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# The Medical Humanities: Toward a Renewed Praxis

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**Abstract** In this essay, I explore medical humanities practice in the United States with descriptions offered by fifteen faculty members who participated in an electronic survey. The questions posed focused on the desirability of a core humanities curriculum in medical education; on the knowledge, skills, and values that are found in such a curriculum; and on who should teach medical humanities and make curriculum decisions regarding content and placement. I conclude with a call for a renewed interdisciplinarity in the medical humanities and a move away from the territorial aspects of disciplinary knowledge and methods sometimes found in medical humanities practice.

**Keywords** Medical humanities · Medical curriculum · Interdisciplinary teaching · Interdisciplinary curriculum

**Curriculum . . . is the social product of contending forces. —Michael apple**

The medical curriculum has changed very little over the past century: with slight variations, it consists of 2 years of basic sciences followed by 2 years of clinical rotations and electives. The content of the basic sciences, be it microbiology, neuroanatomy or behavioral sciences, is fairly predictable across medical schools even as methods of instruction may vary. Content of the medical curriculum is driven by disciplinary traditions *and*—at least in the United States—by what appears on licensure examinations (USMLE). This three-part examination leading to medical licensure in the United States, sponsored by the National Board of Medical Examiners and the Federation of State Medical Boards, is prepared by medical educators and clinicians from appointed "examination committees." These committees decide what knowledge and skills will be tested; it is also important to remember that they decide what will *not* be tested.

Thus, when compared to the basic and clinical sciences, the content of the medical humanities in the undergraduate medical curriculum is not as predictable or uniform, nor is it found in any significant form on licensure examinations other than the section "medical ethics, jurisprudence, and professional behavior," which comprises 5–10% of the behavioral

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sciences portion of USMLE Step 1.[1] When one considers that the humanities disciplines include, among others, history, literature, philosophy, comparative religion, and "those aspects of social sciences which have humanistic content and employ humanistic methods,"[2] all relevant to medical inquiry and practice, it is curious that the humanities in the undergraduate curriculum are often narrowly equated with bioethics, a few lectures in legal issues in medicine, or more recently, with "professionalism" efforts. Of course, many schools offer humanities electives,[3] but this is hardly evidence of robust humanities content that is consistent and required, similar to what is found in the basic science curriculum. Historically and in its present form, the medical humanities curriculum is driven primarily by local context, including not only the values and traditions of individual medical schools but also—and perhaps more significantly—the disciplinary credentials of local faculty and the number of full-time faculty positions in medical humanities, if any. Herbert Spencer's question posed in 1860—"What knowledge is of most worth?"—continues to be a relevant question in the medical humanities.

The purpose of this inquiry is to begin an examination of medical humanities practice in the United States. I was not interested in an extensive empirical study but rather a small survey of medical humanities faculty members that could serve if not as a catalyst for a larger examination of the field then at least as a conversation starter among peers theorizing our practice. Fifteen faculty members from a contact list provided by the most recent ASBH annual meeting participated in a survey of questions posed electronically. I selected faculty who by reputation were more broadly aligned with the medical humanities rather more narrowly with bioethics. Representativeness was not an issue—this inquiry sought to generate a small amount of data to theorize. The seven questions I posed sought answers that might offer current images of the curricular beliefs and values of medical humanities scholars in the United States. These questions focused on the desirability of a core humanities curriculum in medical education; the knowledge, skills, and values that are found in such a curriculum; and the often uneasy question surrounding who teaches in the curriculum and makes curriculum decisions regarding humanities content and placement. Ancillary to these curricular questions were those addressing the usefulness of medical humanities' major professional association and the tag "medical humanities" itself.

First, however, I provide a brief background of the origins of the medical humanities in the United States, examining the rationales put forth over thirty-five years ago by the scholars associated with the Institute on Human Values in Medicine whose efforts brought forth many of the teaching programs still operating today. This does not suggest that the medical humanities has remained a static entity; indeed, the field has been further developed and influenced over the past thirty-five years by such intellectual and pedagogical projects as postmodernism, feminism, disability studies, multiculturalism, cultural studies, and narrative inquiry along with other political and disciplinary issues. Still, the Institute provides a useful starting point for this inquiry.

