MEDICINA NEI SECOLI ARTE E SCIENZA, 30/1 (2018) 467-476
Journal of History of Medicine

Leonardo's Corner

MEDICAL HUMANITIES

SILVIA IORIO, SILVIA MARINOZZI
Department of Molecular Medicine, Unit of History of Medicine and Bioethics
Sapienza University of Rome, I

SUMMARY

This year, the International Journal "Medicina nei Secoli" – Journal of the History of Medicine, Sapienza University of Rome, Italy – inaugurated a special section entitled "Leonardo's Corner", dedicated to Medical Humanities and Museums. Medicine remains a combination of art and science. Therefore, the humanism that has always distinguished it from the other sciences must be integrated also into a technical and specialised training.

Introduction

The history of medicine, as well as deontology, ethics and bioethics, have long been subjects provided by the *curricula* of the degree courses in every medical and health profession. However, in order to strengthen the teaching of humanities and human sciences, numerous tools and professional training are needed – a truly interdisciplinary approach that enriches research and provides educational tools and training that are effective and complete. The meaning of the word "humanities" is not limited to the humanistic disciplines of the human sciences in the strict sense of the word, such as history, philosophy, epistemology and bioethics. The humanities also include artistic areas of study such as literature, theatre, cinematography, visual arts and the fine arts, as well as social disciples such

Key words: Medical Humanities - Medical Education

as anthropology, sociology, pedagogy and psychology applied to the community and the individual as well as the field of health care. For all intents and purposes, historians of medicine and science have long offered important contributions to the historical analysis of texts from different disciplines in which we refer to places of care, diseases, doctors, or the perception of the body, health and disease. In the same way, works of art, as well as minor arts, have made retrospective diagnoses of specific pathologies quite possible, in statues as well as paintings, thanks to a perfect representation of reality carried out by the artist. This also includes metaphors on torment, pain, melancholy, love sickness, and madness seen in the fine arts and music. Certainly, cinema has offered further and even more immediate representations of physical and mental illness and suffering, capable of raising awareness among the public and shedding light on situations of marginality through scripts and films written with this aim in mind. Furthermore, this also applies to the enhancement of the historical heritage that is specifically linked to the history of medicine, meaning the collections and museums dedicated to medicine, offering semi-holistic objects of historical, cultural, disciplinary and specialized contexts in which and through which medicine has developed and grown. Lastly, in the past thirty years, a great deal has been done in museology, with projects for the enhancement and dissemination of cultural heritage in the medical field. These projects have shown the effectiveness of museums in cultural awareness as well as in didactic training. However, less objective evidence might still be found on the efficacy and objective results of the teaching of Medical Humanities, which bring together, enrich and broaden the horizons of those studying human sciences. This applies above all to the social sciences, such as medical and cultural anthropology, psychology and sociology, which make use – in the healthcare sector – of rather disparate pedagogical and communicative tools in the health education of individuals and population groups as well as

in mediation within the clinical setting. Moreover, the same can be said for research and analysis methodologies important for "photographing" any shortcomings in health policies, such as the level of medical literacy among the populations.
The goal of "Leonardo's Corner" is precisely that of creating a solid connection among humanistic areas of study applied to medicine, building a bridge between medicine and the humanities.

Medical Humanities applied to Medical Education

For some time now, the topic of Medical Humanities applied to Medical Education has found a rather large audience in international scientific literature. The multidisciplinary nature that defines Medical Humanities also helps clarify the complexity of the debate that gravitates around such an articulated field of study that includes philosophy, ethics, history, sociology, anthropology, psychology, literature and the arts[1]. However, international literature has not brought about innovative developments on the subject, showing a rather complacent attitude that lacks constructive analyses. The thinking that revolves around Medical Humanities tends to place an emphasis on the critical issues of the current biomedical training system, to which the phenomena of depersonalization and reification of the patient and the commercialization of the medical professions are currently ascribed. Moreover, we find even fewer discussions and proposals designed to develop common guidelines that might lead to the establishment of appropriate training programs within medical schools. Furthermore, numerous academic contributions highlight the difficulties encountered in measuring the impact of HD in training courses, underlining the indeterminacy and lack of clarity of these measurements generated by interdisciplinary studies[2.] Several authors[3] have expressed concern in this regard, stating that the lack of quantitative evidence regarding the effectiveness of HD teaching may result in the devaluation of the usefulness of an inclusive approach in academic courses. However,

they also note that it is nearly impossible to measure the impact and efficacy of HD in the tools that are prevalent in medical education today, identifying likely insurmountable methodological obstacles due to the wide variety of possible foundations and co-founders[4]. This leads us to the clear criticality in the measurement of the impact of training, despite the fact that this does not exclude the need for greater clarity regarding the epistemological foundations, aims, methods and tools to be used in the training of students. An interesting observation by Clayton J. Beker et al[5] proposes a complex evaluation approach that uses not only an empirical, numerical and taxonomic methodology, but also which can be combined with the collection of narratives concerning the individual experience of medical students.

