Bringing Home the Health Humanities: Narrative Humility, Structural Competency, and Engaged Pedagogy

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Abstract

As health humanities programs grow and thrive across the country, encouraging medical students to read, write, and become more reflective about their professional roles, educators must bring a sense of self-reflexivity to the discipline itself. In the health humanities, novels, patient histories, and pieces of reflective writing are often treated as architectural spaces or "homes" that one can enter and examine. Yet, narrative-based learning in health care settings does not always allow its participants to feel "at home"; when not taught with a critical attention to power and pedagogy, the health humanities can be unsettling and even dangerous. Educators can mitigate these risks by considering not only what they teach but also *how* they teach it.

In this essay, the authors present three pedagogical pillars that educators can use to invite learners to engage more fully, develop critical awareness of medical narratives, and feel "at home" in the health humanities. These pedagogical pillars are narrative humility (an awareness of one's prejudices, expectations, and frames of listening), structural competency (attention to sources of power and privilege), and engaged pedagogy (the protection of students' security and well-being). Incorporating these concepts into pedagogical practices can create safe and productive classroom spaces for all, including those most vulnerable and at risk of being "unhomed" by conventional hierarchies and oppressive social structures. This model then can be translated through a parallel process from classroom to clinic, such that empowered, engaged, and cared-for learners become empowering, engaging, and caring clinicians.

Novelist Iris Murdoch[1] once wrote that "a novel must be a house fit for free characters to live in." In the health humanities, novels, patient histories, and pieces of reflective writing are often treated as architectural spaces or "homes" that one can enter and examine. Yet, narrative-based learning does not always allow its participants to feel "at home." In fact, when not managed appropriately, such learning can be experienced as the very opposite: unsettling, disturbing, and even dangerous. Consider a patient with cancer in a writing group who tells of her childhood sexual abuse but does not have time to process the story or is not connected with support services. Picture a medical student in a humanities workshop who reveals her parents' undocumented immigration status and then deeply regrets her openness, fearing that she has put her family at risk of job discrimination, detention, or even deportation. Or imagine a physician who gets high praise in a writing workshop and goes on to publish a reflection about a patient without getting express permission from that individual or her family. In all of these cases, the health humanities can "unhome" the very participants it seeks to benefit.

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Acad Med. XXXX;XX:00–00.
First published online
doi: 10.1097/ACM.0000000000000743

About the Health Humanities

Up to this point, the health humanities—a term borrowed from the *Health Humanities Reader* to be more inclusive of health care fields outside of medicine[2]—have promoted the achievement of a critical consciousness,[3] compassion and empathy,[4–8] and alternative epistemologies.[7,9] Less attention, however, has been paid to the risks of this type of instruction. As Kumagai and Wear[3] claim, literature and the arts often "[portray] daily events, habits, practices, and people … in a way that disturbs and disrupts one's assumptions, perspectives, and ways of acting so that one sees the self, others, and the world anew." Although these disruptions can be beneficial, they also have the potential to make students feel uncomfortable and unsettled in their own views and values.

Shapiro and colleagues[4] briefly address this concern when they report that some of their medical students criticized health humanities programs because the reflection and personal engagement with the texts that humanities-based exercises promote can feel "excessively intimate and intrusive"; as the authors write, "the very 'softness' of the humanities can pose a threat to students by forcing them to examine their own vulnerability and uncertainty." This finding suggests that medical students closely associate the content and pedagogy of health humanities programs with their own identities and values, which they are repeatedly asked to contemplate and externalize by narration.[3–5,7–12] By giving students the opportunity to write or talk about painful personal experiences, and by exposing them to texts that might evoke distressing thoughts, health humanities educators put students at risk of being retraumatized by their disclosures, especially those who already feel vulnerable or marginalized.

Though there are dangers to doing narrative work in health professional schools and health care settings, educators should seek to mitigate these dangers rather than abandon this

training altogether, because the health humanities can present myriad benefits to students that outweigh the risks. Miller and colleagues[13] explain that medical students at Columbia University "report that narrative medicine seminars support complex interior, interpersonal, perceptual, and expressive capacities" and that they "frequently recognized the clinical salience of what they had undergone." Additionally, Kumagai and Wear[3] note that the health humanities may encourage a "reexamination of patient–physician relationships in terms of human interactions and provide health care professionals an opportunity—an 'open space'—to bear witness and engage with other individuals during challenging times." Also, Shapiro and colleagues[4] argue that "medical humanities have a significant *moral* function … to reconceptualize health care, through influencing students and practitioners to query their own attitudes and behaviors, while offering a nuanced and integrated perspective on the fundamental aspects of illness, suffering, and healing."

