Medical Humanities (MH) is a broad area of academic and pedagogical pursuits that encompasses multiple and sometimes conflicting purposes. It refers both to a specialized field of rigorous scholarship and to practical educational interventions in the training of health professionals. It claims disciplinary fields as diverse as literature, visual and performing arts, history of medicine, and bioethics. Evans (2002) defined MH as "an integrated, interdisciplinary, philosophical approach to recording and interpreting human experiences of illness, disability, and medical intervention…" Some scholars in the field regard MH as an ill-defined, unsatisfying label (Campo, 2005), susceptible to sentimentality and vagueness, and inaccurately confounded with humanism (Polianski & Fangerau, 2011; Belling, 2005). Among clinicians, the term can provoke reactions of confusion or even contempt (Knight, 2006), yet they endorse many of its goals. These dissatisfactions may reflect the unresolved, and perhaps inherent, contradictions in the field.

In particular, MH continues to wrestle with a profoundly existential question: What are the goals and purposes of humanities and arts in medical and medical educational settings? Is the intention to challenge uncritical assumptions about the culture of medicine? Is the aim to make better doctors? How we answer such questions has major implications for defining the outcomes of training in MH and for determining how these outcomes should be measured (Kirklin, 2011).

Broderick (2011) usefully distinguishes among various goals of value to the diversity of stakeholders in arts and humanities practices in healthcare settings. Specifically, she observes that art therapists hope patients will achieve therapeutic insight

and relief in a safe space; service users (patients – and students) may focus on catharsis and community; physicians (and administrators) want evidence-based confirmation of positive clinical/educational outcomes; and artists look for creativity and aesthetic statements. To this may be added scholars' perceptions that the primary role of MH is to cultivate ways of thinking that instill skepticism and questioning of the dominant assumptions and beliefs about the world of medicine. These differing disciplinary and philosophical agendas and perspectives necessarily lead to contestation and disputation within the field. Below I consider one such debate in terms of acquiescence versus resistance; and how this frame does not adequately represent day-to-day pedagogical activities in MH.

## The Purposes of Humanities/Arts in Medicine and Medical Education

**Models of acquiescence.** For several years humanities scholars have expressed concern that MH has been subverted to support the goals and priorities of medicine, in the process significantly diminishing its most significant values and possibilities. Some protest that arts and humanities have been relegated to a benign and servile posture in relation to medicine (Macneill, 2001). Peterson, Bleakley, Bromer, & Marshall (2008) highlight the danger that MH may become "a tool of governance for the dominant culture." Dror (2011) contends that the introduction of the humanities into medicine has "medicalized" the humanities, thereby controlling and taming their potential contributions. Others warn of the ease with which the arts and the humanities can be co-opted into serving the utilitarian, perhaps even pacificatory, needs of the dominant medical power structure (Meade and Shaw, 2007) (i.e., the idea that exposure to the arts

in some way "mollifies" patients and students, making them more content, and therefore easier to manage).

I designate these concerns as describing a **model of acquiescence**, which in turn has two dimensions, "ornamental" (Greaves, 2001) and "instrumental." In its ornamental role, MH sometimes seems valued primarily for the enrichment and comfort it offers physicians (Friedman, 2002), with the implication that these are trivial and conciliatory goals. From this vantage point, MH is merely a way for burned-out medical students and physicians to relax, refresh, and perhaps acquire a patina of culture before returning to the trenches of clinical practice (MacNaughton, 2001). In this frame, MH has been drafted into the project of keeping medical practitioners patched together, so that they can continue to carry out the functions of the medical power structure.

Of particular alarm is that MH is seen as targeting instrumental ends valued by the dominant medical culture (Gillis, 2008); and that instead of being valued as an end in itself, it is only a means to ends determined by the medical establishment. In this view, MH is tolerated in medical education only if it can be used to produce excessively narrow skills, such as improved communication or empathy (Avrahami, 2011). As a result, MH ends up serving an "additive" function, compensating for the deficits of medical training (Greaves & Evans, 2000; Bishop, 2008). Stempsey writes scornfully (1999) about humanities courses that attempt, futilely in his view, "remedial humanization" of learners. The suspicion is that such repurposing of the humanities will result in support for the powerful medical status quo and manipulate both doctors and patients into roles of cooperation and compliance.

