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Cover Page Footnote

Kathleen Welch is an Assistant Clinical Professor at the University of Missouri-Kansas City School of Medicine. Her most recent publication, “Writing for Literature and Medicine,” appears in the book Approaches to Teaching Literature and Medicine (MLA, January 2000).

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As medical students enter the world of clinical discourse, they must absorb not only the vocabulary, but also the structure, logic, and attitude of clinical medicine. Learning medical jargon is one of the crucial steps medical students take toward becoming full-fledged physicians. For the most part, the clinical language medical students learn during training is an impersonal and detached discourse. Michel Foucault argues that medical students learn early on in their training to avoid making any reference to how they personally feel about a patient or a medical procedure; they are taught instead to 'stick to the diagnosis.' As medical students become further and further immersed in the passive diagnosis-centered discourse of clinical medicine, they often (even unconsciously) begin to use this medical discourse to maintain some distance from their patients. By reformulating a patient's pain and problems into a language that the patient doesn't even speak, the students are sometimes able to reduce the situation's emotional impact. Even medical students who want to talk more personally about doctor/patient encounters are not apt to do so since they know mastering the clinical language of medicine is essential if they wish to become acceptable members of the professional community of medicine.

"The Literature and Medicine" movement, which took place in the 1960s, was begun in an effort to counteract the impersonal nature of clinical medical discourse. With increased criticism from outside sources that teaching clinical discourse alone was an ineffective way to train physicians, isolated physicians began to look to the humanities, to disciplines such as literary studies, religion, and philosophy, to effect progress in teaching medical students how to communicate with the whole patient. Firmly believing that reading literature works against the traditional tendencies of medical education, medical humanists started employing literature as a means to teach medical students how to think beyond their limited world of experiences to see 'thicker descriptions' of our human situation. Believing that medical schools produce medical students adept at diagnosing biological illnesses, but less able to make sound, independent judgments based on personal experiences, medical humanists believe that reading literature can help medical students become "wiser, more observant, and more humane doctors" (Fishbein 651). Current research supports the notion that how well a doctor communicates with and shows a caring attitude toward his or her patients is the most important criterion patients consider when choosing a new physician (Shaw 8),

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but assessing whether reading literature can create more humane and understanding doctors is still open to debate. Although two smaller qualitative studies have been done to assess the immediate effects of a literature and medicine experience (Kohn; Welch), to date, there have been no extensive, longitudinal, quantitative studies done to determine to what extent exposing medical students to literature and medicine courses can improve clinical practice and possibly benefit future patients. Evaluating the long-term benefits of literature and medicine courses is not a high priority area for medicine and literature scholars since faculty release time and funding for such studies are not readily available. Additionally, since the majority of medical schools offer medicine and literature courses on an elective basis, it is difficult to gauge the effects of the course experience since students who enroll in the courses are likely to already be the more well rounded and observant medical students.

This essay will argue that although the field of literature and medicine has not reached a point where disciplinary members are able to demonstrate convincingly the long-term benefits of immersing medical students in literature, recent qualitative data from a study does suggest that one specific tangible benefit of teaching medical students how to read, interpret, and evaluate literature is that it provides medical students a brief but important time for "pausing" to consider medicine and themselves in another light. Although it is not possible based on this one limited study to predict exactly how this "pausing period" will influence the future behavior of these soon-to-be physicians, it is possible to suggest that this course did help these medical students reflect on the fact that medicine is a personal, as well as a professional, discourse by showing them that life experiences and personal prejudices do affect how doctors and patients communicate during medical encounters.

Background of Study

From April 1994 through May 1995, to provide modest insight into whether reading literature really helps medical students deal with the physician-patient encounter, I conducted an ethnographic study of medical students who were taking a required three-hour literature and medicine course. The fact that these medical students were required to take this course is noteworthy since a medical humanities course is usually taken as an elective, thereby drawing only the "captivated" medical student. By engaging with these medical students' writing, thinking, and actions for a limited period of time, I attempted to learn how medical students talk about the practice of medicine. One question entertained at the beginning stages of my study was the following: When a group of fifth and sixth-year medical students takes a literature and medicine course, considered an interdisciplinary course, what can I learn about the discourse of medicine? I observed two medical humanities classes that fulfilled the students' course requirement: "The Body Image in Medicine and the Arts" (60 students) and "Literature: A Healing Art" (14 students). Each course had the identical schedule (four weeks, five days a week, two hours each day), required a great deal of writing, and shared many of the same texts. Before each meeting, students were responsible for readings ranging from books such as Richard Seltzer's *Down From Troy* to poems

