

Experiential Learning Portfolio

School for Advanced Studies in the Arts and Humanities

Coordinating the 2015-16 Medical Humanities Scholars' Program
for the American Medical Students' Association (AMSA)

July 2015 through April 2016

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Medical Humanities Scholars' Program Description

The American Medical Students' Association (AMSA) runs several online courses as part of their Scholars' Program. These courses provide an opportunity for medical students to learn what is not traditionally taught by their medical schools. As such, the goal is not to add to the students' already rigorous workload, but to provide them an opportunity to supplement their studies with new ideas.

I coordinated the Medical Humanities course as part of a team of three women. We developed the following curriculum, facilitated webinars, managed a website, and invited guest speakers. The course ran from September 2015 to March 2016 with a total of eight webinars (seminars hosted on an online platform) and nearly thirty students from across the USA. Each webinar had a distinct theme with assigned readings and a guest speaker. There was a loosely-structured final project for the students to apply what they had learned without adding to their heavy medical school workload. Regular attendance and completion of the final project earned the students a certificate from AMSA.

This portfolio includes the syllabi that guided each webinar, along with reflections on the process of coordinating this program. In April of 2016, I presented at TEDx talk at the University of St Andrews, which was a cumulation of the work I had done for AMSA.

Why Stories Matter: An Introduction to Narrative Medicine and Ethics

Description:

When a patient sits across from the doctor in an office, she/he is ultimately telling a story of illness and health. When the various lab results are compiled, they are ultimately telling a story of the patient's illness and health. When the anaesthesiologist consults with the surgeon, she/he is ultimately sharing a story about the patient's illness and health. Stories are fundamental to medicine, yet are often ignored as society increasingly privileges the STEM side of medicine. This introductory webinar will explore how we can bring the "human side" of medicine back by recognising how medical practice is—at its core—an exchange of stories. And who's better at understanding stories than literature students? Hence, we will be exploring how an engagement with literature and narrative theory/ethics can improve medical practice. More specifically, we will introduce ourselves to the fundamental premises, theories, practices, and outcomes of narrative medicine: an approach to medical humanities founded by Rita Charon at Columbia University.

Guest Speaker:

Danielle Spencer is a Faculty member of the program in Narrative Medicine at Columbia University as well as the Einstein-Cardozo Master of Science in Bioethics program. Spencer worked as artist/musician David Byrne's Art Director for many years as well as with photographer Nan Goldin and studied literary theory in Paris. She has been published in WIRED magazine and Creative Nonfiction and is at work on a book about identity and perceptual/cognitive differences. Spencer holds a B.A. from Yale University and an M.S. in Narrative Medicine from Columbia University.

Learning outcomes:

- Develop a nuanced definition of narrative medicine and medical humanities more broadly
- Understand how narratives function in medicine, and how to practice narrative competence
- Identify ways in which narrative and humanities practices/theories can be applied to everyday medical practice, and the barriers that may prevent this
- Reflect upon what medical practice gains through an engagement with literature and narrative theory/ethics
- Contextualise narrative medicine with the broader discipline of medical humanities

Resources:

Charon, Rita. "At the Membranes of Care: Stories in Narrative Medicine." *Academic Medicine* 87 (2012): 1-6.

Charon proposes close reading and reflective writing as tools to practice narrative medicine. She begins by broadly identifying the prevalence and importance of narratives as ways of knowing one's self and singularity of others, then applies it to the stories that circulate in the medical context. By drawing upon narrative theory, Charon argues that physicians must not only analyse the content of their patients' stories, but also the *form*, and that this level of narrative competence can be trained through the practices of close reading and reflective writing.

Charon, Rita. "Honoring the Stories of Illness." TEDx video, duration 18:16. Posted November 4, 2011. <https://www.youtube.com/watch?v=24kHX2HtU3o>.

Charon introduces narrative medicine—"the clinical practice fortified by the knowledge of stories"—by retelling her own story: her story of being an avid reader, discovering that her patients were paying her to *listen to their stories*, getting her Ph.D. in literature, and how her practice

changed after her postgraduate studies. Charon posits that a literary and narratological education allows physicians to interpret, honour, and be moved to action by the stories of patients. Her talk is especially effective as she illustrates her theoretical framework for narrative medicine through anecdotes of her real patients, and highlighting the ways in which close reading and reflective writing allows her to connect with, understand, and build trust with her patients.

Charon, Rita. "Narrative Medicine: A Model for Empathy, Reflection, Profession, and Trust." *JAMA* 286 (2001): 1897-1902.

Charon proposes narrative medicine as a model for improved medical practice, and defines it as "medicine practiced with narrative competence...that is, the ability to acknowledge, absorb, interpret, and act on the stories and plights of others" (1897). Charon's core argument is that narrative medicine facilitates more positive outcomes in four key relationships: physician and patient, physician and colleagues, physician and self, and physician and society. Narrative medicine equips physicians with the tools to extend empathy to patients, access the patient's *whole* story, engage in therapeutic practices of reflection, foster respect and professionalism amongst colleagues, and inspire society to trust them.

Charon, Rita. "The Parallel Chart." In *Narrative Medicine: Honoring Stories of Illness*. New York: Oxford University Press, 2006.

This chapter of Charon's book moves from a theoretical framework of narrative medicine to concrete practice. Charon proposes the use of a "parallel chart" as a tool to implement narrative medicine into a physician's daily practice. The "parallel chart" compliments the traditional medical chart that is often very limiting, reductive, and distanced from the patient's story; instead, Charon encourages physicians to keep their own "parallel chart" in which they can write more thorough narratives of their encounters with their patients. This encourage physicians to listen to the patient's *whole* story, rather than just the pieces that fit a traditional medical chart. The "parallel chart" also provides a chance for physicians to reflect upon and critically analyse their patient's story.

Irvine, Craig. "The Other Side of Silence: Levinas, Medicine, and Literature." *Literature and Medicine* 24 (2005): 8-18.

Irvine argues that the power of literature is its ability to "bring close distance," or in other words: to heighten the reader's awareness of the distance that will always exist between the one telling a story and the one receiving it. Drawing upon Emanuel Levinas' theories, Irvine theorises that literature allows readers to come into contact with the distance between themselves and the Other—a distance that can never be bridged, but can begin to be understood and perceived through literature. Yet by virtue of seeking to reveal and understand the Other (that which cannot be accessed or understood), literature effaces it. As a result, literature reveals to medicine its own attempts to know the Other (the patient) and how this can be a destructive endeavours. Thus, literature incites medicine to be constantly self-critical and reflective of its methods.

Narrative Medicine Beyond Literature: Film, Theatre, Comics, Photography, and Visual Art

Description:

This session will begin with an introduction to semiotics, narrative theory, and narratology in order to deepen and nuance our understanding of how stories are produced and function—to develop our “narrative competence” so that we can more effectively practice narrative medicine. This theoretical foundation will be applied to narrative forms beyond the literary foundation we began with; film, photography, visual art, theatre, and comics will be considered as other art forms through which narrative medicine can be fostered. We will be exploring what each art form has to offer medicine, how it can be practically used in medical classrooms, and what its benefits and limitations are in comparison to literature.

Learning Outcomes:

- Gain a basic understanding of the fundamentals of semiotics, narrative theory, and narratology
- Critically analyse stories in terms of temporality, focalisation, narration, metaphors, and metonymies
- Recognise how mediums beyond literature produce stories and to what effect, and how this can be harnessed to train narrative competencies for a medical context
- Reflect upon what transferrable skills can be trained and honed through an engagement with stories in various art forms
- Consider what film, photography, visual art, theatre, and comics have to offer medicine in comparison to literature

Guest Speaker:

Maura Spiegel is a professor of English who has been teaching fiction and film at Columbia University and Barnard College for the past 15 years. She is a founding member of the core faculty in the Program in Narrative Medicine at Columbia College of Physicians and Surgeons, where she offers film courses to second-year medical students. With Rita Charon, M.D., Ph.D., she was the co-editor-in-chief of the journal *Literature and Medicine* (Johns Hopkins UP) for seven years. She co-authored *The Grim Reader: Writings on Death, Dying and Living On* (Anchor/Doubleday) and *The Breast Book: An Intimate and Curious History* (Workman). She writes on numerous topics related to narrative, and she is currently writing a book on the films of Sidney Lumet.

Resources:

Cohan, Stevem and Linda Shires. *Telling Stories: A Theoretical Analysis of Narrative Fiction*. New York: Routledge, 1988. 30-36, 54-61, 84-89, 94-104.

