CRITICAL CONDITION: USING THE HUMANITIES AND POSTHUMANISM TO DEVELOP CRITICAL THINKING IN THE MEDICAL ENGLISH CLASS

Daniel CLINCI
"Ovidius" University of Constanţa

Abstract: *The so-called "Medical Humanities" is a fairly recent field of research and teaching in Medicine that tries to include the humanities. The aim of Medical Humanities is to train medical professionals that will be better equipped to deal with patients as real individuals, and not just organs and diseases. However, Medical Humanities has quickly turned into "Medical Post-humanities," a field that uses the most recent posthumanist insights, theories and practices to develop critical thinking inside the field of Medicine. In this paper, I will discuss the possibility of introducing and using Medical (Post)Humanities during the Medical English class to promote critical reasoning and a certain shift in the traditional biomedical and humanist framework. I will also provide some examples of recent topics in Medicine that can be translated and interpreted by using Medical Posthumanities.*

Keywords: *Medical Humanities, critical thinking, posthumanism, Medical English*

This paper focuses on exploring the possibility of adapting and teaching some aspects of medical humanities and medical posthumanities as a part of a Medical English course in order to develop students` critical thinking. From my point of view, any Medical English course (and ESP courses in general) that employs content-based language teaching could use methodologies and techniques specifically designed as wider frameworks in the teaching of medicine. Of course, a Medical English class teaches primarily relevant vocabulary and communication skills; however, it also focuses on "soft skills" such as teamwork, problem-solving and critical thinking, among others. Thus, this paper wants to explore a question and its answers: Given the fact that most medical schools do not provide specific Medical Humanities classes (or aim to develop students` soft skills), is it possible to somehow "detour" the Medical English class from its more visible or obvious goals of teaching lexis and communication and use it a context in which to discuss Medical Humanities and maybe also critical medical posthumanities? This will be a departure from the common way of thinking about English for Medicine, giving it a wider set of goals and objectives, an attempt that might prove risky in practice. However, it may also be true that a change of framework is needed in a field that is always at risk at remaining stuck in older models. For this matter, I will start by briefly looking at the historical development of medical training in order to see how these models can inform the Medical English course.

When medicine became an institution, in the 18th and 19th centuries, it drew upon a tradition of rationalism that promoted a "mechanistic biomedical model" of the human body and, as such, of medical "gazing" and training, one that is still used today as a framework for the study and practice of medicine. This is roughly what Foucault talks about in his *Birth of the Clinic*, the development of the teaching hospital in which the "medical gaze" of the doctor would reduce the patient to organs and diseases. This rationalization of medicine was based on the works of Harvey and Descartes (Hewa & Hetherington 132); William Harvey`s *De Motu Cordis* (1628), the discovery of blood circulation, explained the human cardiovascular system as a mechanical device, while Cartesian rationalism strictly separated the body and the mind (*De Homine*, 1662), treating the body as a sort of machine controlled by the rational soul (which was to be found in the pineal gland):

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> This mechanistic view of the human body grew apace with subsequent discoveries in medicine which reinforced the idea that illnesses are a result of the failure of the mechanical functions of various parts of the human body. Within this paradigm it is believed that medicine is a science that has concrete answers to everything that goes wrong with the body. […] the practice of modern medicine became dominated by the idea that the human body can be manipulated and cured either by introducing chemical compounds into the mechanical system of the body, or by replacing and repairing parts. (Hewa & Hetherington 133-134)

This rational mechanistic model is known today under the name "biomedical model." It influenced not only the practice of medicine, but also medical training and education, where theoretical and technical knowledge is given utmost importance, as opposed to patient care and management.

The biomedical model was vastly criticized in the second half of the 20th century for this mechanistic view of the human being, both in medical education and medical practice. A few alternative models appeared, but the one that reached a certain degree of prominence was the "biopsychosocial model" developed by George L. Engels. Criticizing the approach of the biomedical model that treats health as the absence of disease and only takes into account biological or biochemical information, the biopsychosocial model promotes the integration of social, cultural and psychological criteria in medicine: "[…] health and well-being of people must be defined in terms of a new medical model which includes the general quality of life (e.g. housing and education), clean environment, and psychological or spiritual quality of life" (Hewa & Hetherington 132).

