

Piloting an Undergraduate Survey Course in Medical Humanities and Social Medicine: Lessons, Tradeoffs, and Institutional Context

By Eileen P. Anderson-Fye, EdD,
Julia Knopes, PhD (cand.), MA, and Hillary Villarreal, MA

Undergraduate course offerings in health humanities and social medicine in the United States have increased dramatically in recent years, with one report finding that the number of programs had more than quadrupled since 2000.¹ As of December 2016, 58 baccalaureate programs could be found at campuses across the country, with more in development.¹ Although the programs share many common elements, they can vary widely in emphasis and structure. As the December 2017 special issue of the *Journal of Medical Humanities* demonstrates, many of these undergraduate programs have become more inclusive of a wide array of disciplinary perspectives on medicine and human health.^{2,3} Some focus more on humanities, some more on society, and still others prioritize philosophy, ethics, and/or culture. Curricula also differ; for example, just over one-third of the undergraduate programs offer an introductory survey course providing a higher-level

overview across fields, while others encourage students to begin taking courses within their particular areas of interest from the very start. At Case Western Reserve University (CWRU), we launched a survey course specifically to assess the benefits and drawbacks of this choice at our own institution. Thanks largely to the deep engagement of students in the class, as well as their thoughtful candor afterwards, the lessons drawn from this direct experience exceeded our expectations in myriad ways. In this article, we [\[a\]](#) share details of our preliminary survey course and its context; observations about strengths and opportunities for improvement; and reflections regarding the teaching of health humanities and social medicine to undergraduates in pre-health, and in other fields that are not necessarily pre-clinical. As these subjects continue to inspire rapidly-growing enthusiasm across higher education, we hope this article helps advance

our collective understanding of effective ways to realize the opportunities now before us.

Our Institutional Context

Based in Cleveland, Ohio, CWRU enrolls more than 11,000 students, including approximately 5,100 undergraduates. The top four majors in Fall 2016, based on student enrollment, were: Biomedical Engineering, Mechanical Engineering, Nursing, and Biology. The institution is well known for its health-related programs, which include multiple degree programs in medicine, dental medicine, nursing, and social work, as well as a concentration for juris doctor students within the nation's first health-law program.

We have built on these strengths in recent years by expanding our undergraduate and graduate offerings in medical and health humanities, and social medicine. As a part of campus initiatives designed to gauge interest in interdisciplinary programming across these areas, we began a university-wide medical humanities and social medicine reading group in 2014. This monthly gathering drew strong and regular participation among faculty, graduate and professional students, and undergraduates. The group continues to meet today, and also serves formally as the Medicine, Society and Culture Seminar. In 2015, the School of Medicine initiated a humanities pathway for MD students led by a member of our initiative's advisory group; the following year, we launched the Medicine, Society and Culture concentration within the Bioethics and Medical Humanities MA degree (case.edu/medicine/msc). In 2017, the university's Board of Trustees approved an undergraduate minor in Bioethics and Medical Humanities. The minor emerged from student-led efforts and responds to their

increasing demands for curricular programming that spans ethics, humanities, and social science training.

Our programming at CWRU reflects the synergistic relationships among the fields of bioethics, health humanities, and social medicine. Each of these fields is concerned with identifying and analyzing hidden assumptions regarding health, healing, and illness, as well as their conflicts at individual and structural levels. Bioethics also moves toward resolution of value conflicts, often employing perspectives from medical humanities and social sciences. Topics of interest in health humanities and social medicine almost always have related ethical concerns. As a result, even our earliest efforts to join these fields in explicit interdisciplinary ways has inspired significant interest and enthusiasm—with regard to both programming and scholarship. This new undergraduate minor is offered through the medical school's highly interdisciplinary bioethics department, and includes electives from around the university.

When developing the focal survey pilot course, we examined practices at other colleges and universities, within the field of health humanities and outside of it. We concluded that, as with many curricular choices, offering multi-disciplinary survey courses related to health humanities requires tradeoffs. Among the courses' strongest benefits are opportunities to identify and distinguish among various disciplinary perspectives that come to bear upon the field. Students in survey classes receive wide exposure to multiple types of epistemologies, theories, methods, data, literature and experiences. As a result, they often better understand which approaches to apply to address different sorts of questions. Nevertheless, survey courses by their very nature involve broad examinations of different disciplines. Even when classes include attention to distinct approaches and

ways of thinking, students do not explore any in particular depth. The other primary drawback of such a course is that students can experience a sense of disjointedness in their learning as they traverse sometimes-divergent concepts. These findings led us to make disciplinary integration a key goal of the pilot course.

