Medical themes in a literature classroom: An alternate perspective on Medical Humanities pedagogy in India

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Abstract

This article examines the transferability of conversations in literary studies to a more sensitive, holistic, ethically informed, medical education. The article begins with a discussion of a class assignment on medical humanities in a literature course. The assignment enabled an immersive engagement with medical discourse by diverse students through different modes – through textual analysis, direct, and reflective encounters with communities of patients, caregivers, health professionals. The effort was to suggest that literature and medicine be studied as continuous shared strategies of reading and narrating lived experiences of health and illness. The insights of such learning should ideally be integral to the curriculum of medical students in India. Though the Medical Council of India's mandate for the humanities is inadequately sketched out, it nevertheless provides an opportunity to demand a larger citizenship and broader base of social sensitivity and knowledge for medical humanities.

Literature in conversation with Medicine

Medical Humanities, broadly speaking, seeks to gather theoretical, critical and practical insights from across the social sciences and humanities to explore the complex meanings that get attached to health, illness, disease, disability, and therapeutic encounters - generally studied through narratives of patients/caregivers/medical professionals. It is a subject most often taught to medical students with a view to inculcating a holistic and more ethical approach to illness and healing. However, transplanting this to the Indian medical curriculum involves many factors – the Medical Council of India guidelines suggest 60 hours of "Introduction to Community Medicine including Humanities" in the Pre-Clinical Phase 1 where one of the two skills to be acquired is the "art of communication with patients including history taking and medico-social work" (1). This is a grossly insufficient accommodation of the true gamut and potential of medical humanities which, even at a beginner level, must necessarily branch out in two directions: a) a nuanced understanding of ethics and sensitive practice of medicine (beyond 'doctor-patient communication'), and b) a conceptual clarity on contextualising medical practice in the socio-cultural context of India. While it will require several steps to understand how this could be manifested in the medical curriculum, one place to start is the possibilities of medical humanities *in* the humanities – in this case, a literature classroom. We can examine how the conversations that literature has/had with medicine can help us modify the medical curriculum so that the good intention (of a holistic education) be pertinent, effective and meaningful.

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While medical humanities as a vital subject in medical education began to be formulated in the late 1960s and 1970s (2), the appointment of the first professor of literature as full-time faculty in a medical school – Joanne Trautmann Banks joined the Pennsylvania State University College of Medicine at Hershey in 1972 – invited a long fertile conversation on what literature can do for medical education and practice (3). Ann Hudson Jones points out the two distinctly different ideas about the use of literature in medical education that emerged in the late 1970s – the first is "the aesthetic" approach argued by Banks and the second is "the ethical" posited by Robert Coles (4). The aesthetic approach invests in the study of literature to develop close reading and interpretative skills of complex narratives that are transferable to medical practice and patient care. The ethical approach believes that by attending to nuances in literature, the medical student will develop deep moral sensibilities and ethical reflection. The two approaches are not as divisive as they may seem, more a matter of emphasis in approach, since the methodology of close reading that the discipline of literature brings to medical education – a more integrative way of absorbing not just content of narrative, but form, context and subtext – has increasingly become a mainstay in medical humanities pedagogy (5). This is to repeat the central assumption of much of science studies today—ie, that science does not take place in a vacuum, but in society. Rita Charon coins the term "narrative medicine" for this interface of medicine and literature so that medicine is practiced with "narrative skills of recognizing, absorbing, interpreting, and being moved by the stories of illness" (6). The hope is that an engagement with literature would produce a more empathetic doctor. Additionally, it reinforces the deep investment that the disciplines of literature and medical humanities have in the pedagogical potential of pathographies (autobiographical accounts of illness) and personal narratives of a researcher/reader/writer. This emphasis on the personal voice, whether in the narrative elements of the text, the act of writing, or

the ethics of reading, is hence central to understanding the dynamics between literary studies and medicine (especially the voices of patient and caregiver).

This paper seeks to discuss a Medical Humanities course *taught in a literature classroom* as a possible model for a dynamic incorporation of literary studies *in the medical classroom* in line with the hope of a more sensitive, holistic, ethically informed, medical education. More specifically, this paper focuses on a class assignment that emphasises the importance of personal narratives and reflective engagement as a mode of developing the central imperative of any medical humanities course – humanising the medical experience. The main argument is to challenge the more conventional approach to medical humanities in India as either a pedagogical tool (say, a visual arts project to explain a medical condition) or the "soft skills" training in "bedside manners" (doctor-patient communication). Instead, the effort here is to suggest that literature and medicine be studied as continuous shared strategies of reading and narrating lived experiences of health and illness.

