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What Skills Should Be Taught in Health Humanities Education?

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Abstract
This essay argues that those working and teaching in the new field of Health Humanities should avoid definitions of their work that borrow from existing disciplines and focus instead on three fundamental skills. A case study is provided to differentiate health humanities questions from those typically asked by bioethicists. Three skills are given detailed examination: empathic listening, involving the capacity to expand our imagination to others; emotional equanimity, involving the ability to understand and learn from our emotional responses; and the de-centering skills of taming our moral vanity and recognizing the full humanity of others. These are not the only skills in play in health humanities, but these three are basic and will lead to the other skills needed.

Keywords: Health Humanities, education, skills, bioethics

Introduction

Teachers of health humanities span a wide range of disciplines. Some are nurses, physicians, social workers, or other health professionals. Lawyers, chaplains, clinical psychologists, health administrators, theologians, literary scholars and a wide range of other professionals are also involved. Instead of thinking that there is some common discipline or methodology that all such teachers should adhere to, I find it simpler and more practical to consider what teachers from all disciplines and fields should emphasize as common skills. These skills do not belong to any one field, but are important for all practitioners, no matter what their disciplinary background.

Referring to these capacities and abilities as skills is meant to suggest that one can learn them, practice them, and get better at them, and that education in health humanities should include practical opportunities to let students experience these skills at work, practice them for themselves under the supervision of a mentor, receive feedback and work toward mastery. Like tennis, cooking, carpentry, or the critical reading of texts, practice is essential in getting better. Health humanities education should provide ample opportunities for students to rehearse these skills and gauge their improvement over time.

In this essay I will discuss three skills. These three are not the only ones that are important to health humanities work. Still, these three should be on everyone's list of the basic, or essential skills. A case illustration will help us to see how these skills work.

> *Imagine that your involvement and advice is sought for a 55-year-old female patient who is refusing surgery. She was treated a few years earlier for her cancer that required a lower left*

leg amputation, but her cancer has returned. Her physician remains optimistic that with additional surgery and a course of chemotherapy she can add meaningful years to her life. Yet after a full explanation of the procedure, the patient refuses any further intervention.

Those familiar with the principles of bioethics will likely interpret this as a case of respect for patient autonomy vs. physician beneficence. The physician wants to intervene to help secure the best health outcome for this patient, but the patient doesn't want the treatment, and she refuses with full awareness that lack of treatment will lead to her death. This framing supposes that the central question is which principle—autonomy or beneficence—to follow. Such an analysis, however, is missing a central ingredient, viz., how the patient understands her situation. For the physician, the patient's refusal is a moral problem. Yet when we begin to listen to the patient, we understand that she does not have a problem. Her decision of no further intervention is grounded in the language of "sacrifice," "atonement," and "doing the Lord's work." A strongly religious person, she interprets her illness as an occasion for further witnessing to God's providential grace and love, and a surgical procedure and course of chemotherapy will interrupt that mission. So for this patient, there is no moral tension between alternatives, and hence no choice to be made. The arc of her life, and its moral responsibilities, are clear, and if her journey involves a premature death from treatment refusal, she has a way of understanding that outcome as part of her personal religious history.

Of importance here is that a person schooled in the skills of health humanities will not automatically adopt the bioethics frame of autonomy vs. beneficence, but will probe the situation with questions such as these:

- *For whom is there an ethical problem? Why for the physician but not the patient?*
- *Who gets to say what decision processes and outcomes are most important?*
- *What is gained and lost if this situation is framed exclusively as a conflict of principles?*
- *What is gained and lost if the situation is interpreted as part of the patient's life story?*
- *Do skills in addition to logical reasoning have a place, for example, storytelling, memory, imagination, ritual practices, or affective acuity?*

The skills of health humanities will lead to asking these sorts of questions, and to a broader framing of this situation than would be provided by bioethics alone. Health humanities recognizes that the moral life is more than just episodic decisions, but must include the overall arc of a life, into which particular medical decisions will fit or not fit. Health humanities also recognizes that there are many human capacities for moral discernment, not just logical reasoning, and that sound decisions can be reached by other ways than following the thread of an argument to its conclusion. Often, in reaching a sound decision, the fit into the patient's overall life narrative is the most important ingredient.

