

Scholar spotlight

Scholar spotlight is a new feature in *Medical Humanities* which focuses on individuals and explores their careers and experiences in the field of medical humanities.

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What is your current role and what are you working on at the moment?

My current position is Postdoctoral Research Fellow at the Centre for Medical Humanities, Humanities Research Institute, University of Leeds. I am also Research Affiliate at the Program in Placebo Studies, Harvard Medical School.

My research is currently focused on the role of the placebo effect in psychotherapy. My main interest is in understanding how the placebo concept applies to psychotherapy, and what ethical repercussions this has for psychotherapy training and education and for clinical ethics. This brings together philosophy of science, psychotherapy research and clinical ethics. I am very driven by research that identifies and solves real-world problems.

How did you become interested in the health humanities?

My research in the health humanities emerged during my PhD, but I can probably track it back to my schooldays. I dabbled briefly with the idea of medicine at school, but was thwarted by the bottleneck of A-level choices and the inevitable 'arts' versus 'sciences' junction. Ignoring the advice of my teachers, my choices spanned both, and after false starts with a biology degree, and fine art, I lit on philosophy. My PhD was in philosophy of science and philosophy of mind, and my interest in philosophy of medicine and philosophy of psychiatry arose from this training. I became engrossed in such questions as: Is medicine an art? Is psychiatry a science? How do we classify mental disorders? How *should* we classify them? These kinds of questions hooked me in.

What path did you take to your current role?

My research path has been colourful (I think!). It started with a PhD at Queen's University Belfast followed by teaching philosophy at Queen's for 5 years, while also teaching philosophy in schools, and to adult learners. Then in 2013 I had a

short Postdoctoral Fellowship at the Centre for Cognitive Evolution at the Ruhr University, Bochum, Germany. Following this, I secured a 2-year Irish Research Council Postdoctoral Award at the School of Philosophy, University College Dublin ('UCD'). During my time at UCD I was fortunate to work closely with the Directors of the Program in Placebo Studies at Harvard, and the Director Ted Kaptchuk generously offered me Affiliate status. I then applied for an Institutional Strategic Support Fund Wellcome Trust Postdoctoral Fellowship at the Centre for Medical Humanities, University of Leeds.

Since my PhD, the common theme through these appointments is interdisciplinarity. There is a lot of lip-service paid to that phrase but for scholars whose work is genuinely cross-faculty, research communities and mentors who not only value interdisciplinary research, but encourage it, are veritable academic oases.

The humanities are often assumed to lend value to healthcare education: you have interrogated that assumption, why?

The medical humanities undoubtedly has a history of directly (and indirectly) selling itself as a panacea for medical education. For example, there are frequent references in the literature to the idea that the humanities humanises medic—it improves fine awareness of patients' lives, increases empathy, augments critical skills, refines doctors' judgements, reduces medical hubris and so on.

I have two observations of this discourse. First, while it is certainly possible that this plethora of positive outcomes may emerge from a humanities education, these propositions need to be identified as empirical assumptions—as speculative hypotheses. And while some of these hypotheses are difficult to evaluate (for good reasons), many of the claims are amenable to psychological investigation; as such they can even be viewed as an opportunity to launch cross-faculty research. Such research may even have the potential to embed the humanities more robustly within medical curricula—or at least get clear about when scholars are false advertising.

The second observation is the (unwitting) bait-and-switch tactic in the manifesto. There are often direct appeals to the 'instrumental value' of the humanities in medical education (the kinds of outcomes listed above) yet these are often repackaged (almost as a sort of insurance measure) as having 'intrinsic worth'. The concept of

intrinsic worth is defined as having value in its own right, not subjugated to utility, or in producing effective practitioners. However, upon closer examination this esteemed, even lofty, validation does not appear to hold up—for two reasons. The first reason is that many scholars in fact go on to list instrumental justifications under the very rubric of 'intrinsic value'. The second reason is that the distinction between 'intrinsic' versus 'instrumental' values appears to promulgate problematic, sharp dichotomies¹—theoretical versus applied, educated versus trained. The medical humanities, in my view, needs to be very careful about falling into the easy rhetoric of the two cultures debate.

Who has influenced you in your career so far?

My academic heroes are people who have traversed the limits of distinct academic traditions. They are interpreters who understand the language and culture of multiple research traditions, but they are deeply mindful of the limitations of insular scholarship. My heroes set out to create and to foster progressive, new research cultures. They embody a wise academic cosmopolitanism, and the desire to bridge ideas located in different traditions.