The excerpts from Cohan and Shires’ book provides an introduction to Saussure’s theory of linguistic signs, defines syntagmatic and paradigmatic metaphors and metonymies, and applies this knowledge to analyse a passage from Lewis Thomas’ memoir *The Youngest Science*. This passage provides a metaphorical account of the role of nurses in a hospital, thus making this example of close reading especially pertinent to medical humanities. These experts also include analyses of how narratives are structured in terms of events, temporality, and focalisation. Cohan and Shires’ book expertly explain these complex terms in clear language, without ever being reductive, thereby making narratology and semiotics accessible to students who have only ever studied science at the university level. By engaging with narrative theory, the students will become equipped to conduct a more nuanced analysis of the narratives they encounter throughout the course and in their practice.

Helle, Anita. “When the Photograph Speaks: Photo-Analysis in Narrative Medicine.” *Literature and Medicine* 29 (2011): 297-324.

Helle argues that photographs must be analysed (read) with the same rigour that literary texts are read. Empathy and witnessing are key concepts in narrative medicine, and rigorous photo-analysis forces viewers to re-conceptualise these concepts. The photograph is perceived as being more directly connected to the “real” than literature or paintings, and thus offers a re-conceptualisation of empathy and witnessing that is uniquely possible through photo-analysis.

Jenkins, Tamara, dir. *The Savages*. 2007. Fox Searchlight, 2008. DVD.

“The Savages” explores the lives of two siblings brought together by the need to care for their elderly father with dementia. The story of their father’s illness becomes intertwined with his children’s stories (bringing up the history of abuse, their present loneliness, and their uncertain future). As a result, this film asks medical students to critically consider how illness narratives circulate and how the story of one’s physical illness cannot be separated from the story of one’s life (and that of one’s loved ones). The “dysfunctional family” theme is highly relatable and will inevitably incite viewers to make connections with their own narratives; therefore, this film allows students to reflect upon how their own experiences influence the way they interpret and perceive the stories of others, like their patients. The imminent and inevitable death of the father heightens the emotions elicited by the siblings, and thus, also incites a heightened sense of emotions in the viewers, making this film an especially powerful “affective exercise” for medical students.

Lerner, Marcia. “Drawing From Experience: Cartoonist Ben Schwartz discusses the visual side of learning medicine.” *Proto Magazine*, September 22 2014. <http://protomag.com/articles/Ben-Schwartz-medical-cartoons>.

In this interview, Ben Schwartz discusses the benefits of using cartoons for medical education. He notes the parallel between how comics tell their story through both images and words, just as a patient’s story is told through both visual content (e.g. body language, lab result graphs) and words (e.g. spoken by the patient, written down in a medical chart). As a result, analysing and creating comics allows medical students to recognise how words and visual content combine to produce meaning in medical encounters.

Nisker, Jeff. “Theatre and Research in the Reproductive Sciences.” *Journal of Medical Humanities* 31 (2010): 81-90.

Although this article discusses how theatre can be harnessed as a tool to research the public’s perspectives on reproductive ethics, Nisker’s focus on the power of narratives can be applied to narrative medicine. Nisker notes how theatre is a powerful tool as it allows audience members to engage in the narrative and emotions of the characters on stage, and thus incites greater understanding, empathy, and reflection from the audience. This not only encourages in-depth responses and opinions from audience members towards the medical ethical dilemmas faced by characters, but can also facilitate in-depth narrative analysis and emotional reflection from medical students towards illness experiences presented on stage.

Spiegel, Maura and Arthur Heiserman. “Narrative Permeability: Crossing the Dissociative Barrier In and Out of Films.” *Literature and Medicine* 25 (2006): 463-464.

Spiegel and Heiserman posit that watching films is not a process of passive perception, but an active process. Watching films activates powerful emotions that we rarely access and incites an interaction between the viewer’s narrative and the film’s narrative. Watching films, thus, is not merely outward looking (onto the screen), but also inward looking (onto our own emotions, narratives, and subjectivity). Viewers not only transform the film’s narrative by bringing in our own narratives and emotions, but the viewer’s own narratives and emotions are transformed through the process of film watching. This intimate dialogue between viewer and film parallels the dialogue between the patient and physician’s narratives and emotions, and thus, watching films can be used as a powerful tool for physicians to better understand their patients and themselves.

Wellbery, Caroline and Rebecca A. McAteer. "The Art of Observation: A Pedagogical Framework." *Academic Medicine* 90 (2015) 1624-1630.

Wellbery explores the act of closely observing the arts as the foundation of what makes what makes medical humanities education powerful and important. More specifically, she presents "the pedagogical benefits of arts observation" and offers a potential arts observation curriculum. She focuses on science writing as a way to recognise how objective observation leads to subjective engagement; she equates poetic precision to the detail and exactness necessary for safe medicine; she posits arts observations as a way for to recognise when observation is problematic (voyeuristic); and she notes how the arts often challenge cultural systems, which will allow medical students to recognise what needs to be challenge in medical culture.

At the Heart of Medicine: Metaphors in Medicine

Description:

Medical discourse is littered with metaphorical language, from the “battle” against cancer to the “plumbing” in your digestive tract. Both physicians and patients often speak in metaphors, thus it is important to understand and analyse metaphors. The previous seminar’s narratological approach to metaphors will be discussed alongside Jeffrey Donaldson’s cognitive approach to metaphors in order to establish a theoretical framework of how metaphors are produced and function. This theoretical framework will be applied to gain a deeper understanding of the implication of metaphorical language in the medical context. In this webinar, we will explore specific metaphors used in medicine, their regular use, and their effects on how medical professionals and patients understand and react to illness.

Learning Outcomes:

- Gain a theoretical framework for how metaphors are produced and function
- Identify metaphors that recur in medical discourse
- Discuss how metaphors shape one’s understanding of illness, and how this influences the patient’s and physician’s actions and decisions
- Reflect upon when metaphors are both beneficial and destructive to medical discourse

Guest Speaker:

Shane Neilson is a Canadian physician and poet. Neilson studied biochemistry at the University of New Brunswick for three years. At the age of nineteen, Neilson was granted acceptance into Dalhousie Medical School and in 2000 began his medical residency. Dr. Neilson’s success in the medical field is paralleled to his success as an author. In 2006, Shane published, *Call me Doctor*, an autobiographical account of his medical experience. Shane has also published multiple books of poetry, which have been widely received. In 2010, he was awarded the Arc Poetry Magazine’s 15th Annual Poem of the Year award.

Resources:

Donaldson, Jeffery. “Introduction.” *Missing Link: The Evolution of Metaphor and the Metaphor of Evolution*. Montreal; Kingston: McGill-Queen’s University Press, 2015.

Donaldson understands metaphors as “an *is* and an *is not*”—in other words, metaphors establish what *is* similar between things, but ultimately one thing *is not* actually the other. Donaldson’s approach to metaphors is founded in cognition—in how the brain functions, rather than how simply language functions. He traces metaphors to the “origins of matter” by understanding not only language in terms of metaphors, but also fundamental matter (like molecular bonds) in terms of metaphors. Thus, *Missing Link* explicitly establishes the link between arts and sciences. This book makes it clear why studying metaphors in language is so important for scientists (like doctors): it allows them to understand what is ultimately at the core of all science—metaphor.

Khullar, Dhruv. “The Trouble with Medicine’s Metaphors.” *The Atlantic*, August 7 2014. <http://www.theatlantic.com/health/archive/2014/08/the-trouble-with-medicines-metaphors/374982/>.

Kullar, a physician himself, reflects on the enormous prevalence of metaphorical language in medicine. He draws upon a wealth of relevant scientific and theoretical articles to make his case that the metaphors one uses, especially in medicine, have a direct impact on what the patients and clinicians do and think. In particular, he explores the problems that arise when cancer is

metaphorically presented as a “battle,” making a very clear example of how insidious and influential metaphorical language is in medicine.

Neilson, Shane. “Pain as Metaphor: Metaphor and Medicine.” *Medical Humanities* (2015): 1-8. Neilson explores how pain has been metaphorically understood by philosophers (like Aristotle) and via visual metaphorical diagrams of pain transmission through nerves in medical textbooks. He notes how pain is predominantly conceptualised through “damage/weapon and neurological metaphors” that ignore the “narrative” of pain—the actual experience and affects of living with pain. Neilson posits that this metaphorical conception of pain contributes to medicine’s poor capacity for dealing with chronic pain. Ultimately, he argues that in order to change the way pain is treated in medicine, the metaphors of pain must first be changed and expanded.

