COMMENTS

The disappearing act: Humanities in the medical curriculum in India

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Abstract

The field of Medical Humanities, shaped by a belief in the vitality of interdisciplinary and non-hierarchical conversations across disciplines, would only be sustainable if both components of the field – 'medical' and 'humanities' were given equal validity and weightage. The challenge for any exploration of Medical Humanities within the medical curriculum would be to take seriously the methodology and scholarship of the Humanities and its millennia-rich study of health, illness, mortality and human wellbeing. While Humanities has to work within the parameters of medical education, there needs to be more clarity on how to locate and explore subjects from the Humanities in this educational process. The Medical Council of India has made various forays in engaging with the issue. While the previous regulations (1997, last updated in 2017) were non-committal and insufficiently specific, the new guidelines of 2018 do not contain a single inclusion of the word 'Humanities'. Further, the only overture to all the non-medical components have been ossified under the umbrella of AETCOM (Attitude, Ethics and Communication) with prefabricated topics. Both curricular formulations are deeply inadequate: the earlier formulation was lost in vagueness, and the new is instrumental. This revised emphasis on capsules of information, rather than the epistemological approaches that have informed the interplay of Medicine and Humanities means the disappearing act of any possibility of a genuine engagement with the ethos of Medical Humanities. This article attempts to address this invisibility of the Humanities in contemporary formulations of medical syllabi and pedagogy in India.

At the threshold of a new medical curriculum

In November 2018, the Medical Council of India (MCI) released a new curriculum for undergraduate medical education in India, the first substantial revision since 1997 (1). This completely revamped curriculum will come into effect for students starting their MBBS programme from August 2019. The new curriculum, called the Competency-based Undergraduate Curriculum states its express goal as the creation of an "Indian Medical Graduate" (IMG) who possesses "requisite knowledge, skills, attitudes, values and responsiveness, so that she or he may function appropriately and effectively as a physician of first contact of the community while being globally relevant" (2).

The curriculum is laid out in a grid that opens up vertical and horizontal integration of subjects across various specialisations, with more emphasis on practical knowledge, along with a longitudinal programme titled AETCOM (an acronym for attitude, ethics, and communication). As one compares the 2018 curriculum with its 1997 predecessor, particularly with an eye on the new formulation and placement of AETCOM, it becomes obvious that this acronym stands in for the only "non-medical" or "additional skills" component of the curriculum. At first glance, AETCOM appears to be a consolidation and gesture towards one word that has gone missing in the new curriculum – Humanities. This essay is an effort to understand the resonances of this semantic disappearance and what it implies for generations of medical students embarking on the newly introduced curriculum.

As part of an ongoing discussion, specifically in this journal, on the pedagogical resonances of a discipline called Medical Humanities or Health Humanities, I have written of my experiences with teaching the discipline to students of literature in Manipal, the site of India's first private medical college (3). I had suggested the rich possibilities of teaching similar modes of narrative and ethical responses that employ methodologies and scholarship from the Humanities to medical students, in the hope of engendering robust reflexive learning experiences. There is an understandable importance to memorising facts and data in medical courses. A class on Medical Humanities would further expose students to the process of critical and creative thinking – to learn how to ask relevant questions of any body of knowledge, especially when it is about human society, experiences and emotions. A core feature of the Humanities is to not assume data is fixed, but that it is gathered and created by fallible human beings and contingent to health policy. For example, homosexuality was classified for several decades by medical science as a mental illness. Similarly, by looking at different scholarship and approach from the Humanities (through literature, through field research, through historical archives), a broader way of thinking about the body vis-à-vis a larger human experience and citizenship would be instilled.

