Humanities Competencies - Sari Altschuler

The COVID-19 pandemic put pressure on healthcare-as-usual. While many in the system had long paid lip service to the importance of the humanities, in the early days of the pandemic, something called "the humanities" gained new import as a tool for healthcare workers under new pressures to process trauma, weigh novel ethical issues, and prevent burnout. In response to the *JAMA* issue on narrative medicine that appeared two months after the WHO declared COVID-19 a pandemic, physician and writer Suzanne Koven tweeted: "A whole issue of @JAMA_current devoted to narratives...Who knew interest in storytelling and #medhum [medical humanities] would surge during a pandemic? (We knew)." Healthcare workers and laypeople alike sought to make sense of the seemingly unprecedented, especially in literature and history.

Just as the humanities offered tools to make sense of individual experiences of new global shifts, the shifts wrought by a global pandemic also offered a clearer picture of what the humanities could do for health and healthcare. The humanities provided resources for making sense of novel and unsettling circumstances, for weighing pressing new ethical issues, and for learning how to live with uncertainty. The pandemic also revealed something more: the unique ability of the humanities to understand and make sense of the simultaneity and interconnectedness of the individual and structural dimensions of health. The most powerful analytical work the humanities can do for health and healthcare, I am arguing, is to facilitate understanding between different scales. The humanities instruct us how to think between 1) ambiguities, contingencies, and complex particularity, 2) cultural, narrative, rhetorical, ethical, and historical structures, and 3) social, political, and economic structures.[1] They can help illuminate the interconnectedness and simultaneity of these dimension of health and healthcare.

This description of the humanities answers questions that have long dogged the medical and health humanities. Namely: What does or should the word humanities *mean* in the health humanities? And what do the humanities *do* for the study of health and practice of healthcare?

Various scholars, most prominently some of those among us at this seminar, have issued powerful and persuasive answers to these questions for disciplines, particularly narrative (Rita Charon) and history (David Jones with Jeremy Greene, Jacalyn Duffin, and John Harley Warner), but when the question dilates to consider what *the humanities* offer the answer often grows vague and, more troublingly, deskilled. As Jeremy Greene and David Jones explain, "emphasizing the sorts of things that can be taught by any particular combination of disciplines... paradoxically constrains the claims for the value of medical humanities in medical education, relegating them to valuable but generic tasks such as the cultivation of professionalism, empathy, or estrangement" (1662). Many program websites advertise the humanities's ability to increase empathy, prevent practitioner burnout, and, at best, invite a tolerance for ambiguity or provide an avenue for social justice. The reasons for the vagueness of these descriptions range from limited resources to a desire to retrofit humanities work to established values and criteria in medical education to the sense (which often begins in healthcare) that the role of the humanities is to restore "humanity" or humaneness. The definitions, however, remain so capacious—intentionally so—that they risk categorical collapse. The medical and health humanities have come to name everything from the academic disciplines of the humanities to the social sciences, art therapy, the arts, and even cooking, quilting, and capoeira (e.g. Crawford, Brown, and Charise). Recent efforts to sharpen definitions turn toward shared values and motivations—and away from method (e.g. Klugman and Lamb).

Whereas the impulse is to extend the purview and import of the humanities, over-extending descriptions of "the humanities" actually diminishes their power and usefulness. Once "gallery and museum visiting," "shared music listening," and "knitting" are categorized as humanities topics (see Crawford, Brown, and Charise 244, 324, 413) the humanities cease to be a set of rigorous skills or critical knowledge practices.[2] The big-tent spirit here is laudable, but its effects are dangerous. The lack of clarity about what the humanities are for the health humanities makes it the domain of any right-feeling person, opening the door to arguments that emphasize "exposure to" the humanities rather

than *training in* the humanities (e.g. Mangione, et al.) and amplifying the tensions between, at the poles, experts with advanced training in the humanities and physicians who enjoy the arts. As one physician put it recently, insisting on advanced degrees in the humanities "is tribalism, and nothing more…There is a great deal of humanistic knowledge to be gained by the actual practice of medicine" (Binder). Yet more striking, the category "Humanities" in *JAMA* describes "essays that demonstrate the relevance of the arts" to medicine, "personal vignettes," and "original poems," none of which describe the work of scholars with advanced training in the humanities ("Instructions for Authors"). The confusion over whether the humanities require specialized skill and knowledge is understandable, given that the word has long been confused (and historically entangled) with *humanism* or *humanness*, especially in medicine, and humanities scholars have frequently deemphasized their own expertise to extend the purview of their fields (Altschuler, "Humanities," XX).