**Models of resistance.** Positing an alternative model, these scholars call for the arts and humanities to open a "discursive space" that critiques conventional assumptions about medicine and the healthcare system (Squier, 2007). Here, the emphasis is on critical conceptualization and analysis, reflexivity and reflective capacity (Bolton, 2004). The role of MH should be to "catalyze emancipatory insights" (Kester, 2004) and to create an environment of "sustained critical reflection" (Broderick, 2011). MH should not shore up the status quo in medicine, but instead should help learners question their own and more importantly the system's preconceptions and prejudgments (Kirklin, 2011) to make transparent the values, culture, and ideology of medicine (Dror, 2011). According to this view, MH should provoke discomfort and resistance in learners, and disrupt their conventional thinking (Belling, 2010; Wear, 2006). Still other scholars reject outright participation of the arts/humanities in healthcare, contending that the unequal power arrangements will inevitably smooth out the differences of the arts perspective in favor of the dominant viewpoint, and thus will diminish the potential subversiveness of arts/humanities (Beech, 2008). Similarly, O'Carroll (2009) laments that the medical perspective remains the "final arbiter of truth" in the healthcare setting, intimating that the overwhelming power of the established medical system inevitably will determine what is acceptable and valuable from the arts and literature.

**Deconstructing Arguments against the MH Model of Acquiescence**

The model of resistance advocated among many MH scholars is an exciting model that points to a radical transformation of medical culture and medical education that I have also endorsed (Shapiro, 2007). However, the pervasive calls in the literature for

supporting such activist goals, combined with a perhaps unintended condemnation of less militant projects risk doing a disservice to the multiple uses of MH in medical education. For this reason, it is worth considering the concerns expressed about the acquiescence model in some detail.

Regarding the charge of "ornamentalism," it is likely true that many medical school administrations regard MH as a nice but certainly not necessary adornment, perhaps a way of keeping students happy or at least mollified. It is similarly true that students sometimes endorse the relaxing and stress-reducing aspects of studying the humanities (Shapiro, Kasman, & Shafer 2006). But concern about the "mere" relaxation function of MH activities discounts what actually happens among teachers and learners in this context. It implies that reading a poem or gazing at a work of art in an environment of rigorous inquiry is the equivalent of jumping on an exercise bike for all the effect on the *person* of the reader or viewer it has. A different conceptualization suggests that with the proper pedagogical guidance exposure to medically-themed literature and art will encourage critical thinking, emotional engagement, and reflection, no matter how enjoyable or relaxing it is. It is perhaps even not unreasonable to argue that simply encouraging physicians to engage in the self-care that results from relaxation might be considered a subversive act, as despite the voluminous professional literature on burn-out, there is still painfully little attention to the supporting the *actual* wellbeing of physicians and student-physicians in the clinical setting.

The instrumental argument against current MH practices is more complex and worrisome. According to this line of thinking, MH has been destabilized to support

outcomes desired by the dominant medical power to maintain systemic order and control. Specifically, scholars have noted that apparently beneficial qualities such as empathy, the ability to engender trust, and good communication skills can be employed to encourage docility and compliance in less powerful individuals (i.e., patients). This is no doubt true, and provides a critical caveat to simplistic acceptance of such constructs. But any pedagogically-motivated exposure to MH – and indeed to any educational intervention – is designed to produce *some* sort of outcome. In other words, there has to be an effect resulting from any educational activity such that the learner is changed or influenced in some desired way. Otherwise, we would judge the intervention to be inefficacious. Along these lines, Slouka (2009) does not hesitate to use the highly mechanistic metaphor of a delivery system when he argues that instruction in the humanities promotes democratic values. Similarly, Macneill (2011) acknowledges that discovery, controversy, and debate about .the meaning and implications of a particular work of art are all instrumental outcomes. The study of MH purely as an end in itself surely would seem solipsistic.