Neilson, Shane. “All Pain Can Be Controlled by Shane.” <http://rpo.library.utoronto.ca/poems/all-pain-can-be-controlled>.

Shane Neilson’s poem skilfully employs metaphorical language to explore how clinicians seek to control pain. This poem is a more creative way of exploring many of the same issues that Shane Neilson addresses in his essay on “Pain as Metaphor.”

Sontag, Susan. *Illness as Metaphor*. New York: Farrar, Strauss, Giroux, 1978. 5-20, 72-88. *Illness as Metaphor* was the first thorough analysis of metaphorical language in medicine, and heightens readers’ awareness of the occurrences and implications of medical metaphors. Sontag explores how tuberculosis and cancer have been conceptualised through metaphorical language, and how this affects the medical world and other realms, like politics. Sontag concludes that illness metaphors should be eradicated from language, yet her own language frequently succumbs to these metaphors, beginning as early as the introduction with her metaphor of illness as a geographical place to which one acquires citizenship. Thus, *Illness as Metaphor* also forces readers to consider whether it is even possible to understand illness without metaphors.

Wellbery, Caroline and Melissa Chan. “White coat, patient gown.” *Medical Humanities* 40 (2013): 90-96.

Wellbery and Chan explore the power dynamics in the doctor-patient dyad by understanding the metaphorical implications of patient gowns. They conclude that patient gowns function as metaphors for the patient’s vulnerability in contrast to the physician’s white gown, which has become a metaphor for authority and power. This article presents several close analyses of visual art, which clearly demonstrates how art forms beyond literature can be harnessed in the medical humanities. By using analyses of art, Wellbery and Chan reveal how medical practitioners must be conscious of visual metaphors, not just linguistic ones.

Wynn, L.L., Angel M. Foster, and James Trussell. “Would you say you had unprotected sex if...? Sexual health language in emails to a reproductive health website.” *Culture, Health and Sexuality* 12 (2010): 499-514.

This article analysed over 1000 emails sent to a confidential emergency contraceptive website in order to understand how definitions of sex, unprotected sex, and emergency contraception vary. Medical practitioners often consider these definitions to be stable and unanimous; however, this article reveals how sexual health is often understood through metaphorical language that results in unstable and varied definitions. This ambiguity in language affects both the patient and physician’s perception of pregnancy, sexual disease, and moral risks, which then influences medical care decisions. Wynn, Foster, and Trussell’s research reveals how metaphorical language can directly

influence health care, and thus makes the case for why medical practitioners should engage with literature.

Sexton, Anne. "The Touch." http://famouspoetsandpoems.com/poets/anne_sexton/poems/18208.

Anne Sexton's poem draws upon numerous rhetorical devices—most significantly: metaphor—to understand the feeling of touch. This poem is a valuable resource for medical students and professionals as it is not explicitly related to medicine, but addresses something that all humans have experienced: the sense of touch. Moreover, this work is likely to draw interesting parallels with medicine where clinicians must use their hands to conduct one of the oldest diagnostic tests: the physical examination.

The Body as Text: How Physicians Read and Write the Body

Description:

Doctors are intimately tied to bodies: the bodies they dissect in an anatomy lab, the bodies they touch in the clinic or operating room, and their own bodies. Often, only the physiological aspect of these bodies are considered, from the patient's heart rate to the amount of caffeine pumping through the doctor's veins. However, tools such as stethoscopes or fetal heart monitors are not enough as bodies speak in complex ways—from the patient's eyes fixed on the clinician as bad news is about to be delivered to a physician's implicit racial biases against a patient's skin colour. The relationship between physicians and bodies must be read in terms of the intersections of gender, race, class, and sexuality in order to thoroughly understand the effects of power dynamics in the medical encounter. Bodies are at risk of being objectified, rejected, or devalued in medicine if we do not critically reflect upon the physician's relationship to bodies. In this webinar, we will investigate how bodies are understood, perceived, and read by physicians in medical settings. We will explore how these "readings" of bodies affect the clinical encounter, from the physician to the patient to society.

Learning Outcomes:

- Become familiar with the role of bodies in medicine from historical and cultural perspectives
- Reflect upon how medical school incites students to distance themselves from and thus defamiliarise patient bodies
- Be able to critically analyse presentation of bodies through narrative forms such as literature and visual art
- Recognise how power dynamics are established between physician and patient through the intersections of race, gender, class, and sexuality, and how these dynamics impact the standard of care
- Understand how the oppression of marginalised bodies manifests itself in medical interactions, and how to change practices so that this does not occur
- Consider innovative ways to interact and enhance our relationship with bodies in medicine

Guest Speaker:

A 2015 Guggenheim Fellow in Nonfiction, Dr. Christine Montross is Assistant Professor of Psychiatry and Human Behaviour, and the Director of Counselling Resources at the Warren Alpert Medical School of Brown University. She is also a staff psychiatrist at Butler Hospital in Providence, Rhode Island. She completed medical school and residency training at Brown University, where she received the Isaac Ray Award in Psychiatry and the Martin B. Keller Outstanding Brown Psychiatry Resident Award.

Dr. Montross received her undergraduate degrees and a Master of Fine Arts in poetry from the University of Michigan, where she also taught writing classes as a lecturer following graduation. She was born and raised in Indianapolis.

Dr. Montross has been named a 2010 MacColl Johnson fellow in Poetry, and the winner of the 2009 Eugene and Marilyn Glick Emerging Indiana Authors Award. She has had several poems published in literary journals, and her manuscript *Embouchure* was a finalist for the National Poetry Series. She has also written for many national publications including *The New York Times*, *The Washington Post Book World*, *Good Housekeeping* and *O, The Oprah Magazine*.

Dr. Montross's first book, *Body of Work*, was named an Editors' Choice by The New York Times and one of The Washington Post's best nonfiction books of 2007. Her second book, *Falling Into the Fire* was named a *New Yorker* Book to Watch Out For. She and her partner, the playwright Deborah Salem Smith, live in Rhode Island with their two young children.

Resources:

Barnes, Whitney. "The Medicalization of Transgenderism." *Trans Health*, July 18 2001. <http://www.trans-health.com/2001/medicalization-of-transgenderism/>.

This paper draws upon the disciplines of gender studies, queer theory, psychiatry, and medicine to explore how transgender individuals are perceived and subsequently treated by medical professionals. Barnes highlights the contradiction between disciplines like queer theory and medicine—the later of which seeks to understand and/or explain transgenderism in condescending, disrespectful, objectifying, and restrictive terms that often impede a transgender individual's (physical and psychological) health. This paper makes the case of why medicine needs to learn from the humanities by exploring the particular case of transgenderism.

Cooper, Lisa et al. "The Associations of Clinicians' Implicit Attitudes About Race With Medical Visit Communication and Patient Ratings of Interpersonal Care." *American Journal of Public Health* 102 (2012): 979-987.

This study demonstrates how implicit racial bias not only exists amongst primary care physicians, but has a real impact on the doctor-patient encounter. In particular it analyzes communication between the doctor and patient, along with the patient's rating of the encounter, and then relates these metrics to the doctor's implicit bias test scores. This study is limited to black versus white patients. Lisa Cooper and her research team present a compelling approach to quantifying and statistically analysing racial bias in medicine, but this study still opens up discussion regarding what nuances a quantitative rather than qualitative approach misses.

DasGupta, Sayantani. "Reading Bodies, Writing Bodies: Self Reflection and Cultural Criticism in Narrative Medicine Curriculum." *Literature and Medicine* 22 (2003): 241-256.

DasGupta draws upon the experience of female medical students in her elective seminar on "Reading Bodies, Writing Bodies" to explore issues of gender, power, and marginalisation in medicine. DasGupta argues that restrictive dualities in medicine (like mind/body, man/woman, doctor/patient) seek to separate medical students from their bodies in order to fit the hegemonic norm of a male, white doctor, thereby leaving any medical students who deviate from this norm alienated from their bodies. This essay reveals the ways in which issues related to "the body" reflect back onto the clinicians themselves, and provides a useful example of a narrative medicine syllabus that can help address these issues.

Eakins, Thomas. "The Gross Clinic." <http://www.philamuseum.org/collections/permanent/299524.html>.

Eakins' painting epitomises the traditional power dynamics and approaches to the body that plague medicine. Although the painting is more than a century old, it is still important to analyse because the legacy of the approaches, attitudes, and dynamics depicted in the painting are still the root of many problems in the medical world today.

Montross, Christine. "First Cut"; "The Bodies of Strangers." In *A Body of Work: Meditations on Mortality from the Human Anatomy Lab*. New York: The Penguin Press (2007).