## Historical perspectives of the medical humanities: What they said, what they proposed

The history of humanities inquiry in medical education offers clues to how the seemingly arbitrary curricular configurations of the medical humanities evolved in U.S. medical education when other dimensions of the curriculum have remained almost mind-numbingly consistent. In the proceedings of the first session of the Institute on Human Values in Medicine in 1972, Pellegrino maintained that the hope for the Institute was to "bring some

of us in medicine who are concerned with issues involving human values into close discourse with those . . . in the disciplines outside of medicine who have interest in, and perhaps a desire to help us with, the human problems that arise in medicine for the patient and the physicians."[4] He noted that on almost every medical campus there was a "subterranean current of interest in exploring potential contributions from the humanities" to medicine, but as we know now, such "currents" arise from a variety of locations and faculty on any given campus with divergent interests and expertise. Nothing in those first proceedings suggested a rigid prescription of which humanities disciplines should be "invited" into the curriculum, although the usual ones were always mentioned. Presenters were careful to cast a wide net for all the humanities disciplines and often the social sciences as well, noting what their individual and collective interdisciplinary presence might mean to medical education. In those same Proceedings Clouser suggested that

> each [humanities] discipline should be working to interrelate conceptually with some discipline of the medical world. They should be seeking areas of overlap, where each from its own perspective, methods, and resources can raise questions or shed light to the mutual benefit of both. It is an interdisciplinary enterprise aiming for new insights and understanding.[5]

This seemingly straightforward assertion—that the disciplines of the humanities and medicine should seek areas of overlap—would prove to be one of the more important explanatory frames for how we do our work today.

In documents subsequently arising from the work of the Institute over a number of years, it became clear that the "human values teaching programs" that arose during that period were as varied as the administrative units in which they were housed. Ronald NcNeur, then executive director of the Institute on Human Values in Medicine, noted that one of its charges—to assist medical schools in the development of programs in the humanities and medicine—was "tailored to the needs and styles of the specific schools."[6] At the time one of the Institute reports was written in 1976, over sixty schools had received its services. The programs that arose from these early efforts were called just that—"programs"—but they also morphed administratively into full-blown Departments of Humanities or Departments of Medical Humanities; some became a Department of Medicine in Society or a Division of Social Sciences and Humanities; one was designated an Office of Humanities while another was run by a Committee on the Medical Humanities. The curricular locations where medical humanities took place then and now are similarly varied. When required, such courses are found across the curriculum, some free standing, others embedded in other courses variously called, "Physician, Patient and Society," "Doctoring,""Medicine in Contemporary Society," and the like. Many are elective, particularly those that are disciplinary-based such as literature and medicine, history of medicine, or bioethics.

In addition, the great diversity of those who teach medical humanities then and now also explains its lack of agreed-upon standards, methods, theories, and core curriculum content across medical education. Some medical schools have faculty credentialed in the various humanities disciplines who do most of the teaching; other schools rely on faculty without academic or professional credentials but who have knowledge and interest in particular humanities disciplines and whose backgrounds can "trigger different relevant theories and expertise" based on their unique, often clinical expertise.[7] And even in schools with credentialed experts, faculty members' varied disciplinary orientations make common agreement on content, theories, and methods difficult across all medical education. Thus, the medical humanities' interdisciplinarity, its various enactments across medical education, its diverse faculty, and even

disagreement on what the field should be called—"health humanities" is one interesting alternative recently posed[8] —all make it a slippery and contested curriculum construction.

I now turn to a contemporary examination of the medical humanities based on the responses of the fifteen faculty who participated in this project. I will continue, however, to look back at the language found in these early Institutes to examine issues that remain current and those that have evolved, comparing how current faculty characterize medical humanities inquiry with those who theorized its place in medical settings more than thirty-five years ago.

