as philosophy, religion, literature) fine arts, as well as social science research that gives insight to the human condition (such as history, anthropology, sociology, and cultural studies.) The Health Humanities use methods such as reflection, contextualization, deep textual reading, and slow critical thinking to examine the human condition, the patient's experience, the healer's experience, and to provide renewal for the health care professional (Health Humanities Consortium).

These two definitions indicate a wide divide in the field; medical professionals see the collaboration with the humanities as a tool to enrich medical education, with little room to explore how medicine can contribute to the humanities whereas the Health Humanities Consortium, comprised of an interdisciplinary group of scholars, focuses on a more holistic approach.

However, pedagogy is still an essential part of the field and all research in the medical humanities comes back to the classroom to achieve one of the most important goals of the field: creating more ethical and empathic healthcare professionals (although medical humanities scholarship has important implications outside the classroom, such as public policy or medical research). Currently, medical schools regularly offer medical humanities classes. These classes are largely viewed by students as useful, although they are often still elective options rather than required courses. A 2021 study in the *Journal of Evaluation in Clinical Practice* found that medical humanities classes have a:

[...] range of benefits including better grades, less burnout, improved clinical judgement, better critical appraisal skills (including about wider problems such as overdiagnosis) better prepared students for real life careers in medicine, enhanced medical professionalism, greater empathy, and appreciation that patients' problems go beyond their biology. (Howick et al. 87)

Their results show that medical humanities classes are being taught in the UK, Canada, and the US: "We identified 18 accredited medical school programmes in Canada, 41 in the UK, and 154 in the US. Of these, nine (56%) in Canada, 34 (73%) in the UK and 124 (80%) in the US offered at least one medical humanities course that was not ethics" (Howick et al. 86). Most medical humanities scholars would argue that there should be more than just one or two humanities classes in medical education, but even a small inclusion of the field into the healthcare classroom shows that the medical humanities has firmly found a place in medical training.

Despite the role medical humanities plays in medical education, the perception of these classes can vary greatly. In a 2021 study of medical students' views of medical humanities classes, surveys revealed that the students were divided on the importance of a medical humanities curriculum. When asked how the humanities related to medicine:

[P]articipants were split 55 to 45% in favor of humanities being a compulsory component of the course. The main reasons against compulsory integration were either the humanities being unnecessary to medical education or that students would be disinterested in the topics, which may be due to the lack of discussion

around the utility of humanities in medicine. Disinterest as a reason to avoid compulsory teaching could strengthen the idea that many students perceive the medical humanities as a separate entity from medicine. Conversely, those in favor of integration, cited its importance to a well-rounded education, and proposed that students in “need” of the skills obtained by the study of the humanities are those who would opt out from elective courses. (Petrou et al. 5)

This data suggests that there is still a prevalent belief among medical students that the humanities is not part of medicine at all, but rather a tool that can help medicine if one chooses to take the elective class. The false dichotomy—that the humanities and sciences are entirely separate disciplines—is troubling. And since medical humanities classes are still largely elective, one can reasonably assume that humanities is seen as a service discipline here, too. With these classes as electives, the implication is that the humanities can aid science education, but these classes are not an integral part of a medical education, but rather a helpful bonus, provided that a student wishes to partake.

This perspective, which sees the humanities as service to medicine, is the reason why it took so long for me to incorporate health humanities topics into my classes. Even I saw the medical humanities as a useful tool for future medical professionals, rather than as a vital lens for looking at the world. I am aware that the push for medical humanities in a general education classroom may seem like an attempt to either justify my own scholarly existence or to simply get the opportunity to teach my specialty. This perception is another reason why I resisted bringing the health humanities into classes for non-science majors for so long; what purpose does the health humanities have outside of an undergraduate or graduate medical classroom? Does your average student, the business major or the criminal justice major, need to read illness narratives and discuss medical ethics? Rather, I kept my specialty contained to my own research and writing, and the occasional class for nursing majors.

Naturally, as with many things in our daily lives, the COVID-19 pandemic changed my thinking and my teaching. During the pandemic, I noticed that many COVID-19 policies were written for local governments, businesses, schools, and other venues by people who were not medical professionals. Many of these policies were impossible to follow, difficult to understand, or downright odd. For example, an order from the state of Michigan allowed hardware stores to remain open but would not allow for customers to purchase paint, plants, or flooring (Oosting). A town in New York banned the use of leaf blowers, fearing the machines would spread the disease (“Explanation of Ban on Leaf Blower Use”). When my university wrote our COVID policy, we looked at many area schools and found many other confusing and strange policies. Wisely, my university worked with our county’s public health department to put together a strategy which allowed for on-campus COVID testing and vaccination clinics—useful and proven disease mitigation tactics.

The chaos and confusion during the pandemic offered a real-life learning experience for my technical writing students. Technical writers need to have both knowledge (or collaborate with a specialist) and the writing skills necessary to explain their topic to their audience. So, I tackled this dilemma in my *Special Topics on Technical Writing Class: COVID-19 Policies*, taught in Spring 2022. The class contained no science

majors. All students were either majoring or minoring in Business or English (the two most common majors for our technical writing classes). Our goal: learn how to write easy-to-understand health policies for schools and businesses.

The class, a short 8-week course designed for seniors perusing our technical writing minor, culminated in an assignment which asked students to choose a venue and write a COVID-19 policy for the summer of 2022. The policy had to be written for the public and would be, theoretically, displayed online (as opposed to an internal memo for employees only). Students also wrote a rationale, explaining how they designed and wrote this policy. Their policy and rationale had to cite current and credible medical research into COVID-19. The students did exceptionally well; their policies were simple, made sense, and all students had plans for how the policies could be adapted as new medical, federal, or state guidelines evolved. The most important part of the assignment—also the hardest part—was for students to learn how to find and read current and accurate medical guidelines and explain those guidelines to an audience with a low-to-average health and reading literacy.