Medical Humanities and Related Fields

As the survey course was being designed and implemented, it was especially important for the teaching team to consider the ways in which multiple disciplines intersect, and to choose terminology that would communicate to students the relatedness of disciplinary perspectives. “Medical humanities” itself is an interdisciplinary field that studies medicine and health through literature, history, ethics, philosophy, religion, anthropology, and other approaches.^{4,5} Medical humanities scholars examine “cultural and historical contexts, emotional and existential dimensions, and literary and artistic representations” of human health, sickness and related practice.⁶ The medical humanities are not viewed as opposed to bioscientific understandings of illness, disease, and human biology, but rather encourage study that incorporates clinical concepts of health and disease alongside humanistic analyses of them. Medical humanities scholars seek to illustrate how health can be impacted by the social, cultural, historical, and personal contexts in which people become ill and caregivers seek to heal them. Advocates for the teaching of medical humanities to future healthcare providers consider the topic integral to the practice of scientific medicine.^{7,8} In essence, they argue, it is impossible to understand how these multiple dimensions intersect

and interact without exploring perspectives that span traditional disciplinary boundaries.

In describing this interdisciplinary area of research and practice, some scholars have alternatively adopted the term “health humanities” rather than “medical humanities” to indicate that humanistic approaches to health must attend to all dimensions of human well-being and the promotion of wellness, rather than focusing on pathological states and professional medical systems’ treatment of them.⁹⁻¹² Health humanities is also more inclusive of allied health fields and all participants in healthcare, including patients.⁹ In our case, due to the strong regional and institutional identification with medical institutions and the programming’s location in a school of medicine, “medical humanities” was the institutionally preferred term at this time.

Both medical and health humanities are usually inclusive of medical social sciences such as medical anthropology. However, some medical social scientists employ the term “social medicine” to refer more specifically to the study of the relationship among human behavior, community practices, structural inequalities, and health.^{13,14} Social medicine is not necessarily distinct from the medical humanities. First, both overlap with bioethics and clinical ethics, narrative medicine, and the history of medicine. Second, each also seeks to describe how human behaviors, beliefs, and practices influence and are influenced by health and medicine. Given this terminological scope and in the context of CWRU’s unique culture and history, we chose to use tandem terms in the survey course and in this article. For our purposes, “medical humanities” refers to humanities-based approaches to health and medicine such as literature, history, art and art history, ethics, and philosophy. “Social medicine,” meanwhile, involves

social sciences including medical anthropology, sociology, psychology, neuroscience, economics, and health policy.

In sum, *medical and health humanities* and *social medicine* are terms that widely encompass approaches to the study of illness and human health outside of, but aligned with, the biosciences. We used the terms to let prospective students know that the survey course would include disciplinary approaches to health across the humanities and social sciences alike. We use these terms more interchangeably in this article.

Pedagogy in Medical Humanities

Existing literature on medical humanities and social medicine pedagogy centers largely on two areas. First are articles on pedagogy and course design of single-discipline courses in medical humanities. These include courses on literature and medicine, medical anthropology, the history of medicine, and medicine within the visual arts.¹⁵⁻²² Second, substantial literature exists regarding cross-disciplinary medical humanities training at the post-baccalaureate level, most commonly within medical education.²³⁻²⁵ These areas of scholarship demonstrate the value and position of perspectives on medicine that extend beyond the biosciences. However, we found limited literature on the nature and content of medical humanities and social medicine coursework for undergraduate baccalaureate students. The literature that does exist often focuses on pre-medical and pre-health professional students—a fact that Jones, Lamb, and Berry similarly observe (2017).^{3,26,27} Our class emphasized interdisciplinarity among a cohort of baccalaureate students pursuing a broad, expansive

range of majors, including the sciences, social sciences, and humanities.

Most commonly, “undergraduate” is used in medical humanities literature to refer to medical students in the first four years of training; current research on “undergraduate medical humanities” educational programs typically refers to coursework in medical humanities and social medicine for physicians-in-training.