## Current rationales

### Why teach medical humanities?

The rationales for the medical humanities provided by the faculty focused mainly on the benefits of *perspective* supposedly brought about by the content and methods of the humanities inquiry, in particular the perspectives of patients as unique persons living with an illness as only they can, as members of very particular cultures or communities, or as caregivers themselves. Many also suggested that humanities inquiry helps to situate students themselves in social, cultural, and political contexts not only with patients and families but also with other health care professionals and entities that vastly influence health and illness, such as the insurance industry, the government, and the legal profession. One faculty summarized the thinking of many:

> Medical humanities provides both content and form for students to understand the context of medicine. . . . Content includes how others live and think as well as an understanding of 'who one is' influences how one sees and experiences the world . . . [and] our own frailties, strengths, prejudices, and the capacity to care. Form provided by medical humanities includes tools for lifelong critical thinking skills, openness to and respect for different and differing opinions, passion and curiosity, understanding of cross disciplinary discourse and interactions, and a tolerance for . . . multiple meanings.

Faculty often danced around the link between medical humanities inquiry and the development of empathy and compassion, a causal relationship medical humanities scholars have most often been reluctant to propose directly. Yet several faculty did cite this relationship outright, that humanities inquiry promotes "empathy, in the sense of recognizing, experiencing, and being moved by other perspectives" and "the humanistic development of students." Others implied the link by using such phrases as "stretching the imaginations of medical students," "engaging the emotions as well as the cognitions," "open[ing] windows to . . . the lives of others," "broadening understanding of the human condition," and Charon's often quoted "attention, representation, and *affiliation*"[9] (current author's emphasis).

### What form should medical humanities take?

Answers to this question ranged from "each school will need to decide what commitment is to be made" to strong arguments for a required core curriculum across all medical education. One faculty argued that "adopting a core curriculum would make clear the standards in medical humanities . . . there is arguably too much local control and not enough standards. . . . [The medical humanities] curriculum is currently being taught in an

ad hoc and haphazard way from one school to the next"; another argued with absolute conviction that there should be a "core curriculum in the medical humanities in every medical school in the country. The size (extent/depth) and shape . . . should be determined by each medical school, but it should be there." Another similarly believed that it is "important to establish a common body of knowledge, but as a jumping off point, not in any sense as a limit to the kinds of questions that can be asked or the kind of knowledge that is welcomed."

Most faculty members suggested that the first and second year should include "introductory survey courses" or "introductory blocks" that included descriptors such as "interdisciplinary" or "multidisciplinary"—a critical distinction that I will explore later. One faculty argued for

> a core program that is integrated both horizontally and vertically. In this model, *all* students in each year would have to complete certain core experiences that were relevant to their level of training, e.g. anatomy lab tied to respect, emotional desensitization, humor, etc.; second year focus on experience of patienthood; third year tied to topics that arise in the clerkships; fourth year capstone looking at ownership of oneself as a physician and wrestling with topics such as medical error, the limitations of medical treatment, systemic shortcomings, poverty medicine, etc. Plus some free-standing electives throughout.

Yet another believed that "each school will need to decide what commitment is to be made." Clearly, no consensus was found on this issue.

Who should develop medical humanities curriculum?

Faculty variously believed the following groups should be involved in the development of the medical humanities: medical humanities faculty, a team of interdisciplinary scholars, curriculum committees/deans, and a task force from the American Society of Bioethics and Humanities (ASBH). Several used the word "stakeholders," one referring locally to basic scientists, clinicians, administrators, and students, another referring to "experienced teachers from diverse settings across the country [who can] share best practices along with leadership provided from an organization like ASBH . . . [to] have some weight behind recommendations." One faculty wrote the following intriguing statement about who should decide: "I do *not* think medical humanities faculty should run the show, because in my view medical humanities teaching is (or should be) inherently multi-disciplinary . . . so it has to be carefully coordinated not only with other curricula, but with other viewpoints."

Who should teach medical humanities?

