The Art of Medicine: Training Future Doctors in Medical Humanities

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Literature Review
Spring 2016
Grinnell College

Through recent changes in the medical field, steps have been taken to revise a system that overemphasizes objectivity for the sake of "efficiency". Medical students are trained in a way that limits their creativity and emotional development, resulting in doctors who are technically skilled but lack an understanding of developing rapport through interpersonal communication. The "Medical Humanities" however, bridge this gap. The Medical Humanities focus on teaching skills through art and the social sciences, which help address the inherently subjective – but often overlooked - aspect of medicine. Ambiguity is typically not accounted for in the medical field, and therefore doctors do not know how to properly relieve situations of emotional or psychological tension; doing so, however, has shown marked improvements in patient outcome and physician satisfaction. Incorporation of arts and humanities into the curriculum for medical school students aims at preventing burnout, improving patient-physician communication, and facilitating treatment intervention strategies in a way that the current medical model lacks.

Keywords: Medical Humanities, Science Education, Narrative Medicine, Empathy, Art Incorporation

Introduction

White walls, plastic gloves, and the lingering scent of sterility – for most people, these descriptors do not scream of warmth or comfort. They do, however, conjure up visuals of a doctor's office, ironically a place meant for healing and treatment. In recent decades, the focus on medicine as an objective science has taken out the "human" dimension of how patients are viewed, thus engendering an environment that inhibits true connection at the cost of supposed competence (Ahlzén, 2007). In reality however, the decline of empathy and moral sensibility has contributed to a sense of underperformance and increased rates of burnout for physicians universally (Bleakley, 2015). In efforts to shift this startling dynamic that compromises healthcare quality both provided and received, incorporation of Medical Humanities to teach medical students strengthens the connection to fields of academia typically viewed as "softer". The arts align with the more subjective side of human nature, drawing a portrait of how emotions

and environmental factors might affect one's mindset and mental state; all these factors invariably contribute to the onset and progression of disease. By critically addressing flaws in the biomedical model to illuminate inherent complexities of physiology, medical students can conceptualize disease in a way that prepares them for the rigor of treating people – not just "patients" (Bleakley, 2015). The current medical model used to train medical students has created physicians who lack resilience, multiculturalism, and compassion – qualities that increases the likelihood of burnout. Modifying the approach to how medicine is conceptualized and instructed with an emphasis on Medical Humanities and narrative medicine offers a route for improved care, both on the part of the future physician and patient.

History of Medicine

The origins of modern medicine are intricately linked to Christian orthodoxy, evident through the acceptance of dissections as a practice to better understand the mind-body connection (Engel, 1977). The body was conventionally viewed as a weak vessel for the transfer of the soul; in large part, this idea equated the body as a machine, disease as a consequence of machine breakdown, and a doctor as the individual whose task was to repair the machinery; taking on a reductionist approach in which the whole body is just the sum of individual, discrete parts is how much of modern medicine was constructed (Engel, 1977). Health, for this reason, has been consistently viewed as the absence of disease rather than the promotion of wellness and wellbeing. This definition needs to change. In many ways, the classic approach to medicine has become dogma, unsurprising for a concept derived from religious ideology. However, by addressing the flaws of a model that has marginally changed for centuries, this offers a point of entry to fix a system that in desperate need of surgery.

The conventional biomedical model accounts for deviations in health compared to normal biological systems; in other words, disease is treated as a factor independent of social components and therefore isolated through a reductionist approach. More than that, disease has consistently been viewed as exclusionist under the biomedical model; this implies that whatever cannot be explained through medicine should be excluded in the diagnosis, probably influenced by psychological or societal factors outside the realm of science (Engel, 1977). However, this misses out on the "human" component of disease. People are not raised in vacuums or laboratories, there is a dynamic interplay between biological, sociological, and psychological factors that all contribute to the overall experience of an individual – both in terms of disease and general lifestyle. In this way, Engel's (1977) biopsychosocial model argues for incorporation of external factors in considering patient wellbeing and prognosis. "Type A" behavior, for instance, is correlated with high blood pressure and reduced lifespan in a way that clarifies how negative affect can poorly influence one's health (Matarazzo, 1983). The lack of emphasis on seemingly "unscientific" factors has had a prominent effect on patient-physician interactions, and levels of trust in a way that does more harm than good. A 2012 survey cited by the organization Dignity Health documented decreased levels of trust in health practitioners by about 42% compared to 1966, along with data that indicate that an average of 27% of men and women surveyed tell "white lies" to their doctors (Harding, 2014; Dignity Health, 2016). The growing tensions are in large part a reason for why the medical system needs to change. There seems to be a lack of true interest demonstrated by all too many doctors in today's "corporate-influenced" and "production-oriented" occupation (Hoff et al., 2014).