**The outcome of empathy.** While scholars sometimes criticize the pursuit of empathy outcomes through MH as excessively soft and subjective (Smajdor, Stockle, & Salter, 2011) or excessively reductive and mechanistic, they seem more comfortable putting forth the claim that studying the humanities will advance capacities for critical thinking (CT). CT is an appealing end because it is a purely cognitive process that seems "hard" and rigorous in a fight for territory dominated by the sciences. CT doesn't lead to any one understanding or conclusion; rather, it is an intellectual process based on close observation, reflection, and reasoning that questions received wisdom and promotes a

position of skepticism toward conventional attitudes and assumptions. However, in fact CT is as much an outcome in the study of MH as empathy, and despite protestations empathy may well be as desirable and necessary a quality in the practice of medicine as critical thinking.

I would argue that empathy is not a fixed trait or a set of replicable behaviors, any more than is CT, but rather is an ongoing, dynamic process of positioning oneself intellectually *and emotionally* in relation to others. Jones (2007) writes that the rationale for MH is to provide essential interpretive skills for medical students, such as listening more discerningly, appreciating multiple perspectives and meanings, and tolerating diverse, ambiguous, and contradictory responses. What are such skills if not manifestations of empathy?

When scholars talk about "producing" empathy, or point out how empathy can be subverted into manipulation of less powerful, vulnerable patients, or caution that empathy can appropriate the patient's voice or support the dominant power structure (Garden, 2010, 2007), empathy sounds like a dangerous instrument of oppression.. True, these critiques offer valid, indeed essential refinements that serve to qualify our conceptions of empathy; and in fact represent an excellent application of CT to a construct that is widely and uncritically endorsed in medical education.

But let's take a step back. Are we really arguing that empathy (or caring, or compassion) is undesirable to encourage, foster, and cultivate in relation to patient care? Rees (2010) radically and provocatively proposes an ethic of "caring for nothing," instead of the conventional assumption in medicine of "caring for persons." But is this actually

what we want to advocate in the clinical context? Clinical medicine concerns not abstract philosophy, but the real suffering of real people. I would hazard a guess that regardless of theoretical debates about ultimate meaninglessness, patients want physicians who provide care from a deeply empathic perspective.

Further, it is rare in my view that an MH approach can be distorted into widget-like, assembly-line production of "empathic" physicians. While strictly behavioral models of empathy, compassion, and communication are rightly criticized for their superficiality, performative emphasis, and lack of internalization (Shapiro, 2008; Wear & Zarconi, 2007; Hanna & Finns, 2006), in my experience this is *not* what happens when empathy is discussed as part of reading a poem by Rafael Campo (Shapiro, 2011), gazing at Millet's The Gleaners (Stein, 2003) or participating in a reading of Wit (Lorenz, Steckart, & Rosenfeld, 2004). Such texts and artwork are too complex, too open to multiple interpretations, too ambiguous to "produce" any set conclusions. As Kirklin (2011) points out, it is poor teaching that leads to unitary, predefined conclusions about MH texts and performative processes, not the texts or processes themselves.

Empathy, kindness, compassion, like CT, can be considered habits of mind. But because medicine is a practice profession, a mere attitude of empathy (or for that matter, a mere capacity for critical thinking) is insufficient. As Gardner (2007) and others have observed, empathy must lead to action, the intent of which is to reduce the suffering of others. Brody (2009) reminds us that the ultimate goal of MH is to make a difference in the world of practice, to assist in the moral development of medical practitioners so that they will be guided by wisdom and virtue. Just as CT does not lead to one predictable line

of conduct, neither does empathy. Capacities of empathy, critical thinking, self- and other-awareness might indeed all be used to bolster the medical status quo, but they might equally be used to challenge and change it. A true attitude of empathy, derived from reflective processes leading to heightened self and other awareness, may result in diverse outcomes ranging from a small gesture of kindness to agitating for single payer healthcare.