While medical education has had to make a case for reading literary texts, its close relationship with medicine has always been a given in literary studies – the recesses of the mind, the body in health, physicians and medicine, sickness and recovery, hospitalisation and disability, sex and sexuality, death and decay. Health has been a central concern of literature of all cultures—from the Sanjeevani of the *Ramayana*, or the key cultural imagination of the poet as blind, for example, a Milton or a Surdas. As we shall see, insights from a Medical Humanities course taught in a literature classroom has the potential to travel back into the medical curriculum in a more efficacious manner. What such an approach foregrounds, more than anything else, is Susan Sontag's argument in *Illness as metaphor* that language can be as damaging as physical suffering, and that we need to study text as constructed, as discourse with real-world resonances and manifestations. Sontag's example is the word "cancer" - a metaphor so laden with fatal connotations that for a patient who hears it for the first time in a doctor's room, the word itself (and not the experience/ outcome of illness) is equal to death (7). This awareness of the power of language would persuade the students to challenge how we formulate binaries of experience and representation, pain and articulation, sanity and insanity, normal and abnormal, normative health and diseased self, disability and ability.

Porous walls of the literature classroom in a medical campus

I regularly teach Medical Humanities as a core course in the MA (English) programme at Manipal. Our classroom is located in a campus-town that germinated from a medical school and is the most important medical hub in the region (Udupi district in coastal Karnataka). Doctors, patients, nurses, medical students, medical researchers, hospital auxiliary staff, pharmacists, caregivers, donors, medical technicians – the town has a very high density of all these people within a two kilometre radius. The academic community comprises of varied disciplines and students from across the country and various parts of the world. This diverse cosmopolitan and yet geographically contained backdrop that has the distinction of being home to the first private medical college in the country, has always seemed like the ideal setting for opening up the medical humanities question to the four "Es" that Anne Whitehead suggests – ethics, education, experience and entanglement (8). The last 'E' is offered by Whitehead as a particular contribution of "critical medical humanities" which she defines as the critical reengagement with the methodologies and orientations of the discipline of medical humanities itself. Such an approach would necessitate making room for the reflexive positioning of the teacher/scholar in the field. As Deborah H Holdstein and David Bleich have argued, humanistic inquiry cannot develop successfully without reference to the varieties of subjective, intersubjective, and collective experience of teachers and researchers (9: p 1). And these subjective and intersubjective situations of the scholar, in their view, has to be done *as part of the subject matter* so as to admit "the full range of human experience" into scholarly work [emphasis in original] (9: p 2).

Keeping this in mind, during the first class of any Medical Humanities course, I take some time to explain my intellectual and affective investment in the subject to the class – this includes my role in an investigative documentary about a controversial drug trial, two decades ago (10), and my current duties as a non-scientific member on the Institutional Ethics Committee of our university's hospital. The syllabus I share includes an explanation of my interest in mental health narratives, and a detailed rationale on how and why we will progress between selected texts. All of these are attempts to consciously place the personal on the same scale as the scholarly from the start of the semester. This is also to draw attention to our situatedness in the Indian socio-cultural context, sometimes to discuss ongoing medical debates in the newspapers, such as the perspectives on euthanasia - in the legal battles fought by Pinki Virani for Aruna Shanbaug (11) - the social and sexual hierarchies in transgender communities - for instance, in Gayatri Reddy's ethnographic work in Secunderabad (12) - the ethics of organ donation - as depicted in contemporary cinema such as *Ship of Theseus* - or life narratives and deliberations about body and mental health in legal deliberations on Section 377 of the Indian Penal Code.

The readings for the course in the semester of August-December 2016 included texts with historical and theoretical insights such as Michel Foucault's *Birth of the clinic* and Susan Sontag's *Illness as metaphor*, alongside texts that dealt with the association between writing and illness such as William Styron's *Darkness visible* and Paul Kalanithi's *When breath becomes air*. We also looked at texts that when juxtaposed with each other could unearth the several ethical conundrums in narratives about ill health– for instance, Sigmund Freud's *Fragment of an analysis of a case of hysteria* was examined alongside HD's *Writing on the wall*, a modernist representation of her experience of being analysed by Freud. And in line with more traditional approaches to literature in medical education, we also read literary texts that describe illness from within the walls of homes and minds, such as Leo Tolstoy's *The death of*

Ivan Ilyich and Jerry Pinto's *Em and the big Hoom*. The process of collective close-reading and open classroom discussions in our course was equally about the stylistic considerations of the narratives (of structure, voice, imagery etc), as about the interpretations and arguments from a medical humanities perspective.

A pedagogical case study of narrative and medicine

It was not the first time that I was teaching or discussing many of these medical humanities texts in a classroom space. But that semester was a unique moment for me as a teacher. My class had 16 students, mostly in the 21-24 age group. Among the many texts we read in class, were powerful memoirs such as Alison Bechdel's *Fun home*, and Linda Gray Sexton's *Searching for Mercy Street*, both about the untimely deaths of difficult parents and about the challenges of revealing deep personal truths (issues of mental health and sexuality) in a genre that is famously fraught and contentious. That same semester, outside of the class, alongside it, through it, I was writing my own medical memoir about a difficult love for a dead parent (13). While I was teaching the course, I had also been agonising over the ethics of publishing the memoir in the face of objections from friends and family. It felt impossible, even disingenuous, to talk about a medical memoir in class, without discussing the process of an affective reading, and without doing it simultaneously as scholar and writer. I found myself making references to my own unfinished memoir to the class, although I did not feel ready to share any excerpts or details from the manuscript. But this mirroring of life and scholarship became the starting point for a memorable pedagogical experience.