This article expands pedagogical scholarship on medical humanities by synthesizing the medical humanities and medical social sciences in one baccalaureate-level (which we refer to also as “undergraduate” level, reflecting common US academic terminology) survey course.

We also suggest new directions for future offerings of this course based on students’ feedback. These reflections may be especially helpful for fellow educators to consider in an age of rapid growth in the number of undergraduate major, minor, and certificate programs in the medical and health humanities across the US. Further, this article explores the interests of undergraduate students preparing for a diverse range of pre-health studies as well as those seeking degrees in engineering, social sciences, and the humanities.

Our Research Findings. The recent report by Berry, Lamb, and Jones (2016) has documented rapid growth of baccalaureate medical health humanities programs in the US, and has inspired new national conversations on the topic.¹ Using this report as a starting point, we reviewed the pedagogical content of the 58 known undergraduate medical humanities programs in the US by examining each program’s website. These programs include majors, minors, and concentrations. For the purposes of this article we focus on: (1) whether the

curriculum focused on health humanities, social medicine, or bioethics, and (2) whether survey courses were offered to students.

Of the 58 programs, approximately 38 percent ($n=22$) offered curricula that emphasized both medical humanities and social medicine, but not medical ethics. Of the 58 programs, 22 percent ($n=13$) appeared to emphasize medical humanities, social medicine, and bioethics curricula together. Nearly 14 percent ($n=8$) emphasized medical humanities, and 10 percent ($n=6$) offered curricula focused on social medicine disciplines. About 9 percent ($n=5$) of the programs concentrated on medical humanities along with bioethics, and 5 percent ($n=3$) focused on both social medicine and bioethics. Only one of these identified programs focused solely on bioethics.[\[b\]](#)

Eight of these programs did not have enough information listed on their websites to determine whether they offered survey courses. Of the remaining 50 programs, approximately 38 percent ($n=19$) offered a survey course. The disciplines studied varied; some spanned the humanities and social sciences, while others focused on only one of the two. The focus of the survey courses usually correlated with the overall emphasis of the program's curriculum. A few programs had more than one survey course. For example, one program offered separate survey courses for disciplines in the medical humanities and social sciences.[\[c\]](#) Most of the programs that had a survey course required it to be taken, although suggested timelines differed. Many of the medical humanities programs suggested or required that the course be taken as a prerequisite, while several considered the survey course to be a part of upper-level undergraduate education. Lastly, of these 58 programs, approximately 20 percent ($n=12$) require students to take a bioethics course in addition to one or more survey courses.

Design and Description of the Survey Course

The development of the pilot of CWRU's baccalaureate-level survey course, *Perspectives on Health: Introduction to Medical Humanities and Social Medicine*, benefitted enormously from the institution's history of strengths in medicine. Over the years, this aspect of the university's identity has drawn scholars in humanities and social science fields whose work relates to health, illness, and/or the delivery of care. Not surprisingly, many of these faculty members served on the university's Medical Humanities and Social Medicine (MHSM) advisory committee. Because these professors already had engaged for years in the development of the MHSM initiative, they readily agreed to serve as guest lecturers for the survey class. In addition, the university hosts one of the nation's foremost museums of medical history (the Dittrick Center for Medical History), has a longstanding partnership with a world-renowned art museum (The Cleveland Museum of Art), and also has a growing relationship with the nearby natural history museum (The Cleveland Museum of Natural History). A faculty member in art history has extensive experience in medical imagery, while the natural history museum is one of the few in the country to include a wing dedicated to human health. In short, we had a surfeit of faculty and facilities relevant to the proposed course.

CONCEPTUAL ORGANIZATION

One of our goals for this course was to clarify differences among individual disciplines while also deepening understanding of how multiple academic perspectives can apply to considerations of health, illness, and medicine. These subjects are inherently human issues that transcend disciplinary boundaries;

we organized the course to give students a broad understanding of the distinctions among disciplines, as well as the ways in which one discipline can complement another in the study of medicine and health.

We designed the class in three parts:

- The first section concentrated on large structural perspectives, drawn primarily from the social sciences.
- The second explored individual-level perspectives, and bridged the social sciences and humanities.
- The third emphasized humanities and included museum visits.

The course introduced bioethics as a discipline at the beginning of the semester, touched upon multiple ethical subjects throughout the term, and finally returned to the topic as a discipline near the end of the academic year (Fig. 1).