Initially, the main goal of the class was to strengthen the student's ability to write policy, but one of the most valuable things that came out of the class was the in-class discussions and readings. In the class, we dove into issues of illness, disability, and the realities of public health policy. Students were tasked to find readings outside of our syllabus and share them with the class. For example, at the beginning of the course, we had a lively discussion on COVID-19 vaccines. Everyone in the room was vaccinated and most students held the view that people who were vaccine-hesitant or anti-vaccine were uneducated, conspiracy theorists, or, as one student said, "just bad people." However, throughout the course, we began uncovering why people would not trust our medical system and why conspiracy theories were prevalent. The conversations ultimately led to a greater understanding of why some people chose not to be vaccinated. We discussed how personal freedom, deliberate dis- and misinformation campaigns, medical trauma, and historical medical injustice (such as the Tuskegee Syphilis Study¹) could make people skeptical of public health initiatives. The goal of this was not to have students question vaccination. In fact, we spent a great deal of time going over the research to understand why vaccines were an important part of slowing the pandemic. Instead, we discovered empathy for those skeptical of vaccines. Students realized that if we villainize those who make decisions different than ours, we cannot collectively work toward a healthier society. This lesson is something healthcare professionals learn quickly in their studies and on the job, but for those outside the healthcare industry, understanding why people behave and think differently from you about public health creates a greater sense of understanding and tolerance towards difference. In today's heated political climate, these lessons are vital.

Of course, as a humanities professor, I value these types of conversations, regardless of students' disciplinary home. Education is inherently a political act;

¹In the 1930s and 40s, The Tuskegee Syphilis Study unethically studied syphilis in black men. The subjects of the study did not give their informed consent and, once penicillin existed, were not offered the drug to cure the disease ("The Untreated Syphilis Study").

landmark pedagogical texts like Paulo Freire's *Pedagogy of the Oppressed* (1968) and bell hook's *Teaching to Transgress* (1994) make cases for education to give voice to those marginalized by society. The humanities has a history of incorporating social justice issues into the classroom as a way to literally do what our name suggests: explore and understand humanity. Writing studies, for example, has long brought in queer theory or critical race theory into the writing classroom. It's in this environment that most writing professors today have been trained; bringing in issues of race, class, sex, and gender are all common themes in humanities, particularly, writing classes.

Issues of ableism, health disparities, and more generally, health literacy, are not as common in the humanities classroom, even though many instructors are trained in leading these often-uncomfortable instructions. Building on social justice pedagogy, which many of us already incorporate into our classrooms, the health humanities provides a lens for students to challenge their own assumptions about health and ability, understand those around them, and become more educated and health literate. Health literacy (the ability to find care and understand basic healthcare directions) is remarkably poor in the United States, with “only 12% of Americans hav[ing] proficient health literacy skills. Many adults may have difficulty completing routine health tasks like understanding a drug label or using a map to locate the closest health center,” according to the National Assessment of Adult Literacy (Office of the Surgeon General). In the United Kingdom, the National Institute of Health Care and Research estimates that 4 in 10 adults struggle to understand “health content written for the public” (Gursul). Undoubtedly, this issue exists in many other countries.

One of the barriers to health literacy is poor literacy skills. Even on the college level, many students struggle with reading. One study proposes that “One in five employed American adults with a bachelor's degree lacks important skills in literacy” (Fain). Humanities classes, which often require critical thinking, reading, and writing skills could address the literacy problem, while a medical humanities focus could improve health knowledge. By critically thinking about health issues, learning the realities of health care disparities, and by being exposed to medical humanities texts, students can leave the class empowered to make their own health decisions and understand medical settings and self-advocacy better. Of course, major issues with literacy cannot be solved by one course, but attention to critical thinking through the humanities is always helpful. Combined with the fact that many humanities instructors already bring in social justice and other difficult issues into class, why not the medical humanities?

I don't expect most instructors will find themselves in the position to teach a class on COVID-19 policies. However, there are many ways to incorporate the medical humanities into general education courses. One assignment I often incorporate into my writing classes asks students to write an essay describing pain. I don't define pain at all; students can interpret pain as a physical or emotional state (or both). The assignment encourages students to develop their vocabulary and ability to describe difficult concepts (key skills for writing), but also has them question the logic of the traditional pain scale. I pair this writing prompt with Eula Biss's 2005 creative nonfiction piece “The Pain Scale.” Her work questions the logic of the commonly used pain scale as she tries to

register and rate her own severe and chronic pain. “I struggle to consider my pain in proportion to the pain of a napalmed Vietnamese girl,” Biss writes, “whose skin is slowly melting off as she walks naked in the sun” (12). “You are not meant to be rating world suffering” Biss’s friend advises, “This scale applies only to you and your experience” (12).

This writing exercise always brings up questions of medical necessity in class. If a doctor tells you to go to the ER if your headache is a 10/10, how do you know what a 10 is? When and how do we advocate for ourselves in a medical setting? Why are women and people of color less likely to be believed about pain? The medical humanities, in this instance, provides interdisciplinary education to students while equipping them with valuable life skills. Incorporating the medical humanities into humanities classrooms provides an answer to Mita Banerjee’s question: instead of thinking only about what the humanities can add to medicine, adding medical humanities into non-medical classrooms gives concrete and practical evidence that medicine and science can aid the humanities.



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