such as those by Sylvia Plath and short stories such as "The Birthmark" by Nathaniel Hawthorne. Class time was devoted to reviewing the material, with each instructor allotting a certain amount of time to discuss a topic in his or her area of expertise. As well as attending classes regularly, students wrote three journal entries, approximately five pages each, that connected to topics discussed in class. In addition to journal writing, students took a final exam at the end of the course in which each instructor wrote two questions based on his or her area of expertise. All these materials were taken into consideration when determining final student grades.

I began my study with the working hypothesis that interdisciplinary learning, such as this medical literature class, can broaden students' thinking patterns by providing them exposure to forms of learning not common to their disciplines. Gerald Graff says that within their respective university programs, students are never allowed to answer questions such as "What is the most important knowledge—scientific, humanistic or in some measure both? What do these terms mean and what is their relation? Is increasing specialization good or bad?" Graff concludes his discussion by saying that recent interdisciplinary programs have emerged to give students the ability to understand the relationships among disciplines (143). Taking Graff's beliefs as my starting point, I chose to study medical students because I believed them to be a group of students particularly vulnerable to a specialized mode of training. I envisioned this specialization as a key ingredient in helping me recognize subtle advantages of interdisciplinary learning since a literature/writing class during the third year of medical school is a highly unusual activity for medical students.

Whether one calls the process by which ethnographers combine personal views with systematic collection narration, inscription, or allegory, the end result is the same. Ethnographers purposely weave together the data they obtain from research sites and their own personal interpretations to provide an image of "the story" that coheres for a particular community. Although more formalistic researchers often categorize data around previously formed assumptions, ethnographers adopt a "wait and see" attitude, withholding judgment until the weight of evidence determines particular directions to take. Following this methodology, I developed several themes and patterns in this study about medical students' experiences in a medicine literature class only after several months of intensely immersing myself in their environment (e.g., I observed the daily classroom activities, read student essays, handed out questionnaires, interviewed both teachers and students, and made myself a part of their community by "hanging out" with them during breaks or before and after class). A basic premise behind my study was the belief that "the meaning and value of a text [e.g., a piece of writing or a conversation] is created in the reciprocal social relations that writers [speakers] and readers construct in their own language" (Brodkey 96). I assumed that by engaging with this environment for an extended period of time, I would be able to determine what meanings of medicine medical students constructed through their day-to-day social and written interactions in this particular class. Thus, while ethnographic methods allow the researcher opportunities for personal insight, they also require verifications of and challenges to those insights through identification with other evidence. Based on my research, I argue that this literature and

medicine experience gave these medical students a brief but important time for pausing to talk about and listen to expressions of medicine instead of memorizing medical concepts.

A Medical Humanities Class: A Pertinent Pause

When I first began formulating a metaphor to conceptualize what happened to the particular medical students I observed in a medical humanities course, I kept returning to the word "blip" because this word seemed to best convey what these medical students experienced during this class. I associated the word "blip" with concepts that are "brief," "irregular," "strange," "small," and "quick," yet "definitive" and "apparent." As I thought further about what I was trying to convey by using the word "blip," I realized that the term "pause" might be more appropriate because of the word's medical connotations. A "pause" in medicine is any obvious break in the rhythmic activity of the body. For instance, since the heart generally beats in very rhythmic, synchronous beats, whenever there's an irregular heart, it's defined in medical terms as a "period of pausing." Since the healthy body is rhythmic, any unnatural "pause" or "irregular rhythmic activity" is suspect. All the medical connotations for the word "pause" nicely complement my notion of this course being a "blip" in these students' lives. Not only does "pause" connote images of this course being a brief or reflective stop, on the medical circuit, it also accurately conveys how this course was perceived by medical students. This course was as an "irregular" or "arrhythmic pause" on the students' "rhythmic" medical beat.