Here medical humanities faculty were often ecumenical, but only to a degree. The majority of faculty cited interdisciplinary teaching teams of credentialed humanities/social sciences scholars and clinicians/basic scientists "who by training or by avocation have developed interests in one of the humanities." A fourth felt strongly about the necessity of credentialed humanities faculty in teaching activities. One faculty who disagreed with this position believed the field should move past its reliance on philosophers or "conventional literary scholars" who define the field and are most often those involved in teaching to include scholars working on medical issues in cultural studies, geography, even agriculture. The

goal for such widening would be "to expose medical students to the full range of cultural meanings of medicine as well as to get them to think hard about the limits of the field . . . as their medical school curriculum frames it."

Others were more "agnostic," as one put it, in terms of credentials being the exclusive criteria for teaching humanities in medical settings. One wrote of a conviction for the "'democratization' of medical humanities," which derives from the assumption that it is "fundamentally different from an undergraduate or graduate seminar in literary analysis." Another believed that while "some" humanities scholars should be involved, the

> sine qua non is good teaching. The claim that one must have training in English lit to teach it is about as persuasive as the claim that one must have a JD to teach medical jurisprudence or analog reasoning, or that a PhD in Pharm is required to teach Clinical Therapeutics. Demanding disciplinary expertise for teaching is both counterproductive educationally but suicidal programmatically.

Indeed, for many involved in this project, medical humanities faculty may be thought of as a "convenience sample" of faculty with affinities for humanities inquiry, some of them credentialed, some not—whoever is around, available, and enthusiastic about the field. Such a characterization would undoubtedly be challenged if a formal survey were conducted of the larger medical humanities programs that have strong disciplinary representation.

## Discussion

Responses to questions were at times predictable and familiar, even as they raised ongoing philosophical and pedagogical issues in the medical humanities. Two are of particular interest here and will form the basis for this discussion: (1) the relationship between humanities inquiry and, variously, humanism, humaneness, empathy, compassion, and other such virtues; and (2) the varied interpretations of interdisciplinarity and how they are at play in current enactments of medical humanities curricula.

### The humanism conundrum

The relationship between humanities inquiry and humanism in medicine was raised over thirty-five years ago in the Proceedings of the First Session of the Institute on Human Values in Medicine, and it continues to be raised if not directly then by implication by the faculty responses here. Pellegrino suggested that because of his or her engagement with humanities inquiry a physician may be more attuned to the "human dimensions of his practice" and will have a "higher probability of consciously respecting the person of his patient. This may not be the same as compassionate care and humanitarianism, but it can move the physician further along this road."[10] Many of the responses to the questions posed here have clear affinities with Pellegrino's claims about what the humanities offer without declaring causal relationships. Clouser, however, was more forthright in his belief about this perceived relationship: "This is a fairly insidious progression, for not only does it rob humanities of its true calling, but it absolves other departments of a responsibility that should be shared by all. To compartmentalize the responsibility for humanizing is to confuse virtue and knowledge."[5]

Over three decades later, one of the faculty members in this study similarly regretted the "odd assumption that a humanities scholar and a humanist are the same thing." But the

assumptions linking humanities inquiry and humanism are hardly odd. Some of the faculty participants here made that very link; others used language that may split hairs: what is the difference between, say, Charon's *affiliation* with a patient and *empathy* for that patient? For that matter, what are the differences that matter between the following definitions humanism ("any system or mode of thought or action in which human interests, values, and dignity predominate") and empathy ("the intellectual identification with or vicarious experiencing of the feelings, thoughts, or attitudes of another"), or what some faculty suggested here are the rationales for humanities inquiry: "stretching the imaginations of medical students," "engaging the emotions as well as the cognitions," "open[ing] windows to . . . the lives of others," "broadening understanding of the human condition"?