The main goals of the biopsychosocial model were to supersede the Cartesian distinction between mind and body and to create a framework in which social factors would be included in medical practice:

> To provide a basis for understanding the determinants of disease and arriving at rational treatments and patterns of health care, a medical model must also take into account the patient, the social context in which he lives, and the complementary system devised by society to deal with the disruptive effects of illness, that is, the physician`s role and the health care system. (Engel 132)

As we can see, the biopsychosocial model expanded the scope of medical practice, including previously ignored aspects, usually centered on what goes today under the name "lifestyle." However, no matter how "inclusive" this model tried to become, it still failed to take into account some of the more "humanistic" components of medical practice and training: bedside manners, effective communication, the patient`s inclusion in the decision-making process and so on. These aspects were targeted by the new development in medical teaching called "Medical Humanities."

What is Medical Humanities?

Medical Humanities appeared as a response to concerns over the fact that the medical profession is becoming more and more technical and, in a sense, "scientific," rigid and insensitive. Maybe the development of Medical Humanities has something to do with the general epistemic shift towards a more inclusive culture, in the context of post-colonialism, but also a certain crisis of the humanities, which tried to find new ways to regain some

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relevance. Medical Humanities addressed issues such as the lack of empathy and the numbing associated with the medical profession, proposing a new focus on patient-centeredness.

> It is experts – mainly consultants and specialists – who hold sensibility capital (diagnostic and treatment acumen; how to do a physical examination and take a history; how to diagnose and how to treat both generally and within specialties). […] However, if they are not expert educators as well as expert clinicians, such sharing of capital can backfire or be misplaced. As an unintended consequence of medical education, again what can result is an increase in insensibility among students – a kind of numbing or insensitivity. (Bleakley 5)

These concerns, the decline of empathy in medical education, the moral erosion, high rates of medical error, were studied and researched. In Bleakley`s *Medical Humanities and Medical Education* (2015), one can find examples of such issues, alongside others like the increased influence of technology in the medical field that makes the whole ritual of the doctor-patient encounter redundant. In short:

> Now we also realize that learning communication skills instrumentally is failing to humanize medicine. It may be, however, that the medical humanities can provide the extra curriculum dimension to educate for both patient-centeredness and democratic team practice. Medicine requires a medium for translation of clinical scientific knowledge into patient care and that medium may be the medical humanities. (Bleakley 9)

Of course, just like any other new methodology and theory of teaching, Medical Humanities went through a first stage, "medical humanities lite", described as "naïve […], attracting raw enthusiasm rather than reflective scholarship", and a second wave, more skeptical, as "critical medical humanities," having brought "maturity and complexity" (Bleakley 40). Since there were multiple perspectives on what Medical Humanities is supposed to be, some of them belonging to scholars that have had no clinical experience (like historians, arts and literature teachers and so on) and some of them belonging to medical professionals, many practices associated with this new field were developed. Bleakley describes five meanings of the term "medical humanities": 1) humanities studying medicine; 2) arts and humanities in medical education ("medicine as art"); 3) the arts dealing with medical topics; 4) artistic activities with the patients ("arts as medicine"); 5) arts therapies in psychotherapy (Bleakley 45).

As a teaching methodology, and consequently as a practical approach to medicine, Medical Humanities was sometimes criticized for being only a separate course, with a very different focus than the general approach; those critics proposed that Medical Humanities should be integrated in all medical disciplines:

> The issue for these authors is a pedagogical one – simply, medicine is not taught as a process of critical thinking and reflection but one of direct, pragmatic application. The humanities bring pedagogical process as well as content, such as critical dialogue and theory as 'sense making'. Ways of learning that are more critical could be introduced […]. Humanities should not be an 'add-on' but integrated. (Bleakley 41)