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In recent months, I had an opportunity to teach a module on Medical Humanities to MBBS students as part of a first-year course in community medicine. This course from the ongoing (1997) MCI curriculum has been titled 'Humanities and Community Medicine' and allotted 60 hours of teaching. While it was not ideal to model critical thinking sessions in large non-elective classrooms (of about 125 students each), this experience quickly brought to the forefront the confusion of placing Humanities in the predominantly rigid science-arts divide of our education system. The Humanities scholar in this milieu then finds herself having to justify everything about her discipline – be it pedagogy, scholarship, methodology, or content. The ambiguity towards that which is not strictly within the purview of health sciences has also been reflected in the vague articulation of interdisciplinarity in the 1997 curriculum. The Humanities and Community Medicine course is encapsulated as an "introduction to the subjects of demography, health economics, medical sociology, hospital management, behavioural sciences inclusive of psychology" (4). In this spectrum of disciplines, what does the MCI articulate as a desired skill for students from this community medicine course? Two are mentioned - the first is to understand the practice of medicine in community settings and the second is "the art of communication with patients including history taking and medico-social work" (4). This remains the only mention of Humanities and its desired outcome in the MBBS curriculum that has been taught in the country for over two decades. While this may have been ambiguous for several educators, the open formulation also gave some sense of Humanities as a discipline that could be—as it ought to be—accommodated from an interdisciplinary perspective[1]. In addition, it kept a window open for a whole cluster of disciplines (philosophy, sociology, literature, history etc) that an instructor could include and interpret according to her expertise.

Over the past few years, Medical Humanities pedagogy in Indian medical colleges can be observed as having panned out in broadly three directions – firstly, and most obviously as teaching and practice of communication skills (for instance, how to talk/listen to a patient); secondly, as introduction to applied bioethics (for instance, guidelines around organ donation); thirdly as creative expression, the emphasis being on expressing oneself to generate empathy (for instance, with the much-appreciated Theatre of the Oppressed workshops). In short, these approaches focus on communication, bioethics or expressivist pedagogies.

What has been less explored, and which to my mind offers the most possibilities for a holistic and productive engagement with the Humanities, is to expose medical students to Medical Humanities as methodology. But before one thinks about what this methodology might involve, one has to return to the new curriculum. There is no contesting that this revised detailed model of learning and teaching is a sustained improvement on the previous sparse regulations. However, in a document that runs to three volumes of 690 pages and an additional document of 85 pages devoted entirely to AETCOM, there isn't a single mention of Humanities or the Social Sciences. The intention is not to lament the semantic loss of a term in the new curriculum, but to see these gaps and changing curricular systems as an opportunity to discuss all the ethical and practical implications of what goes missing or is skewed in syllabi formulations.

Is AETCOM sufficient to build an ethical perspective?

Just as I had searched for "Humanities" in the new document, noted disability rights activist Dr Satendra Singh had looked for the word "dignity" – the word was missing in the previous curriculum and is also conspicuously absent in the new one (5). To teach anything akin to "patient dignity" without employing those crucial two words to young medical students is clearly missing the core of the post-second-world-war human rights regime that has defined bioethics for the current practice of medicine. Hence, it is more than the loss of a phrase. It may well mark the loss of a whole ethical perspective and commitment. In the context of disability rights, Dr Satendra Singh led a sustained campaign for including a substantial component on disability rights and the dignity of disabled people, and the curriculum was recently revised to this effect by the MCI (6). This is a heartening development.

Notwithstanding these crucial gaps, the curriculum repeatedly emphasises five goals in medical pedagogy:

- a compassionate care provider,
- a member of health care teams,
- an effective communicator,
- a lifelong learner, and
- an ethical professional (2: p 7).

Given these philanthropic overtones and emphasis on ethics, one cannot help noting that the panel of experts for the new curriculum did not include any scholar from the humanities or social sciences. Nevertheless, the MCI document is explicit in its repeated commitment to the AETCOM component that will be taught for a total of 34 hours in five modules distributed across four years of the MBBS programme.

Dr Jayshree Mehta, President of MCI, writes in her Foreword to the AETCOM module: "the 'conative domain' which hitherto was not appropriately incorporated and structured in the curriculum has been specifically dispensed of by providing a definitive model for the same titled AETCOM" (7). Our attention is invariably drawn to the phrase "conative domain" that Dr Mehta has foregrounded for us with the added emphasis of quotation marks. Conative has been conventionally distinguished from the affective (or emotions) and the cognitive (or thoughts)—conative is that which decides how one acts on those thoughts or emotions. In other words, action and volition, will, agency.

