Letter from Mumbai

INTRODUCING THE HUMANITIES IN MEDICAL EDUCATION

The term 'humanities' comprises a study of the qualities that make us human. Such study enables us to lead lives that affirm ethics and espouse philosophy, culture in general and literature, art, music, theatre, history and humour in particular. We learn to treasure the classics. We endeavour to reach the status of the 'compleat' or quintessential human being, cognizant not only of what is good for our own well-being but also about what will benefit others around us and society at large. Self-reflection and the development of a strong conscience are tools vital to this effort. These, in turn, engender empathy and efforts to better the lot of others. As we do so, we enrich our stay and that of others on this 'pale blue dot'. (You may recall the photograph of planet Earth taken on 14 February 1990 by the Voyager 1 space probe from about six billion kilometres where the size of the earth was less than one pixel! In case you have somehow missed this, you might wish to learn Carl Sagan's ruminations on it in *www.youtube.com/watch?v=kmP4Xzt0rN4*.)

Most medical colleges in India have neither time nor inclination to encourage the humanities. Honourable exceptions include St John's Institute of Medicine, Bengaluru; University College of Medical Sciences, Delhi and the Seth G.S. Medical College in Mumbai.

The inculcation of the humanities into students requires teachers who have taken to heart Pope's prescription to drink deeply of the Pierian spring. (Alexander Pope [1688–1744] advocated this in *An essay on criticism* published in 1711.) It also needs students who have been selected to join medical college on the basis of a demonstrated aptitude for the art and science of medicine. Alas! both are generally wanting in our halls of academia. Were the majority of our staff and students to be tested in the humanities we might be faced with results that shock instead of delight us.

How many medical teachers do you know who revel in weaving facts from the history of medicine into their discussions with undergraduate and postgraduate students, inspire them using examples of the likes of Çaraka, Susruta, John Hunter, Oliver Wendell Holmes, Ignaz Semmelweiss, Charles Morehead, William Osler and Bhau Daji Lad or display effortlessly in outpatient clinics and the wards the principles of ethics and respect for the rights of their poorest patients? How many of them can hold forth on the lives and works of Valmiki, Kalidasa, Amir Khusro, Tulsidas, Tukaram, Kabir, John Milton, Samuel Johnson, Thomas Carlyle or John Keats?

Our students are severely handicapped by the time they aim for admission to medical college by a strait-jacketed curriculum, unimaginative methods of teaching that destroy the urge to question and innovate and a system of evaluation that punishes any deviation from the prescribed texts. Even in the medical colleges, we are witness to a decline in the quality of teaching, trend towards abolition of hands-on techniques of learning such as dissection in human anatomy and autopsies in pathology and the pernicious coaching classes that aim only at securing huge number of marks by pandering to the quirks and quiddities of examiners rather than improving the understanding of scientific principles and broadening of the spirit of enquiry and experiment in their students.

Change, we must, if we are not to remain mired in this arid rut that passes for medical education.

Such change will require great and prolonged effort on the part of administrators, teachers and students. Each of these three cadres must first learn to accept the failings of the present system and feel the need for improvement. Lasting change for the better must come from within and cannot be imposed from without.

In the realm of medical practice, teacher and student alike must restore to the patient, especially the poor and dispossessed patient, primacy in all matters. The patient's interests and well-being must be consistently promoted. In doing so, all personnel must strive to develop concern, gentleness, patience and courtesy towards those seeking our help despite their failings through ignorance, illiteracy, poverty, anxiety and other factors and experiences that may tend to irritate and frustrate the clinician.

Placing ourselves in the position of our patients can result in techniques that improve their lot. Here is an example. Patients in hospitals are usually surrounded by cement, concrete and machines that beep incessantly. What if we were to restore to them, especially when they are in intensive care units, trees, flowers, grass, the chirping of birds, the pitter-patter of raindrops, the gurgle of a stream, views of clouds and other natural events?

What if we were to make the learning and practice of medicine exciting, joyous and intellectually stimulating and rewarding? Can we make students learn more from questioning, experiment and observation rather than by cramming?

The widening of horizons is always welcome and when doctors spread their attentions beyond the humdrum limits imposed by mere medical science, they may discover new realms and show enhanced creativity.

It will be necessary to convince administrators and funding bodies that such change is vital. To do so, we may need research projects that show the superior results of medical education with humanities as an essential component as contrasted to present-day practices.

Our medical libraries and museums must incorporate methods that have been so successfully used by the Smithsonian Museums in Washington and the British Museum in London, the National Library of Medicine in Bethesda and the British Library and the Wellcome Library in London.