Moreover, what remains interesting if not troubling about "confusing virtue and knowledge" is that on many accounts such thinking deepens the binaries that seem to occupy (if not preoccupy) our thinking in the field. While a few of the faculty cited here specifically used the words "empathy," throughout the literature one finds a resistance to any hint of a relationship between our curricular efforts in the medical humanities and anything beyond mere cognition, as if the development of a "moral imagination"[11] and "self reflection,"[12] or "fostering habits of discourse on social and moral issues in medicine"[13] are cognitive ends in themselves. This, of course, speaks to the differences between cognitive and vicarious empathy, the former more palatable to those who view "teaching" empathy as a knowledge/skill set that can "used" on patients and can be measured. Much of this has to do with the soft-hard binary and the perception (as one humanities scholar rued elsewhere) that "the value of medical humanities lies in its perceived 'softness'."[14] This perception positions some humanities scholars in medical settings in an apologetic stance if they are associated with "feelings" or if they seem unconcerned with seeking empirical "outcomes" for their teaching.

Of late this has sometimes resulted in a curious machismo in the medical humanities literature, complete with calls for getting overtly and unabashedly "harder,"[14] as though the past several decades have been defined largely by softness in both the goals (to move students toward greater empathy) and methods of humanities inquiry (not rigorous, not grounded in disciplinary norms). This perceived softness with its underlying implication of anti-intellectualism is actually a straw man; it is far easier to position those who teach literature and medicine, for example, as softies if they use literature in its most literal sense as a mirror of reality compared to the way the "hard" faculty (read: rigorous) do. The content and methods of humanities are, in fact, far more complex and context-bound that such a binary suggests. And in spite of his often-quoted phrase about "confus[ing] virtue and knowledge," even Clouser acknowledged that there are possible clinical effects of the theoretical or academic sides of humanities disciplines in medical settings. That is,

> the overtones and implications of some humanities courses are bound to stimulate "humanitarian" concern. A by-product, say of a literature course, might be genuine empathy for the horror of dying, the pain of loneliness, or the imprisonment of poverty….Needless to say, those involved cannot be disdainful of practical fallout from their discipline; indeed they would hopefully seek it, attempting to relate to the clinical needs wherever they can. But notice that the humanities are not necessarily providing the motivation to be "humanitarian."[5]

As reported above, some the faculty in this project remained squarely in cognitive domains when discussing the merits of humanities inquiry while others did not, the latter explicitly mentioning what Clouser called the possible "humanitarian" benefits of such inquiry. In an era of

increasing instrumentality, efficiency maximization, and—help us all—outcomes/competencies/evidence for everything we do, it may be an interesting if not provocative issue to consider again if and how humanities inquiry may, as Bishop suggests, call doctors out of their "objectifying and categorizing stupor" and "into being there with the other."[15] Such a renewed consideration might also include a critical look at the varied concepts of empathy itself, too often viewed of late as a skill that can be conjured up at will by physicians *toward* their patients.

## The interdisciplinarity challenge

The term interdisciplinary has consistently been used to characterize the practice of medical humanities. In the 1976 *Human Values Teaching Programs for Health Professionals*, NcNeur described the Institute's work in providing services to medical schools to develop programs that were "essentially interdisciplinary": "It is clear that the human value questions that are inherent in contemporary medicine necessitate serious interchange between medicine and the humanistic disciplines such as history, philosophy, literature, theology, anthropology, and others . . . [It is] study at the interface of these disciplines."[6] Responding to questions in the present study, most medical humanities faculty cited lists of humanities disciplines that were to be used for the content and methods each brought to the study of medicine, including historical, sociological, literary, economic, and ethical analysis; the phrase "interdisciplinary" was also used along with "multidisciplinary."