What skills will be helpful in seeing this patient and her situation in a wider and more accurate context? The three discussed below are not all one will need, but they constitute a good beginning, and mastering them will lead to other skills (Churchill 2020, 31-69).

Empathic Listening: Expanding Our Imagination

Psychiatrist Richard Sobel describes empathy as "the ability of an individual to discern, both cognitively and emotionally, what another person is thinking or feeling at a particular moment in time" (Sobel 2008, 471-78).

Empathy thus defined always involves some distance between people. It is not a merging of feeling, nor is it exclusively emotional. What many think of as empathy, feeling what another person feels, Sobel refers to as sympathy. In sympathy we may laugh or cry spontaneously when others do so, in a kind of mirroring response. Sympathy, in this sense, is affective echoing. Empathy, by contrast, is a term indicating a more sophisticated, imaginative movement in which identity of feeling is not the core phenomenon, but in which imaginative insight is the key. The exercise of empathy allows for understanding another's thoughts and feeling without necessarily feeling them oneself. Empathy is the correct sense of what it must be like to walk in your shoes, and to have the experiences you have. Sympathy is "I feel your pain" (when genuine and not a hackneyed effort to relate); empathy is "I can imagine what it must be like for you to have this pain." The object of empathy is an experience of another person—I do not have your experience, nor do I merge feelings with you—but your situation comes alive in my imagination and is respected and validated for what it is. Empathy for the 55-year-old patient described above will help us to see her choice as consistent within her larger life narrative.

Studies have repeatedly shown that we are most likely to have natural empathy for people most like ourselves in age, sex, race, occupation, religious affiliation, and especially socio-economic status. The most difficult reaches of empathy are for those who differ from us on these indices. For example, white, middle-aged, professional males are likely to have little or no natural empathy for young Black or Hispanic female workers who clean their offices. Why is this important? Because failures in empathy prohibit us from taking the moral perspectives of others into account. Rather, we are likely to dismiss them with labels and assumptions that imply that whatever moral perspectives they hold are likely inferior to our own. Lack of empathy cuts us off from serious listening. It treats others—those who look and act differently—as alien to us.

Empathy is not easy. It requires effort to try to imagine what another person is going through, and the lack of effort to understand is one of the more basic forms of disrespect. It says, "You are not worth knowing, not worth the effort to hear your views and see how they are rooted in your life experiences, just as mine are." It says, "I don't know how you size up your world morally, and it couldn't possibly matter to me. I can't imagine that you have anything to teach me." The repeated denial of empathy in one's life thus leads to an impoverished moral sensibility, one based on self-righteous pride and willful ignorance.

Here lies a point of significance. The non-empathic person is arrested from even the most elementary moves and insights of ethics. We do not stretch into imaginative recognition and emotional resonance with others just out of kindness, or because we are warm and sensitive people. We *must* do it if we are to learn---both about ourselves and about others. As social creatures we are interactive mirrors for one another in a vast range of ways, some self-conscious, some not. I need a range of social interactions with diverse people to even have an accurate sense of who I am morally. So a fundamental question is: "With whom do I (or can I) empathize?" Some failures in ethics are cognitive failures, lapses in the logical application of principles, but more often ethical failures are lapses of empathic imagination, that is, a problem of narrow sentiments, a stunted or underdeveloped range of moral imagination.

The primatologist Frans de Waal puts it this way: "Our brain has been designed to blur the line between self and other. It is an ancient neural circuitry that marks every mammal, from mouse to elephant." On our good days humans can be as kind-hearted as bonobos and on our bad days as systematically cruel as chimps; we are the most "bipolar ape" (de Waal 2013, 52.82).