Incorporation of Medical Humanities

To improve patient-physician interactions, educating medical students should be a high priority that facilitates growth and open communication that trains the "whole" physician. Medical Humanities (when implemented properly) strive to instill compassion, cultural sensitivity, and resilience - characteristics absent in preparation for future doctors. Nonetheless, such aspects correct for the business-based model of medicine by reducing negative behaviors including unprofessional behavior, disproportionate emphases on science in curing rather than caring, and emotional distancing as a defense mechanism to achieve objectivity (Hoff et al., 2014). Initial incorporations of Medical Humanities have seen success in recent years, offering hope for future doctors in a way that aims to bridge the unfortunate gap that has arisen between patient and physician. Harvard University's 2015 launch of the "Arts and Humanities Initiative" promotes compassion, creativity, and community through the humanities is a way that benefits medical students, physicians, and patients themselves (Cooney, 2015). Bailey (2015) noted that through increased observation and empathy training influenced by drama, dance, and literature, Harvard's growing trend of arts education in medical schools has seen positive results for students actively thinking about themselves in relation to others. The significant decrease in empathy during the third year of medical school – an alarming statistic for doctors and patients – is why addressing medical education in this way offers promise for improved interpersonal communication and understanding should be praised (Bleakley, 2015). This opens up the doorway for narrative-medicine as a method of challenging the norm for which medicine is enacted, allowing for linguistic performance and patient-centered listening to develop the core of more effective clinical experiences (Bleakley, 2015).

Empathy

In the words of renowned physician William Osler, “The practice of medicine is an art, not a trade; a calling in which your heart will be exercised equally with your head” (Silverman, 2008). Osler’s vision of deep humanity fights against the maladaptive structure of medical education that glamorizes overexertion and objectivity in diagnoses, all at the sake of accuracy. Medical education has taken on a direction of insensitivity, insensibility, and stifled creativity – concepts that negatively frame a career whose goals are ironically centered around improving the lifestyle of a patient (Bleakley, 2015). Although this might be the case, empathy and compassion can prevent such outcomes (Seppala et al., 2014). Patients treated with compassion have even demonstrated positive effects on obesity, hypertension, and asthma as well as faster healing and decreased anxiety/pain (Kelley et al., 2014). Overall, the fact that increased physician empathy leads to less complications offers quantitative research for why Medical Humanities is needed to educate future doctors (Kelley et al., 2014). By listening to patients, being comfortable with silence, and pausing to read nonverbal cues, doctors can perform in ways that benefit both themselves and their patients through this added attention (C. Miller, personal communication, February 20, 2016). Many of these skills can be cultivated through classes emphasizing theatrical techniques, especially the idea that one should “take what is being given”; this Meisner-approach to drama involves direct response to how another individual appears to feel based on subjective interpretation of body language and nonverbal/verbal indications (Meisner, 2012). In this way, an arts and humanities education can train doctors in attentiveness for cues that all too often go unnoticed.

Trust

In conjunction with empathy, trust is paramount. Building strong patient-physician rapport ensures improved satisfaction on account of both parties. Medical Humanities help develop this perspective for students because influential literature, history, and movies are remarkable for a reason – they teach about the human condition (Frances, 2015). Who better to explain the alienation that comes with disease than Thucidydes, or the impact of grief than Tolstoy or Joyce (Frances, 2015)? The Medical Humanities therefore attempt to recapture the conception of doctors as healers rather than technicians, reviving tenets of the Hippocratic Oath that allow doctors to explore the nuance and ambiguity of disease as a collaborative approach with their patients (Frances, 2015; Campo, 2005).