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This is probably the ultimate goal of employing Medical Humanities, in my opinion: to help develop critical thinking, teamwork, empathy and all the other "soft skills" that are missing from medical training. Moreover, if we think of a brief genealogy of such an approach, we notice that the first step towards this mash-up between medicine and the humanities is, of course, Foucault`s account on the "medical gaze" (*The Birth of the Clinic*) – the development of a certain form of biomedical power in the practice of clinical/diagnostic medicine. This is probably the best way to understand the place and purpose of Medical Humanities: as an alternative to the biomedical model. A large part of the literature on Medical Humanities deals with the so-called narrative medicine, which has become the most well-known practice of "patient-centeredness". However, narrative medicine is only one approach to Medical Humanities, albeit the most common one and maybe the most useful. For instance, there is the approach in which medical students are exposed to drama and professional acting as a means to help them understand the performativity of their own profession.

Medical Humanities, in keeping with the ethics of patient-centeredness (as opposed to the foucauldian doctor-centered "medical gaze"), obviously aims at developing better communication skills and soft skills, but it perpetuates the same "humanism", the human-centered point of view that fails to deliver a wider critical questioning (and tends to exclude all the other objects and factors that contribute to or take part in the medical process: medical technologies, the environment, capital etc.).

Medical Humanities meets posthumanist critique

The critique provided by Medical Humanities is, of course, essential in medical education, being able to surpass the biomedical model and present new ways of communication and a different framework for dealing with patients. For Medical Humanities, the focus on the patient means that the illness is seen as part of the story, but it is still understood as a deviation from some sort of norm that the medical field creates. Ultimately, it is a question of control shifting from the doctor`s gaze to the patient`s experience and perspective.

If Medical Humanities is a very difficult concept to define, comprising all kinds of practices, posthumanism is even more complicated. Probably the easiest description would be the analysis of the new practices brought about by the technological development; this may include all kinds of medical prostheses, from computers to molecules. However, in my opinion, posthumanism is best understood as a departure from humanism; in our case, a departure from the inherent humanism of "Medical Humanities." This recent type of critique has questioned and debated the human-centeredness of Western thought. In the medical field, this seems absolutely shocking because the traditional model and the newer, "humanist" one are both based on a relationship and a power play between humans, doctor and patient. Everything else, tools, pathogens, even organs, chemicals and hormones are details that create the context for a definition of "normality" vs. "illness". Posthumanist critical thinking engages with notions like "normality", "normalization" etc. Also, posthumanist thinking deals with discussing the body, technology and what has become known as the Anthropocene, the recent geological age marked by the phenomena caused by climate change. Obviously, all these have become, in some way or another, extremely relevant for contemporary medicine. But above all else, in this case, posthumanism is a kind of critical thinking about the workings and relationships that are established within the medical field. Medicine is not only a technique, it is also a technology of power; it is not only communication, but also control; and no matter how difficult it is to accept, it is not only human or humanistic, but also post-human and political. It may seem strange to include all these concepts and ideas in a Medical English class, but what better *locus* of departure from the traditional biomedical model is there? Both

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Medical Humanities and posthumanism can inform our approach to create debates, to widen topics, and eventually to train more effective medical professionals.

"Critical Medical English" – an alternative perspective

In order to develop our students` critical thinking, we must offer them the conceptual and theoretical tools that will help them organize their thinking and deal with contemporary medical issues such as illness, infections, doctor-patient rapport, but also power relations in the field of medicine and pharmaceutics, strategies of capitalism, the patient becoming more and more a "consumer" of health services etc.

I will provide here some examples of controversial situations that can be useful to debate with medical students, for them to change their focus from the biomedical framework to a more critical one in thinking about how medicine works and what it means to work in the field of medicine.

Medicine can and has been used as a biopolitical tool to gain control over the body. The biomedical model of medicine constructs a "normal" bodily identity, and all that is outside it is defined as "illness." This is probably best seen in psychiatry, a field in which deviations from the social norm become "disorders"; this is a process that started ever since the psyche was medicalized by Freud in the second half of the 19th century. Foucault`s *Birth of the Clinic* shows how, for instance, institutionalized medicine constructed a scientific identity of the body. Thus, a truth about the human body was created by the power of the medical field as a science; consequently, this truth also became the norm.