All of these benefits can and often do come at the expense of students' comfort: To query one's own attitudes, to develop complex interpersonal and expressive capacities, and to bear witness to others' pain can be quite distressing. However, it does not follow that educators should be unresponsive or oblivious to their students' negative feelings, or—despite recent controversies on trigger warnings—that they should censor conversations about violence or trauma in class. Rather, solicitude for students' comfort and well-being means acknowledging that each participant has her or his own specific life history, family context, and identity and that these realities have an impact on how students respond to any given text or exercise—sometimes even making it necessary for them to close a book or leave the room.[14] In fact, this is where pedagogy can play a significant role: Educators can turn discomfort, when it is experienced, into something productive rather than potentially harmful. As health humanities programs grow and thrive across the country, educators have a moral responsibility to create spaces of safety and security and to consider not only what they teach but also *how* they teach it.

The authors of this essay—three recent graduates and a faculty member from the Master's Program in Narrative Medicine at Columbia University—explored this very question of how to construct safe spaces within health humanities programs in a semester-long independent study, entitled *Embodied Borderlands: Diasporic Fiction and Narrative Medicine*. Our studies centered on the work of literary theorist Homi Bhabha, who asks in response to Murdoch's claims about the novel: "What kind of narrative can house unfree people? Is the novel also a house where the unhomely can live?"[15] Although Bhabha speaks primarily about the postcolonial experience—the forced or chosen movements of people across cultures and continents—we used his concept of the "unhomely" to critically examine literary and pedagogical spaces alike. Just as medical classrooms and clinic rooms are diverse spaces, so too are health humanities classrooms. In each of these spaces, it is important to attend to and destabilize traditional hierarchies that could otherwise silence or oppress those students who are most vulnerable or "othered" because of their race, gender, sexuality, nationality, and/or class. Drawing from texts written about and from the diaspora, we considered how literature might serve to make certain groups of marginalized readers feel more "at home" by presenting not a single canonical voice but a multiplicity of genres and perspectives. As we read and discussed these texts together, a model of "homely" pedagogy seemed to emerge. Each week, we drew on our individual voices, experiences, and backgrounds to construct an evolving syllabus that accommodated and built on the previous weeks' conversations. The architecture of the course was constructed neither from the top down nor from the bottom up but instead laterally among the four of us, students and teacher alike.

In this essay, we advocate translating this pedagogical model beyond the walls of our classroom to enhance the "homeliness" of health humanities education. We present three pedagogical pillars—narrative humility, structural competency, and engaged pedagogy—that educators can rely on to create safer and more productive classroom spaces that bring "home" the health humanities and allow its benefits to be fully realized. Although our focus is on teaching medical students, these points are just as applicable to teaching residents, senior clinicians, and patients.

Narrative Humility

Narrative humility in medicine suggests that clinicians and educators be aware of their own prejudices, expectations, and frames of listening.[16] DasGupta[16] adapts this term from Tervalon and Murray-García's[17] term *cultural humility*, which they recommend as an alternative to traditional approaches to cultural competency in medicine. Tervalon and Murray-García argue that medicine tends to reify culture into fixed facts, which encourages practitioners to approach cultural background as something they can completely understand. Instead, they suggest that practitioners acknowledge how their own backgrounds affect the ways in which they interpret the views and values of others. DasGupta further develops this concept to extend to all narratives, asserting that practitioners must humble themselves when they receive the narratives of their patients and recognize that those patients' backgrounds and identities cannot be easily reduced and understood:

> Narrative humility acknowledges that our patients' stories are not objects that we can comprehend or master, but rather dynamic entities that we can approach and engage with, while simultaneously remaining open to their ambiguity and contradiction, and engaging in constant self-evaluation and self-critique about issues such as our own role in the story, our expectations of the story, our responsibilities to the story, and our identifications with the story.[16]

Narrative humility, when applied to the health humanities, requires that educators not only treat the narratives of their students in a balanced, respectful manner but also that they reflect on their own power when eliciting such narratives. For example, if an educator teaches students who depend on her for their grade, she must work to ensure that they feel both safe sharing their reflective writing and comfortable opting *not* to share. She should consider beginning a writing session by asking students why they are taking the class, instead of immediately launching into her own agenda. Furthermore, she should ask herself whether her role is that of a didactic instructor or, as educator and philosopher Paulo Freire[18] would suggest, a co-learner. Considerations like these demonstrate how educators can influence the delicately balanced environment of the classroom and, consequently, the narratives of students.