The following two questions were included on a survey filled out by the students:

1. A friend of mine, when I told him that I was observing a medicine and literature class, commented that he thought these kinds of classes were "a waste of time," since medical doctors need to know as much as possible about medical issues and all their time should be spent in these kinds of classes. What is your reaction to this statement? Do you agree, disagree, both? In other words, what did you learn in this kind of class?

2. What, if anything, would you say is the most valuable lesson or lessons you've learned from this class? Would you recommend it to others or not? Explain.

When I presented these questions to the students, I expected some students to agree that this course was valuable and worthwhile, but I never expected to receive as many positive responses as were given. Out of approximately seventy completed surveys, only three students commented the course was inconvenient or "a waste of time." The large majority of students believed the course was valuable if for no other reason than it provided a break from the medical routine. One student writes, "We spend 90% of our time doing the science of medicine. This class was a break where we were reminded of broader social perspectives." A

second said "as a medical student [she feels] in a rush to learn the facts" and this class "was a break that caused [her] to question the origins and reasons behind medicine and related issues." A third student writes, "This class is a reminder not to forget that the patient is a person, which you might be surprised to find out can happen (not blatantly though) when you rush thru six clinic patients in three hours due to time constraints" (Welch 310).

For a short but decisive amount of time these students put aside the "rhythmic" world of medicine to hear the "pauses" within the rhythms. Although it is not possible, based on this limited study, to predict exactly how this "pausing period" will influence the future behavior of these soon-to-be physicians, I think it is possible to suggest that because this course exposed these students to other aspects of doctor/patient encounters, these students did begin to conceptualize that medicine is not simply a digested body of knowledge, but a real-to-life, complicated activity. Although it isn't likely that the average medical student will change into "a different physician" because of this medical humanities experience, it is likely that most of these students will leave this class perceiving and/or approaching their patients a little bit differently. This accomplishment may be as much as medical humanists can hope for since the discourse of medicine is always at the front of these students' minds.

The "Pausing" Components of a Medical Humanities Experience

A series of textual examples from my qualitative study are included below to illustrate some of the specific ways that reading, discussing, and writing about literature prompted these students to pause and self reflect. One undeniable factor that precipitated medical students' learning within this environment was the presence of Marjorie Sirridge, MD. Sirridge openly admitted that because she is a physician, students more naturally respond to her messages:

> The first time we taught this course, we recognized that there were differences in the way students responded [to me and the Education instructor in the course] even though I made all kinds of efforts to downplay my physician role. Unless I had clinical rounds, I would go in my street clothes. [B]ut when it was all over, students wrote in their evaluations that they liked my 'practical' medical stories. (Welch 210)

One student, Carrie[1], said:

> [I]t's nice to be able to talk to a physician like [Sirridge] because she knows how our clinics [medical rounds] work, how our medical school system is, and it's good to be able to talk and listen to somebody like that. (Welch 213)

[1] All student names are coded, and all transcripts of student/faculty/classroom data are taken from Welch.

One powerful example from the two courses that demonstrates Sirridge's effect upon the medical students occurred during a September 27 discussion of assisted suicide. The students had read "A Summer Tragedy" by Arna Bontemps, a short story about an elderly couple who chose to drive into a lake to control their own deaths. They had also read an article by Dr. Robert Hudson "The Meaning of Kevorkian," a story that relays the humane side of Dr. Kevorkian's assisted-suicide cases. As they discussed the readings, the physician-instructor commented that she knows from her 50 years of medical practice that long before the days of intense debate over the issue of physician-assisted suicide, "there isn't one doctor who hasn't helped a patient die, sort of like hospice, providing them with comfort." At this point, an intense discussion ensued. I relay this discussion verbatim here to demonstrate how eager the medical students were to learn from "someone who knows" about the practice of medicine.