## Boots-on-the-Ground Reports in Relation to the Medical Humanities Debate

This special issue of JLTA is not a philosophical or theoretical presentation of medical humanities. Rather, it offers boots-on-the-ground reports, far from the academy's debates, of initiatives, programs, and experiments in MH. The editors encouraged thick description of activities and curriculum, as we hope readers will wish to duplicate/modify one or more of these projects to assess their value and efficacy in their own institutional settings. Although the articles speak for themselves, a few points are worth highlighting, as they suggest that the acquiescence/resistance frame is inadequate to represent what actually transpires on a daily basis in MH teaching.

**Interdisciplinarity in MH work.** First, by way of context, is the overwhelmingly interdisciplinary and interprofessional nature of this collection as a whole. The authors include academic physicians (especially family and emergency medicine doctors) and nurses, medical students, professors of English, social work, and education, scholars with background in the history of medicine, cultural studies, and medical humanities, an ethicist, a museum curator, even a writer/storyteller. The target audience for their courses and programs are variously medical, dental, and nursing students, medical school faculty,

medical residents, design/art students, and premedical and pre-health professional undergraduate students, sometimes in disciplinary groupings, sometimes in interprofessional combination. This diversity supports the proposition that MH is inarguably an interdisciplinary endeavor, not conducted or owned exclusively by any one discipline, but rather emerging organically (yet inevitably with some tension) through the collaboration (and perhaps at times contestation) of various disciplines coming together to work toward a common purpose. This essential interdisciplinarity of MH (Wear, 2009) underscores that the field cannot be dominated by a single perspective or understanding.

Related to this interdisciplinarity is the multiplicity of literary, visual, and performing arts utilized. These include reading poetry, short stories, and first person essays; reflective writing and story work; video; Theater of the Oppressed and Forum Theater, as well as theater games and exercises; viewing museum artwork and actual learner drawing; as well as mixed media educational interventions. This diversity demonstrates the elasticity of the MH term, but also suggests the challenge of discussing its theoretical underpinnings in any cohesive, unitary sense when it draws so broadly on such a range of arts. One common threat that seems to unite this disparate list is that the approaches of the authors, no matter the specific medium employed, tend to emphasize participatory involvement and stimulate links to practical doing.

**“Resistant” goals and outcomes.** In light of the above discussion, it is worthwhile to contemplate the goals that the authors hope to achieve through their curricula, programs, and projects in terms of the resistant/acquiescent dimension and the actual outcomes reported. Some of the projects described I would categorize as explicitly

subversive, in the sense of directly confronting and challenging the dominant status quo. For example, we find a resistant focus in the video project of Mahajan (2012), which highlights the limits and abuses of medical education, suggesting these can lead to student depression and, at the most extreme, suicide. This report tackles the medical education establishment by challenging its compassion and humanity, and by portraying how its relentless pressures on students, such as workload and social isolation, can oppress and demoralize them. It criticizes the distance between faculty and students, noting that the former are often detached and oblivious to student suffering. Like the Auerbach & Baruch article (2012), Mahajan pays special attention to the aesthetic features of his film, thus positioning it as art rather than didactic polemic. Yet this stringent critique of medical education is embraced by the students and faculty who attend a showing of the video, and who apparently are not threatened by its subversive subtext.

Love's (2012) incorporation of Theater of the Oppressed (TO), the origins of which lie in confronting social injustice in South America in the 1970s, interrogates issues of power and hierarchy in healthcare practices. In particular, she highlights power inequalities in patient care and nursing education. The TO approach emphasizes empowerment of oppressed groups through active engagement in role-play to explore where different actions lead in response to situations of ethical conflict, hierarchical power, and horizontal violence. It is explicitly designed as a revolutionary strategy with pragmatic outcomes. Love describes how TO methods can make nursing students more aware of how power operates in health care settings and assist them in developing ways

of being better advocates for their patients and themselves. She concludes that TO is indeed a promising strategy for shifting both perceptions and actions.