Empathy can lead to a higher form of moral life, greater skill in ethical reflection, and an enlarged capacity for kindness. But lack of empathy leads eventually to brutality. Sobel also

makes much the same point and cites two modern authors, John Banville and Ian McEwan. "In John Banville's novel *The Book of Evidence*, the protagonist explains how he came to senselessly murder a young woman: 'This is the worst, the essential sin, I think, the one for which there will be no forgiveness: that I never imagined her vividly enough, that I did not make her live. Yes, that failure of imagination is my real crime, the one that makes the others possible. What I told the policeman is true—I killed her because for me she was not alive'." Ian McEwan's *Atonement* carries the same message: "it wasn't only wickedness and scheming that made people unhappy, it was confusion and misunderstanding; above all, it was the failure to grasp the simple truth that other people are as real as you" (Sobel, 74-78).

Emotional Equanimity: Learning from Our Feelings

Our emotional responses contain moral knowledge. Ethics requires us to notice what is happening in our hearts and our guts in various situations, especially those that make us uncomfortable. "Why does this issue—or this person—makes me uneasy or give me a flash of anger?" is an example of this kind of attention-giving. Of course, paying attention to our feelings does not mean giving them the final, authoritative voice in our judgments and choices, but rather puts us in a position to decide what sort of role they should have.

Most Western philosophical approaches have not considered feelings as a mode of ethical understanding. At best they are considered of no value and at worst a genuine hazard to ethics. In this model of ethics thoughts are trustworthy—because presumably they are subject to reason—whereas feelings just seem to well up in us, are involuntary and thus irrational. When feelings become strong, this orthodoxy warns us, they are likely to lead us astray. This point of view permeates the history of Western ethics. Its roots can be traced at least as far back as Plato. In *Phaedrus*, Plato describes his tripartite view of the soul (Plato 1963, 246b). The highest form of the soul is the rational part, situated in the head, behind the eyes; its position at the top of the body surveying the field symbolizes its importance in governing the lower parts: the spirited soul residing in the chest (the hearts and its emotions), and the appetitive soul, lying in the abdomen (with influence over eating and drinking), and in the groin area (the sexual appetites). In a healthy or well-ordered human life, Plato thought, the rational soul would exercise authority over the spirited and appetitive dimensions of a person. Leading an ethical life, according to this model, means following reason rather than giving the reins to emotions or appetites.

The Platonic discrediting of the emotions as sources of moral knowledge or authority has been a staple of most moral philosophy ever since, and a chief ingredient in the teachings of Christianity, in which the precepts of divine revelation replace the ethical teachings of reason. Even if the governing force has changed from reason to revelation, the natural human emotions remain untrustworthy and morally suspect. The so-called seven deadly sins of Catholicism—pride, envy, anger, sloth, greed, gluttony, and lust—are typically interpreted as the result of perverted submission to the emotions or appetites. The Pauline writings of early Christianity and the teachings of St. Augustine, to take two notable and influential examples, are filled with worries about human emotions leading to sinfulness. This suspicion of emotion has been transmuted into worries about the precariousness of any ethical judgments that are based upon what Kant called human "inclinations" (Kant 1865, 3-14).

There are, of course, counter-examples, for instance, in the writing of Nietzsche and the valorizations of human sentiments in the Scottish Enlightenment writings of David Hume and Adam Smith. Feminist thinkers have also provided forceful corrective to this dualism of a

trustworthy reason reigning in our untrustworthy emotions, but these voices express a minority position in ethical theory.

Skill in ethical deliberation depends upon attention to our emotional life, especially an awareness of the way emotions can instruct us. First, emotions are instructive because they provide clues to the assets and liabilities of one's moral prehistory. Growing up in the rural and segregated southern United States in the 1940s, 50s, and 60s, I had to learn not to be instinctively suspicious of people who were different. This was especially true for me regarding African Americans. It was high school before I had Black classmates. College experiences were another deep lesson in what I could learn from opening myself emotionally and intellectually to the life experiences of my Black acquaintances. Black colleagues and lasting friendships came still later. Emotional responses are not just "how we happen to feel" but indicative of moral norms--for good, but also often for ill.