My academic heroes include Professor Tom Lawson—a philosopher of religion who cofounded the field of cognitive science of religion; Professor Ted Kaptchuk, a doctor of Chinese medicine and acupuncturist who is now professor at Harvard Medical School and one of the world's leading experts on the placebo effect; Professors Leda Cosmides, John Tooby and Jerry Barkow, psychologists who pioneered the field of evolutionary psychology; Professors Paul and Patricia Churchland and Robert McCauley who have argued that findings in cognitive and brain sciences are deeply relevant to answering philosophical problems (but that this does not mean philosophy will run out of questions).

You have also written about the emphasis on medicine and doctors, rather than health and other professionals, do you prefer the concept of the health humanities rather than the medical humanities?

I think the term *health humanities* is preferable because much of what goes under the rubric 'medical humanities' encompasses the roles and expertise of the other health and health-related professions. Of course, the decision to focus on medicine, as distinct from other aspects of healthcare, will

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depend on the questions one is asking. But a wider lens on healthcare research is to be welcomed, and in many circumstances makes more sense. For example, in my own research in psychotherapy, it is notable that a range of healthcare professionals identify as psychotherapists: they include psychiatrists, clinical psychologists and those individuals who are specifically trained in psychotherapy and/or counselling. So in this case, while it remains to be interrogated whether these professions share the same training, expertise and outlook when they practice psychotherapy, it is more appropriate to investigate from a broader perspective—one that recognises the contributions and perspectives of all of these professions including their professional bodies.

Aside from the debate about ‘health humanities’ versus ‘medical humanities’, it is also interesting to focus on the term ‘humanities’. For example, what subjects and research methods should come under the umbrella of the humanities? How do they differ from scientific methodologies? Is there any overlap between the questions that humanities scholars and scientists ask, when it comes to healthcare? And what is the methodological overlap between healthcare sciences and health humanities? It would be great to see more focus on these kinds of questions within the field.

What are the challenges for someone working in the health humanities?

One challenge for people working in the health humanities (I am reliably, but recurrently told!) is getting health and medical faculties (and students) to see the value of the humanities within their education. While I am to some extent sympathetic with the medical student undertaking an already stuffed curriculum, I do lament the fact that medical students (like their peers in other faculties) specialise much too early (certainly, this is the case in the UK). This specialisation, I fear, breeds academic parochialism and results in a defensive devaluation of other modes of scholarship.

A second, and major challenge, is securing funding for research. Getting funded is an increasingly competitive business in academia, and even worse for interdisciplinary projects. The health humanities, as a field, inherently comprise a wide range of disciplines. While not all of this research (perhaps not even most) is best defined as interdisciplinary: for example, much research applies established methodologies, for example, in history or literary studies, to aspects of medicine; for those who wish to undertake very obviously interdisciplinary research (eg, combining medical taxonomies with evolutionary

psychology) it is worth knowing that such projects are much less likely to be funded.² Indeed, evaluative bias in peer review of interdisciplinary projects has been recognised at the highest levels by the President of the European Research Council, Professor Jean-Pierre Bourguignon, and by the Chair of the Research Councils UK, Professor Rick Rylance. However, exactly why this happens is yet to be examined, although it seems likely that peer reviewers have trouble recognising the value of projects which differ (in methodology and content) from their own niche.

Which book or paper would you recommend to someone beginning to explore the field?

That is a tough one! The field is so wide, encompassing so many research traditions. I would encourage people to read (maybe, better—to ‘do’) some philosophy—in part because philosophy uniquely affords a panoramic view of knowledge *and also* a microscopic zoom lens. This is headache inducing but helpful for any scholar, especially one new to a particular field (or even to a new field). Philosophers are like good (but rather annoying) scholarly angels peering over our work, tapping us on the shoulder, asking: “Why are you using these methods? What assumptions are you making here? Why does this research matter?” Philosophy—or a philosophical acumen—is about retaining an outsider’s awareness, jabbing away with the questions, interrogating the answers with a hot spotlight on them. I think that kind of outsider mentality is something every scholar can use. So, I would recommend any introduction to philosophy (especially philosophy of science as a route into philosophy of medicine). In the healthcare context there are some excellent and very accessible books written by philosophers. For example, Rachel Cooper’s *Psychiatry and Philosophy of Science*; Havi Carel’s *Illness: The Cry of the Flesh*; Jeremy Howick’s *The Philosophy of Evidence-Based Medicine* are exceedingly clear, readable introductions to different aspects of philosophy of medicine. And for those interested in a *tour de force* volume tracing the diagnostic history of—what the WHO describes as the leading cause of disability in the world—depression, I recommend, *The Loss of Sadness* by Allan Horwitz and Jerome Wakefield.