> **Student #1**: Well, like, when did it stop being like "Little House on the Prairie," where a doctor just said, there's nothing more we can do, wasn't this with technology?
>
> **M.D. Instructor**: Sure, it's all technology. Can you believe that in my day, there were no ventilators? No breathing machines? So it was acceptable to send someone home. I remember one patient I had with Hodgkin's Disease. She kept turning up the oxygen and I kept saying she didn't need that much. She'd say, well, I feel out of breath.
>
> **Student #2**: Oxygen Toxemia?
>
> **M.D. Instructor**: No, she just felt like she needed help breathing. There were no blood gases, or electrolytes in my day. You guys can't believe it. We had to accept limitations.
>
> **Student #3**: Well, I hate to sound futile, but I think more doctors would do [assisted suicide] if they didn't want to get sued.
>
> **M.D. Instructor** (In a loud and commanding voice): People rarely get sued for that. They get sued for not communicating with families, for not explaining, or being careless. That's why doctors get sued. That's where suits come in. Record what you've done and why, and it will be most unlikely that you will ever get sued. I've never been sued or threatened in 40 years. I'm very aware of that, because I've made mistakes. But these are the things that have saved me, even during high tech procedures. Talk to the family and be honest. (Welch 234)

Throughout this discussion, I recorded in my notes that these students were "silent," "mesmerized," and "totally absorbed" with the physician-instructor's every word. Particularly at these moments when the physician-instructor speaks from the depth of her more than fifty years of medical experience, students found her a unique source of inspiration and a voice of authority. Regardless of what Sirridge was saying, medical students respected her presence, and this accentu-

ated the importance of her message. For the medical students, the fact that Sirridge was simultaneously a physician and a humanist complicated medical students' assumption that learning medical knowledge always had to supersede the study of art or literature. Although all three instructors made the students aware of the humanities, it was the physician-instructor who most grounded the humanities as a legitimate form of learning for these medical students.

Another factor that encouraged these medical students to pause and listen to the non-clinical aspects of medicine were the nonmedical students who participated in the course. As these students voiced their critiques of the readings, many of these medical students began to question the notion that accurately assessing a medical situation is simply a matter of diagnosing a patient's illness. Nonmedical students revealed to medical students the fact that particular social circumstances do affect doctor/patient relationships. Whereas these students had been taught to apply general scientific principles to doctor/patient interactions, the shared experiences of nonmedical students made them aware of the fact that successful doctoring may involve more than diagnosing and treating illnesses.

In the June course, there were eleven nonmedical students (mainly art or literature majors), approximately 20% of the class total. In the September course, two out of the fourteen students were nonmedical students: one was an English major, the other a psychology major. The nonmedical students viewed medical issues differently than the medical students did and these different perspectives enriched the lives of the medical students. As an example, on June 14, during the discussion of women and pregnancy, Sirridge asked the students (particularly women) if they had ever felt separated from their body during a gynecological exam. Carol responded first, saying "well, I've had two children with two different doctors and they were different. One was with an English doctor, who talked with other doctors about betting on the weight of my baby. My second baby was in Independence and they were discussing a baseball game, and I felt separate from my body." Some time later in the discussion, a male medical student interjected that "we keep talking about insensitivity to the patient, but you have to rank it. Babies' needs come first and mothers' comfort given only until it affects the baby." Parsons interrupted the student, asking "according to whom?" The student quickly responds "according to doctors we train with at this hospital." In her interview, Carol comments on this: "I guess the problem is we're dealing with such young students that you get comments like 'when you're having a baby, the baby's the main concern.' I'm sorry, I'm there [having the baby] and I don't want a doctor ignoring me"(Welch 255). In her paper, Carol elaborated that "she felt like an object during her second delivery" and argued that "in her estimation [the doctor who did this delivery] was not a good doctor" since a good doctor "is one who listens and understands." Although many medical students felt uncomfortable listening to a "negative conversation" about the practice of medicine, they seemed genuinely involved in what Carol was expressing and considered her other perspectives of doctoring.

On September 12, another dialogue occurred that illustrates medical and nonmedical students' opposing views of medicine. As the students are discussing Leo Tolstoy's, *The Death of Ivan Illych,* May brings in her perspective that "doctors have a tendency to say you're not getting well." She goes on to say that

"many doctors get angry with [her] because [she] believes in miracles," and she feels "this is wrong." Robert was exasperated with Maryann in the September course because he felt that she kept steering the conversation toward religion and away from medicine. He explains in an early survey that:

> [Mary] is obviously a devout Catholic background and a lot of her discussions center around religion, something me and the other medical students are not into, study, or read [. . .]. I mean I do have conflicts with my grandparents because they're just very oriented toward [religion] for me, it's science. (Welch 252)