Medical Humanities has been making a case, for several decades now, to not only work across disciplinary silos, but to see the interplay of the cognitive, affective and conative as dependent on each other and not as separate domains. To not comprehend this is to set AETCOM apart from the

Humanities. In fact, a closer look at the AETCOM model reveals an instrumental approach to training in prefabricated topics, such as: The foundations of communication, The cadaver as our first teacher, Working in a health care team, Case studies in bioethics, Dealing with death, Ethics and the doctor-industry relationship, Medical negligence, and so on. A primary challenge here is the continued emphasis on functional capsules of information, on product, and not on approach or process or method. Students are indeed encouraged to explore the topics as pertains to their inclinations. However, nothing in the module would teach them *how* to do this so as to include a wider spectrum of voices from various fields. The pedagogy outlined is primarily about proposing case studies for discussion and inviting students to settle back into the "problem-solving" model that has somehow become the hallmark of science education from the school curriculum itself. This model would preclude lateral thinking that starts with the premise that human societies are complex and not always amenable to logistical solutions that apply equally across multiple domains.

Engaging with methodologies from the humanities

It is worth noting that while medical education is grappling with finding a suitable rationale for Humanities in its curriculum, for disciplines in the Humanities, such as philosophy and literature, the close engagement with body, health, suffering, wellbeing and mortality is already embedded and intuitive. A student or practitioner of medicine exposed to this humanities-medicine engagement would already have access to wider, richer comprehensions. For instance, just as a class of Literary Studies or Gender Studies might read transgender activist A Revathi's memoir *The truth about me: A Hijra life* to explore articulations and experiences of flesh and identity, so too would a health sciences sensibility be enriched by understanding how an entire parallel cultural and medical economy flourishes around society's inability to fully accommodate the liminal and transitional voice of a person challenging normative gender binaries (8).

Texts and narratives such as Revathi's autobiographical account help us think about medical humanities as methodology. Training in the discipline would include reflection on how to read/listen/encounter narrative (its subtexts and contexts), how to think critically and laterally outside/through/around the problem-solving model, and how to incorporate contemporary scholarship from the Humanities into our understanding of key debates on health.

Needless to say, this critical encounter between medical science and humanities then becomes *a way of looking at the world, a mode of reading*. These modes might include textual close reading or analysis, archival research, ethnographic fieldwork, and theoretical debates. An awareness of these diverse modes helps pivot the emphasis from content to process, and to the use of various tools from allied disciplines to collectively and fruitfully engage with the many preoccupations of human society. Say, for instance, any discussion about legalising active euthanasia would have to be more than a problem that needs a solution. It would entail several ethical, socio-cultural, theological, legal and (of course) medical narratives and any ambiguities therein—and as seen through non-hierarchised varied disciplinary approaches.

To think through the approach regarding methodology further, it is helpful to draw parallels with disciplines that engaged with issues of identity and inequality. These include Gender Studies, Dalit Studies, Disability Studies that have a strong advocacy instinct of placing the applicability of knowledge in real-world situations as continuous with textual or theoretical study. When one brings the lens of Gender Studies to any text or situation, one reads and unpacks the text/situation by framing questions about gender dynamics, power hierarchies and bias in gender equations. This could happen through applying any of the tools mentioned above (such as critical close reading or collecting/analysing ethnographic data). Simultaneously, a feminist or queer or disability rights approach/scholarship is also a sensibility. It is a way of linking the empirical with the theoretical, a sensibility that frames the way we look at both scholarship and real-world manifestations.

Equally, a literary engagement with medicine can't be about a gathering that reads poetry together (though those are welcome too). Instead it needs to look at the questions we ask of this poetry, the ways in which we can stay between the lines, the constructions of form and affect within the line, or how it unpacks ideas of suffering or healing. This is what Medical Humanities in its full expression ought to do as a discipline. It ought to bring the methodologies of the Humanities to any text/situation situated at the overlap (and vast terrain) of health sciences and social studies, and do so with the awareness that it is an advocacy position. A critical thinking with specific tools that is sustained through both theory and praxis. Such a medical humanities scholar, therefore, does not just want to say that medicine and humanities have shared roots or close interactions, or even that it is an affective space, but advocates for this space to be reflexive, meaningful and action-oriented.

A hybrid discipline like Medical Humanities, with its two disciplines conjoined, is shaped by a belief in the vitality of interdisciplinary and non-hierarchical conversations across disciplinary boundaries. This would only be sustainable if both components of the field – 'medical' and 'humanities' were given equal validity and weightage. While it is completely understandable and acceptable that Humanities has to work within the parameters of medical education, we need to continue to seek more clarity on how to locate and explore subjects from the Humanities within the existing medical educational process.