What areas do you think the field has overlooked or underconsidered?

The term interdisciplinary is such a Trojan horse in scholarship today—including the

health humanities. We find common reference, and appeal to, ‘multidisciplinary’ or ‘interdisciplinary’ research, yet there is surprisingly little reflection about what those terms might mean. Philosophy of science has much to contribute here in terms of describing how levels of explanation fit together, and how we can expedite research between neighbouring fields of enquiry. Interdisciplinarity is not merely about mixing two or more fields and seeing what emerges; I think that risks a sort of intellectual hobbyism—just as randomly mixing distinct colours can result in muddy brown paint. In short, there are better and worse ways of conducting interdisciplinary work.

What does ‘impact’ mean for you?

Impact means a variety of things to me. I do believe that there is an ethical imperative for individual researchers or research groups to leave the cloisters at least occasionally, and to communicate research findings to the taxpayers who funded it. There is still a degree of nose-holding and exaggerated gasping from the pews, when academics talk ideas with the public. I think that is both revealing of academic politics, and embedded professional misconceptions. Certainly as I see it, communicating ideas to the public is no different from communication among peers in different research fields, or among postgraduates or undergraduates. The point is to explain the research clearly, to demonstrate why it is important or interesting, and to maintain the attention of the audience. When one talks to academic peers, undergraduates and lay punters in the street, the skills required in every case are the same—the only thing that differs is the pixel size of the explanations.

Impact, for me, also means the effective translation of research in order to solve real-world problems. In this respect the old dichotomies (which I have already mentioned) of theoretical versus applied, education versus training, arts versus science, are often rehearsed. And when that happens, it is the latter in the pairing that is associated with impact. This view of research is so myopic as to be blind. As the great medical educator Abraham Flexner observed in his essay ‘The usefulness of useless knowledge’ (1952) when it comes to scientific innovation, ‘Almost every discovery has a long and precarious history’.³ Practical innovations emerge from theoretical frameworks; theories determine the research questions we ask. If we value the impact of research, then we need to care about the quality of our

Scholar spotlight

theories (and that includes paying attention to their empirical content).

Notwithstanding, I do not take the defence of theoretical modes of scholarship as a defence of theoretical research *tout court*. Still too often research papers within the humanities make pronouncements or bases ideas on outdated empirical assumptions all the while remaining disengaged from, and sometimes tutting at ‘philistine scientists’. The knife cuts both ways: this is why critical dialogue across research traditions and modes of scholarship is so important.

What advice would you give to someone starting out in a career in the health humanities?

My advice to anyone starting out in an academic research career is to read widely—including beyond your own discipline—and do not stop reading!

What would you like to see more of in the health humanities?

The isolationism and hubris within medicine is frequently and I think justifiably criticised by scholars in the health humanities and other fields. But the benefits of self-critique and inviting other scholars to question our own justifications and practices may reap enormous rewards; including (but certainly not limited to) sounder reasons for our presence within medical schools. In addition, I would like to see the health humanities look beyond itself even more than it is currently doing, and having the courage to embrace more cross-disciplinary research—research that reaches out to the cognitive and psychological sciences.

And less of?

We have recently observed the so-called ‘replication crisis’ in psychology, the major methodological challenge of the failure of published experiments to yield the same results. As a relatively new but very broad field (and sticking my head above the parapet here) I think it is also fair to say that some scholarship within health humanities risks being reiterative and unsystematic. I think that is inevitable given the expansiveness of the research traditions that the health humanities encompasses. But to return to the theme that has perhaps run throughout my answers, my biggest concern across academe is what I will call the Nigel-Farage style underbelly to specialism. Distinctive academic specialism is (of course) deeply important within academia but I do worry that this can promote insularity, and even foster unenlightened

forms of academic jingoism (“I respect your right to have those views, but please stay over there!”). For example, as a philosopher of science by training, I do find it jarring when terms like ‘positivist’ and ‘reductionist’ are appropriated and misapplied, usually as epithets. On the flip side, nor am I advocating a sort of politically correct epistemic relativism—that anything goes. Perhaps the future would be brighter if academics (like doctors) also had a duty of candour—to admit what they do not know, and when they have made mistakes.

PROFESSOR ALLAN PETERKIN, HEALTH, ARTS AND HUMANITIES DIRECTOR, UNIVERSITY OF TORONTO How did you come to be involved and interested in the medical humanities?