Each unit included one or two lectures on an individual discipline, and small-group discussions and analyses of relevant videos, case studies, or material culture (the physical aspect of culture as represented in objects such as those in museums). As noted early in this article, choices within interdisciplinary courses often require tradeoffs. Our guiding principle for the design of this course, then, was to assess choices in terms of how they would affect students' ability to compare and contrast disciplines as they applied to medicine and health. As a result we encouraged students to differentiate disciplines based on how they might use them to investigate a specific health-related topic. This approach helped students situate social science fields alongside humanities disciplines with a comparable level of analysis. For example, while health psychology (social science) and narrative medicine (humanities) are

epistemologically distinct disciplines, their inclusion alongside one another in the syllabus helped students to learn that both fields emphasize health and illness at

Figure 1. Survey Course Sections and Disciplines

Section 1: Large Structural Perspectives	Section 2: Individual-level Perspectives	Section 3: Humanities & Arts Perspectives
Medical Anthropology	Health Psychology	Medical History and Material Medical Culture
Medical Sociology	Psychological Anthropology	Religious Studies
Health Policy	Cognitive Neuroscience	Literature
Health Economics	Narrative Medicine and Illness Narratives	Philosophy
Science and Technology Studies	Medical Rhetoric	Art History and Art of Seeing
		Music and Medical Hearing

NOTE: Bioethics was introduced early and held as a theme throughout the course.

the level of the individual. Similarly, this structure encouraged students to compare disciplines that might focus on different levels of scope, even when they explored similar topics. For instance, clinical ethics involving end-of-life care focuses primarily on individual cases, while political science, sociology, and economics typically would consider the issue from a policy or societal-level view (for example, with regard to laws on physician-assisted suicide).

Although our approach appeared to resonate with students, it did not reflect the many complexities of how disciplines are categorized, or the scope of their analysis. For instance, we introduced bioethics in the first unit on structural-level approaches, even though ethics also can operate on an individual basis (clinical ethics) and at the structural level (policy). Similarly, the history of medicine often depicts movements in medical science and practice that are societal rather than individual in scope. Yet we placed this topic in a unit with other humanities approaches that more specifically emphasized individual accounts of illness and health, such as narrative medicine.

‘NUTS AND BOLTS’ ORGANIZATION

Undergraduate courses at our university typically meet three times per week for 50 minutes at every session or twice per week for 75 minutes each time. Although the former option would have provided an opportunity for a weekly discussion section, we determined that to delve into these various disciplinary areas thoroughly a longer class time would be preferred. Teaching assistants with interdisciplinary subject matter expertise were integral to the success of the course. With students enrolled from across the university—from engineering to “hard” sciences to humanities—the “touches” required for all students to achieve mastery of the material were substantial. For example, some students were surprised in an epistemological way. One said she had only ever taken classes where there were right and wrong answers. To engage materials where an answer could depend on context, argumentation, or political economy carried tremendous educational value, but also required significant cognitive and skill adjustments. Fortunately, having a teaching team allowed students enough space

to discuss challenges and explore ways to engage them constructively.

ASSIGNMENTS

Students had three types of assignments: (1) disciplinary worksheets, (2) section exams, and (3) a final interdisciplinary project (Fig. 2).

EVALUATION: AREAS OF SUCCESS

At the end of each third of the class, we asked students to submit identified or anonymous comments to help inform our choices about adjustments to the course in future years. Their responses confirmed the value of presenting students multiple approaches from which to engage a question or issue. The students not only expressed broad appreciation for the multi- and interdisciplinary nature of the course, but also cited specific benefits—for example, their ability to think critically about health and illness from several perspectives. Some described gaining a more holistic view of health and healthcare, while others noted new appreciation for the ways that values and beliefs can affect treatment, recovery and policy.