Reciprocal engagements between the health sciences and the humanities

This is admittedly a vast complex issue. To start tentatively from my experiences teaching Medical Humanities in both a medical school and a humanities centre, there is a sharp

need for more interwoven engagements, which would require Humanities scholars to be invited to teach electives or modules to medical students. While it would be a challenge to find quality scholars/scholarship in the Humanities who are inclined to reflexive engagement with medicine, we can at the least start with the premise that a discipline needs to be taught by its practitioners.

The difficulties of multi/inter/intra disciplinary approaches is that we cannot have set notions about who would teach, what they would teach or the pedagogy they choose, and precisely because Humanities is more accepting of diversity and ambiguity in knowledge bases, this becomes a prejudice against it. A recommendation would be to invite reputed serious scholars to teach the subject of their expertise.The focus should not be how the course is 'useful' or directly 'relevant' because the primary assumption should be that an exposure to a quality Humanities class would encourage more critical thinking. This exposure would lead to reading/ listening to various health narratives (any conscientious doctor would agree this is key to the profession) and it would offer possibilities of understanding ethics as a broader world view, not just an informed consent form to be filled in the clinic.

The specific course that I taught medical students was designed as a survey course – it included modules on various overlaps of humanities and medicine, for instance a) the body as projected by Renaissance painters and the significance of illustration (and description of body) in Vesalius' canonical book (1543) on anatomy b) the impact of colonisation and trade in how illness traveled (cholera and international intrigues around the Suez canal) and how medicine was practised/developed in the colonies (finding a cure for malaria, or availability of cadavers for dissection) c) the power of metaphors and the role of war imagery in the discourse around cancer d) personal narratives of sexual identities and subjectivities, examples of our inherited gender biases e) a personal narrative of documenting a drug trial that did not practise ethical processes, and so on. These are just some examples of interdisciplinary approaches.

Another important need in terms of teaching any medical humanities course is to make it optional and not compulsory. This means it should be a graded elective with credits. Although this is likely to be controversial and contested, one can argue that it is unlikely that attending 34 hours of mandatory AETCOM modules would conjure up ethical doctors. Many complex factors go into shaping an individual's worldview, and forced learning is no learning at all. Students learn best when given choices, especially the choice to consolidate and hone their ethical compass. Simultaneously, the pedagogy of AETCOM needs more thought – as we all know, it is never entirely about *what* we teach but *how* we teach and *who* teaches. Lastly, we need to create more opportunities for medical students in these interdisciplinary forays of medical humanities, in terms of access to projects and forums, collaborations and institutional support, and further applications in praxis.

The recent guidelines and revisions to the MBBS curriculum have brought in many commendable upgrades to what was a fairly sparse document, both in terms of detailed content and pedagogical synthesis. In the coming semesters, once this curriculum is tested in classrooms, there will surely be many more deliberations and concrete feedback that will shape later revisions and updates of both content and structure of medical education in India. However, one does not feel optimistic about the direction that the medical educational community has taken regarding its attitude to the Humanities. What has disappeared and will remain muted, I fear, is not only a word, but the possibilities of a genuine engagement with both the ethics and the ethos of Medical Humanities.

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Note [1]

As a representative sample within the *Indian Journal of Medical Ethics*, please see:

- Singh S, Barua P, Dhaliwal U, Singh N. Harnessing the medical humanities for experiential learning. 2017 Jul-Sep;2(3):147-52.;
- Varma J, Anusha P, Suman S. Perceived need and attitudes towards communication skill training in recently admitted undergraduate medical students. 2018 Jul-Sep;3(3):196-200;
- Pandya R, Shukla R, Gor AP, Ganguly B. Personal experience narratives by students: a teaching-learning tool in bioethics.2016 Jul-Sep;1(3) NS:144-7.

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2. Medical Council of India. Competency based Undergraduate curriculum for the Indian Medical Graduate, 2018. Vol 1; p 14.
3. Prabhu G. Medical themes in a literature classroom: an alternate perspective on Medical humanities pedagogy in Indian. *Indian J Med Ethics*. 2019 Jan-Mar; 4(1)NS:35-8. DOI:10.20529/IJME.2018.060.
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5. Personal interview with Dr Satendra Singh. Columbia Global Centre, Mumbai. February 18, 2019.
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