Second, and on the positive side, emotions are instructive in the sense that feeling compassion for others, or even just affinity with others, bespeaks a depth of human interconnectivity that eludes reason and logical processes. It is one thing to respect a noble ideal, such as the fundamental equality of persons, but the impetus to action comes from a felt response in the presence of another person. Without those feelings of connection, many of the ethical ideals to which reason leads us would have no motive force or staying power. In Jesus's parable, the Good Samaritan did not act on a moral ideal but was "moved by compassion" for the beaten man in the road (Luke 10:33-35).

Buddhism teaches a helpful approach to human emotions. Rather than label emotions good or bad, Buddhism endorses a curiosity about them. The growing popularity of mindfulness adapts some of this Buddhist understanding. The idea is to become a witness to my feelings, rather than being captured by them and acting them out or trying to ignore them. Then I can decide if they are toxic impulses I wish to change, or whether alternatively they are positively instructive and reinforcing to my moral ideals.

In a 1997 article Leon Kass coined the phrase "the wisdom of repugnance," an early expression of what we now call "the yuck factor" (Kass 1997, 17-26).

Repugnance or disgust is not a moral argument, but it may well express a deep emotional wisdom. Such wisdom can be beyond our power to fully explain on rational grounds. For example, conceiving a child to create an organ donor for one's sick toddler may evoke a "yuck" response from some. For others, thinking of the suffering of pigs--how they are raised in confined and squalid conditions, pumped with antibiotics, and then killed for bacon and sausage--can call forth the revulsion of a "yuck" response. Kass's point is an important one. Deep feeling often carry a moral message of value beyond our powers to analyze fully. Still, examining critically what we find yucky may turn up misunderstandings or unrecognized biases. Yuck responses should above all make us curious and initiate an inquiry into why. Our response to the 55-year-old patient described above may be instinctively negative—as it is for many health care professionals toward patients who refuse their offer of help. One of the key skills of health humanities is reflective interrogation of our emotional responses, seeking to ferret out and rethink prejudices built into the emotional layers of our moral sensibilities.

De-Centering Skill: Taming Moral Vanity and Recognizing Others

Most of us not only have a good opinion of ourselves morally but also have a major investment in the belief that we are good people. We often fall prey to a distorted self-image. As David Brooks says, we "grade ourselves on a forgiving curve" (Brooks 2015). The need to think of oneself as genuinely good, sometimes despite lapses and appearances to the contrary, may in fact be an early moral teaching perpetuated in adult life. In the face of clear wrong-doing, many of us as children were told that the deed was "not worthy of us," or that we were acting "out of character," that we are "better than that," and so on. These are all variations on the effort to separate an essentially good self from the bad action and thus shield our core moral identity. Even in adult life we are usually hesitant to call someone evil, and we speak instead of the actions, attitudes, behaviors, or choices, rather than the person, as morally deficient. This hesitance is simply part of foregoing judgment about the deep inner moral core we want to protect in both ourselves and others. And this is certainly a useful strategy, but it can be taken too far. In its toxic form, this separation of action and attitudes from a protected core self is an exercise in vanity and a denial of responsibility.

Consider, for example, occasions in which we attribute questionable motives to others but not to ourselves for the same actions. One instance of this double standard is the findings regarding physicians' perceptions of the influence of accepting gifts from pharmaceutic firms. Surveys have consistently shown two things. The first is that physicians generally consider themselves immune to the influence of gifts that are small in value, such as pens, note pads, meals, or small favors for clinical staff. A typical response to the idea that a meal paid by a drug rep could influence prescribing behavior is, "I can't be bought for a pizza." The American Medical Association (AMA) advice for physicians on accepting pharmaceutical gifts suggest that those of small monetary worth are not ethically problematic (AMA Guidelines 2015). This guideline reinforces a general consumerist valuing of gifts based solely on price, as if the relational and bonding power of giving and receiving doesn't matter. Studies have shown, however, that no gift is too small to have an impact (Grande et al. 2009, 887-93). Equally important, the tone of the AMA's recommendation legitimates a common feeling among physicians that they are such high-minded people as to be above all that. Lois Shepherd presents a convincing argument that in fact the touted altruism of doctors may serve as a moral blind spot of exactly the sort I am addressing here (Shepherd 2015, 509-17). If both the public and doctors themselves assume that physicians operate out of altruism to an unusual extent, then self-serving actions are less likely to be interrogated. Moreover, they are more likely to be mis-categorized as altruistic, when in fact they are simply self-interested. The second finding from physician attitudes about pharmaceutical gifts indicates even more clearly the toxic effects of moral vanity. In a major survey many physicians said they were worried that their colleagues might well be inappropriately influenced by such gifts, but that they themselves were not (Halperin et al. 2004, 1477-83).