A number of students reported moving beyond having a “feeling” that more was at stake in medical treatment than science or technology. Specifically, they now said

Figure 2. Types and Descriptions of Course Assignments

	Assignment Type 1: Disciplinary Worksheets	Assignment Type 2: Section Exams	Assignment Type 3: Final Interdisciplinary Project
Number of assignments per term	10 due for grading	3 (1 per section)	1 (at end of course)

<p>Description</p>	<p>Worksheets had students provide analyses of each distinct discipline covered (Fig. 1). Epistemology, theory, methods, and data of a discipline were covered along with kinds of questions and hypotheses the discipline might best address. Students also explained how their specific interests might relate from a discipline's mode of inquiry, and were encouraged to make connections between and among disciplines as they related to human health.</p>	<p>Exams were comprehensive across each section and included true/false and multiple-choice questions, short-answer questions, and short-essay questions. This blend of approaches allowed the professor and teaching assistants to assess students' mastery of content as well as their ability to apply knowledge to specific situations. The exams also called upon students to include information from all aspects of the course—lectures, small-group discussions, readings and other activities.</p>	<p>Students chose topics that addressed a research question at the intersection of at least three disciplines, including at least one from the humanities and one from the social sciences. Students identified the strengths and weaknesses of the individual disciplines they selected to examine the problem. They explained why more than one discipline was needed to study the question, and how the disciplines could be integrated to enhance the understanding of the research question. This project gave students a meaningful opportunity to conduct research into an area of their interest that may not have been covered in class.</p>
<p>Percentage of Grade*</p>	<p>20</p>	<p>40</p>	<p>20</p>

*The remaining 20% of the grade was in-class participation.

they could articulate the multi-level components of a specific clinical case, disease category, or treatment setting. They said they expected that learning this type of analysis would improve their future clinical practice, research endeavors, or other professional experiences. Several students reported learning that people engage pluralistic medical systems, such as religious-based healing or traditional herbal therapies, even as they seek biomedical care. Another student majoring in biomedical engineering remarked that the course taught her that the medical humanities are not merely an account of how medical technologies have advanced in a historical sense, but rather a framework for interpreting patients' experiences in a meaningful way. In these examples and others, students discussed learning discrete field areas, and also how to compare and contrast them through a variety of disciplinary lenses. In addition, students also appreciated the opportunity to discover approaches that most interested them and to be able to pursue them more deeply in their final projects. Nearly half the students in the course met with the professor or teaching assistants to explore other courses in health humanities or social medicine that they could take in the future. For example, a student in biomedical engineering sought out guidance for future courses in medical history or art history—courses he said he would not have known about or sought without having first taken this survey course.

Several students remarked that the course would be instrumentally useful as they prepared for careers in diverse health professions, and specifically commented that the survey introduced them to multiple ways of thinking about the social and personal dimensions of health. In particular, they said what they learned in the course would help them when evaluating patients of diverse backgrounds in one-on-one clinical interactions. One student predicted that she would “be

a better doctor” because learning about illness narratives would help her understand and treat patients as more than just a set of symptoms. Similar responses included those from students who learned that patients also bring concepts of illness and healing to clinical interactions that may or may not align with biomedical assumptions. Other pre-clinical students reported that through medical sociology and anthropology, they now understand that people are inherently influenced by their culture and environment. Still others were eager to continue to engage bioethics and understood they would likely navigate value conflicts arising in everyday practice. In sum, this course introduced pre-medical students to ways to relate and respond to non-biomedical dimensions of clinical practice—among them the resolution of value differences, analysis of ethical questions, and the ways that patients’ concepts of health, illness, and well-being can be culturally and socially informed.

EVALUATION: AREAS FOR IMPROVEMENT

Students also provided useful critiques and suggestions. The most common recommendation was that we increase the amount and degree of guided integration of concepts across disciplines. In particular, they asked for more built-in class time for small-group discussions, since they had found those especially helpful in deepening their understanding of various concepts. During these small-group discussions, instructors would spend a few minutes with each team to help them work through the prompt and answer any questions; from there the students could consider the relationships between concepts and disciplinary approaches with the simultaneous feedback from one another. Students also suggested that instructors could hold a “debriefing” session following guest lectures to help connect ideas that students already had

encountered with the faculty expert’s new material. Finally, students asked for additional semi-structured group study sessions outside of class with teaching assistants. In this pilot, we offered two-hour long study sessions before unit exams as well as private, one-on-one office hours with the professor and teaching assistants. Students responded very positively to opportunities for less structured yet guided discussions in addition to class time.