Creativity

Through Penn State University's course in "Impressionism and the Art of Communication", listening skills are fundamental; by asking open and close-ended questions to a partner without seeing a piece of artwork, students were able to reconstruct pieces by van Gogh in efforts to hone their skills of communication and instruction (Penn State University, 2016). Related activities allowed for discovery of the conventional medical track as overly formulaic and structured. Medical students are taught to go about patient-physician interactions by asking baseline questions to tailor and narrow profiles of diagnosis, unaware of the fact that doing so actually limits interpretation of one's health status. Just as conventional patient reports are presented in terms of "age, ethnicity, and gender", creating an algorithmic pattern for human lives narrows the scope with which doctors can asses a situation (C. Miller, personal communication, March 7, 2016). Bleakley's (2015) call for open ended questions and patient-

centered techniques aims to develop true patient-centered dialogue. Establishing and practicing this form of discussion through the arts is conducive for future success in medicine in that the arts create an opening for ambiguity and variability in which students can understand how detrimental it is to place subjects in a "box". Grabel et al.'s (2013) movement-based incorporation of art into education is a prime example of this. Although targeted at students from middle school to college, teachings on genetics through movement based exercises in conceptualizing genes and DNA yielded positive feedback, allowing kinesthetic mnemonics to help integrate challenging information for the students (Grabel et al., 2013). Doing so supports the idea of Medical Humanities enhancing student understanding of disease, simply by catering to different forms of learning through varying mediums; this approach can be utilized for patient diagnoses to help determine adequate treatment regimens based on individual needs. Medical Humanities therefore enables doctors to explore emotional and ethical terrains that allow them to dig and develop as future practitioners (Maitra, 2016). Imagination and creativity develop a fundamental link between science and art, which both offer a bidirectional relationship that is intricately linked. Creativity through the arts entails a sense of self-discipline and lifelong commitment that directly parallels that of medicine such that both artists and doctors become "performers" (Wong, 2014).

Miller et al. (2013) notes that visual thinking strategies through the application of art-viewing can additionally benefit curricular interventions for clinical observation. Learning to improve visual skills and asking the right questions when first faced with a situation allows for more critical observation even based on rapid visual encounters (Miller et al., 2013). Training visual literacy in this way improves student acumen in both clinical and art imagery – an area that needs further refinement evidenced by inadequate physical examination skills performed by

many medical students (Naghshineh, 2008). Challenging future doctors to apply careful and unbiased observations to the clinical setting through visual diagnostic skill training and art-viewing techniques offers a readily implementable curricular change.

Discrimination

Freire (1993), as quoted by Kumagai and Wear (2014), introduces the idea of "reading the world" in a way that exposes inequalities of social justice that can be applied to medicine. Doctors can "read the world" to go beyond textbook definitions of disease and illness to fight systems of oppression that tend to facilitate institutional racism; this enables physicians to become aware of how their actions contribute to interpersonal relations with the community at large. An important factor of Medical Humanities is its focus on multiculturalism, or cultural relativism. Incorporating arts and humanities into the training processes allows for enhanced discussion on the medical experience for different ethnicities, genders, sexualities, and marginalized communities that have not been addressed in conventional frameworks. The white-dominated healthcare industry lacks diversity in the sense that the narrative being told is from the perspective of the dominant class, inherently revealing a power dynamic that highlights institutional racism due to ethnocentric medical techniques. Williams and Wyatt (2015) notes that fewer procedures and poorer quality care have been given to blacks and minority groups compared to white individuals, primarily in southern states. However, the problem of prejudice is by no means isolated to the "South", but seems to be universal in treatment of minorities within health care. Implicit clinician biases have been linked with unequal care for black patients, exposing that although overt forms of racial bias have notably declined over the past 50 years, automatic/implicit biases still remain prevalent (Williams & Wyatt, 2015; Todd et al., 2011). In

fact, automatic evaluative processes have been associated with poorer patient-physician communication and ratings in black individuals who have early onset for multiple illnesses and higher levels of comorbidity (Williams & Wyatt, 2015).