Structural Competency

Structural competency in medicine is the notion that structural forces are just as important when making diagnoses and proposing treatments as are physiological determinants of disease. Metzl[19] coins this term to suggest that the "pathologies of social structures affect the material realities of people's lives"; thus, patients are susceptible to unique and diverse social conditions that lead to disparities in health and health care. Metzl and Hansen[20] develop structural competency to include the ability to discern not only how "food delivery systems, zoning laws, and … infrastructures" influence "symptoms, attitudes, or disease" but also how "assumptions embedded in language and attitude … serve as rhetorical social conduits for some groups of persons, and as barriers to others." Though the importance of attending to the legal and infrastructural determinants of health should not be understated, this section will focus on the latter half of this definition—that is, the notion that the rhetoric and culture of an individual institution can serve to empower some and disempower others.

If educators are to apply structural competency to the health humanities classroom, they must be mindful of which stories are usually told and heard in hospitals and health professional schools and which are silenced or marginalized. They might consider, for example, how a lesbian, gay, bisexual, transgender, or queer student's narrative would be heard by heterosexual colleagues, if at all. Likewise, educators should concern themselves with broader structural forces that could impact a student's ability to speak honestly in a workshop setting or that could subject her to harassment or differential treatment.

Structural competency in narrative work also implies sensitivity to the types of texts and writing exercises used with students. In a multisession course, educators should ensure that a diversity of voices vis-à-vis race, gender, ability, sexuality, and nationality is included in the syllabus. Alongside canonical mainstays, educators should also include less "privileged" genres, such as spoken word poetry, graphic novels, or oral history interviews. That way, a broader range of students may feel that their perspectives are welcomed and represented in the classroom.

Engaged Pedagogy

In *Teaching to Transgress: Education as the Practice of Freedom*, professor and feminist scholar bell hooks[18] draws on Freire's notion of *conscientization*, translated as critical awareness and engagement, to advocate an engaged pedagogy in the classroom.[21] In her words, "to teach in a manner that respects and cares for the souls of our students is essential if we are to provide the necessary conditions where learning can most deeply and intimately begin." Caring for the "souls" of health humanities students seems a tall, ephemeral order, but it has practical manifestations. In some classrooms, for example, students might feel an unspoken pressure to "bare all" in their writing, in effect rendering themselves both vulnerable and emotionally "comprehensible" to teachers and colleagues. Here, classroom safety is of vital importance. A writing exercise that asks students to describe a suffering patient might feel appropriate at the end of a 14-session class, but it could be overwhelming during a one-hour, single-session workshop with insufficient time to provide closure or establish a communal "safe space" among participants.

Another requirement of hooks'[21] engaged pedagogy is that the educator make herself vulnerable before her students to provide the proper environment in which they all may explore subjective, biased, and potentially emotional topics together:

> Professors who expect students to share confessional narratives but who are themselves unwilling to share are exercising power in a manner that could be coercive…. When professors bring narratives of their experiences into classroom discussions it eliminates the possibility that we can function as all-knowing, silent interrogators.

For example, during reflective writing exercises, educators should participate in the writing and occasionally offer to share what they have written with the class, so that students are not the only members of the group who are asked to divulge personal experiences. In addition, during this sharing, educators should invite feedback from their listeners, so that they are not the only sources of commentary on others' writing. By adhering to these practices, educators can allow the experience of vulnerability, when it does occur, to be multidirectional and shared amongst all rather than a task required only of students.

In Conclusion

Health humanities environments are spaces that can challenge and diversify participants' perspectives, allowing for the toleration of ambiguity and the destabilization of otherwise rigid hierarchies in clinical education and practice. However, if they are not facilitated appropriately and mindfully, these spaces can enact the self-same power hierarchies that the field ideally seeks to undercut. Health humanities educators have the opportunity as well as the responsibility to create safe environments for all who participate in narrative-based learning. By incorporating narrative humility, structural competency, and engaged pedagogy into health humanities classrooms, educators can establish a narrative practice that is personalized and conducive to self-care—a space in which students can make themselves "at home" within the health humanities.

Narrative education in health care requires deep attention, self-awareness, and thoughtful training. It demands an interdisciplinary team of teachers comprising not only clinical educators but also English professors, disability activists, philosophers, and cultural studies thinkers. The walls of the health humanities "home" should not be rigid but more akin to porous membranes, allowing the flow and exchange of myriad perspectives, ideas, and experiences. Educators should remember, however, that they are not the sole architects of this "home" but are mere guests, there at the invitation of their students and patients, all of them subjects and objects of a changing health care landscape. One can only hope to make this space more inviting by training the next generation of clinicians to be narratively humble, structurally competent, and engaged listeners to the stories of their future colleagues and patients. The pedagogy employed in health humanities environments then can be translated through a parallel process from classroom to clinic, generating more engaged health care in all our varied medical homes.

Acknowledgments: The authors wish to thank the anonymous reviewers and Joel Tsevat, MD, MPH, for their helpful comments.

Funding/Support: None reported.

Other disclosures: None reported.

Ethical approval: Reported as not applicable.

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