My undergraduate degree was in French and English literature and I always wanted to be a writer. When I entered medicine I promised myself I was going to keep my love of reading and writing alive no matter what. It was a revelation when I discovered like-minded doctors (and other health practitioners) in the USA, UK and Canada. They reminded me (and did so repeatedly) that your avocation and vocation could actually become one!

You were one of the key people in setting up this journal (working with Deborah Kirklin), what are your memories of those early days?

Deborah is a terrific writer and a generous, rigorous editor. I was delighted when she invited me to become an Associate Editor of *Medical Humanities* some years back after she had published a couple of my pieces. I saw how she steadfastly expanded the list of writers, reviewers and readers over time (and worldwide). The journal is part of the glue that keeps us all together. I have been impressed how often you publish new voices, including students and young scholars.

What particular areas of medical humanities interest you and why?

I am very interested in patient narratives; inviting them to write and to tell their stories about illness, resilience and experiences with healthcare in their own words. I am passionate about recruiting patients to work with students as empowered educators and advocates, using those stories.

I am exploring how we can best cultivate reflective capacity in learners and practitioners across disciplines and how this skill fosters better self-care

alongside a more humanistic, patient-centred care.

I am fascinated by how close reading of literary, visual and cinematic texts facilitates interprofessional learning by levelling the playing field. We can all work with texts and stories and our entrenched titles/disciplines seem to give way to collective meaning making and problem solving.

Is medical humanities flourishing in Canada?

I am happy to say yes! Some colleagues and I just completed a survey of all 17 medical schools in this country and ALL now have both mandatory and elective offerings in the humanities and arts-based learning. Our annual conference CREATING SPACE (modelled after an *Association of Medical Humanities* meeting that was hosted by Professor Alan Bleakley in Cornwall some years back) will be in its seventh year this Spring and has pulled together a community of clinicians and educators across disciplines, alongside artists and performers. Our community of scholars and practitioners keeps growing and provides a home for new (and dissident!) voices. We engage artists and humanities scholars as equals to challenge the culture of medicine and we make sure we pay them for their time.

Who has been most influential on your career and why?

I have been lucky to learn and teach with Rita Charon and her group at Columbia University and with Alan Bleakley in the UK. I am a big fan of the work of Tess Jones, Audrey Shafer, Rebecca Garden and Delese Wear in the USA.

Various ‘Med-Literature’ list-servs (an online community to share messages and to facilitate discussion on a theme or topic) have been a lifeline for me over the years. You could post a question and always get generous, helpful, encouraging replies.

What areas do you think the medical humanities have neglected or overlooked?

As we develop the insights that the humanities can bring us, we should always ask how we can translate those insights into action. That means providing safe, humanistic patient care informed by social justice delivered within a democratic, accountable healthcare hierarchy. I am less interested in abstract, critical theory that does not invoke deep reflection or call for change.

What has been the biggest disappointment to you in your career in the medical humanities?

I am disappointed that we seem to have to prove ourselves over and over. In biomedical research, quantitative studies still prevail over qualitative and narrative-based inquiry. (A health humanities scholar once said to me—"nobody asks the bioethicists to keep justifying their existence! Why must we?") Health Humanities programmes the world over are vulnerable because they exist at the whim of the Deanery. We still see good programmes being dismantled over funding and politics.

Who have been your principal collaborators and how did you come to work together?

I have just edited a book called *Keeping Reflection Fresh* with Pamela Brett-MacLean which will be out from Kent State Press in September. We received inspiring submissions from top educators in Canada, the USA, the UK, Australia and Hong Kong about fostering creativity in clinical learners. Pamela and I cofounded our national humanities conference called *Creating Space* in 2010 and have had great discussions over the years about our work, creative aspirations and the obstacles we have sometimes faced promoting the humanities in a Canadian context. We had a great time working on this book.

Alan Bleakley and I have just adapted my book *Staying Human During Residency Training* for a UK audience (Taylor and Francis). Alan had asked me to speak at *Association of Medical Humanities* conferences in the UK over the years and he has given keynotes at *Creating Space*, so this has been an ongoing across—the pond dialogue/collaboration/friendship. We had been following the plight of UK junior doctors closely, so we felt the timing was right to advocate for their well-being and fair treatment. It has been fascinating to compare the UK and North American training models.

As a clinician, how does your work in the medical humanities inform your practice?

As a psychotherapist, story-telling informs every aspect of my work—that is probably why I chose psychiatry in the first place!

I helped create a therapeutic writing model for patients living with HIV and other chronic illnesses and have seen how encouraging narrative expression can activate healing and agency. Our patients

actually developed new identities as writers and story-tellers.