Yet the word interdisciplinary has very specific uses, and medical humanities scholars may not share the same set of assumptions when they use the term to describe the medical humanities field in general or their own practice in particular. Lattuca's important work, *Creating Interdisciplinarity*, investigates how we use and think about the disciplines singly and in relationship to each other. She argues that disciplines are "powerful but constraining ways of knowing . . . [that] delimit the range of research questions that are asked, the kinds of methods that are used to investigate phenomena, and the types of answers that are considered legitimate."[16] Their constraining nature refers to strong loyalty to disciplinary knowledge, methods, and boundaries, even when scholars find themselves "trespassing" across disciplinary borders, or as others have described such activity, members of "raiding parties" crossing over borders.[17] Among medical humanities scholars, a range exists between those who attempt to cement their own disciplinary norms into medical frames and those who are "eager to interrupt disciplinary discourse and to challenge traditional notions of knowledge and scholarship."[18] Indeed, scholars of the former stripe are often the ones criticizing medical humanities practice for not being "disciplined" enough, sometimes presuming a lack of rigor from assumed dilettantes untrained in the field. According to Lattuca, "this is still the most common, and probably the least demonstrated, criticism" of interdisciplinary work.[19]

Luttuca offers an intriguing representation for the organization of how disciplines work together and are transformed through their integration. A close look at each entity of her schematic may prompt medical humanities faculty to examine how we do our work and the assumptions guiding our practice related to our disciplinary orientations. These entities include *informed disciplinarity*, *synthetic interdisciplinarity*, *transdisciplinarity*, and *conceptual interdisciplinarity*.

*Informed disciplinarity* This organization of content and methods is essentially disciplinary in nature, often motivated by disciplinary questions. To the extent that another discipline is engaged, teachers use *examples* from that other discipline to make connections between disciplines without changing the focus from the original discipline and its norms. Lattuca argues that "mere borrowing of methods, theories, concepts, or other disciplinary

components to . . . teach a course is not sufficient for interdisciplinarity."[20] History of medicine courses, along with some literature and medicine or ethics courses, are examples of informed disciplinarity when the norms of those disciplines remain intact even when examining medical phenomena.

*Synthetic interdisciplinarity* Lattuca posits that this occurs when we teach issues that bridge disciplines while keeping the components of disciplines intact. In fact, such components are readily identifiable as belonging to this or that discipline, particularly when such disciplines have strong paradigms dictating content and methods. The study of pathographies, various literary readings of the medical record, and certainly much in bioethics could be designated as synthetic interdisciplinarity. Lattuca reminds us that the questions posed in synthetic interdisciplinarity often restrict the kinds of connections that can be made between disciplines because of the specificity of content and methods tied to the respective disciplines. Still, synthetic interdisciplinarity highlights the contributions of various disciplines and "offers an opportunity to witness the negotiation between or among competing paradigms."[21]

*Transdisciplinarity* While synthetic interdisciplinarity highlights individual disciplinary contributions to such inquiry, transdisciplinarity erases or disregards the sources of theories and methods so that when applied they are no longer associated with a particular discipline. In transdisciplinary inquiry, the question or problem is the focus; methods are relevant only to the extent that they are useful and are not an end in themselves. Examples of transdisciplinarity inquiry might include questions focusing on the development of empathy or professionalism.

*Conceptual transdisciplinarity* Teaching with this orientation assumes that multiple perspectives must be included in the examination of issues or problems. Most often evident in courses without a disciplinary base, conceptual transdisciplinarity curriculum organization is topical or thematic, often with a focus on process rather than disciplinary content or methods. In fact, this interdisciplinarity is "often lauded for its perceived ability to solve social and technological problems that cannot be answered by a single discipline."[22] Courses such as "Physician, Patient, and Society" may be examples of this kind of interdisciplinarity. Using these conceptions of interdisciplinarity, the early and present conceptions of medical humanities often use a limited range of possibilities. Indeed, most of us remain in some kind of state of continuous advocacy for our home disciplines and what they bring to medical inquiry with local curriculum committees, in such organizations as the ASBH, and in the literature where arguments are made for consensus positions on what specific disciplines offer to the study of medicine. It may be argued that this is no different from the allegiance of basic and clinical sciences faculty to their own disciplines, particularly when curriculum time is up for grabs. Yet the dynamics are quite different: the medical humanities often lack widespread endorsement for their very presence in the medical curriculum, an assumption other scientific and clinical domains take for granted.