As can be seen from this quote, Robert's frustration with Mary had more to do with his own family background than it did with medicine. At a later point in the semester when I interviewed Robert, he had come to realize that Mary's in-class comments about her own faith had provoked him to reflect on his own family tensions that have arisen between him and his devout Southern Baptist grandparents as he has begun practicing medicine. This is one of many demonstrations of how nonmedical students from alternative discursive backgrounds affected the focused lives of these medical students. Tammy, a medical student, comments about this fact during her interview. She says that mixed conversations in a literature and medicine class are helpful for these soon-to-be doctors:

> It's kind of interesting to hear somebody's view who isn't one of us. Sometimes we're so geared into thinking one way and you hear things like "oh, there are miracles," and it's a thought we are not even in tune with. It goes against all the things we have been taught. Now we're beginning to consider that maybe people out there who aren't in the medical profession think this way. (Welch 248)

While these medical students' traditional training had prepared them to "read" patients in order to interpret medical signs, it had not prepared them to "read" other signs affecting doctor/patient encounters. Thus, as nonmedical students shared their real-life medical experiences, these medical students began to pause to consider the fact that other factors also enter into medical encounters.

A third activity that provided these medical students the opportunity to connect more personally and reflectively to the practice of medicine were the journal writing assignments. The writing assignment for the journal essays, as stated in the syllabus, was to write "three journals of approximately 5 pages […] that should include discussion of several examples of works of art, items in the popular media, literary works, patient encounters, etc. which are relevant to the subjects covered in the course." This writing assignment was a challenging task for many of these students because their traditional medical classes had never asked them to connect outside experiences to clinical experiences. It was apparent from reading journal essays that many medical students didn't comprehend (or chose to ignore) the statement on the syllabus that they were to integrate "outside experiences" into journal essays. A large majority of medical students primarily focused on telling their own personal, e.g., usually clinical, stories rather than incorporate many "outside" sources.

A brief, poignant passage of Mike's description of his own strong body image and his brother's weak image demonstrates that writing does help him clarify his thoughts and feelings about his brother:

> While my brother stumbled his way through grade school, I made up my mind to become a doctor and was quickly placed in gifted and talented classes as I began to really apply myself [. . .]. [Pete] always considered himself an ugly duckling in all the possible meanings of the phrase [. . .]. The thing is, he died two weeks before his wedding [. . .]. [T]he moral of all this scribble is that I have learned how important the body image is in determining not only how others look at and perceive the world, but also how others look and perceive. (Welch 265)

Another female student, Kathy, writes an essay about a former AIDS patient in an attempt to understand what this experience taught her. She begins the essay expressing her initial anger and frustration with this patient, writing "I was furious. This guy must think I'm a joke, believing some story like that from some guy straight off the streets I don't know anything about. He doesn't even have a complete record. How could I be so easily fooled?" The writer then puts herself in her patient's shoes and reflects on why this patient may have lied to her, saying "After I got over my anger, I thought more practically. Would I have lied if I were in my patient's position." Toward the end, Kathy tells how she confronted this patient with his lie and provoked him to share his personal feelings. She says,

> I told him, I thought about reasons why you might have lied to me, but I can't think of anything that would be important enough to sacrifice your health over. Our following conversation more than answered my questions. "My life was going pretty good when I found out I was HIV positive," he said as tears welled in his eyes. At the time he was going to school part-time and waiting tables. When he found out his lover of three years tested positive, he got tested himself.

In the conclusion, she reflects on her own persona: "Did I treat him differently when I knew he had AIDS? No, not homosexuals. But what about winos or punk gang members or women pregnant time and time again and using abortions as birth control? I didn't feel so good about myself after being honest with myself and realizing I had been judgmental in the past" (Welch 277).

Although these students were trained to write down only what they could "see" or "determine" during a particular medical situation, they discovered through their journal writings that it is also important to note situational factors that aren't necessarily perceptible or apparent at first glance. For these soon-to-be doctors, learning to read the "unknown" was an important first stride toward comprehending actual doctor/patient relationships. This course contested science's traditional approach to writing by exposing these students to the fact that they do not remain

"detached" during doctor/patient encounters. By teaching them this lesson, many of these students left this medical humanities experience wiser about the fact that medicine is much more than an impersonal, get-the-facts transaction. Since five years of medical training hadn't made room for such a discovery, this class was valuable because it gave these students the chance to reflect, at least momentarily, in a less concrete fashion on themselves and their own life experiences through the process of writing. Journal essay writing allowed these students the opportunity to create some sense of connection between their professional and personal selves, and most of these students wanted and needed to articulate such a connection.