The Whiting, Wear, Aultman, & Zupp article (2012) reports the effects on physician faculty facilitators of a curricular initiative that encouraged students to interrogate personal/professional issues and develop critical awareness of the socialization pressures involved in becoming a doctor through selected readings and reflective writing. This article too reflects a "resistant" position in the sense that it highlights profound gaps in the experiences of these teachers that are not being met through standard teaching. Just as the concept of relationship-centered care (Beach & Inui, 2005) addressed a critical omission in patient-centered care theory that ignored the person of the physician, so the Whiting et al. article recognizes that medical educators also have needs, desires, and priorities that must be met for effective teaching to occur, including learning new ways of thinking and perceiving and feeling. Faculty report they return year after year to the course because it nurtures critical sides of who they are as professionals and as people.

The article by Auerbach & Baruch (2012) can also be conceptualized as subversive, if only indirectly, because it identifies as its primary goal the development of creativity (Broderick, 2011), noting that "If [other] worthy outcomes [sensitivity, empathy, professionalism] were achieved, they were welcome side effects rather than primary objectives." This view may be interpreted as a refutation of the instrumental goal of "producing" better physicians as, despite some intriguing arguments linking creativity to excellent physician practice (Ness, 2011), the construct is nowhere mentioned in

medical education professional organizations as a necessary or desired competency. More radically still, the article embodies Peterkin's argument (2008) that the humanities can help physicians pay attention to the aesthetic dimension of medicine, what makes their work "beautiful," and learn to value and cultivate this aspect of practice.

Through a dialogue between storyteller and (now) family physician, Clarke & de Jong (2012) explore the relevance of narrative and story work for healthcare and the development of the physician. The authors describe their experiment as explicitly "countercultural," challenging the norms and assumptions of mainstream healthcare and medicine, including the conventions of clinical discourse. What starts out as the simple research project of a medical student has profound and far-reaching effects on both teacher and student. In particular, story work applied in the palliative care setting challenged typical student-physician beliefs about expertise, acknowledging terminally ill patients and their caregivers as the authority on their dying. The physician-author also developed more nuanced, fluid thinking about concepts such as empathy and communication, as well as how to process emotions that arise in response to difficult clinical situations; which has allowed her to carry story work into her current clinical practice.

**"Acquiescent" goals and outcomes.** Other articles in this collection seem at first glance more "acquiescent" and benign, according to the definition offered above. The stated intention of most of the curricular initiatives in this grouping is an instrumental one, i.e. to build or expand on widely endorsed clinical skills and attitudes. These articles might be interpreted as usurping MH content to uncritically support medicine's

predetermined ends. For example, Winter's (2012) multimedia approach is designed to help family medicine residents learn techniques of clinical reasoning across the developmental spectrum and to grasp what it means to care for patients within the context of family. Yet, in addition to the goals of the teacher, residents engaged with the humanities material not only on a cognitive, knowledge level but also on a personal/process level, relating the official learning to their lived experience. Poetry, film, and music led participants to new insights and deeper understanding. Thus the benignity of MH functioning in a purely conventional role may be harder to achieve than is sometimes supposed.

Brett-MacLean, Yiu, & Farooq's use of Forum Theater (2012) describes a project aimed at helping students understand professionalism, another well-established objective in medical education, in the context of small group learning. Their project uses a historically radical method (an aspect of Boal's Theater of the Oppressed) for a relatively anodyne end (encouraging students to be more mature and professional in their classroom behavior). Yet the method itself empowers learners, transforming them from passive recipients of knowledge into active players and co-creators of knowledge. Further, the implications of "storming" or challenging accepted norms and dynamics is explored in the exercise; and the script itself portrays lack of professionalism not only in students but in the faculty small group facilitator. As Brett-MacLean et al. state, "The overall process is intended to be dialogical, rather than didactic." The process of this teaching challenges both normative models still prevalent in much of medical education, as well as in the traditional patient-doctor relationship.