EVALUATION: SUBSEQUENT CHANGES

Upon reflecting on student feedback and our own experiences as course instructors, we made adjustments to improve the course in subsequent semesters, while considering student and instructor feasibility. After determining that additional mandatory discussion sections outside of class were not feasible, we offered both more in-class options for small group integrative discussion as well as optional out-of-class group study session time with a teaching assistant. In addition, in the subsequent semester, we piloted the case method in the last week of classes. Using carefully-chosen cases with ethical, cultural, social, political, and historical key components turned out to be an effective means to have all students engage the multi- and interdisciplinary analyses we sought to teach. Students provided very positive feedback to these changes; we will continue this integrated approach.

Given our university’s broad faculty strengths in health humanities fields, and faculty desire for teaching in these areas, we are likely to have some variation in topics covered every semester based on availability and interest. In the beginning-of-the-year information sheet we ask students to fill out, we will include questions about their exposure to humanities and social sciences and their own academic and

professional interests. In the case that someone has a related interest we cannot cover formally in class, we can help that student scaffold their interests out of class to include in the final assignment. We have also considered adding a discussion of health-related careers that are not clinical, a topic of great interest to our diverse student body.

Conclusion

The pilot of our baccalaureate-level survey course, *Perspectives on Health: Introduction to Medical Humanities and Social Medicine*, was a success. We believe a number of factors aided this success, including: (1) knowing the local institutional resources in the medical and health humanities, (2) study of national peer offerings, and (3) a seasoned teaching team with significant interdisciplinary training and experience. The general organization of the course provided a strong and logical structure. The assignments—born of the professor’s prior 15 years of teaching interdisciplinary materials—seem to have been effective in assessing and promoting learning as well as appealing to different learning styles. Still, improvements can be made, such as further integration across topics and speakers.

A blended health humanities and social sciences curriculum for undergraduate students expands their understanding of health beyond illness and immediate treatment, encouraging them to consider the ways in which recovery and rehabilitation are shaped by social, historical, ethical, economic, and other factors. Students in our class were challenged to complicate their understanding of what it means to *heal*, in that what it takes to be “well” is defined by how a society defines the sick role and sets expectations around participation in that social world. These conversations

encourage students to think about health in a holistic way that aligns closely with occupational therapy and physical therapy—fields where health professionals must actively consider how the broader context in which a person acts and functions will determine what it means to be rehabilitated for that social world. Our class encouraged students to think about wellness beyond biological function, to include (as others have observed) wellness as characterized by civic engagement,²⁸ function within and with family units,²⁹ and across stages of the life course.³⁰ In this way, our students learned to critically think about health outside of a strictly medical-clinical setting, and instead consider a more inclusive and therapeutic perspective on wellness that is echoed in the health humanities.

In a climate of expanding programing in health humanities and related fields, we expect that consideration of courses like this one will become more common. Although this interdisciplinary area of medical and health humanities and social medicine is unlikely to have a singular body of canonical work, we believe in careful evaluation of curricular offerings, especially as they relate to major, minor, or certificate programs. Perhaps our strongest learning through our own program and curricular development is the importance of institutional context. Knowing one’s own institutional strengths and limitations is key in developing interdisciplinary offerings. From scholarly expertise to political boundaries, the local climate is important to understand for successful educational endeavors. For example, at CWRU—with its historical strengths in scholarship on health—we gauged a talented and interested faculty across schools with whom to collaborate. We housed the course in an interdisciplinary department within the medical school, a location supportive of such work and appealing to many different types of majors. In our case, we could also integrate museum visits at nearby institutions, and

are considering some collaborative course sessions with other area students at neighboring universities interested in medical humanities and social medicine.

Our context also included a demand on the campus and in the neighboring community for learning experiences such as this one. While the students drove the interest for our undergraduate minor in Bioethics and Medical Humanities, our faculty members also appreciate and celebrate interdisciplinary intellectual engagement and are willing and eager to participate with each other in multiple venues. It is our hope that this survey course can provide a stimulating environment for learning and discovery whether this is the only health humanities offering a student engages, or whether the student then pursues further education in this area.

Our initial round of feedback led us to believe that we are not overly ambitious in hoping to:

- Offer pre-clinical students a wider view on health, medicine, and healing;
- Foster interest in medical humanities and social sciences among students with limited prior exposure;
- Help students discern which fields of study are most needed for their areas of interest; and
- Aid more focused students by knowing where their discipline, clinical or not clinical, relates to others in the health humanities.