Montross' book *A Body of Work* recounts her experience as a medical student, with a particular focus on how that experience shaped her relationship to bodies—those in the anatomy lab, those of patients, and her own body. Medical school, especially one's first experience in the anatomy lab (which is recounted in the chapter "First Cut"), is often considered the first instance in which clinicians begin to lose their connection to the human inside the body—the first instance in which the body becomes a mere bundle of symptoms and diseases. Montross is a skilful narrator, making this piece also a powerful work on literature that can be analysed for its form as well as content.

Picasso, Pablo. "Science and Charity." <http://www.bcn.cat/museupicasso/en/collection/mpb110-046.html>.

Pablo Picasso's painting of a doctor at a patient's bedside depicts traditional dynamics in medicine (e.g. white, male physician in contrast to frail, female patients, etc.), while also containing subtle nuances that suggest a more humane approach to medicine (e.g. doctor sitting at patient's level, caregiving in the patient's home, etc.).

Yalom, Irving. "Fat Lady." <https://sites.google.com/a/georgetown.edu/mdarts/units/unit1/section-2/essay-irvin-yalom-fat-lady-excerpt>.

Yalom's short story forces us to confront how the medical world often perceives and treats overweight patients. This story reveals the deepest and darkest thoughts that so often run through a clinician's mind, but are never openly discussed, thus, foreclosing the opportunity to address these problematic perceptions. Yalom's writing style mimics that of everyday conversations and thoughts, making this piece especially accessible to readers of all levels.

The Stories of Our Lives: Illness Narratives

Description:

Illness narratives are the foundation of patient-centred care. Illness narratives are how patients express themselves to physicians, and thus physicians must be equipped to understand, value, and analyse these narratives in all their complexity. Patients need illness narratives in order to express themselves, yet these narratives are often prevented from being told in the first place or simply ignored and misunderstood. This webinar will explore how medical practices can impede the expression of illness narratives, and how medical practices can be changed to gain insight from illness narratives. We will also explore how illness narratives are structured and their effects at a theoretical level, and then apply this to analyse illness narratives of real patients. Illness narratives will also be explored beyond simply the patient: loved ones and the health care providers also have illness narratives to share as their experiences intersect with those of the patient.

Learning Objectives:

- Learn to analyse, value, and recognise illness narratives in a variety of form, from written words to visual art
- Reflect upon the value and limitations of expressing illness through narratives forms
- Understand the impact of expressing illness narratives on the patient themselves, the health care providers, loved ones, and society
- Recognise and apply illness narrative concepts to clinical situations
- Reflect upon what medical practices impede the expression of illness narratives and how this can be improved
- Consider the illness narratives that loved ones and physicians have to share

Guest Speaker:

Arthur Frank is Professor Emeritus of Sociology at the University of Calgary, where he has taught since 1975. He currently is professor at VID Specialized University, Bergen, Norway, and core faculty at the Center for Narrative Practice in Boston. He lives in Calgary.

Trained as a medical sociologist (Ph.D., Yale, 1975), he is the author of a memoir of critical illness, *At the Will of the Body* (1991; new edition 2002); a study of first-person illness narratives, *The Wounded Storyteller* (1995; expanded edition, 2013); a book on care as dialogue, *The Renewal of Generosity: Illness, Medicine and How to Live* (2004); and most recently, a book on how stories affect our lives, *Letting Stories Breathe: A Socio-narratology* (2010).

Dr. Frank has been visiting professor at the University of Sydney, Ritsumeikan University in Kyoto, Keio University in Tokyo, and the University of Toronto, and a visiting fellow in bioethics at the University of Otago, New Zealand. For many years he was book review editor of the journal *health: an interdisciplinary journal* and among other editorial board appointments, he is a contributing editor to *Literature and Medicine*. Dr. Frank is an elected Fellow of The Hastings Center and a Fellow of the Royal Society of Canada. He was the 2008 recipient of the Abbyann Lynch Medal for Bioethics, awarded by the Royal Society of Canada.

Resources:

DasGupta, Sayantani and Rita Charon. "Personal Illness Narratives: Using Reflective Writing to Teach Empathy." *Academic Medicine* 79 (2004): 351-356.

DasGupta and Charon argue that reflective writing can foster the capacity for medical students to engage in empathetic relationships with patients. Students were asked to reflect by writing personal illness narratives: reflections on their own illness experience, reflections on their family or friends' illness experiences, and reflections on their patients' illness experience. These personal illness narratives allow students to bridge the distance between themselves and their patients, reflect upon the biases they bring to the patients' illness experience, and becomes more in touch with their bodily identities (gender, class, sexuality, ethnicity). Thus, this article connects the previous discussion on "The Body" with the current discussion on "Illness Narratives."

Enslar, Eve. "Eve Enslar: Suddenly, my body." TEDx video, duration 12:58. August 5, 2011. <https://www.youtube.com/watch?v=bHLgTUV0XWI>.

Eve Enslar reads aloud from her memoir *In The Body of the World*, which intertwines the story of her cancer experience with the story of her life, especially in terms of her feminist activism. Her illness narrative is a powerful example of how the patient's entire story is crucial to understanding his/her illness. As a playwright, Enslar's illness narrative is particularly literary and lends itself well to the kind of literary analysis narrative medicine impels us to do. It is especially important to listen to illness narratives rather than just read them because real clinical encounters involve oratory narratives.

Frank, Arthur. "Seeing Through Pain"; "Denial and Affirmation"; "Valuing Illness." In *At The Will of The Body: Reflections on Illness*. Boston: Houghton Mifflin, 2002. 29-35, 99-107, 115-122.

Frank's narrative of his own heart attack and cancer experience provides the foundation of his theorisation of the illness experience and illness narratives. Pain is the starting point of Frank's own illness narrative, rather than just simply the medical narrative created for him. Frank also recounts how his illness narrative and experience was consistently denied: he was denied the chance to be anything but an illness, his suffering due to illness was denied, the experience of his caregiver (his wife) was denied, and many of his relationships were denied. Frank posits that illness can only be valued once societal perceptions and attitudes towards human productivity change.

Frank, Arthur. "When Bodies Need Voices." In *The Wounded Storyteller: Body, Illness, and Ethics*. Chicago: The University of Chicago Press, 1997. 1-25.

Frank argues that we are transitioning from modern times (when the medical narrative is the most important) to postmodern times (when patients recognise that *their* narratives are the most important). Frank's theory assumes that the patient's world is changed through illness, and that they *need* their own narratives in order to understand and navigate this post-illness world. Thus, Frank draws upon postcolonial theory to theorise the patient's illness experience and narrative: how the patient is able to speak *through* their body rather than have their body *spoken for* (colonised). This provides a unique theoretical framework through which to analyse illness narratives.

Hemon, Aleksandar. "The Aquarium: A Child's Isolating Illness." *The New Yorker*, June 13 2011. <http://www.newyorker.com/magazine/2011/06/13/the-aquarium>.

Hemon provides a raw and honest account of his infant daughter's cancer experience and traces its impact on him and his wife as caregivers—a perspective and role that is often forgotten. He uses the metaphor of an aquarium to express and understand their sense of entrapment and discontent. Most significantly, he challenges the notion that humans suffer for some higher purpose, and frankly reflects on how his daughter's death has brought only sadness in their lives. This story challenges how patients and their caregivers are often expected to come to terms with illness, and gives a uniquely refreshing take on how one deals with death.

Hydèn, Lars-Christer. "Illness and Narrative." *Sociology of Health and Illness* 19 (1997): 48-69. Hydèn conducts a literature review of research on illness narratives from 1987-1997, noting a thematic shift in focus from medical practitioners to patients, a theoretical shift from the periphery to the centre, and a methodological shift towards recognising how narratives change depending on context. Hydèn also concludes that illness narratives have been shown to help construct, understand, and explain one's illness experience; assert the patient's identity; and transform individual illness into a collective experience. This article thus provides a solid foundation from which to begin the discussion of illness narratives.

Murray, Jock. "Images of Illness: The Art of Robert Pope." Nova Scotia: Robert Pope Foundation, 2007.

Jock Murray's paintings depicts narratives of illness through the visual rather than the written narratives we so often encounter, thus providing a new form through which to understand illness and how it is founded in narrative.

Neilson, Shane. "Sitting." In *Will*. Winnipeg: Einfield & Wizenty, 2013. 51-66.