The Jacques et al. article (2012) is explicit in its desire to provide skills that will make students better doctors, and states overtly that the method of cooperative critical thinking promulgated by the ODIP (Observe, Describe, Interpret, Prove) model is "inherent in medical practice." In this sense, the goals of the project apparently are to "use" art in the service of the ends of medicine, in this case honing the sort of CT necessary in differential diagnosis. Indeed, the word "prove" as part of the acronym raises the specter of reductive assessment of right and wrong interpretations of what students see. But here as well, reflections on paintings lead to some unexpected interactions. For example, students are asked through the paintings they observe to answer questions such as "What does empathy look like?" This sort of open-ended question will not tend to result in simplistic, behavioral definitions of empathy. Further, the program stresses questions without right or wrong answers, creative thinking, personal observation, interpretation, and growth. These "outcomes" are equally embraced by the authors in conjunction with the teaching of critical thinking, thus rejecting in their approach the art/science dichotomy (Davis & Morris, 2008). Acquiescence and resistance are irretrievably, and beneficially, blurred.

Another family physician, Susan Arjmand (2012), adapts literature to develop cultural awareness and sensitivity in learners through narrative competence (Charon, 2006), an approach that has been challenged in the academy as running the risk of inadvertently promoting otherness and marginalizing certain patients (Hooker & Noonan, 2011). But what emerges in the application of Arjmand's work is not evidence of cultural stereotyping and otherness, but rather appreciation for patient stories, critical analysis of

assumptions and judgment, awareness of how multiple perspectives operate in the clinical context, and insights into how medicine itself functions as a culture with its own foundational assumptions, rituals, and preconceived notions. A fairly conventional, nonradical approach again "produces" the kinds of outcomes endorsed by resistant models of MH education.

Another group of authors pursues the "instrumental" but unexceptionable goal of developing empathy in learners. Reilly, Trial, Piver, and Schaff's article (2012) is a prime example of the kind of targeted objective criticized in the literature (Osmond et al. and Jacques et al. also note empathy as a desired outcome), yet here too things do not go completely as expected. While faculty and actors were enthusiastic about the effects of this educational intervention, students were more reserved, suggesting that developmental and perspectival differences may influence the perceived nature of an educational experience. The findings of these educators intimates that empathy is not easily "produced" through exposure to MH; and that in an educational intervention, various possible outcomes are continually being contested and examined. One hopes that in future sessions, the various stakeholders can share directly their differing perceptions of the experience, and how these complicate the construct of empathy.

Silk & Shields (2012), also family physicians, use a multimedia approach incorporating readings, reflective writing, story work, artwork, and didactic sessions to give family medicine residents and students skills to diminish burn-out and engage in meaning-making with their patients through appreciation of patient stories. These goals might fall under the acquiescent categories of both "ornamentation," because of their

emphasis on promoting physician wellbeing; and "remediation," because of the program's intention to encourage humanistic attitudes. The authors find that, through exposure to poetry and literature, learners discover that there is no one algorithmic way to break bad news; they develop respect for perspectives that differ from their own; and they realize that difficult clinical situations will trigger powerful and complicated emotions in physicians that deserve attention and critical analysis. These outcomes all call into question dominant ways of approaching these issues within medical training and praxis, and suggest more expanded ways of thinking than merely plugging behavioral deficits.

Osmond et al's article (2012), using the intriguing format of an open letter to learners, sets forth course goals for pre-health professional undergraduate students that also could be defined as humanistic remediation, with the aim of filling in existing gaps in standard health professions education. The letter promises incoming undergraduates that their course will foster "empathy, discernment, insight, wisdom, emotional and spiritual strength, and concern for others". While this work appears to grow out of a deficit model, it equally describes a process of critical thinking and a more nuanced, more compassionate, and more questioning way of being in the medical world that, in its execution, may well create different relationships with patients and different understandings of the healthcare system.