No survey class can cover everything, but our focus on exploring epistemological and methodological distinction, as well as evaluation of which types of health issues and concerns are best suited to various types of study, appears to have provided students the tools they need to continue to engage important

questions related to health in their next educational and professional steps.

[a] The authors are the teaching team for the course. The first author is a medical anthropologist and the professor who developed and taught the course. She is director of the Bioethics & Medical Humanities MA Degree Program, as well as the Medicine, Society and Culture (MSC) master's degree Concentration in the School of Medicine's Department of Bioethics, which also serves as the hub of university-wide initiatives in medical humanities and social medicine. She and the associate MSC director, medical historian Jonathan Sadowsky, have led the internal and external research on program building in this area for several years. The second author was the head teaching assistant for the course, a humanities-trained medical anthropology PhD candidate and instructor in bioethics. She is also the administrative coordinator for the MSC program. The third author was a teaching assistant for the course and is a master's-trained bioethicist with a medical humanities background.

[b] The University of Washington, Bioethics and Humanities program.

[c] Lehigh University's Health, Medicine and Society program.

References

1. Berry S, Lamb EG, Jones T. Health Humanities Baccalaureate Programs in the United States. Hiram, OH: Hiram College Center for Literature and Medicine; 2016. Available at: <http://www.hiram.edu/academics/centers-of-distinction/center-for-literature-medicine/baccalaureate-health-humanities-programs-in-the-u-s/>
2. Berry S, Lamb EG. Pre-health humanities. *J Med Hum.* 2017;38(4)(special issue);351-547.

3. Jones T, Lamb EG, Berry S, eds. Health humanities: the future of pre-health education is here. *J Med Hum.* 2017;38(4)(special issue);353-360.
4. Whitehead A, Wood A, eds. *The Edinburgh Companion to the Critical Medical Humanities.* Edinburgh, Scotland: Edinburgh University Press; 2016.
5. Chiapperino L, Boniolo G. Rethinking medical humanities. *J Med Hum.* 2014;35:377-387.
6. Cole T, Carlin N, Carson R. *Medical Humanities: An Introduction.* 1st Cambridge, UK: Cambridge University Press; 2015.
7. Greaves D, Evans M. Medical humanities. *BMJ Med Hum.* 2000;26(1):1-2.
8. Shapiro J, Coulehan J, Wear D, Montello M. Medical humanities and their discontents: definitions, critiques, and implications. *Acad Med.* 2009;84:192-198.
9. Crawford P, Brown B, Tischler V, Baker C. Health humanities: the future of medical humanities? *Mental Health Rev J.* 2010;15:4-10.
10. Crawford P, Brown B, Tischler V, Baker C, eds. *Health Humanities.* London, UK: Palgrave MacMillan; 2015. <https://www.palgrave.com/us/book/9781137282590>.
11. Jones T, Blackie M, Garden R, Wear D. The almost right word: the move from medical to health humanities. *Acad Med.* 2017;92:932-935.
12. Atkinson S, Evans B, Woods A, Kearns R. 'The medical' and 'health' in a critical medical humanities. *J Med Hum.* 2015;36(1):71-81.
13. Farmer P. *Infections and Inequalities: The Modern Plagues.* Berkeley, CA: University of California Press; 1999.
14. Henderson G, Estroff S, Churchill L, King NMP, Oberlander J, eds. *The Social Medicine Reader.* 2nd Durham, NC: Duke University Press; 2005.
15. Skelton J, Macleod J, Thomas C. Teaching literature and medicine to medical students, part II: why literature and medicine? *Lancet.* 2000;356:2001-2003.
16. Shapiro J, Morrison E, Boker J. Teaching empathy to first year medical students: evaluation of an elective literature and medicine course. *Edu Health.* 2004;17:73-84.
17. Wooden SR. Narrative medicine in the literature classroom: ethical pedagogy and Mark Haddon's *The Curious Incident of the Dog in the Night-time.* *Lit Med.* 2011;29:274-296.
18. Kleinman, A. The teaching of clinically applied medical anthropology on a psychiatric consultation-liaison service. In: Chrisman N, Marezki T, eds. *Clinically Applied Anthropology.* Netherlands: Springer; 1982:83-115.
19. Madsen W. Teaching history to nurses: will this make me a better nurse? *Nurse Edu Today.* 2008;28:524-529.
20. Shapiro J, Rucker L, Beck J. Training the clinical eye and mind: using the arts to develop medical students' observational and pattern recognition skills. *Med Edu.* 2006;40:263-268.
21. Shapiro J, Hunt L. All the world's a stage: the use of theatrical performance in medical education. *Med Edu.* 2003;37:922-927.
22. Zazulak J, Sanaee M, Frolic A, Knibb N, Tesluk E, et al. The art of medicine: arts-based training in observation and mindfulness for fostering the empathic response in medical residents. *BMJ Med Hum.* 2017;43(3):192-198.
23. Grant VJ. Making room for medical humanities. *Med Hum.* 2002;28:45-48.
24. Macnaughton J. The humanities in medical education: context, outcomes and structures. *Med Hum.* 2000;26:23-30.
25. Charon R. Narrative medicine: a model for empathy, reflection, profession, and trust. *JAMA.* 2001;286:1897-1902.
26. Bruer JT, Warren KS. Liberal arts and the premedical curriculum. *JAMA.* 1981;245:364-366.
27. Engel MF. Achieving 'narrative flow': pre-medical education as an essential chapter of a physician's story. *J Med Hum.* 2005;26:39.
28. Smith M, Nowacek R, Bernstein, J. *Citizenship Across the Curriculum.* 1st Bloomington, IN: Indiana University Press; 2010.
29. Duke MP. A voyage homeward: fiction and family stories—resilience and rehabilitation. *J Hum Rehabil.* 2015. Available at: <https://scholarblogs.emory.edu/journalofhumanitiesinrehabilitation/2015/07/08/a-voyage-homeward-fiction-and-family-storiesresilience-and-rehabilitation/>. Accessed Jan 9, 2018.
30. deBono MC. The rollercoaster ride: the lived experience of people acquiring a physical impairment in youth. *J Hum Rehabil.* 2017. Available at: <https://scholarblogs.emory.edu/journalofhumanitiesinrehabilitation/2017/10/17/the-rollercoaster-ride-the-lived-experience-of-people-acquiring-a-physical-impairment-in-youth/>. Accessed Jan 9, 2018.