Shane Neilson's short story, told through the perspective of a physician who is now paralysed, blurs the line between physician and patient. This illness narrative also confronts and challenges the perceptions and assumptions we have of people with disability. While readers may struggle to connect with the narrator's disability, they are likely to connect with the tone and style: casual, witty, and disconnected, it mimics the way many of us compose our inner-most thoughts.

Schleifer, Ronald and Jerry B. Vannetta. "The Patient's Story: The Apprehension of Narration." In *The Chief Concern of Medicine*. USA: University of Michigan, 2013. 168-210.

Schleifer and Vannetta argue that the chief concern of medicine is the "meaningful whole" of the patient's illness narrative, as opposed to the chief medical complaint which is usually focused upon. They argue that the chief concern of medicine can only be reached when narrative knowledge is used to understand illness narratives, and when medical practitioners are conscious of "story filters" (like anger or cultural difference) that may be preventing communication between patient and physician. Schleifer and Vannetta ground their theoretical discussion by analysing poetry, detective fiction, patient records, and transcriptions of doctor-patient encounters.

Schweizer, Harold. "To Give Suffering a Language." *Literature and Medicine* 14 (1995): 210-221.

Schweizer compares illness narratives and literature, and literary critics and medical practitioners. Neither literature nor illness narratives can ever be wholly understood, yet it is known that they are important; both literary critics and medical practitioners strive to understand literature and illness narratives, respectively, but with suspicions since they recognise the multiplicity of interpretations. Literature and illness narratives tempt interpretations, but ultimately always elude it—and it is this paradoxical and irrational nature of literature that Schweizer believes can be harnessed for medical practitioners to witness and acknowledge that "irreducible secrecy of suffering."

Medicine Beyond Boundaries: Cross-Cultural Medicine

Description:

plays a significant role in shaping the narrative of one's life, and thus inevitably impacts a patient's medical narrative. As a result, engagement with the humanities (and narratives in particular) plays a crucial role in how cross-cultural medical encounters unfold. As discussed in previous webinars, the arts and humanities provide a key entry point into how narratives function and to what effect. This webinar will explore how the medical humanities can be applied to cross-cultural medicine. What impedes the transmission of patient narratives across cultural boundaries? What stories are not told (or heard) across cultural boundaries? How can we begin to deconstruct these boundaries? What role does the medical humanities have to play in this deconstruction? The theoretical content will be contextualised in practice by discussing narratives of cross-cultural medical encounters in order to illuminate the benefits and limitations of the various theoretical perspectives.

Learning Outcomes:

- Critically analyse what factors impede effective medical encounters across cultures
- Recognise the limitations of cultural competency models
- Identify the hidden assumptions of Western medicine, and reflect upon how these may be destructive to cross-cultural medical encounters
- Consider how cross-cultural medical encounters can be improved through engagement with narratives in the arts and humanities
- Explore the benefits and limitations of theoretical frameworks for cross-cultural medicine
- Reflect upon how lessons from past webinars can be applied to cross-cultural medical encounters in order to facilitate more positive relationships and outcomes

Guest Speaker:

Aliye Runyan, MD, is a first year resident in OB-GYN at Wayne State/Detroit Medical Center. Originally from St. Petersburg, Florida, Aliye most recently lived in the DC area, where she spent two years as the Education and Research Fellow for the American Medical Student Association. Her role involved creating educational models to address gaps in traditional medical education, including health policy and advocacy, wellness in medical training, and quality improvement initiatives. She was also the founder, and director from 2008-2011, of the AMSA Medical Humanities Scholars Program. From 2010-2011, she was a Howard Hughes Medical Institute –NIH research fellow, studying the role of osmotic transport pathways in uterine fibroid growth. Aliye's career interests include family planning, international public health, reproductive rights, medical humanities and wellness, and medical education. She intends to pursue a career in academic medicine.

Resources:

Fadiman, Anne. *The Spirit Catches You and You Fall Down*. New York: Farrar, Straus, Giroux (1997). 68-77, 144-153, 164-170, 255-261.

Fadiman's medical anthropology novel recounts the story of an epileptic Hmong girl being treated in a small Californian town, where her family relocated as refugees. This extensively detailed account spans a decade, includes the perspectives of everyone involved from the mother to the physicians to the translators, and draws upon pertinent history, theory, and medical research. As such, Fadiman's work is a valuable case if one seeks to understand all the nuances and complexity of cross-cultural medicine, and offers insight about best (and worst) practices that can be applied to any cross-cultural medical encounter.

Abuelaish, Izzeldin. *I Shall Not Hate: A Gaza Doctor's Journey on the Road to Peace and Dignity*. New York: Walker & Co. (2011). 77-82, 172-175.

Dr. Abuelaish's intimate memoir recounts his life from being born into poverty in Gaza, to becoming the first Palestinian doctor in Isreal, to losing his wife and three daughters. His story explores when medicine is impeded not just by cultural factors, but by the politics that put those cultures in conflict (namely: Palestinians and Israelis). He exemplifies how medicine can be harnessed to overcome cultural, political, religious, and national boundaries and prompts readers to explore the ways in which medicine can—and must—be used as a tool for peace and unity.

Western University Faculty of Arts and Humanities. "Indigenous Health and Wellbeing." Youtube video, 1:29:20. Posted May 25, 2015. 6:20-26:00. <https://www.youtube.com/watch?v=IGV4InYPFzo&index=5&list=PLcsqp9WTjiHLNbI8NQn0LRdhl7hkrPA9h>.

v=IGV4InYPFzo&index=5&list=PLcsqp9WTjiHLNbI8NQn0LRdhl7hkrPA9h.

This oral patient narrative confronts the issues of indigenous health: how physicians' negative perceptions and stereotypes of indigenous individuals results in them receiving sub-par health care. The speaker explores how the legacy of colonialism perpetuates health care disparities, while also presenting concrete ways for clinicians to positively change the way they interact with and treat indigenous patients. When discussing medicine in North America, a settler-colony, it is imperative to have these kind of discussions about how indigenous peoples are systematically disadvantaged through health care.

Kleinman, Arthur. *Patients and Healers in the Context of Culture*. Berkeley, CA: Univ of California Press, 1980.

Arthur Kleinman's patient explanatory model has been adopted by medical educators and practitioners across the world as a valuable tool for addressing cross-cultural care. The simple questions allow the clinician to access how the patient understands his/her own health and illness, and thus highlights to clinicians where their medical understanding diverges from that of their patients. These differences often arise due to cultural differences; recognising these differences allows the clinician to alter how she/he interacts with and treats the patient in order to reach a more mutual understanding and trust. It is also important to discuss how Kleinman's questions can become reductive, or what questions could be added.

Trevalon, Melanie and Jann Murray-Garcia. "Cultural Humility Versus Cultural Competency: A Critical Distinction in Defining Physician Training Outcomes in Multicultural Education." *Journal of Health Care for the Poor and Underserved* 9 (1998): 117-125.

Trevalon and Murray-Garcia challenge how teaching cultural competencies in medical education assumes an end-point for the learner. Rather, they propose teaching cultural humility, which requires continuous self-reflection and self-critique. Learning through cultural competencies often leaves the learner with the impression that she can master different cultures; however, Trevalon and Murray-Garcia point out the fallacy of such an endeavour and suggest cultural humility as a way to teach medical practitioners that they must be life-long cultural learner. This model promotes a healthier mindset towards how culture influences medical practice.

DasGupta, Sayantani. "Narrative Humility." *The Lancet* 371 (2008): 980-981.

Expanding upon the work of Trevalon and Murray-Garcia, DasGupta proposes that we should approach narrative medicine by teaching narrative *humility*, competencies. Her notion of narrative humility asks us to continuously interrogate how we approach the stories of others—what assumptions we bring and impose on their stories—and urges us to recognise that we can never

assume to fully know another's story. This concept is especially significant in the context of cross-cultural medicine where often our life experiences impel us to impose certain values or perceptions upon the narratives of our patients—to know the patient's narrative on our own terms--rather than humbly recognising that we can never truly know what that patient experiences.

Kascak, Lauren. "The Poor Deserve Perfection: The Case Against Pre-Health Volunteers in Global Health." *Voices in Bioethics*, July 16 2014. <https://voicesinbioethics.org/2014/07/16/the-poor-deserve-perfection-the-case-against-pre-health-volunteers-in-global-health/>.

Kascak's essay reflects upon her own experience volunteering on a short-term medical mission in Ghana—on her own experience with voluntourism. She critiques the unsustainable nature of the aid, the dangerous medical practices, the image that is produced of the "Third World," and the propagation of white saviour attitudes. Kascak highlights problematic ways in which medicines from the "global north" cross into the "global south"—the risks as medicine crosses cultural, national, and socioeconomic boundaries—and how these problems can be addressed by drawing upon the theoretical models of cultural and narrative humility.