I consult to general practitioners when the therapeutic relationship (aka the story) gets blocked by discussing ways to practice narrative-based care. Diagnosis can actually be an antinarrative act. How can we open the story up rather than shutting it down?

How have you managed to fund your work in medical humanities?

The University of Toronto school funds me as Faculty Lead in undergraduate humanities and my own department, Psychiatry funds my work in postgraduate education, faculty development and liaison across the university. I have been fortunate that my Dean, Departmental Chair and the Head of my hospital psychiatric service value this work.

We have explored novel ways of funding some of our Artist-In-Residence Programs through pursuing provincial arts funding and private donors and sharing costs with other departments/colleges on campus.

Are you optimistic about the future of medical humanities?

Overall, yes. Narrative is being abbreviated everywhere in our culture and reflexivity curtailed by the immediate gratification offered by social media. This is the world we and our learners live in.

As long as we accompany patients in their suffering, help them make meaning of their experiences and swim in ambiguity, we will need the attributes that the medical humanities help to foster narrative competence and humility, reflective capacity, visual (non-verbal) literacy and critical thinking. We should also promote the wellness factor to those who doubt the value of our work: reflective practitioners take better care of their patients, but they also take better care of themselves and find more satisfaction in their work.

I should add that I was able to be promoted to full professor for this work based on really progressive promotion criteria at our university, called Creative Professional Activity. I encourage colleagues everywhere to lobby for similar streams so that they can be funded and advanced for their humanities work.

What is next for you in terms of work in the medical humanities?

I have enjoyed cowriting/coediting so much that I have two new book projects in the works. The first is a collection of comics drawn by medical trainees

worldwide (Penn State) about the treacherous process of becoming a doctor. This is with our Illustrator-in-Residence Shelley Wall. The other (with Dr Anna Skorzevska and being prepared for Oxford University Press) explores practical ways of keeping undergraduate humanities-based teaching alive within residency or foundation training because that is when complexity, ambiguity and professional challenges actually reach their peak for trainees.

For me, the ongoing enterprise will always be about building connections and community and nurturing the next generation of health humanities researchers, practitioners and educators. Succession planning is key. Our list-serv keeps growing and we are finding out about people doing tremendous work (sometimes in splendid isolation) on our own campus.

What advice would you give to an early years' researcher or scholar beginning their career in the medical humanities?

Find a mentor who shares your interests and knows about research funding agencies and opportunities. Learn rigorous approaches to qualitative research and inquiry informed by narrative and the arts. Only pursue questions that you are passionate about.

Attend medical humanities conferences and join web communities worldwide to broaden your perspective and form new collaborations. Create or join an inclusive community of clinicians, artists and medical humanities students and educators across disciplines. There comes a time when your collective voice cannot be ignored in your university! Creating a website, list-serv, literary journal and scheduling lunch and learns, journal clubs and rounds can help with that cohesion. Evaluate your offerings to demonstrate impact.

Observe which gaps need to be filled in your school's existing medical curriculum and offer to help address them with arts-based offerings. Review promotions criteria carefully and lobby for the inclusion of a category like Creative Professional Activity.

How do you see the relationship between the medical humanities and narrative medicine?

Medical humanities as a discipline concerns itself with the human side of medicine. Narrative (spoken, written, prayed, sung, painted, performed) is how we as human beings have always made meaning and coped with uncertainty. The best healers have always known this.

Scholar spotlight

Narrative medicine and literary studies can be seen as a core component of all of the medical humanities because they ground the other disciplines including philosophy, bioethics, film and art studies, medical history, theatre, graphic medicine and the growing arts for health movement (including expressive writing and art and music therapy).

What medical humanities paper or text has most inspired you and why?

Trisha Greenhalgh's and Brian Hurwitz's *Narrative-based Medicine* got me thinking about how stories are coconstructed by doctor and patient over time and how absolutely central they are to our work as physicians, regardless of specialty.

Rita Charon's *Narrative Medicine—Honoring The Stories of Illness* helped to explain how close reading and reflective

writing can be learnt, taught and practiced with students and colleagues.

Victoria Bates' and Alan Bleakley's *Medicine, The Health and the Arts—Approaches To The Medical Humanities* made me think about the critical humanities as a truly democratising force within health-care and reminded me that artists, arts-based therapists and humanities scholars must be partners in this process—not just well-intentioned doctors and other clinicians.

Finally, *The Virtues In Medical Practice* by Edmund Pellegrino is beautifully written and reminds us all that trust, compassion, prudence, justice, courage, temperance, and effacement of self-interest must always be cultivated in our work, no matter what our level of experience or erudition.

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