About the Authors



Eileen P. Anderson-Fye, EdD, is director of the Master of Arts degree program in Bioethics and Medical Humanities in the School of Medicine at Case Western Reserve University. Also an associate professor of bioethics, she founded the Medicine Society and Culture track of the Bioethics MA to give students a broader understanding of the many non-biological factors that not only affect well-being itself, but also our disparate understandings of what conditions constitute health, illness and healing. This program, along with her research in medical and psychological anthropology, reflects a long-held belief in the power of interdisciplinary approaches to provide valuable insights about some of the world's most challenging questions. Her own research focuses on how adolescents and young adults adapt to changes in their environments in ways that both advance and harm their physical and mental health. An award-winning teacher and mentor, Anderson-Fye earned her bachelor's degree at Brown University and her master's and doctorate at Harvard University.



Julia Knopes, PhD (cand.), MA, in anthropology at Case Western Reserve University, and the program coordinator of Medicine, Society & Culture in the CWRU Department of Bioethics. She is also an Adjunct Instructor of Bioethics at Case Western Reserve University School of Medicine. Julia is the founder and current administrative chair of the CWRU Graduate Society of Medical Humanities, a graduate and professional student organization centered on scholarship in the medical humanities and medical social sciences. She holds an M.A. in Humanities from the University of Chicago and a B.A. in English from Washington and Jefferson College. Julia's ethnographic dissertation explores American medical students' experiences of knowing, not knowing, and knowing "enough." Her work draws widely from the medical humanities, social medicine, and Science and Technology Studies (STS.)



***Hillary Villarreal, MA**, was awarded a Master of Arts from Case Western Reserve University in Bioethics with a concentration in Medicine, Society and Culture. She received her Bachelor of Arts in Medical Humanities from Baylor University. She will begin working on her PhD in Health Care Ethics next Fall. She plans to pursue careers as both a clinical ethicist, providing ethics consultations to clinicians, and as a university professor, helping train future health care professionals in medical ethics. Her research interests include the intersections between medical ethics and narrative medicine. She believes the humanities are crucial to understanding the real-world context of making ethical decisions in the health care setting.*