Overestimating the benevolent aspects of our motivational complex is, I believe, a general hazard, and perhaps a special hazard for those whose social role and professional self-definition routinely calls for altruism.

I do not argue that all high moral self-regard is necessarily bad, and certainly not that a solid moral self-respect is problematic. I do not argue that vanity must be rooted out, but rather that it must be tamed. And taming it requires a process of de-centering—dislodging ourselves sufficiently from our self-love so that we can distinguish the useful from the toxic forms. A certain good opinion of oneself is likely an enabling element to make it through the tough patches, and to recover after moral lapses, from which we all suffer. Yet as Simon Blackburn argues, an excess of

vanity makes us even more vulnerable than we already are to the commercial enticements that routinely prey upon our self-love (Blackburn 2104, 189).

This vulnerability to consumer blandishments might be reason enough to reconsider the extent of our self-affection. My focus here, however, is on the ways excessive vanity always involves self-deception. More precisely, I am concerned with the moral impact of that self-deception, in the same way that narcissism is antithetical to accurate moral self-awareness.

In Greek mythology, Narcissus is drawn by Nemesis to a pool, where he falls in love with his own reflected self-image. Taking this reflection for reality, Narcissus is thereby doomed to unwitting and unrequited self-love—and by implication a truncated capacity for engaging both self and others appropriately. Among other things narcissism places severe limits on empathy. Narcissus chased his fantasy lover relentlessly, and in the end, he drowned in pursuit of it. Thus does the vanity of narcissism come to a dead end—a full stop for any movement toward ethical awareness and maturity. Empathy, the skill of imaginatively entering another's thoughts and feelings, clearly depends on displacing oneself from this terminal version of vanity (Baron-Cohen 2011).

Taming our moral vanity means seeking communication with and care for concrete others who are not simply mirror images of oneself.

To recognize you, in the full sense of seeing and understanding, as a moral agent means that I understand that you, like me, are a center of consciousness, with a history, values, life priorities, wants, fears, aspirations, and goals, indeed with the entire panoply of human attributes that I find in myself. When I begin to see you as a moral agent, you are morally alive to me, complex rather than simple, and I discern that you are as alive to yourself as I am to myself. In this sense of being-alive-as-embodied-moral-selves, we are equals, individuals on the same plane of life.

When others disagree with us or fail to heed our advice, as with the 55-year-old patient described in the case above, our moral vanity may be especially strong. We may pride ourselves in thinking that we have used our best moral resources to arrive at our position; we may further believe we have arrived at the only sensible choice, viz., undergoing the life-extending surgery and chemotherapy. De-centering from this kind of moral certainty means, among other things, admitting we could be wrong, and that looking at the patient's choice from her perspective, rather than our own, will help us see why refusing treatment seems sensible to her. It should be obvious now how empathy and emotional self-awareness are skills that will also be in play as we include this patient in the full range of our ethical understanding.

Conclusion

The field of health humanities is a newcomer, not an old and established field like philosophy, medicine, or nursing. As such, health humanities is still able to create its fundamental orientation as a field of work and define those practices that make it distinctive. My hope is that it will not follow a strict disciplinary track or narrow its concerns into a specialized professional niche. Rather than embrace a specialized body of knowledge as its domain of work, health humanities should be known for its practice of a set of skills that highlights a humanistic orientation and encourages empathy, emotional awareness, and moral de-centering. In this sense one could be a health humanities doctor, or a health humanities social worker, or a health humanities literary

scholar, indicating a person marked both by possession of these humane and humanizing skills and a person committed to teaching these skills to others.

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