Nevertheless, as a set of expert fields, the "humanities" name something different. According to the National Endowment for the Humanities, the "humanities" means the "study and interpretation" of a vast array of human cultural production. Or, to borrow Catherine Belling's sharper formulation, "The humanities are not defined by their impossibly huge set of objects – human activity and its products – but by their methods: the description, interpretation, and evaluation of what people make, in and of the (formerly) natural world" (23). In short, if we insist on a "modern" understanding of medicine—a field whose knowledge practices emerged at the turn of the twentieth century—we should not, in the same breath, cast the humanities as a set of timeless enterprises.[3] And while it may be tempting to abandon definitions of the health humanities it given divergent understandings of the humanities, humanities scholars would do better to claim and clarify their expertise, especially given the rapid expansion and prestige accorded to the field since COVID.

That is, even if we wish to maintain the big-tent spirit of the *health humanities*—and I think we should—we must, at the same time, center the humanities at its core as something more specific and rigorous.[4] The arts, art therapy, and the social sciences do different work, but the humanities' sharp

analytical power offer distinct contributions to how we understand and make sense of the world. To do so, I've proposed *humanities competencies* as an analytical core for the health humanities.[5] Building on decades of work, I identify these as *narrative*, *historical perspective*, *attention and observation*, and *ethics and judgment*. The idea of humanities competencies offers a complement to Jonathan Metzl's social science idea of "structural competency" and a replacement for the problematic notion of "cultural competency," which was designed to do some of this work.[6] Nevertheless, in grouping them here, I hope not only to describe, collectively, what the humanities have to offer but to shift the emphasis of that work from centering the individual in healthcare to the humanities's distinct ability to make connections between dimensions of health and healthcare at different scales.

Here are some examples of how the humanities do this:

The history of narrative's entrance into medicine is instructive. Narrative only became a more explicitly useful tool for healthcare after 1980s shifts in literary studies redefined narrative not simply as a person or text's "account of a series of events" but as "a representation of a history, biography, process, etc., in which a sequence of events has been constructed into a story in accordance with a particular ideology" (OED). This newer definition demonstrated not only narrative's more extensive usefulness but its deeply structural function. Narrative competence thus not only teaches us, in Rita Charon's influential terms, "the ability to acknowledge, absorb, interpret, and act on the stories and plights of others" but about how formal features (characterization, trope, mode, genre) broadly structure the accounts we give and how social, political, economic, cultural, and material forces shape the narratives that govern health and healthcare from patient experience to digital technology and global health (e.g. Ostherr, Wald).

Historical perspective likewise teaches us to interrogate the histories (genealogies) of contemporary healthcare knowledge and practice while appreciating their contingency and the ways personal and structural histories shape individual healthcare encounters. David Jones, Jeremy Green, Jacalyn Duffin, and John Harley Warner write, "History offers essential insights about the causes of

disease (e.g., the non-reductionistic mechanisms needed to account for changes in the burden of disease over time), the nature of efficacy (e.g., why doctors think that their treatments work, and how have their assessments changed over time), and the contingency of medical knowledge and practice amid the social, economic, and political contexts of medicine" (623). Historical perspective also teaches practitioners to attend to the particularity and idiosyncrasy of individuals, situations, and circumstances within these broader contexts.[7]

Attention and observation teach us to pause, notice, and describe before interpretating while educating us to recognize how visual and verbal conventions shape what we see and how we see it. Training should connect the observation of particular visual elements to broader lessons about how ways of seeing are socially and culturally constructed and change over time. Developing the capacity for attention and opening a space between observation and analysis, as Dovlev, Friedlaender, and Braverman showed long ago, makes better diagnosticians, while training practitioners to recognize social and cultural structures that shape what we see, how we see it, and its historical contingency promises to improve everything from clinical judgment to fields like global and digital health.