There a few accounts on the medicalization of society and about medicine as a biopolitical institution. "Medicalization" is a term used in sociology to denote processes and practices that construct "medical conditions" or "illnesses" (Zola 1972; Conrad 1992; Conrad 2007). Conrad (2007) offers some examples like ADHD, baldness, andropause, social anxiety disorder etc., that were previously facts of life (unruly children, normal hair loss, aging, shyness), but were at some point deemed to be illnesses that need medical diagnoses and treatments; likewise, the people became "patients." Society itself becomes medicalized in all its aspects, from childbirth to death, and the medical field becomes a practice of biopower, in spite of the patient-centeredness. Furthermore, this invention of medical conditions is promoted by pharmaceutical companies interested in developing and selling more drugs; sometimes, the medical condition follows the invention of the drug (Conrad 2007:143). This over-medicalization is, obviously, a result of capitalist strategies of need/desire-making; eventually, medicine ends up being a tool of the pharmaceutical industry, and medicalization ends up as commodification of disease.

This context constructs the patients as "consumers" of health services and pharmaceutical drugs within the logic of capitalism. The state of medicine under capitalism and the various critical perspectives are important issues which can be debated not only among sociologists and activists, but also among medical students. For instance, Gusmano et al. (2019) analyze the way in which the patient-centered care starts to merge with the "consumer-driven health." At the end of the 1960s, there were voices in the medical field that argued for a "patient-centered medicine" as opposed to an "illness-orientated medicine" (Balint 269). Thus, during the 1970s, together with the biopsychosocial model, a certain revolutionary change in medical education and practice was attempted. However, today the medical field treats the patient as a consumer. Among issues related to medical insurance and so on, Gusmano et al. (2019) also discuss the loss of professionalism in medicine. Since it is treated as a market, medical care functions with a "the customer is always right" attitude, which brings about the erosion of professionalism. The authors argue that patient-centered

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care is inclusive and tries to meet the patients` needs and preferences, empowering the patients, but "consumer-driven health" only asks that the patients engage in a capitalistic relationship with the medical field (Gusmano 372).

There are other issues that medicine under capitalism has to face. Another example is the increasing resistance of bacteria to antibiotics, which is probably the most severe crisis that affects contemporary medicine. The World Health Organization stated in 2018 that "antibiotic resistance is rising to dangerously high levels in all parts of the world" (WHO 2018). In this context, pharmaceutical companies do not find it profitable to develop new antibiotics, in spite of the WHO`s warnings (Sukkar 2013). Moreover, since the Arctic permafrost is thawing due to climate change, new bacteria are released. Recent research proves that these new bacteria already possess antibiotic resistance genes (Kashuba et al. 2017). In this context, the biomedical and humanistic discourses of medicine keep insisting on the development of new drugs and on the restriction of the current ones. However, a critical posthumanist perspective, one that acknowledges the fact that humans (and all other beings, for that matter) are never purely human, but multiplicities, bodies that live together with other organisms (viruses, bacteria, fungi), has a different perspective on the matter. For instance, Haraway speaks of her attempt to "build attachment sites and tie sticky knots to bind intra-acting critters, including people, together […]" (Haraway 287). In other words, one of posthumanism`s directions is the one that analyzes the species in a wide symbiosis. Following this line of thought, Yong mentions the "coincidental evolution hypothesis," or the "shit happens" hypothesis proposed by microbiologist Bruce Levin, that shifts the focus from the anthropocentric experience of bacterial infection and states that humans are only a "medium," a battlefield and a breeding ground for various types of bacteria (Yong 2014). In the long run, the fact that bacteria are developing resistance genes is impossible to control, and there is not much that we can do about it; but maybe the answer is this new approach to thinking about medicine that is critical posthumanism, doing away with human exceptionalism and accepting the fact that we are, just like every other being or thing on this planet, co-existing and intra-acting. So, immunology itself is a form of biopolitics, a discourse and a practice constructed as a deeply humanistic negation of other species (Goffey 2015). One question that arises from this is "is there any possibility for a posthuman medicine?" The answer is yet to be hypothesized.