In addition to the methodological issues described above, there also appears to be a convergence of the different perspectives regarding HD based on the understanding of the need to accept two fundamental assumptions that define its usefulness[6]. On the one hand, we find the need to recognize a vision that can historicize European and Western medicine, in order to try to understand how the medical world is made up of a distinct reality for those who are about to immerse themselves in the study of medicine. On the other hand, there is the awareness of the cognitive and operational advances of biomedicine. This progress has allowed for the expansion of Public Health in the global sphere, leading to a considerable control of infectious diseases. However, these advances have also encouraged, together with processes of another order and degree, the consequent and progressive emergence of other disease, including degenerative diseases, towards which the virtuous models of scientific work seem to have lost a large part of their bite. On the contrary, there is also a growing need for the study and development of the compliance between the physician and patient.

In his famous study, *The Birth of the Clinic*, Michel Foucault[7] (1963) critically recognizes how the nucleus of biomedicine is based on a

"visibility" of logos that is empirical to body and disease. Scientific medicine bases its viewpoint on the empiricist paradigm that allows us to look to the body as a thing in a world of things[8].

The clinical method is based on viewing and looking. Signs and symptoms are connected based on the disease's frequency of repetition. Decrypted from their individual meaning, signs and symptoms therefore become signifiers: the disease takes on a fixed meaning.

> *It is the description [...] that authorizes the transformation from the symptom into sign, the transition from patient to disease, the access from the individual to that which is conceptual. [...] Describing means following the order of events, but also following the intelligible sequence of their genesis; It is to see and know at a time, because, by saying what you see, it integrates spontaneously with what you know – it is also learning to see, since it means gaining the key to a language that masters that which is visible*[9].

In the same way, disease is tied to mechanistic visibility and therefore entirely disconnected from the world of "invisibility" that builds it, and that which disease or illness itself helps to build. This entirely empiricist view ignores the fact "that human beings are not only bodies, but social and symbolic animals whose existence can be understood in its various manifestations only if we take into account the social and cultural determinants that contribute to shaping all individuals of the species, often in ways that are very different form one another"[10]. Unlike scientific approaches within other medical perspectives, illness falls into the broader "moral" field of emotion and misfortune. Through the contribution of Marc Augé, disease is seen as the most personal and the most social of events:

> *Feeling it menacingly grow within, an individual can feel a sense of detachment from others and from everything that constituted their previous life. Yet, everything in it is also social, not only because a number of institutions take charge of the various stages of its evolution, but also because the thought patterns that allow you to identify it, to give the disease (it) a*

> *name and treat it, are eminently social: thinking about their own illness also means making reference to other people*[11].

Therefore, we are alone in experiencing disease, despite the fact that we are never alone in being declared sick – being ill is a status conferred by or from others. The patient is always part of a network of relationships with other individuals willing to sanction or deny the illness or infirmity of the individual. Clearly, we are never naturally healthy or naturally sick – being normal and ill are not essences, but rather established rules generated by the incorporation processes of historical reality. De Martino (1977) suggested taking "historical reality", and not "reality" itself, as a parameter to distinguish the healthy from the sick. More recently, the theoretical contribution of Tomas Csordas (1990) has provided the key that allows for the transition from a conception of the body as an object to the idea of a body that is the subject of experience, history and culture, through the acquisition of a phenomenological perspective. He referring to the homonymous philosophical train (Husserl, Heidegger, Merleau-Ponty), which provided the theoretical assumptions from which to think in terms of "thinking bodies", "embedded world" or, more generally, of "embodiment". The most specific theorization for the latter term, in fact, was formulated by Csordas in the article *Embodiment as a Paradigm for Anthropology*[12], where he makes use of the work of Maurice Merleau-Ponty[13], presenting it in parallel to the theory of Pierre Bourdieu's[14] practices, with the aim of founding the idea based on an innovative vision.

Reuniting the mind and body in the methodological approach means bringing a stop to the study of the body as an object of culture. This is done in order to study it as a real subject of culture, aimed at bringing it back to the position classically attributed to it by pre-dichotomous or holistic thought. According to Csordas, Merleau-Ponty and Bourdieu succeeded in doing just this – one in the analysis of

perception, while the other in the study on the relationship between theory and practice of action. For the French philosopher, the body is the origin of everything: an aggregate that is formed in relation to the world, and which also perceives the world. Therefore, perception does not reside in the external stimuli that the body would passively register, but rather in the body itself. Moreover, perception is indeterminate until it encounters an object. Before the sentient body, there is no object and nothing can be grasped objectively apart from a perceptive operation of objectification that has been culturally organized beforehand. A body in the world abstracts and represents itself, gives meaning to the indeterminacy of the world by projecting into its consciousness a cultural interpretation of the surrounding reality. Furthermore, it has to accomplish these operations on the basis of cultural aspects and values, through which it directs its perception into the indeterminacy, in itself meaningless, that surrounds it. The body subjected to culture is acting and at the same time acted upon as an object of cultural developments that orientate its action of perception. Moreover, Bourdieu - intent on overcoming the analysis of the social aspects - leads the reading towards a thought process that begins with the concept of "habitus", for which Csordas provides the following definition: "A system of perpetual dispositions which is the unconscious, collectively inculcated principle for the generation and structuring of practices and representations"[15]. A socially-shaped body, in every sense of the word, internalizes and embodies "habitus". However, in addition to being culturally structured, the body in turn becomes a part of cultural structure – bodies that cultures produce are the same bodies that live in the world, producing culture, practicing it and recreating it in a subjective manner. Injecting means to make our capacities, until assimilation, deeply our own and personal, becoming poietic. The processes of incorporation of experience are processes from the body and of the body – an elaboration of social and cultural creation. This comes from the body, due to the