Loh, Lawrence. "Little white girls & boys aren't the problem; the way we currently volunteer abroad short-term is." *The 53rd Week*, July 7 2014. <http://www.53rdweek.org/blog/little-white-girls-boys-arent-the-problem-the-way-we-currently-volunteer-ab>.

Loh resists the highly negative reflections of authors like Kascak, and instead suggests that a "middle ground" can be found. Loh argues that short-term volunteering abroad is not inherently problematic, but the way in which it has been carried out often is. He urges us to recognise the often noble and generous sentiments that underpin those who want to volunteer abroad short-term, and to harness these good intentions in order to find better ways to volunteer abroad short-term.

When the Caretakers Need Care: Mental Health and Self Care for Healthcare Providers

Description:

Medical humanities, insofar as it is concerned with bringing the “human” back to medicine, is inherently invested in mental health. The previous topics have illuminated the many ways in which the medical humanities asks and trains health care providers to become attuned to the psychological nuances of their patient’s illness experience, but this topic inverts that framework by focusing on the health care provider’s mental health. In order to truly listen to their patients, health care providers must also learn to truly listen to themselves. As cliché as it may be, you really can’t take care of someone else until you take care of yourself. Continuous contact with illness and death, long working hours, and high stress situations inevitably lead to mental health issues amongst health care providers; however, conversations about health care providers’ mental health are uncommon in the medical world. This webinar will start these critical conversations, focus on the importance of taking care of one’s self, and explore techniques to do so. In particular, we will focus on writing as a powerful tool for introspection and self-care in the medical context.

Learning Outcomes:

- Evaluate in what ways mental health is an inherent aspect of humanities-based approaches to medicine
- Reflect upon the mental health challenges faced by those who provide healthcare, and what techniques can be used to tackle them
- Start more open and honest conversations about mental health in the medical context
- Consider how writing can be harnessed as a tool for self-reflection and self-care

Guest Speaker:

Kristen Slesar is a bilingual trauma-focused psychotherapist at the Child and Adolescent Witness Support Program and in private practice. Her specialties are trauma-focused therapy with survivors of interpersonal violence; narrative therapy, training and education on the dynamics of domestic violence, sexual assault and trauma; and clinical supervision of LMSW and MSW Student Interns. She is also an adjunct faculty member of the Narrative Medicine Program at the College of Physicians and Surgeons of Columbia University and a consultant and trainer for the Graduate School of Applied Psychology of New York University and the New York City Alliance Against Sexual Assault. Kristen previously coordinated the Sexual Assault Forensic Examiner and Volunteer Advocate Programs at a major private hospital in New York City and managed a small basic center/shelter for homeless LGBTQ teens and young adults in Harlem. Kristen has a Bachelor's degree in Latin American Studies from Stanford University, a Master's of Social Work from New York University and a Master's of Science in Narrative Medicine from Columbia University.

Resources:

Irvine, Craig. “The Ethics of Self-Care.” In *Faculty Health in Academic Medicine: Physicians, Scientists, and the Pressures of Success*. Ed. Thomas R. Cole, Thelma Jean Goodrich and Ellen R. Gitz, 127-146. Humana Press, 2009. 158-200.

Irvine critiques biomedical ethics, and instead posits narrative ethics as a more effective approach because it requires not only care of the patient, but care of the physician’s self. Irvine’s argues that humans understand, create, and recreate themselves through narratives, so to care for others and ourselves we must think through our narratives. Biomedical ethics rely upon universalist principles that erase the particularity of an illness narrative, seek to understand illness narratives outside of

time, require physicians to isolate themselves from the world of the ill, and thus deny death as it solely strives to sustain life. In contrast, the narrative ethics that Irvine proposes emphasises the singularity of each narratives, requires attention to the temporality of the narrative, fosters relationships and communities, and acknowledges death. These characteristics of narrative ethics not only attend to the patient, but also the physician as they forces physicians to reflect back upon their own singular experience treating the patient, to consider their experience in time, to recognise their intersubjective narratives (and relationships), and thus to confront narratives that end in death.

Laub, Dori. "An Event Without a Witness: Truth, Testimony, and Survival." In *Testimony: Crises of Witnessing in Literature, Psychoanalysis, and History*. Ed. Shoshana Feldman and Dori Laub. Great London: Routledge, 1992. 75-92.

Laub understands the Holocaust as an event that produced no witnesses because those who witnessed it were killed, or so traumatised that they could not properly witness their own incomprehensible experience of suffering. This incomprehensible nature of the Holocaust means that language will never suffice for the victims to tell their stories; however, these stories *must* be told through testimony because silence breeds further suffering and trauma. Laub recognises that there is simultaneously a need to survive (the holocaust) in order to be able to tell the story, but there is also need to tell the story in order to continue surviving; the testimony itself is not nearly as important as the experience of living *through* that testimony. A similar *need* for testimony can be applied to patients who encounter incomprehensible suffering and trauma due to their illness.

MacCurdy, Marian M.. "From Trauma to Writing: A Theoretical Model for Practical Use." In *Writing and Healing: Toward an Informed Practice*. Ed. Charles M. Andreson and Marian M. MacCurdy. Urbana: NCTE, 2000. 159-200.

MacCurdy uses trauma theory and research to argue for the value of personal essay writing. Traumatic events result in deeply encoded symbolic images that are intimately tied to strong emotions, thus trauma is fundamentally non-verbal. However, research also indicates that recalling these images in a specific, concrete, detailed way (like though literary language) help us heal. MacCurdy argues that effective prose writing and therapeutic effects go hand-in-hand because both require connecting images with emotions. Thus, personal reflective writing can be harnessed as a therapeutic self-care tool for medical students and practitioners who regularly encounter traumatic events.

Ofri, Danielle. "Torment." *New England Journal of Medicine* 350 (2004): 2233-2236.

Ofri writes of an encounter with a "difficult" patient. This story explores a patient with depression, cultural factors that impede medical care, and the physicians' inner emotional turmoil when caring for this patients. The honesty of Ofri's innermost thoughts provides a refreshing case to examine how illness is not just psychologically challenging for the patient but also the physician, thus prompting more open discussion about the mental challenges physicians regularly face: guilt, exhaustion, frustration, and more.

Evening Rounds: Final Reflections and Critiques

Description:

This final seminar will conclude the program and be largely led by reflective group discussions. These discussions will primarily focus on how the knowledge from this program can be harnessed in your own medical practices, and the challenges you may face doing so. We will also more broadly explore the challenges that medical humanities faces, and how we envision the field progressing in the future. This session will also introduce the final project that is necessary to complete in order to receive your certificate from AMSA.

Learning Outcomes:

- Creating connections between the topics of focus in each seminar
- Brainstorming ways to implement what has been learned from the program into your medical practice
- Discussing challenges you may face implementing humanities-based approaches in your medical practice
- Suggesting how the humanities add value to medicine beyond those addressed in the program
- Critically reflecting on how the field of medical humanities can continue to progress

Resources:

Ho Ping Kong, Herbert. 'Entering the Grey Zone.' In *The Art of Medicine: Healing and the Limits of Technology*. Toronto: ECW Press, 2014.

Dr. Ho Ping Kong's approach to medicine through what he dubs "the art of medicine" provides one clear example of how the humanities can be implemented into everyday medical practice—from an initial physical examination to end-of-life care. His approach is founded upon the art of observation through the five senses, and how this uncovers a much more thorough patient narrative, which often leads to more accurate and swift diagnoses and treatments. This approach relies upon the same attention to detail and nuance that studying the arts and humanities does, and Dr. Ho Ping Kong's narratives of encounters with his patients clearly demonstrate how this can be applied in practice. In particular, Dr. Ho Ping Kong believes this approach is especially important when dealing with patients in the "Grey Zone," those whose symptoms cannot be diagnosed, or whose diagnosis cannot be cured.

Bleakley, Alan. 'Evaluating the impact of medical humanities provision.' In *Medical Humanities and Medical Education*. New York: Routledge, 2015. 206-227.

Bleakley problematizes what it means to evaluate the impact of the medical humanities, and how the medical humanities have often been measured in the past. He argues that the focus on measuring the outcomes of medical humanities interventions is largely led by skeptics who are often proponents of evidence-based medicine as the only legitimate approach. Instead, Bleakley urges us to stay focused on the more pressing issue of developing rigorous rationales for why the humanities should be integrated into medical education.