Steps have been taken in recent years to alleviate these tensions, even through the recent change in the 2015 MCAT. Increased focus on health disparities in the United States have resulted from cultural barriers and physician insensitivity, both of which can be combatted through efficient incorporation of multiculturalism in medical training (Feroe & Loebs, 2015). Due to language barriers, Asians and Hispanics feel that they are listened to less by their doctor than black/white patients, with Asians and American Indians least likely to report their health status as fair or poor compared to whites (Feroe & Loebs, 2015). The data suggest that there is a discrepancy in ethnic awareness by the current healthcare industry, resulting in lower patient patient satisfaction and adherence (Feroe & Loebs, 2015). Although steps have been taken to navigate this issue and improve physician knowledge of marginalized groups, more needs to be done. Incorporation of arts and humanities offers a window into how different cultures and ethnicities can relate to medicine, therefore serving as an essential stage of academia for preparation of medical students. Frida Kahlo's medical imagery for instance paints a vivid image of her struggles with childbirth, heightened by paintings of subsequent isolation and vulnerability due to additional health concerns influenced by her environment in New Mexico (Lomas & Howell, 1989). By incorporating arts and humanities into the discussion, this is a direct application of "perspective taking" and "perspective giving" – two social justice techniques that have shown recent improvements in reducing automatic racial biases. Perspective taking, or imagining the viewpoint of a marginalized individual or group, has demonstrated reductions in automatic evaluative processes thus easing tension between in-group and out-group mentalities

in regards to ethnicity (Todd et al., 2011). Perspective giving, on the other hand, offers the marginalized group a chance to share their experiences with the dominant class (Bruneau & Saxe, 2012). Both factors contribute to increased empathy by offering a potential avenue for growth in medical students; as previously noted, empathic failures become prevalent in the third year of medical school and are a red flag for why the current system needs to be changed (Bleakley, 2015). Taking advantage of perspective giving and taking allow for training in cultural competency and increased awareness of patient background so as to create a more efficient dialogue from a place of knowledge rather than perceived power – whether explicit or implicit.

Conclusion

The health care system, as it currently stands, is broken. Medical students are taught to view humans as isolated systems, devoid of ambiguity. By doing so, however, both doctors and patients suffer. They suffer such that their reality does not match what they expect, with the self-worth of all too many students being boiled down to a number or a grade (Des Moines University personal communication, May 5, 2016). After weeks, months, and years of toiling, many medical students forget why they are pursuing this goal in the first place – beaten down and fearful of scores that are perceived to encapsulate all they have worked for. This contributes to burnout, resentment, and lack of empathy observed early on in one's medical career. This needs to change.

Medical students don't have the power to make these changes, but unfortunately, too many doctors don't have the time to make them either (Des Moines University personal communication, May 5, 2016). Many argue that although the system is faulty, students are

fighting for both themselves as well as their patients. With the infrastructure at hand, doctors must sacrifice patient-centered communication for the sake of time, efficiency, and money. Medical students are often laced with debt, struggling to pay off years of loans which is why these proposed changes may seem unrealistic. Doctors have argued that with big pharmaceutical companies controlling their every move, having a set amount of patients met per day under strict time requirements does not allow for the close connections that the Medical Humanities call for (Des Moines University personal communication, May 5, 2016). However, I argue that doing so would save time, energy, and effort for all parties involved. Small actions create time. Taking a moment to check in to see how the patient is doing, and respond to their feelings and emotions in just a few moments sets a tone of trust and compassion. Doing so has demonstrated long term benefits in healing, coping, and overall connection between physicians and patients (Kelley et al., 2014).

These are not sweeping gestures that make medicine weak, but rather strengthen a model that disproportionately emphasizes objectivity and distance. Studying – but more importantly, living – the Medical Humanities offers training for doctors both in and out of the clinical setting. It sets the stage for moral growth and introspection, allowing medical students to reframe feelings as inevitable aspects of diagnoses and disease instead of simply ignoring them. Humans are emotional, ambiguous, and challenging – to treat them as machines dictated by cause and effect relationships narrows the mindset of any physician and hurts patient recovery short and long term. Checking one's bias, opening the door for genuine dialogue, and empathizing with patients and families through multicultural and mindful approaches are what will help reignite the vanishing standards once wholeheartedly pledged to by the Hippocratic Oath.

Acknowledgements

I'd like to thank Celeste Miller (Assistance Professor of Dance at Grinnell College) for her primary instruction as an academic mentor. I would also like to thank Maile Leathem-Rietz for her intense collaboration with this project. I additionally acknowledge Dr.'s Gary Hoff, Norma Hirsch, and Lisa Streyffeier for providing guidance and initiating partnership with Des Moines University's osteopathic medical school.

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