Conclusion

Many students revealed that this course was the *first* time during their five or six years of medical training they felt comfortable enough to talk about or deal with issues such as death or suffering and come to terms with their own experiences with these issues. Through the thinking process evoked by this course, students freshly examined themselves and their medical experiences. Robert tells the story of what it was like for him trying to deal with the death of his patients in a room full of senior-level physicians he was trying to impress. He says that this course finally gave him the opportunity to temporarily step back from this experience and become more aware of what it had meant to him personally.

> [This course] is changing the way I read things. It's really helped me with death and dying. What happens in the seniority of the hierarchy of the med school is that patients with terminal illnesses are rolled all the way down the hill to the third-year students. That's what happened to me. My first day [in clinics], I had a patient die. Seven days in, my next patient died. Five days after that, and then two weeks after that, [other patients died]. But when they [did] die, what takes the emotion out of it, I mean, really it does is that my senior partner, the resident, his partner, are all in the room and you don't [show emotion while they're there]. So this class has let me take a little of that [experience] and reflect on things I did a long time ago when I should have been feeling. The stories put [the feelings] back and help me remember old patients. (Welch 281)

Foucault argues that in every discourse community members are prohibited from using particular kinds of discourses since "we all know perfectly well that we are not free to say just anything when we like or where we like" (176). The kind of discourse most barred in the clinical medical environment is what I would term "personal discourse." Jack Coulehan agrees, arguing that young medical professionals learn through their clinical training to "substitute technological intervention for personal interaction" when dealing with patients (17). Clinical training had taught these medical students to avoid making any reference to how they personally felt about a patient or a medical procedure; this medical humanities class emphasized active, self-reflective, and discussion-based aspects of patient care.

Louise Rosenblatt notes that "the reader's role is an active role, not a passive one" (49). Similarly, Ann Herrington argues that as "writers write, they are constantly involved in reading their own writing, reading other material, and using understandings they have acquired from past reading" (232). Writing, reading, and discussing all contributed to broadening these students' understanding of what it means to be a doctor because these activities helped them recognize that being a good doctor doesn't always necessarily entail finding the *right* diagnosis or picking the *right* multiple-choice answer. It also sometimes entails "reading" a particular medical situation in order to figure out what's going on at this one moment. These acknowledgments demonstrate that these students began to recognize a more complicated dimension of doctor/patient interactions as they participated in a medical humanities course. Michael Polanyi defines ineffable knowledge as knowledge that "has a meaning for me [. . .] in itself, not as a sign has a meaning when denoting an object" (91). Polanyi's insight illustrates how a medical humanities class differed from these students traditional academic training. Whereas most of their classes had taught them "fixed rules of conduct," this class alerted them to the fact that what's immediately observable may not tell the whole story. Because the complicated language of patients and doctors was brought forth during this medical humanities course (through the literature, and writing and discussion which ensued), these students began to glimpse the fact that instead of doctoring being a "fixed" procedure dependent upon "impersonal rules," it is often an "interpretive" activity requiring "natural ability, training, and intellectual effort" (Polanyi 106). Joanne Trautmann states that one goal of medical humanities is to "teach [medical students] tolerance for ambiguity and give them the capacity for coming to conclusions when the data are incomplete or capable of being interpreted variously" (171). This goal of "teaching tolerance for ambiguity" was probably the one most accomplished task I observed during my study. These students didn't learn to fully appreciate literature; they didn't significantly alter their medical perspectives; and they didn't develop a broader appreciation of the humanities. They did, however, come to recognize that "the practice of medicine is an interpretive activity," because doctors must often "[adjust] scientific abstractions to the individual case" (Hunter xvii). An interdisciplinary literature and medicine course contributes to the education of medical students because it provides them a brief, but important, time for retrospection. As Rita Charon says, "reflecting on practice can grant to doctors time's ultimate dividend—second sight [. . .] brooding can enrich a doctor's vision of individual patients and themselves so as to be all the more attentive and able to care" (68).

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