Ethics and judgment reveal that healthcare is governed by foundational moral values and principles, such as justice, beneficence, and non-maleficence, the application of which, as our philosophy colleague John Basl has taught us, is not simple. These values often present conflicting recommendations, and it can be unclear what each value or principle recommends. Ethics and judgment prepare individuals to understand and adjudicate such difficulties, to make responsible informed decisions, and to identify the ethical contours of a wide variety of healthcare debates at individual, interpersonal, social, and cultural levels. At the center of such training is rigorous and informed analysis and an ability to identify and articulate value-laden judgments.

Taken together, humanities training offers special insight. The humanities do not dispense with uncertainty, ambiguity, contingency, and contradiction as anomaly, but rather identify them as indicators of individual and structural complexity that require more attention. The pandemic and the

structural failures it has made visible reveal to us, if it were not already obvious, this kind of training is sorely needed, not only in a variety of healthcare professions but also by the public more broadly.

Finally, while the competencies I offer here center the rigorous knowledge practices of the humanities, I recognize that there is not currently space in medical school curricula to adopt a full program of humanities competencies. They might, of course, be partially adopted in schools with the faculty to support them, but the ideal place to adopt such a schema is before or after medical school or in other forms of professional healthcare training. Our four years' experience running an undergraduate based this on this framing has taught us that humanities competencies provides a program and its students with more structure and a clearer sense of what distinct knowledge practices humanities training offers for work in healthcare.[8]

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[1] One reason it has been difficult to identify this potential has been because of the degree to which medical and health humanities programs have framed their purview as attending to the individual, especially when centering literature as a site of intervention. I wouldn't go as far as Olivia Banner who recently write that the medical humanities's "focus on self-expression and interpersonal skills recuperates neoliberal logics that relentlessly foreground the individual and that undercut our ability to identify (and resist) structural inequalities" (3), but I would rather say that in focusing on the clinical encounter as the prime site of medical humanities work and the patient-physician dyad as the central encounter, the medical humanities unnecessarily limited its purview and foreclosed the broader training the humanities can offer to think about the entangled relationships between scales.

[2] Even in their description of the "Critical Medical Humanities," Whitehead and Woods "tak[e] a view of the humanities that extends to encompass the arts and social sciences...not easily characterized by shared disciplinary orientations, methodologies, audiences or areas of inquiry and intervention" (14-15).

[3] Modern humanities disciplines and medicine emerged simultaneously at the turn of the twentieth century through the development of the modern research university. For more, see "Humanities" in *Keywords for Health Humanities*.

[4] This argument echoes a likeminded call from Greene and Jones to emphasize the specific work of disciplines, although I would argue that "narrative," "history," "observation," etc., are actually phenomena over which a variety of humanities disciplines have distinct approaches sets of expertise. For example, historians and anthropologists are certainly experts in narrative in their own right, and each of the humanities disciplines trains students in ways of attending and observing that are complementary but distinct.

[5] I originally used the term "humanistic competencies" to describe this work (*The Medical Imagination* 2018), but I am more recently persuaded that the word *humanistic* retains too much confusion between *humanities* and *humanism*.

[6] I am aware of the critiques of the idea of "competencies," and a shift to replace that word with "humility"—as in "narrative humility" and "cultural humility" (DasGupta, Prasad et al.) Nevertheless, given that healthcare professions continue to use *competencies* as language of training, I find this substitution problematic. Doing so unwittingly reinforces the notion that the humanities are soft and cannot offer the kind of skills STEM, medicine, and the social sciences can. In this sense, *humility* functions like *empathy*—it is a very worthy (if sometimes problematic) goal, but not one that alone makes best use of humanities education. Rather, I think we ought to insist on the word *competency* to

underscore the analytical power of the humanities as a set of expert ways of knowing that require training while refusing to tailor it to evidentiary standards defined by the social and natural sciences. Or, taking a page from Greene and Jones, perhaps it would be better to ask why the humanities require such proof of efficacy where the basic sciences do not (1664), especially since the basic sciences only supplanted the classics as essential prerequisites for medical training in the twentieth century.

[7] Developed with Chris Parsons.

[8] "Humanities Competencies" have been offered an organizing framework for the Health, Humanities, and Society minor Chris Parsons and I have run at Northeastern University since 2018 and will ground our new half major in Health Humanities.