fact that the subject is an active producer of knowledge, and of the body insofar as it is a product of social, cultural and historical dynamics, those hegemonic discursive practices that are deeply rooted in our history and in the biographies of each one of us, receding from the sphere of awareness and leading to unquestioned common sense. Using these theoretical perspectives as our foundation, we can think of training in the biomedical field as the practice that, in the Foucauldian sense, forms the objects of which it speaks:

> *From an emotional point of view, a leg takes on a very different meaning when you remove the skin. It doesn't mean the same thing it did before that. Now, the skin, which is our way of relating with others – in the sense that touching skin means… becoming closer to other people – becomes a negligible part of the situation, much like an orange peel. Once you remove it, you step into an entirely different world*[16].

This excerpt is taken from the interview of a Harvard Medical School medical student during Byron Good's medical education survey in the 1990s. These Harvard students describe a series of changes in their perception that take place within the confined space of training.

> *In the world of medical life, the body is newly built as a "medical body", which is different from the bodies with which we interact every day, and the level of confidence that we establish with it is a reflection of a specific perspective, an organized structure of perceptions and emotional reactions that arise together when the body as a place of medical knowledge emerges*[17].

It is quite clear just how much the process of constructing the idea of the patient as an object of medical attention means having the student undergo the work of cultural modelling. Based on the awareness of this cultural effort within biomedical training, it is rather easy to understand the importance of Medical Humanities, leading us to what Alan Bleakely suggests[18:] the "de-reification" and "de-

objectification" of the patient, meaning the democratization of medicine. Therefore, we might need to overcome the subordination that the MHs cover in relation to biomedicine due to the fact that Medical Humanities are too often pushed into an educational framework of entertainment and leisure for students.

BIBLIOGRAPHY AND NOTES

1. Batistatou A, Doulis EA, Tiniakos D, Anogiannaki A, Charalabopoulos K, The introduction of medical humanities in the undergraduate curriculum of Greek medical schools: challenge and necessity. Hippokratia 2010;14(4):241-243.
2. Baker CJ, Shaw MH, Mooney CJ, et al. The Medical Humanities Effect: a Pilot Study of Pre-Health Professions Students at the University of Rochester. J Med Humanit 2017;38:445.
3. Belling C, Commentary: Sharper Instruments: On Defending the Humanities in Undergraduate Medical Education. Academic Medicine 2010;85(6):938-940; Bleakley A, When I Say… the Medical Humanities in Medical Education. Medical Education 2015;49(10):959-960; Charon R, Commentary: Calculating the Contributions of Humanities to Medical Practice-motives, Methods, and Metrics. Academic Medicine. Journal of the Association of American Medical Colleges 2010;85(6):935-937.
4. Ousager J, Johannessen H, Humanities in Undergraduate Medical Education: A Literature Review. Academic Medicine 2010;85(6):988-998.
5. Baker CJ, Shaw MH, Mooney CJ, et al. ref. 2.
6. Bleakley A, When I Say… the Medical Humanities in Medical Education. Medical Education 2015;49(10):959-960.
7. Foucault M, Nascita della clinica. Un'archeologia dello sguardo medico. Torino: Einaudi; 1998.
8. De Martino E, La fine del mondo. Contributo all'analisi delle apocalissi culturali. Torino: Einaudi; 1977.
9. Foucault M, Nascita della clinica. Un'archeologia dello sguardo medico. Torino: Einaudi; 1998. 127 p.
10. Lupo A, Natalucci G, Iuso A, Astolfi C, Biscaglia L, Medico o dottore? Ti racconto la mia malattia. Roma: Edizioni Panorama Sanità; 2008. 22 p.
11. Augè M, Il senso del male. Antropologia, storia e sociologia della malattia. Milano: Il Saggiatore: 1986.

12. Csordas T J, Embodiment as a Paradigm for Anthropology. Ethos. Journal of the Society for Psychological Anthropology 1990;18(1):5-47.
13. Merleau Ponty M, Fenomenologia della della percezione. Milano: Il Saggiatore; 2003.
14. Bourdieu P, Per una teoria della pratica. Milano: Raffaello Cortina; 2003.
15. Csordas T J, Embodiment as a Paradigm for Anthropology. Ethos. Journal of the Society for Psychological Anthropology 1990;18(1):11.
16. Good BJ, Narrare la malattia. Lo sguardo antropologico sul rapporto medico-paziente. Torino: Piccola Biblioteca Einaudi; 2006. 114 p.
17. *Ibid*. 116 p.
18. Bleakley A, ref. 6

Correspondence should be addressed to:

silvia.marinozzi@uniroma1.it