For their midterm assignment, the students were asked to make a presentation to the class. While all other submissions for the course had comprised essays of textual analysis or literary criticism, for this assignment students were encouraged to think about an embodied experience of the subject. They could work in any genre of their choice and the only stipulation was that they move away from abstract thought or pure textual analysis to engage with some real-life people and situations. The presentation had to be written down, read aloud to the class, and then submitted for grading. Robert J Nash suggests the category of "the scholarly personal narrative" – where the inclusion of the writer's autobiographical presence in the narrative creates the ability to deliver moments of self and social insight that are uncommon in more conventional forms of research (14). Needless to say, the personal essay in the scholarly domain comes with caveats. Nash reminds us of the standard objections the genre has faced in academia – it is considered touchy-feely, anti-intellectual, and its reliability and validity is often suspect (14: p 4). Nonetheless, the "personal academic essay" as Candace Spiegelman terms it, is to be "understood as socially and culturally mediated reconstruction of context-bound events"(15). It fosters self-referential scholarly engagement that has the potential of considerably deepening the texture and depth of research.

On the day of their presentations, the class gathered around one large rectangular table, students and teacher facing each other. The initial atmosphere in the room was one of discomfort, the hesitation that most writers have when it comes to reading aloud from our work, and students were told to share when they felt ready to read, rather than following any order. Although the assignment had given students the option of working with any genre, including visual documentation, nearly all of them had chosen the personal narrative essay. As each student read aloud, the energy in the room also seemed to shift. The experiential was opening up some common ground of empathy between these young scholars and writers, which thus far had been limited to discussing texts in the classroom.

Three of the students had spent time volunteering at a psychiatric rehabilitation centre in the vicinity. One of them wrote about his difficulties with social awkwardness, how that was starkly challenged as he bonded with a young man who had a diagnosis of paranoid schizophrenia. In the same rehabilitation centre, another student, an outgoing young woman, wrote about feeling invisible when interacting with an inmate with severe social withdrawal. She contemplated the ethics of establishing a short-term relationship knowing that it could not be sustained beyond the assignment. Another writer mused on ageing through a tribute to a spirited grandmother who had been diagnosed with Alzheimer's, but found it hard to read through her tears. I offered to read her words for the class, no longer a teacher-figure, but a proxy narrator, purely voice. One writer had recorded personal narratives of two members of the transgender community, while another had visited a public health centre that provides treatment to the HIV positive. The most powerful narratives came from two writers who had requested to be heard at the end of the session. These two narratives turned out to be chronicles of their personal struggles with depression, written with such precision and poignancy, one voice echoing and extending the other, so honest that the empathetic listening of the group became surcharged. We were students, teachers, readers, listeners, and most importantly, writers, collective witnesses to a complete deconstruction of classroom dynamics as I had understood it thus far. I was deeply moved by the generosity, courage and honesty of the students. Equally, the entire class had become a strongly forged community, impacted and re-bonded by the collective listening of these powerful experiences. Not only had the writers written about their topics with sincerity, but many had also woven in reflections about their subject positions, about their choices as researchers and writers, with references to contemporary discourses in the subject, creating a patchwork metanarrative for the course itself. These scholarly personal narratives were as much about medical humanities as they were about the ethics and process of writing. The assignment had expanded our classroom space into the medical discourses of our campus-town, beyond walls and into

the larger affective communities.

The medical humanities classroom in literary studies has repeatedly demonstrated, similar to the exercise above, the power of narratives to simultaneously navigate advocacy, teaching, learning, writing and scholarship. However, one is only too aware that there are several limitations to this model of sustained intellectual inquiry and immersion in medical curriculum. Medical classrooms in India today are typically much larger and the students have crammed schedules. Unlike other educational systems, say the United States, medical students in India do not have the opportunity to have completed a full interdisciplinary undergraduate degree where they can take courses in other disciplines. Even in literary studies, medical humanities is a recent entrant – in India we are yet to build a community of scholars specialising in the field or develop a cohesive pedagogy, and this is probably where we need to start. Simultaneously, medical institutions could invite visiting professors (if not create new positions) of medical humanities to teach not just modules or workshops but a serious, full four-credit course that is assessed and part of the student's transcript. A cursory engagement with the notion of humanities is as good as no engagement at all. One needs to accommodate literary studies in the medical curriculum to train students to build attention to narratives as well as develop the skills of personal reflection and engagement. Doubtless, these changes are difficult to accomplish, but if there is one lesson that medical humanities teaches us, it is that one must persist, against all odds and difficulty, with the ethical choice.

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