Then, and only then, will we be justified in our claim to be medical professionals. Remember the answer Justice Elbert Parr Tuttle, Chief Justice, U.S. 5th Circuit provided when asked, who is a professional?

- The professional man, in essence, is one who provides service.
- It turns out that there is no right price for service, for what is a share of a man worth? If he does not contain the quality of integrity, he is worthless. If he does, he is priceless. The value is either nothing, or it is infinite.
- Certain it is that man must eat, so set what price you must on your service. But never confuse the performance, which is great, with its compensation, be it money, power or fame, which is trivial.

Should we succeed in this endeavour, we can earn the right to be called *the compleat physician*.

THEATRE OF THE OPPRESSED

I had heard much praise of this theatrical form initiated by Augusto Boal of Brazil in the 1960s. Recently, I was privileged to attend one such theatrical performance.

Boal, in turn, was inspired by the work of his fellow countryman, educationist Paulo Freire. Freire's book *Pedagogy of the oppressed* was first published in Portuguese in 1968. He was concerned about the relationship between the colonizer and the colonized. While teaching, Freire deviated from the traditional view of the student as an empty vessel to be crammed with information. He treated the learner as a co-creator of knowledge. He proposed the use of cooperation, unity, organization and cultural synthesis as instruments to free the colonized.

Boal used Freire's principles to create interactive theatre to deliver the oppressed from their yoke. He differed from traditional theatre in that there was no divide between performers and observers. Members of the audience were the performers. He advocated the joker (also termed facilitator and, contrarily, 'difficultator') who, like the joker in a pack of cards, stayed neutral throughout the performance. He led the theatre, provided the 'spect-actors' with games and themes and ensured fair proceedings but never commented on or intervened in the content of the performance. Nor did he shape the proceedings to any particular end. It was up to the spect-actors to draw conclusions, voice opinions and generally bring stories to conclusions of their choices. The spect-actors formed a heterogeneous mass on the stage, closely intermingled yet independent as regards the ability of each participant to comment, criticize and draw conclusions. They were equals. While performing, they observed, experienced and pondered. Their feelings and conclusions were then translated into their actions on stage.

A number of branches of this theatre form followed and many could be and are incorporated into each individual performance of the theatre. For a simple recapitulation of these forms and summary information on the theatre, please see *https://en.wikipedia.org/wiki/Theatre_of_the_Oppressed*.

Initial anxiety among the spect-actors is abolished by one or more games at the start, some ending in hilarity. The spect-actors soon get into the spirit where seniority, position on the academic ladder, sex, age, creed and other similar artificial distinctions are irrelevant.

An announcement at the start of the performance that feelings, views, opinions and advocated steps would remain confidential among the participants of the theatre and not be bruited in public allow the voicing of deep sentiments and cherished views. The fact that any spect-actor can halt the performance in *forum theatre* at any stage and assume the role of the principal performer is empowering. The respect with which each performer is treated and listened to also emboldens shy and introspective persons.

Role-playing, the oppressed in one act becoming the oppressor in another highlighted an understanding of why certain behaviour dominates at times and the terrible consequences for the dispossessed. The example of the outpatient clinic where everyone from the junior resident to the chief of the clinical unit treats an illiterate and poor woman with disdain and abruptness was poignantly enacted. Requests by the joker to devise and implement ways by which the unjust, insensitive and the uncouth could be frustrated or, even better, converted to humanitarian action led to much constructive thought and, at times, yielded remarkable solutions.

At all times, the focus is on NOT advocating any particular path of action. The spect-actors are made to cogitate and even agonise over the situation and come up with their own solutions. These are then subjected to general scrutiny with special reference to whether these are practical and how easily they can be implemented. This technique engenders in them the ability to think along these lines when faced with a real-life situation and bring about a conclusion satisfactory to the patient.

We are fortunate in having two seminal centres where this theatre is flourishing in India. The Centre for Community Dialogue and Change is based in Bengaluru; Dr Radha Ramaswamy is the facilitator. In Delhi, the University College of Medical Sciences, associated with Guru Teg Bahadur Hospital, has a trio fostering this theatre: Dr Satendra Singh, Dr Upreet Dhaliwal and Dr Navjeevan Singh. (In the performance I was privileged to witness, Dr Navjeevan Singh played the role of the joker to perfection.) All these experts are ready and willing to help any institution in India to use this remarkable and productive art form.

I was sorry to learn that the other medical institutes in our national capital city have yet to display any enthusiasm for this admirable endeavour.

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