Yet another issue is that of technology. This may seem like a recurrent question in philosophy, critical theory and of course posthumanism, but in medicine it is taken for granted. However, there are researchers who try to analyze the way in which technology has changed medical practice and its impact on the relationship between medical professional and patient. On the one hand, technology and the practice of contemporary medicine are basically indistinguishable. The various technologies, more or less hi-tech, take over the patient`s body. The proponent and supporters of Medical Humanities argued that technology is the one that de-humanizes the patient. For instance, Verghese, a supporter of narrative medicine) insists that technology (the wide range of technical means and investigative procedures) has changed the practice of medicine (Kugler & Verghese 2010). Students, residents and doctors focus more on analyzing data provided by medical technology instead of authentically interacting with the patient during history taking and the physical exam. Thus, Verghese argues that a return to the basics of patient-centered medicine is much needed, including this direct contact between doctor and patient, which he describes as a ritual. Wehbe et al (2015) acknowledge the fact that medicine was transformed by technology, which "helped transform the patient-physician relationship from one based on physician paternalism to one of more patient autonomy" (Wehbe et al 38). The authors go on to list many of the resources available to both

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patient and physician, but end their paper by stating that medical practice should always be based on communication and the "individual needs of the patient." (Wehbe et al 39). These are interesting points of view, but I believe there is a more intimate relationship between patient, physician and technology at play here. From a posthumanist point of view, it may well be so that technology "creates" both the patient and the medical professional through intra-action, that is, through a combined interaction that constructs a symbiosis. The MRI machine, the catheter piercing the skin, even the drugs (and their inherent histories) are aspects of a cultural-natural experience of being (and working) in the medical field.

My final example of a controversial topic in contemporary medicine has to do with the way it is (and was) used to take over bodies, as a biopolitical tool. The famous case of the athlete Caster Semenya can be studied in this context for a better understanding of how medicine is not limited to diagnosing and treating patients in specific places like hospitals or clinics, but also actively constructs identities and bodies. From this point of view, medicine is also a discourse that speaks about the truth of the human and sets it inside some limits. In short, Caster Semenya won the World Championships in 2009; some debate on whether or not she was female had already arisen, and on the same day the International Association of Athletics Federations asked for gender verification tests because of "ambiguity" regarding her sex. The official reason was that Caster Semenya might have had some "unfair advantage" over her competitors. Eventually, she was found to have higher levels of testosterone than "normal" and was considered "intersex," neither male, nor female, or maybe both. It is not at all strange that the world of sports would resort to such a practice, but the fact that medicine is called upon to give a strict definition of gender based on chromosomes, hormone-levels and gonads is a bit more frustrating. Caster Semenya`s situation is one example of a body not only being described by medicine, but also inscribed in some medical category that is socially and politically relevant; in this case, Semenya`s high levels of testosterone identified by medicine prompted her exclusion from the "female/woman" category. The discourse and assumptions of medicine exercised power over the athlete`s body, more specifically, the assumption that sex/gender is always binary and is decided by hormone levels during the so-called medical procedure of "gender verification".

Medicine as a tool for biopolitics is not something new. Since its institutionalization, there have been theories that try to segregate people in some way or another, and also to give biomedical, "natural" reasons for this segregation. The assumptions made both by the sports and the medical fields are controversial at best: sex is always binary, sport is a level playing field, intersex athletes hold a biological advantage etc. (Cooky & Dworkin 103). Also, there are accounts that show how cultural perspectives have influenced interpretations in genetics and genome analysis (Richardson 2013).

Such perspectives and examples open up a whole new dimension of working in medicine and might help with the development of critical thinking. Usually, the practice of medicine does not focus on issues like effective communication, reflexivity and interpretation. If Medical Humanities and critical posthumanism prove useful in any way, it is because of this challenging of the basic assumptions of medicine. Some authors on Medical Humanities even went as far as to promote a return of the metaphor in the medical field, or maybe an acknowledgement of the fact that medicine creates, utilizes and imposes specific metaphors and truths: gender, illness, body etc. And in the words of Nietzsche: "what then is truth? A mobile army of metaphors, metonymies and anthropomorphisms, in short, a sum of human relations."

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