Shapiro, Johanna, Jack Coulehan, Delese Wear, and Martha Montello. "Medical Humanities and Their Discontents: Definitions, Critiques, and Implications." *Academic Medicine* 84 (2009): 192-198.

This article takes a pedagogical approach to the medical humanities by exploring the general discontent and skepticism many medical students express when it is a mandatory part of their curriculum. To begin, medical humanities is defined in terms of pedagogy, that is, the authors

identify what characterises medical humanities teaching and pinpoint its moral function. The authors explore how medical students critique the relevance of humanities content to medicine, the authority of non-M.D. instructors, resistance to the intimacy of reflective practices, difficulty balancing and placing it effectively in the whole medical curriculum. The authors then propose a conceptual response to these discontents: that medical humanities must be presented in such a way that forces medical students to recognise how the humanities are an inherent part of medicine, not something supplementary or additive. More practically, their response revolves around focusing on narratives (citing Rita Charon) and collaboration in teaching.

Final Project:

The purpose of this project is to apply the knowledge/inspiration that the scholars program has fostered in you. Perhaps you feel compelled to start planning a medical humanities day-long workshop at your institution, or write a series of poems, or produce a film of patient narratives. The possibilities are endless, and all we ask is that you do these two things:

- Write a 500 word abstract outlining:
 - Background: the motivation/inspiration for your project
 - Methods: a description of the project itself and the process
 - Results: and a reflection on the impact of your project on yourself and/or a community (this can also be a reflection on the *potential* impact if your project hasn't launched yet)
 - Conclusion: any final remarks
- Provide a sample of the project itself (e.g. a photograph of a work of art you produced, or a sample syllabus for a workshop you want to run, or a sample of the kind of publication you want to produce)

The project will be due on March 30th at midnight. We recognise that some projects may not be able to come to fruition at this time, so plans for projects are also more than welcome (e.g. the syllabus for a workshop you want to run or publication you want to start at your institution).

Why Medicine Needs Literature

<https://www.youtube.com/watch?v=wCf62ksapII>



Annotated Bibliography for TEDx Talk

Charon, Rita. *Narrative Medicine: Honoring Stories of Illness*. New York: Oxford University Press, 2006.

Charon proposes narrative medicine as a model for improved medical practice, and defines it as “medicine practiced with narrative competence...that is, the ability to acknowledge, absorb, interpret, and act on the stories and plights of others.” Charon emphasises that narratives are at the core of medicine, and thus, medical practitioners must be trained in how to engage with and analyse these narratives. As such, Charon draws upon literary theory and literature to teach medical practitioners how to understand stories at the level of form, not just content. These premises form the foundation for my own talk on why medicine needs literature: medicine needs literature to learn how to attend patients’ stories.

DasGupta, Sayantani. “Narrative Humility.” *The Lancet* 371 (2008): 980-981.

DasGupta challenges Charon’s definition of narrative medicine by proposing that medical practitioners should be trained in narrative *humility*, not in narrative competencies. DasGupta argues that narrative competencies assumes that there is an end-goal—that it is possible to eventually wholly know another’s story; however, DasGupta reveals the paternalistic nature of such an approach, and instead presents the concept of narrative humility. Her notion of narrative humility requires continuous self-reflection and self-critique, recognising that stories are dynamic entities that one must continuously engage with. DasGupta highlights what anyone who engages with literature already knows: stories can never be fully analysed or understood, instead stories are complex and dynamic entities requiring continuous engagement. As such, the concept of narrative humility presents another example of what medicine can learn from literature.

Neilson, Shane. “Pain as Metaphor: Metaphor and Medicine.” *Medical Humanities* (2015): 1-8.

Neilson argues that in the contemporary age pain is predominantly conceptualised through metaphors of visual neurological schematic, especially in medical education textbooks. The metaphors, he argues, produces an illusion that medicine has already reached a final understanding of pain, thus preventing medicine from seeking further ways to understand and treat pain. In order to improve the way medicine deals with pain, Neilson argues that the metaphors of pain must be re-conceptualised. Neilson’s research provides a powerful example of how the literary (in this case, metaphors) impacts medical knowledge and practice, and thus furthers the case for why medicine needs to be attuned to the literary.

Schweizer, Harold. “To Give Suffering a Language.” *Literature and Medicine* 14 (1995): 210-221.

Schweizer draws a comparison between illness narratives and literature, and between literary critics and medical practitioners. He argues that neither literature nor illness narratives can ever be wholly understood, and any such attempt would be reductive. Schweizer recognises that both literature and illness narratives tempt interpretations, but ultimately always eludes interpretation. Medical practitioners, thus, can look to literary critics in order to learn how to navigate the paradox and complexity at the heart of illness narratives. Schweizer’s essay demonstrates how the academy of literature can serve as a model for a more ethical medical practice that is centred on the patient’s illness narrative.

Wynn, L.L., Angel M. Foster, and James Trussell. “Would you say you had unprotected sex if...? Sexual health language in emails to a reproductive health website.” *Culture, Health and Sexuality* 12 (2010): 499-514.

This article analysed over 1000 emails sent to a confidential emergency contraceptive website in order to understand how definitions of sex, unprotected sex, and emergency contraception vary. Medical practitioners often consider these definitions to be stable and unanimous; however, this article reveals how sexual health is often understood through metaphorical language that results in unstable and varied definitions. This ambiguity in language affects both the patient and physician's perception of pregnancy, sexual disease, and moral risks, which then influences medical care decisions. Wynn, Foster, and Trussell's research reveals how metaphorical language can directly influence health care, and thus makes the case for why medical practitioners should engage with literature. This study provides a powerful example of why medicine must be attuned to the literary in order to improve its practices.

Reflections on Curriculum Development

Myself and two fellow coordinators developed this curriculum from scratch (AMSA somehow lost the archives with their past programs). We began by creating a collaborative Google Document with a working list of all relevant materials—from poems and films to scientific articles and essays—and a list of potential guest speakers. We scheduled several Skype calls to discuss various ways in which we could organise the list by roughly grouping all the resources into 8-10 broader topics, and from there we narrowed down the content of each topic into the final eight syllabi. Special attention was also paid to the order of the topics and how knowledge would be built up from one seminar to the next. Looking back, I realise that we didn't start from "scratch"; we started with all that we had been reading and thinking about for years without any particular end-goal. This experience allowed me to clearly see how much knowledge and resources I had accumulated at the intersection of the arts and medicine. It often takes applying your knowledge to realise that you even had that immense store of knowledge in the first place.

I make a conscious effort to continuously engage with pieces that address the medical humanities explicitly, and to continuously reflect upon how my arts and humanities readings could be fruitful in a medical context. Medical students, and especially medical professionals, are often too overwhelmed by their intense medical workload to spend as much time as I do reading and thinking about the medical humanities. This was the case with my fellow coordinators, who were both medical students; it was clear that I had significantly more to offer in terms of resources and speaker suggestions for our curriculum. Through this experience, I realise that what I have to offer the medical humanities endeavours is time. Time to read and sift through the enormous amount of work at the intersection of the humanities and medicine, and decide what is really worth a medical student or professional's time. Time to read and sift through the incredibly enormous amount of arts and humanities work, and time to reflect upon which of those pieces are valuable in the medical context. We can't expect medical professionals to read numerous novels and poems and then decide

which excerpts are best to use with their residents. We can't expect medical professionals to read the entire history of theory and criticism and decide which essays are the best to use in their lecture on gender and racial inequalities in medicine. But people in the arts and humanities can because that is what we are doing anyway—and I believe that is the most valuable thing I bring to this movement to bring the humanities back into medicine. That's the role I found myself playing in this curriculum development experience, and that's a role I genuinely enjoy. At the end of the program, many of the students remarked that what they appreciated most was having a curated selection of relevant resources; they all, of course, have an interest in the medical humanities, but often don't know what materials to prioritise reading when their extracurricular time is already so constrained.