## Concluding Thoughts

The articles represented in this issue can easily be positioned on a continuum of resistant to acquiescent, and it is relevant to note that the more theoretically "resistant" projects also tend to involve humanities and nursing scholars and to target more

interprofessional groups (the video project of Pranav Mahajan, a medical student, is an exception), while more “acquiescent” projects are instigated more by physicians (the Osmond et al. course, coming out of English literature and education backgrounds, and directed toward a range of pre-health professional students, is an exception). However, when we look at the *effects,* or outcomes, of these various endeavors, the distinction between models fades. Resistant projects emerging from more radical philosophical positions have not singlehandedly shifted the cultures of their home institutions. Indeed, a case might be made for the more “conventional” work of Silk and Shield having the most pervasive institutional effect. “Acquiescent” projects, on the other hand, provide no indication that their work has produced behavioral, mechanistic skills that learners will employ robotically to perpetuate the assumptions and values of the dominant power hierarchy.

Instead, regardless of philosophical position, we see outcomes that are very similar – learners who develop their capacity for critical thinking and analysis, perspective taking, empathy for those unlike themselves, awareness and understanding of their own emotional lives, and tolerance of ambiguity and uncertainty. Most of the articles in this collection emphasize links to practice. But the links are not reductive and unitary. Rather, authors urge learners to think broadly and creatively about what the arts and literature are teaching them when translated to patient care. TO and Forum Theater in particular demand exploration of multiple action options, with emphasis not on finding the “right” response, but in discovering where different attitudes and behaviors lead.

This is not to say that there is no difference between the models themselves. Indeed, I would argue that the different approaches to the medical humanities, and the different perspectives and worldviews of the faculty teaching MH, have much to learn from each other. Notably, humanities scholars offer a contextual challenge to existing verities; while clinicians help us not lose sight of the pragmatic, practice focus of medicine, the importance of cultivating ways of being that reduce suffering and benefit vulnerable others.

It is possible to conclude that, regardless of theoretical intent, the very use of MH in medical education is by definition subversive. Even among scholars most concerned about the cooptation of the arts and MH, there is the recognition that simply by their existence in medical settings, "arts practices represent a challenge to prevailing clinical orthodoxy" (Broderick, 2011). One qualitative study in progress (di Teodoro, personal communication 2011) reports that students at one U.S. medical school generally had little or no understanding of how the humanities might be relevant in any way to their education. If this is typical of a larger number of medical students, then simply reading a poem as part of their learning becomes a radical act.

It may be harder to co-opt the medical humanities than humanities scholars fear. At the risk of permanently alienating these colleagues, I would actually like to see the evidence that teaching involving humanities and arts "produces" mechanistic communication skills and superficial empathic behaviors, or that it serves as a pleasant but largely irrelevant break from "real" medical learning, or that it reinforces inequities and injustices within medicine.

Art by itself does not create an effect, rather it is the pedagogical spirit with which the art is approached (Stein, 2003). In reading any complex text, or regarding a multifaceted painting, which teacher dismisses a student's alternative insights simply because they disagree with those of the instructor? It requires very bad teaching indeed such that exposure to source material in the humanities and arts results in manipulation of learners toward superficial predetermined conclusions and outcomes (Macneill, 2011). Of course, what teacher does not have biases and a specific intent in teaching? To claim otherwise is disingenuous. The solution is not to pretend to neutrality, but rather to be as self-aware and transparent as possible with learners about one's background, assumptions, and perspective. Further, the lessons that a particular work of literature or art has to impart are not endless. Not every interpretation is equal to every other interpretation. The process of explicating and justifying one's understanding and insight is what contributes to the rigor of the humanities.

None of the above discussion and analysis is meant to dismiss or invalidate the ongoing conversation about the goals and purposes of MH. My conviction is that abstract understanding and pragmatic teaching both are enhanced and enriched by presentation of various positions along the resistant/acquiescent continuum. My plea is only to consider that often, whatever the philosophical position of the instructor, the effects of MH teaching inevitably contain an element of contestation and questioning. Does the extent of this effect vary from course to course, setting to setting, learners and teachers? Absolutely, and this may not be such a bad thing. In fact, we have very little information yet on the "best" way to approach MH teaching. There is room for both radical and

benign approaches. As in any practice profession, the ultimate answer is found in "what works." Learners who have absorbed skills of both critical thinking in regard to the systems in which they work and compassionate solidarity (Coulehan, 2009) with patients, families, staff, and colleagues are the kinds of future health professionals we need.

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