In light of these disciplinary distinctions and as we reflect on the goals for our teaching, it may be important to assess the role and importance of disciplines, how they work singly or in concert with others to achieve our goals, and how our thinking may be constrained by the tribalism of strict disciplinary thought. If the content and methods we teach arise from identifiable disciplines (fueled by close identification with those disciplines), our work is probably informed disciplinarity or synthetic disciplinarity, which is precisely where many in the field work best and want to be. If, however, we mute the methods and theories of

disciplines, with *questions, problems, or issues* guiding our teaching instead, we are likely involved in transdisciplinary teaching that uses or applies theories and methods from multiple disciplines—whatever works in addressing the question at hand. The beliefs of one faculty cited above—"I do *not* think medical humanities faculty should run the show, because in my view medical humanities teaching is (or should be) inherently multi-disciplinary . . . carefully coordinated not only with other curricula, but with other viewpoints"—is expressing a transdisciplinary approach to medical humanities teaching. Indeed, transdisciplinary teaching looks for an overarching synthesis rather than the acquisition of various disciplinary perspectives or skills.

Similarly, if we do not desire disciplinary perspectives or contributions to dominate our teaching but rather assume that a variety of perspectives must inform a particular issue or problem, we are likely using conceptual interdisciplinarity. Thus, when this orientation is at play, medical humanities are not disciplinary theories, content and methods merely transplanted into medical settings, but are part of myriad domains used to examine and question phenomena important in multiple arenas. Cultural studies is often a model associated with conceptual interdisciplinarity, whereby multiple disciplines contribute to the problem or issue at hand, with no one discipline having all the answers, and all disciplinary assumptions up for critical scrutiny.

This short inquiry arising from questions posed to a few members of the medical humanities community has offered a brief sketch of medical humanities practice in the U.S.; it has also raised persistent questions that some believe have been answered even as others continue to be entertained. We are still a diverse field with diverse identities, epistemologies, teaching strategies, and goals. Many medical humanities programs/departments/institutes still reflect the original goal of the 1972 Institute on Human Values in Medicine, which stated that each site should reflect "the needs and styles of the specific schools." Because of this ongoing legacy of context-driven faculty and curricula, the field has nothing resembling a core curriculum, and there may not be much of an interest in creating one given the diversity of faculty cited above. And given the curricular opportunities arising from richer conceptions of interdisciplinarity, our work as humanities scholars in medical settings can offer even more critical and creative opportunities not only in the education of young physicians but in research as well.

"When the path is clear and given," Derrida reminds us, "when a certain knowledge opens up the way in advance, the decision is already made, it might as well be said that there is none to make: . . . one simply applies or implements a program. Perhaps, and this would be the objection, one never escapes the program."[23] As disciplinary (and disciplined) "specialists" entering the field of medicine, we bring not only "transmitted knowledge, beliefs, morals, and rules of conduct, as well as . . . linguistic and symbolic forms of communication . . . but also a proper measure of loyalty to one's collegial group and of adherence to its norms."[24] As medical humanities faculty, we might consider thinking often and critically about the tribal aspects of disciplined knowledge and methods we bring to our practice. In her eloquent classic, *Teacher as Stranger*, Maxine Greene presses us to confront our beliefs and actions, urging teachers in any setting to

> struggle against unthinking submergence in the social reality that prevails. If he wishes to present himself as a person actively engaged in critical thinking and authentic choosing, he cannot accept any 'ready-made standardized scheme' at face value. He cannot even take for granted the value of intelligence, rationality, or education. Why, after all, *should* a human being act intelligently or rationally? How *does* a teacher justify the educational policies he is assigned to carry out in his school? If the teacher

does not pose such questions to himself, he cannot expect his students to pose the kinds of questions about experience which will involve them in self-inquiry.[25]

If we follow Greene's advice, we may begin to approach the fertile, complex, and moral landscape of medicine differently, temporarily shedding rather than armoring ourselves with our respective disciplinary knowledge and methods. A new spirit and practice of medical humanities inquiry may ensue, one that offers not only a renewed spirit of disciplinary openness, but of humility in our inquiry as well.[26]

## Endnotes

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