I have been using the phrase “medical humanities” because that is the title AMSA chose, but I have some hesitations about it now. Numerous phrases have been used to describe disciplines at the intersection of the arts and humanities, and medicine and health (e.g. medical humanities, health humanities, art of medicine, narrative medicine, etc.). AMSA has chosen medical humanities, and at the beginning of my work with them, I didn't give the choice a second thought. To be more specific: I was rather indifferent and thought the variety of terms were interchangeable—a subtle nuance between word pairings that did not really matter. But doesn't that go against precisely what our medical humanities curriculum was seeking to teach the students: that the subtle nuances in language really do matter? Medical humanities seems to imply that we are only interested in humanities scholarship that is inherently medical, or that we are seeking to uncover the ways in which the humanities becomes medical. Yet it is so often humanities-based works and approaches that have no explicit relationship to medicine that yield the greatest dividends when used in a medical context. Moreover, I believe that the more pressing work is to uncover the ways in which medicine can become more like the humanities by engaging with the stories, emotions, and language that are so central to the humanities. That is one of the many reasons I am particularly drawn to the narrative medicine strand of this kind of work; narrative medicine implies a

recognition of how medicine is ultimately narrative—how it is ultimately founded in a humanities focused endeavour. The work of narrative medicine scholars is first-and-foremost rooted in a rigorous application of the arts and humanities, and this is the kind of work I want to align myself more with in the future.

Reflections on Online Education

The economic barrier to knowledge and education is a significant issue of our time as the cost of things like tuition, journal subscriptions, conferences, and textbooks is rising. In response, however, technology is providing increasing avenues to bypass these economic barriers: students are turning to softwares like Torrent to freely (albeit illegally) download textbooks, non-profits like TED are circulating lectures for free, youtube channels like Khan Academy offer free tutoring, and Ivy league universities are partnering with companies like Coursera to offer free online courses. Although I didn't realise it when I first started working for AMSA, their Scholars' Programs are similarly harnessing technology to make knowledge more accessible. I have attended three narrative medicine workshops at Columbia University thus far and have spent approximately \$5000 in fees, flights, accommodation, and food. The online program in medical humanities, however, cost a mere \$35 to enrol with no extra costs for flights and accommodation. I had to spend thousands of dollars to go to the narrative medicine experts in New York City, whereas the online course allowed us to bring these experts to the students' homes for a minimal fee. I had to spend thousands of dollars to go to New York City so that narrative medicine resources and practices could be shared with me, whereas the online course did the same for a fraction of the cost. This experience made me realise that education and expert knowledge does not need to come at such a high cost—something I had always sensed as my tuition increased year by year, but not thoroughly experienced. Towards the end of the program, many students noted the pressure to attend various workshops, conferences, lectures, and programs in order to further their own education, network, build their CVs, and generally keep up with their competitive peers; however, “keeping up” in this way often comes at a high cost, especially when the cost of university in the U.S. is staggering (several students disclosed they already had hundreds of thousands of dollars of debt by their mid-twenties). As such, there was a real appreciation and sense of relief amongst the group that for a mere \$35, they were able to go through a program with a robust curriculum and leading academics as guest speakers.

Of course, there were some things that the virtual platform simply could not replicate from my real-life narrative medicine education in New York City, the most important being a sense of community. Each time I left New York City, I felt re-invigorated by the support of my colleagues and the new relationships I had formed. This sense of community is especially important in the context of medical humanities as those who have found a passion at this intersection often feel alone in their battle against the STEM focus of medicine. Our online course, however, was not successful in building this sense of community. Although our web-based seminar software allowed students to join with their webcams, many opted to only connect with audio, making it difficult to relate to the faceless names. Most discussions were also facilitated through the guest speakers, rather than students speaking to each other and building relationships amongst the students. Most importantly, the students did not interact with each other beyond the seminars. It's easy to take for granted how valuable the moments before and after a seminar or lecture are to community building; those "before" moments are when students bond over not having prepared the readings, and those "after" moments are when students bond over a drink. We tried to provide more opportunities for the students to engage with each other beyond the seminars by starting various forums on the website that hosted the syllabi; however, very few students would go out of their way to access the forums and contribute. Despite this negative community experience, I am sure that there exists some way to foster a sense of community online because I've seen many communities thrive online, from the anxious pre-medical students exchanging advice on forums like premed101 to teenagers who form long-distance romantic relationships exclusively through Tumblr. Perhaps my younger, more internet-savvy brother can help me tap into precisely what makes online communities tick for next time.

Reflections on TEDx Talk

Millennials are known for their ability to multitask: simultaneously engaging in two conversations (one on their cellphone, the other with the person sitting across from them), studying for exams while binge-watching a series on Netflix, working out while listening to politically-charged podcasts, and more. I thought I was one of these multitasking millennials too—until I began practicing for my TEDx talk. I struggled to balance the task of reciting a memorised speech with being an engaging speaker. If I took one step while reciting my speech, my attention would be diverted to my nervous legs and I would struggle to remember what word came next. If I tried to focus on my volume and facial expressions, I would falter with my words. I never expected memorisation to monopolise so much of my mental capacity, and I'm still unsure how to address the issue. One solution would be to not memorise my speech, but with so much to say in a mere ten minutes, I didn't want to risk rambling.

This experience also made me acutely aware that throughout my three years of university, I have had to present twice. Beyond that, I can probably count on two hands the number of times I have spoken publicly in elementary and secondary school. I know my experience is very common, and thus it's not surprising that being an engaging and eloquent public speaker is such a rare quality to come by. As I've discovered a passion for curriculum development and education over the past few years, I now realise that I should strive to include presentation components into any future courses I envision.

Further reflection has also led me to suspect that my struggles with public speaking, especially on the TEDx stage, are rooted in feelings of “imposter syndrome”—the feeling that you don't belong where you are. In my case, I worried that I was out of a place as a mere student speaking at a conference amongst professionals. I was worried that I was out of place as one of two women speaking alongside seven men. I was worried that I wasn't a doctor, let alone a medical student, and thus had no right to speak up about what needs to change in medicine. As a result, I

lacked the confidence necessary to speak powerfully on that stage. Moreover, my talk turned into an academic essay of sorts, dominated by references to other peoples' studies and ideas rather than my own. This feeling that my own sentiments, experiences, and ideas are only legitimate if supported by experts published in peer-reviewed journals is a reflection of our current education system, where students are continuously pushed to "research the literature" rather than dig through their own experiences and ideas. This is especially problematic when this "literature" is dominated by white men. Nearly my entire education has suggested to me that my own experiences and thoughts carry no legitimate weight—and probably never will. Universities hold themselves up as institutes that inspire students to really think, but what they are often doing is telling most students that their thoughts have no place in academia. Something needs to radically change in our education system, and I hope that I can spend the last year of my undergrad re-cultivating the confidence that my education dug up. I think the scariest thing is that it wasn't until TEDx that I realised how much I de-valued my own thoughts, feelings, and experiences, and that many of my peers probably still don't realise that they are doing that to themselves.

This leads me to a feminist analysis of the comments posted on Youtube about my talk. Let's begin with the shortest one: "She's hot as hell." This comment goes straight to the core of the how society is ordered in terms of patriarchal dichotomies: mind/body is intimately tied to man/woman. What I have to say—what my *mind* produces—is not only de-valued, but entirely ignored: the only thing I have to offer the world is my body—one that is unsurprisingly sexualised. Thus, it is also unsurprising that the most "liked" comments are first-and-foremost concerned with my body: "You look like a mouse who snuck on stage," (Thistlebug) "Stupid English literature student, what a waste of space," (Lenny Susskind) and "What a waste of oxygen. The oxygen that goes into the black hole of your body would help those patients more than your speech" (Newt Gettinrich). Although Thistlebug's comment goes on to state that I have "no public speaking ability with zero charisma," the fact that Thistlebug opens by remarking how I "*look* like a mouse" reminds us that

my being will ultimately always be reduced to my body. It is no coincidence that I am compared to a small, *brown* animal that is largely considered either a pest or a pet—either an animal (*not human*) to be eliminated or an animal to be controlled. The single image of a mouse reveals the intimate connection between the sexism and racism that fuels the comments. Lenny Susskind similarly opens by remarking on my “ridiculous speech,” but his conclusion lets slip his deeper concern for my body and how it is a “waste of *space*”. Newt Gettinrich’s comment also superficially seems concerned with my speech, yet the most predominant image is that of “the black hole of my *body*.” Newt Gettinrich continues by describing me as a “Dummy kim-k sounding fool.” It would be naive to assume that the Kim Kardashian comparison merely stems from the way I speak; the history of sexualisation of female—especially coloured—bodies and how this relates to the image of Kim Kardashian cannot be ignored.

Although I was told by friends and family to ignore the comments because they simply represent the “scum of the scum of society,” I think these kind of analyses reveal that many of the deeper systems that fuel such comments—like sexism and racism—are, unfortunately, prevalent in society. Similarly, the dismissive comments like “Arts and humanities can vanish completely” may be shocking in their bluntness, but are rooted in sentiments that are prevalent in society. After all, I would not be on that stage defending the value of the arts in medicine (and arts in general) if the majority of people did not ultimately think that way.